Reply

The authors thank the reader for providing the latest policy letter in connection with obtaining police clearance before performing autopsy on a suspected medico-legal death.

However, essentially there is no difference in the 'police clearance' forms provided with the policy letters of 06 July 87 and 13 Sept 90. The contents of the latest clearance form automatically mean that police are not suspecting any foul play, they need not hold inquest.

Hence, the authors feel that the police clearance form sent along with policy letter of DGMS 5(a) dtd. 13 Sep 90 does not need any amendment.

The form is provided herewith for the benefit of other readers as well.

Appendix 'A' to Army HQ

Letter No 111952/Pol/DGMS-5A

Dt. 13 Sep 90

POLICE CLEARANCE (VIDE CR PR CODE SEC 174)

1. The police authorities do not intend sending the dead body of _____ for postmortem and have decided not to hold

an inquest. The police have no further interest in this case.

2. There is no objection from the local police to carry on the enquiry/postmortem examination in the death case of No. _____ Rank _____ Name _____ and also further disposal of the dead body by the Military authorities, as may be considered necessary by them.

Station :

Date :

Signature _____

(To be signed by the SUO Police Station)

Name _____

(In block letters)

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Patient Safety : Can the Armed Forces show the way?

Dear Editor,

Medical error in the health care profession has been under intense media and public attention in the last decade in the United States (US) and other western countries. The risk of iatrogenic injuries to patients in acute hospitals has been estimated to vary from 4 to 17% [1]. Investigation of these iatrogenic injuries reveals that they are predominantly due to human error and hence potentially avoidable or preventable. As the 8th leading cause of death in the US with 98,000 preventable deaths per year ahead of motor vehicle accidents, breast cancer or AIDS [2], patient safety has become an important issue on the national agenda. There is now a consensus that a "systems human factors" [3] or as some dub it the "new look" approach is essential to achieve the successes of other complex high-risk industries such as aviation and nuclear power, in minimizing the impact of human error. It is but natural to wonder if these patient safety concerns are unique to one country or are they generic across the profession, because, humans by their very nature commit errors.

The Armed Forces Medical Services (AFMS) are the largest and amongst the best organised health care delivery systems in the country and presumably have one of the best safety records. A recent article however, indicates that health care in Armed Forces may not be immune from human error [4]. Do these medication errors represent just a small segment of health care where human error has been identified? Do we need to do more with regards to patient safety? Can the AFMS show the way to health care in the country in developing a safety culture in medicine? "One of the foundations of a true safety culture is that it is a reporting culture" [5].

Unfortunately, medicine has for long advocated perfection, with mistakes or errors being considered as personal failures. It has

been accepted that the present culture in medicine "name it, blame it, shame it" encourages clinicians to hide their mistakes and there is a need to change this culture. The new human factors approach, focuses on the human component within complex sociotechnical systems and considers that accidents or adverse events cannot be attributed to a single cause, or in most instances, even a single individual. Confidential, non-punitive, voluntary incident reporting, and comprehensive human factor investigation of adverse events are just few of the measures that are essential to understand human error and ensure higher standards of patient safety in health care. All this has to be endorsed by an organization keen to nurture a "safe culture" and a society that recognizes that "physicians too are human".

References

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4. Roy PK. To Err is human, negligence is sin. *MJAFI* 2001;57:326-8.
5. Eliff G. Organizational safety culture, *Proceedings of the 10th International Symposium on Aviation Psychology*. Department of Aviation, Columbus, OH, 1999;1-14.

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