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Death during surgery in Japan

Sir—In the 1994 guidelines of the Japanese Society of Legal Medicine, reportable unusual deaths include unexpected death during or shortly after any medical practice.

According to the Doctor's Act in Japan, doctors must report cases of unusual death to the police. The police or a prosecutor demands autopsy under the guidance of superintendents, who occupy their position generally only for 2–3 years after training for 2 months. In England, coroners, who hold their position for 5 years or more, request autopsy after inquiry with the police, relatives, and forensic pathologists. Medical accidents and other unusual deaths are also frequently autopsied in England (overall rate 24%), whereas, in Japan, medical accidents are rarely reported nor autopsied (roughly 4.3% overall autopsy rate).

In Tokyo and a few other districts, medical examiners decide to do an autopsy in around 25–35% of unusual deaths, but autopsies in other districts are mostly done to investigate possible crimes. Criminality is proved only if the cause is diagnosed exactly by autopsy done under proper judgment.

In Japan, unexpected deaths in hospitals have become increasingly suspected as caused by malpractice. Because of lack of a proper system for complaints from patients' relatives, they sometimes go to the police. Although most cases can ask only for civil liability, the police investigate the hospital in question, which makes doctors hesitate to report. Prosecutors use autopsy to judge criminality but do not disclose autopsy results to protect privacy of investigation. Thus, nearly 700 relatives sue doctors every year in Japan because of this insufficient information.

In 2001, the Japanese Surgical Society announced to the public and the Society of Legal Medicine that patients' death during or shortly after operations should not be counted as an unusual death reportable to the police, but should be reported to the

independent authority, if required. As in the UK, there should only be reasonable cause to suspect unusual death by relatives' judgment. Although deaths in medical accident may sometimes be inevitable or unrelated to the malpractice (eg, unavoidable complication, a patient's particular constitution, etc), doctors' explanations might not be accepted by patients' relatives. However, doctors' explanations of the need for autopsy to clarify the cause of death sometimes do not inform patients adequately to get satisfactory consent for autopsy. Therefore, independent investigation and autopsy are required to find out the cause of death and to disclose and improve medical practice.

The necessity of reporting unusual deaths to start these processes should be more properly understood by Japanese surgeons, and at the same time a proper independent authority responsible for medical accidents is required for doctors and patients.

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Development of modern liver surgery

Sir—H P Grewal, in his Feb 2 Commentary,¹ gives a comprehensive historical account of the development of modern liver surgery and liver transplantation. He repeats most of what has been written on the subject but some facts have never been told.

In 1969, Cortese, Richter, Mori, and I, with Minick as pathologist, at New York Hospital-Cornell Medical Center, did two partial liver transplants. In May of that year, in a woman aged 24 years who had terminal liver failure, we ran into unexpected difficulties after finding that, despite massive ascites, her abdominal cavity was not large enough to accommodate a second liver. Had we proceeded, the resulting tension would have severely interfered with her circulation and respiration. Therefore, I resected the donor liver's left lobe while the organ was being perfused in a steel pan, as outlined 15 years earlier.² The operation was successful.

3 months later, we felt sufficiently confident to again resect the left lobe of the donor liver, obtained from a boy aged 6 years and intended for an

infant aged 20 months with biliary atresia. The resection eliminated the discrepancy in liver size. When we did these pan-lobelectomies, no available text that we knew of described how to deal with this difficulty.

We submitted a report on our initial case to two surgery journals, but it was rejected. The reasons given were that the two unusual features were heterotopic placement of the graft and hepatic lobectomy to reduce liver mass. They claimed heterotopic placement of the graft had been studied extensively in the laboratory and reported clinically, and that no new information was provided. The resection of a liver lobe to provide space in the abdomen was deemed a trivial contribution of only technical interest. This rejection came at a time when the number of transplant cases outside Denver, CO, could almost be counted on the fingers of one hand.

When attempts at normal publication proved futile, we sent the report to the newly established American College of Surgeons/National Institutes of Health Organ Transplantation Registry.³ Although I have made brief references to it several times, to date no official report of it is on record. Consequently, Bismuth and Houssin⁴ are generally credited for having been the first to do this kind of procedure after they applied it in a boy aged 10 years with Byler's disease. In their report, they referred to a case by Fortner and colleagues,⁵ who published the idea.

It is interesting and gratifying to learn after all those years that our idea has ultimately progressed to the split or partial liver transplants that use liver lobes and segments from living donors. That, to me, seems certainly to be a very worthwhile extension of an idea once deemed uninteresting and trivial, and not sufficiently new to warrant publication.

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