Cutting It Close

by TOM McNICHOL

How a small-town DA's office raised disturbing questions about the harvesting of organs

THERE'S SURPRISINGLY little disagreement over what happened to Ruben Navarro on the last day of his life. The 25-year-old man was at death's door in Operating Room 3 at Sierra Vista Regional Medical Center in San Luis Obispo after suffering cardiac arrest and lapsing into a coma. Navarro had a rare, degenerative neurological disease known as adrenoleukodystrophy, or ALD, first diagnosed when he was nine; by his early 20s he was living in an assisted-care facility.

When he had the heart attack in late January 2006,

Tom McNichol is a contributing writer for California Lawyer.

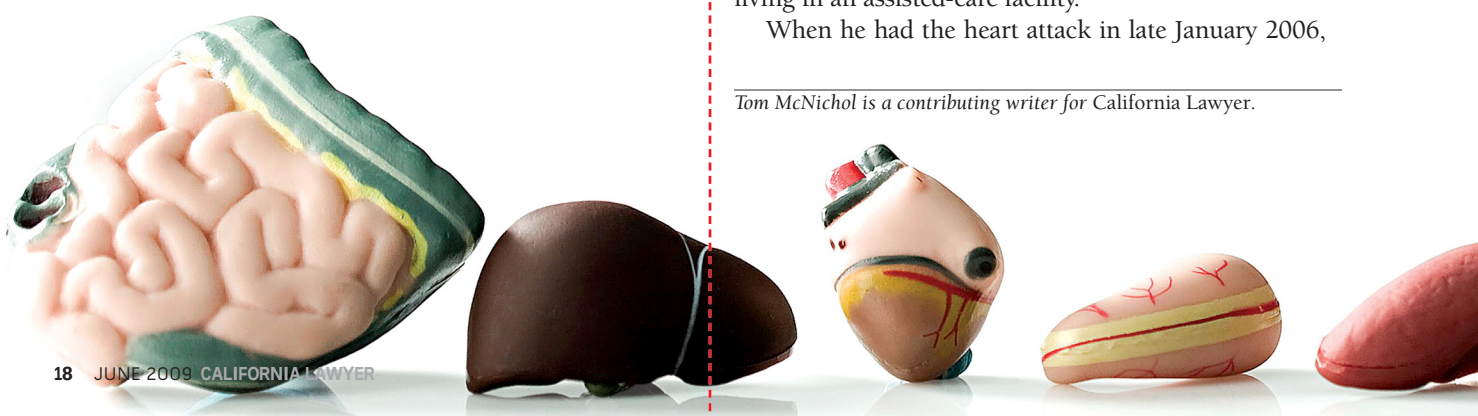

Photo Library

Navarro was rushed to Sierra Vista. His mother, Rosa Navarro, told that her son had suffered irreversible brain damage, agreed to donate Navarro's kidneys and liver after he was removed from life support.

The hospital dispatched a transplant team from the California Transplant Donor Network to remove Navarro's organs once he was pronounced dead. It would be a somber but life-affirming transaction: One person would die so that others might live.

But when doctors disconnected Navarro from the respirator, he did not die as expected. Instead, he lived for another eight hours, and the planned harvesting procedure was never performed.

These were the simple facts of the case. Left to be determined, however, was whether Dr. Hootan Roozrokh, the lead transplant surgeon, would go to prison for his actions that day.

After an 18-month investigation, triggered by a complaint from an anonymous source, the San Luis Obispo County District Attorney's office concluded there was strong evidence that Dr. Roozrokh tried to hasten Navarro's death by administering large doses of prescriptions drugs so that the transplant team could in a more timely fashion carry out its work. Consequently, in July 2007 the 33-year-old physician was charged with three felonies.

Thus, the stage was set for a first-of-its-kind trial that would send shock waves through the medical world. It also threatened to exacerbate an already serious shortage of life-saving organs: In 2007 alone, more than 7,000 Americans died while waiting for an organ transplant.

"With this case, potential donors had the image reinforced in their minds that all transplant doctors are standing at the bedside with a scythe in their hand waiting for the EKG line to go flat," laments Bryan Liang, a physician and law professor at California Western School of Law who specializes in health law and policy. "[The defendant is] being accused criminally of basically being a vampire."

Just eight months before Dr. Roozrokh's trial began last November, another case involving body parts made the news. In this instance, a New Jersey dentist pleaded guilty to running a $4.6 million criminal enterprise in which body parts obtained from corpses at funeral homes were illegally sold for use in transplants and medical research. Several funeral home operators participated in the body-parts ring, and in some cases they forged documents to cover their tracks. The case became even more notorious after it was learned that one of the plundered bodies belonged to Alistair Cooke, the British-born journalist best known as the host of public television's *Masterpiece Theater.*

In Dr. Roozrokh's case, of course, the alleged crime had nothing to do with violating the dead. But media accounts tended to group the Roozrokh case with more grisly organ-transplant abuses. And for some, the mere fact that that the doctor had a foreign-sounding name and was born in Iran gave the case a sinister edge. As one outrageous website headline declared: "Jihad in America Resumes: Muslim Doc Kills Patient for Organs."

IN A WAY, TRANSPLANT MEDICINE HAS BEEN THE victim of its own success. Procedures that would have been impossible a century ago, or dangerous even a generation back, have become almost routine. Once-doomed patients now fill waiting lists for organ transplants, and to a network of body-parts dealers, the human body—once viewed as inviolable—is now simply a commodity. Globally, the traffic in kidneys alone—the most commonly transplanted organ—is estimated at 15,000 annually.

The first kidney transplant was performed in 1950, on a 44-year-old woman with polycystic kidney disease. Other transplant firsts soon followed: pancreas (1966), liver (1967), heart (1967), and lung lobe (1983).

But it was the development of the immuno-suppressive drug Cyclosporin that turned organ transplantation from an experimental procedure into something far more common. In 1980 at the University of Pittsburgh Medical Center, Cyclosporin A proved successful in preventing patients' bodies from rejecting transplanted livers. The drug was approved for use three years later and has since helped save tens of thousands of lives.

Last year nearly 38,000 organ transplants were performed in the United States. However, the number of available organs has not kept up with the demand. More than 100,000 Americans are currently on an organ transplant waiting list, with more than 4,000 names added each month. Nearly 79,000 patients are waiting for a kidney, about 16,000 for a liver, and 2,800 for a heart. And as the population ages, the number of people who need organs replaced continues to grow. Meanwhile, the number of organ donors has remained steady since 2004.

The widening gap between organ supply and demand has in turn led to a thriving black market, especially in poor and developing countries. Brokers have reportedly charged as much as $200,000 to organize an organ transplant for wealthy patients, while impoverished donors may receive as little as $1,000 for one of their kidneys.

China in particular has been a major supplier of organs, many of them harvested from the bodies of executed criminals. In fact, before that country adopted lethal injection as a method of execution, it administered capital punishment with a single bullet to the head, in part to preserve the organs for subsequent sale. In 2005, after many years of denial, China acknowledged the practice and promised to take steps to prevent further nonconsensual organ harvesting. Human rights organizations insist, however, that the Chinese black market for organs still flourishes.

One particularly gruesome organ-harvesting scandal is now raging in India, where a physician has confessed to performing hundreds of illegal transplants for rich Americans,

Brits, Canadians, and Saudi Arabians. He obtained the organs by luring laborers into his clinic, where he offered them up to $2,000 to part with a kidney. More shocking: Some who refused his offer reportedly had kidneys removed anyway, after the doctor drugged them.

Apparently, the United States has managed to avoid such excesses. Here, the bulk of the litigation over body parts centers on the handling of cadavers. According to a 2006 estimate, during a 19-year period more than 16,800 families were represented in lawsuits claiming that the body parts of deceased loved ones had been stolen for profit. Meanwhile, debate continues over both the substance and enforcement of this nation's organ-harvesting protocols.

"You have different protocols for organ procurement across the country, and the system desperately needs to be repaired," observes Wesley J. Smith, a senior fellow in human rights and bioethics at the Discovery Institute who left his law practice in 1985 to pursue a career in writing and public advocacy. For example, he notes, the University of Pittsburgh Medical Center has a two-minute minimum waiting period after cardiac arrest before death can be declared and organs removed. Other hospitals observe a five-minute waiting period. And in Colorado, Smith adds, one infant was declared dead after only 75 seconds.

"There isn't uniform training for the people procuring the organs, either," says Smith. "There are guidelines, but they're not mandatory. People's faith in organ harvesting is a mile wide and an inch deep. And anytime you have an incident where you have a violation of standard protocol, it undermines the public's confidence."

In fact, some hospitals forbid members of the transplant team to be in the same room as the donor until the patient is pronounced dead. And many hospitals do not permit organ-harvesting physicians to provide end-of-life care to a would-be donor. But in Dr. Hootan Roozrokh's case, statements made by hospital staff and even by Roozrokh himself clearly indicate that no such rules were followed that day in San Luis Obispo.

The question for the jury in Roozrokh's case, though,

DONOR

The Law on Donating Organs

How does a person authorize an organ gift in California?
Organ gifts can be stipulated in an advance health care directive under Probate Code section 4701, or under the Uniform Anatomical Gift Act. The stipulation must be clear, and preferably in writing. Other popular methods include checking a box when either applying for or renewing a driver's license, and filling out an online form at www.donatelifecalifornia.org. The law also allows oral agreements for organ gifts to be made "during a terminal illness or injury of the donor, by any form of communication that clearly expresses the donor's wish, addressed to at least two adults, at least one of which is a disinterested witness." If the gift is made verbally, the witnesses then memorialize the communication in writing (Cal. Health & Saf. Code § 7150.20).

What if there is a conflict?
What if instructions in a person's advance health care directive conflict with a gift under the Uniform Anatomical Gift Act? For example, a person may have stipulated in an advance health care directive that specific procedures be taken to provide or withdraw life support in the event of irreversible injuries, and those instructions render organs unsuitable for transplantation. In such cases, the attending physicians are required to confer with the donor-patient, and if that is not possible, then with the person designated in the advance health care directive. The conflict is to be resolved as quickly as possible (Cal. Health & Saf. Code § 7151.10).

Before an actual organ harvesting can occur, how is death determined?
The Uniform Determination of Death Act declares that a person who has sustained either irreversible cessation of circulatory or respiratory functions, or irreversible cessation of all functions of the entire brain, including the brain stem, is dead. The determination of death must be made according to accepted medical standards (Cal. Health & Saf. Code § 7180). At present, 40 states—including California—have adopted the statute, along with the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

How many doctors must concur?
The law requires independent confirmation by at least two physicians, and it expressly stipulates that the doctors who make the determination shall not be the ones removing organs for direct transplantation—that work must be done by an independent medical team (Cal. Health & Saf. Code §§ 7181, 7182).

What are the hospital's responsibilities?
Every general acute-care hospital is required to develop a protocol for identifying potential organ and tissue donors. Among other things, the hospital must notify the next of kin or other person designated in an advance health care directive and inquire whether the deceased was an organ donor, or if the family is a donor family. If not, the family shall be informed of the option to donate organs or tissues. If the family (or designated person) agrees to a donation, the hospital must notify an organ-and-tissue procurement organization and cooperate in the procurement of the anatomical gift. If there is no procurement organization in the region, the hospital is required to contact such an organization outside the region as appropriate (Cal. Health & Saf. Code § 7184).

The protocol must encourage reasonable discretion and sensitivity to the patient's family in all discussions regarding organ and tissue donation. In addition, the protocol must take into account the deceased individual's religious beliefs.

In all cases, if a person stipulates in a health care directive that he or she does not wish to donate organs, those wishes must be honored.

Finally, it is illegal to sell organs that are harvested from a deceased individual. The crime is a felony punishable by a fine of up to $50,000 and up to five years in prison (Cal. Health & Saf. Code § 7150.75).

Is there any protection for doctors?
Doctors who may fear getting caught in the middle of an organ-donation controversy have a safe harbor. A doctor who complies with the statutes, or attempts to do so in good faith, is entitled to immunity from civil claims and criminal prosecution (Cal. Health & Saf. Code § 7150.80).

—Bo Links

was whether his actions in the operating room that day constituted a crime.

THE LAWYER REPRESENTING DR. ROOZROKH was M. Gerald Schwartzbach, a quiet, intense Bay Area attorney widely known for successfully defending actor Robert Blake four years ago against charges he murdered his wife.

Schwartzbach hardly fits the image of a fast-talking, table-pounding celebrity lawyer. In fact, his courtroom manner is studiously understated. At five feet six inches he's shorter than most of his clients, likes to wear bow ties, and sometimes talks so softly that judges ask him to speak up. Still, when it comes to defending those who are widely assumed to be guilty, there is no disputing his effectiveness. "A lot of people threw Dr. Roozrokh under the bus," Schwartzbach observes. "They just assumed the worst."

Prosecutors had charged Roozrokh with dependent adult abuse; administering harmful substances; and prescribing controlled substances without a legitimate medical purpose. However, superior court Judge Martin Tangeman dismissed the two latter charges. That left standing the abuse charge, which carried a maximum prison sentence of four years. Of course, if convicted the doctor would also lose his medical license.

The trial began at San Luis Obispo Superior Court on November 3, 2008. In her opening statement, prosecutor Karen Gray lined up empty vials of morphine and Ativan, an anti-anxiety drug, on a courtroom table to show the jury the drugs Roozrokh had given to Navarro—in doses she suggested were excessive. Several witnesses, she said, recalled Roozrokh referring to the medicine as "candy."

"The only purpose for that medication was to hasten his death, so he could do what he was there to do and harvest his organs," Gray told the jury.

The prosecutor also described a moment, after the supply of drugs in the operating room had been used up, when the doctor ordered more. "Ruben Navarro continued to breathe," Gray said, shaking her head. "His heart continued to pump."

But when it came time for Schwartzbach to make his opening remarks, he offered no apologies for his client. Instead, he insisted that Roozrokh's actions were both proper and necessary to spare the patient any undue pain or suffering.

"Nothing that Dr. Roozrokh did contributed to Ruben Navarro's death," Schwartzbach said in a soft voice. "Nothing that Dr. Roozrokh did harmed Ruben Navarro," he continued. And to underscore the point, he noted that a coroner had found Navarro died of "natural causes."

Schwartzbach did, however, fault the Sierra Vista hospital staff for failing to properly chart Navarro's medication and vital signs. And he noted that Roozrokh had completed his transplant training just seven months earlier; that the Sierra Vista staff had never before handled a donation after cardiac death (DCD) case; and that the hospital lacked protocols for such a procedure. Thus, if Roozrokh overstepped his authority in the operating room, Schwartzbach suggested, it was only because no one was properly attending to Navarro's end-of-life care.

As the trial continued, Schwartzbach began to chip away at the prosecution's case, uncovering small but significant inconsistencies in statements made by nurses who were in the operating room that day. One of those nurses was Diana Stevens, who testified—contrary to what other medical staff said—that Navarro had been given four separate doses of morphine and Ativan before he died.

"Your memory is not precisely accurate to all the events that occurred [in] your care of Ruben Navarro," Schwartzbach said to Stevens on the witness stand.

"Yes," she admitted.

Schwartzbach also noted that when Stevens had worked as a hospice care volunteer, she had witnessed dying cancer patients receive as much as 1,200 milligrams of morphine in an hour. According to witness testimony Navarro, by contrast, was given no more than 200 milligrams in slightly over an hour.

Prosecutor Gray in turn got a break when operating room nurse Jennifer Wiley testified that she was "ignored" when she raised questions about the drugs given to Navarro. "I was told it wasn't that big of a deal that they (the transplant team) remained in the room, that they weren't going to participate in anything," Wiley testified. "After that, I was ignored. I felt this was completely wrong. This person's alive. He deserved dignity, and he didn't get it."

The tide of battle seemed to shift again when Schwartzbach cross-examined one of the prosecution's expert witnesses, Clarence Foster, chief of transplantation at UC Irvine Medical Center. The lawyer played previously videotaped testimony in which Foster contradicted himself over the number of organ procurements he had participated in. (Foster claimed 50; the record showed 8.)

Then Schwartzbach brought to the stand his own medical experts. Dr. Ray d'Amours, a Southern California pain-management expert, declared that the dosages of morphine and Ativan that Navarro received weren't excessive at all, and that agreement on a "recommended" dosage was far from universal.

"Tiny old ladies sometimes need an enormous dosage," d'Amours testified. "The dosage requirements for people vary tremendously. What's important is to give the drug until it works. That's how you know what the right dose is."

"Somebody had to take the bull by the horns and say, 'We're going to provide comfort care,' " declared Dr. John Fung, director of the Cleveland Clinic's transplant center. "The point is, in the end, it's up to the team present to make sure the patient doesn't suffer."

On December 15, a month and a half after the trial of Dr. Hootan Roozrokh began, the case went to the jury. Schwartzbach stayed at the courthouse while the jurors mulled over

the evidence. It was a wait he'd experienced many times before, but this time much more was at stake than the fate of a single client.

DESPITE THE MEDIA ATTENTION GIVEN TO organ-harvesting cases, the public remains woefully uninformed when it comes to the nuances of transplant protocol. "We haven't done a good job of engaging the public and saying, 'This is how the organ-donation system works,' " acknowledges California Western's Dr. Liang. "The basic problem is that, as a culture, we fear death. And second, the idea of using someone else's organs does harken to the Dr. Frankenstein image. You'll never get away from that, unfortunately."

Even many patients on organ waiting lists would be hard-pressed to explain the rules governing procedures for donation after cardiac death, in which the donor is declared dead on the basis of cardiopulmonary criteria (when circulation and respiration irreversibly cease) rather than neurological criteria (irreversible loss of all brain function). Though just a small percentage of organ harvests use this protocol, DCD has become more commonplace in recent years, largely in response to the chronic shortage of organs for transplantation. The procedure—which would have been used with Navarro—expands the pool of potential donors beyond those who have been judged brain dead. In 2002, organs were recovered from 189 donors in DCD procedures in the United States; four years later the number of DCD cases had more than tripled to 645.

> *"The basic problem is that, as a culture, we fear death. And the idea of using someone else's organs does harken to the Dr. Frankenstein image."*
>
> —DR. BRYAN LIANG, CALIFORNIA WESTERN SCHOOL OF LAW

Although there's no mandatory national protocol for DCD, many hospitals follow what's become known as the Pittsburgh Protocol, named after the University of Pittsburgh Medical Center, which helped codify the procedure. It stipulates that a terminally ill patient (or a surrogate, if the patient has lost decision-making capacity) who requests withdrawal of life-sustaining treatment may serve as an organ donor. These patients are weaned from life support in an operating room, attended by primary-care physicians who are unaffiliated with the transplant team. Death is declared two minutes after the heart stops beating. If the heart does not stop beating within about an hour, though, the organs usually deteriorate to the point where they are no longer considered suitable for donation.

At the time of Ruben Navarro's death, Sierra Vista Regional Medical Center had no such rules in place. But the transplant team's direct participation in his care clearly ran counter to the widely accepted protocol. In fact, in February 2007 the United Network for Organ Sharing, an advisory group that oversees organ allocation, reprimanded the California Transplant Donor Network for violating the protocol in the Navarro case.

TWO AND A HALF DAYS AFTER DELIBERATIONS began, the jury filed back into the courtroom and announced that it had found Hootan Roozrokh not guilty. The courtroom burst into applause. Schwartzbach and Roozrokh threw their arms around each other while Navarro's mother, Rosa, sat silently, her eyes brimming with tears. Then, in an unusual move, Judge Tangeman read aloud a statement that the jurors had prepared.

"We the jury … would like to thank the family of Ruben Navarro, and especially Ruben, for bringing to light the issues brought forth in this matter," the statement read. "Refining the nationwide protocol of organ procurements will be an important part of Ruben's legacy, and for that we pay him our respect and owe him our thanks."

Apparently, the medical community had already gotten the message. In fact, even before the verdict, organ-donor organizations such as the United Network for Organ Sharing adopted new bylaws calling for, among other things, a clear separation of responsibilities between transplant professionals and those providing end-of-life care.

However, the legal battles are far from over. Roozrokh still faces a civil suit for wrongful death and malpractice, filed in June 2007 by Rosa Navarro, who earlier settled a separate suit against the hospital. (The Medical Board of California also has a pending administrative complaint against Roozrokh for unprofessional conduct.)

And about three months after Roozrokh's acquittal in the criminal trial, a similar case surfaced in Pennsylvania. The parents of an 18-year-old who suffered brain injury while snowboarding sued doctors at an Erie hospital, charging that the physicians had intentionally hastened their son's death by removing his breathing tube so that they could harvest his organs.

Meanwhile, for more than 100,000 patients across the country, the wait for life-saving organs goes on. "Our population is graying, and that means we're going to need more organs," says Liang. "We really need to focus on making a much broader and effective effort to educate people about these issues. Unless we do something about it now, the problem is going to get a lot worse." CL

"Cutting it Close" originally appeared in the June 2009 issue of ***California Lawyer.***