CARROLL, KELLY, TROTTER, FRANZEN, McKENNA & PEABODY
RICHARD D. CARROLL (SBN 116913)
DAVID P. PRUETT (SBN 155849)
111 West Ocean Boulevard, 14th Floor
Post Office Box 22636
Long Beach, California 90801-5636
Telephone No. (562) 432-5855 / Facsimile No. (562) 432-8785

Attorneys for Respondent, CHILDREN'S HOSPITAL LOS ANGELES

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ISRAEL STINSON, a minor, by Jonee Fonseca his mother,

Petitioner,

vs.

CHILDREN'S HOSPITAL LOS ANGELES

Respondent.

CASE NO.: BS164387

EX PARTE APPLICATION TO DISSOLVE TEMPORARY RESTRAINING ORDER; DECLARATIONS OF DAVID P. PRUETT, BARRY MARKOVITZ, M.D., AND CHERYL LEW, M.D.

DATE: August 25, 2016
TIME: 8:30 a.m.
DEPT: 86

ASSIGNED FOR ALL PURPOSES TO:
JUDGE AMY D. HOGUE
DEPARTMENT 86

TO THE COURT AND JONEE FONSECA, MOTHER OF ISRAEL STINSON AND COURT-APPOINTED "GUARDIAN AD LITEM":

PLEASE TAKE NOTICE that on August 25, 2016, at 8:30 a.m., in Department 86 of the Los Angeles Superior Court, located at 111 North Hill Street, Los Angeles, California, respondent Children's Hospital Los Angeles will be heard on its ex parte application to for an order to dissolve the temporary restraining order entered by the Court on August 18, 2016 and to permit Children's Hospital Los Angeles to take actions, including withdrawal of mechanical support of the physical body of Israel Stinson, based upon the fact that Israel Stinson has been

medically and legally determined to be dead. Alternatively, Children's Hospital Los Angeles will seek an order expediting the proceedings, to hear the issue of whether the Court should enter a preliminary injunction, to be heard by the Court on August 29, 2016, or as soon thereafter as the matter can be heard.

DATED: August 25, 2016

CARROLL, KELLY, TROTTER, FRANZEN, McKENNA & PEABODY

By: _____
RICHARD D. CARROLL
DAVID P. PRUETT
Attorneys for Respondent,
CHILDREN'S HOSPITAL LOS ANGELES

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Children's Hospital Los Angeles seeks ex parte relief from the Temporary Restraining Order (TRO) of August 18, 2016, by which the Court was led to believe that Israel Stinson (DOB 10/5/13) "suffered severe brain damage as a result of an asthma attack and has been comatose ever since" and that "[a]lthough his condition was stable while hospitalized in Guatemala, it has deteriorated since his transfer to the Hospital in July." (TRO, Exhibit 1, p. 1.) In the petition filed by Israel's mother-guardian Jonee Fonseca, it was asserted that "Children's informed me that it intended to remove Israel's ventilator, which will almost certainly result in my son's death." (Petition, Exhibit 2, 4:3-4.) The Court ordered "the Hospital to (1) refrain from removing Israel from the ventilator, (2) take reasonable measures necessary to maintain Israel in a stable condition pending a hearing before this court, and (3) cooperate with Fonseca to facilitate an independent evaluation of Israel by Dr. Shewman."

Children's Hospital Los Angeles (sometimes "CHLA") seeks relief because the "Verified Ex Parte Petition for Temporary Restraining Order" failed to disclose material information that was well-known to the petitioner.

First, the petition failed to disclose that Israel was determined to be dead prior to his transfer to Children's Hospital Los Angeles. Three independent medical-legal examinations were conducted in April 2016; all resulting in determinations that Israel experienced brain death. The first determination was made by a physician at the University of California Davis Medical Center. A second scheduled examination for brain death did not proceed at UC Davis to accommodate the parents' request that Israel be transferred to Kaiser Foundation Hospital, Roseville, specifically to have further assessment for brain death done there – where two further examinations were actually done. Failing to put things in context, the petition asserted that Israel was transferred to Kaiser "for treatment" and that "Dr. Michael Myette, a pediatric intensivist at Kaiser, did not treat Israel, but instead performed a brain death exam." (Exh. 2, 2:1-8.) After those three determinations of brain death, Dr. Myette prepared and filed a Certificate of Death. (Exhibit 3.) Had Children's Hospital Los Angeles been aware of the foregoing facts at the time,

it would not have accepted the transfer of Israel.

Second, the petition failed to disclose prior court orders, by the Placer County Superior Court and the United States District Court for the Eastern District of California, recognizing the validity of the determinations of brain death. On April 29, 2016, the Placer County Superior Court filed its "ORDER OF DISMISSAL" of that action by Israel's parents against UC Davis and Kaiser, dissolving a temporary restraining order, and stating: "The court finds that Health and Safety Code sections 7180 and 7181 have been complied with." (Exhibit 4.) Section 7180 provides for determination of death based upon "irreversible cessation of all functions of the entire brain, including the brain stem," based upon accepted medical standards, with section 7181 providing for "independent confirmation by another physician." There was no appeal.

Then, on May 13, 2016, the District Court dismissed the parents' federal action against Kaiser and Dr. Myette. (Exhibit 5.) The District Court observed that after Israel's first admission to a local hospital for an asthma attack, then his loss of consciousness, intubation and transfer to U.C. Davis, followed by a brain death examination and apnea tests," removal of ventilator allowing carbon dioxide levels within a patient to rise to assess whether a respiratory response would be provoked by the brain, Israel was transferred to Kaiser, where "two doctors performed tests independently to determine whether Israel's brain was still functioning," and "[e]ach doctor determined Israel had suffered brain death," in accordance with sections 7180 and 7181, referred to as California's Uniform Death Determination Act, or "CUDDA." (Exhibit 5, 20:19-21:1.) The District Court rejected the parents' substantive and procedural due process challenges to CUDDA, the statutory definition of death stated in section 7180, and adopted by all 50 states, stating: "Brain death itself is a widely recognized and accepted phenomenon, including in children and infants"; and recognizing the provisions for judicial review, as occurred in Placer County Superior Court, satisfied procedural due process. (Exhibit 5, 24:17-25:12, 28:3-24.) The parents voluntarily dismissed their appeal to the Ninth Circuit. (Exhibit 6, Order of May 26, 2016.)

Finally, the petition failed to disclose that the physician who the parents would have examine Israel simply disagrees with the CUDDA standard for brain death. The District Court

observed that D. Alan Shewmon has published "advocating for a definition of death that looks to more than the brain," and concluding that such concerns raising "a professional doubt surrounding brain death as death, legally or medically, represents a minority position" and that such doubt is insufficient to deem CUDDA substantively unconstitutional. (Exhibit 6, 25:13-28.)

II. CHLA SHOULD HAVE BEEN GIVEN NOTICE OF THE PETITION FOR TRO

Considering Israel's parents have been at Children's Hospital Los Angeles virtually night and day since August 7, 2016, notice of the petition should have been given.

Although Children's Hospital Los Angeles was not informed of the foregoing circumstances prior to the transfer of Israel to it, CHLA had become relatively well-informed of the events leading to and surrounding the determination of death and litigation that ensued in Northern California by the date of the hearing on the petition, August 18, 2016.

Children's Hospital Los Angeles was deprived of the opportunity to inform the Court of the foregoing circumstances because Ms. Fonseca did not give notice prior to seeking the temporary restraining order.

Code of Civil Procedure section 527(c) provides: "No temporary restraining order shall be granted without notice to the opposing party, unless both ... (1) It appears from facts shown by affidavit or by the verified complaint that great or irreparable injury will result to the applicant before the matter can be heard on notice" and (2) the applicant certifies "under oath" one of the following: (A) "within a reasonable time prior ... the applicant informed the opposing party ... at what time and where the application would be made; (B) "the applicant in good faith attempted but was unable to inform the opposing party ... specifying the efforts made"; or (C) "That for reasons specified the applicant should not be required to so inform the opposing party or the opposing party's attorney."

Ms. Fonseca failed to give any notice to Children's Hospital Los Angeles and failed to provide any explanation for not doing so.

The version of the facts that was presented by the petition was not accurate or complete. The lack of notice prevented CHLA from informing the Court of the actual background.

III. PETITIONER ALREADY CHALLENGED THE DETERMINATION OF DEATH AND SHOULD NOT BE PERMITTED TO CHALLENGE REPETITIVELY

In its Order, the District Court recognized that although there is no private right of action, based upon Health & Safety Code section 1254.4(e), but a state court may hear evidence and review a physician's determination that brain death has occurred. (Exhibit 5, 27:25-28:2.) The District Court cited *Dority v. Superior Court* (1983) 145 Cal.App.3d 273, for the Court of Appeal's approval of a procedure as "proper and appropriate," whereby "'[t]he [trial] court, after hearing the medical evidence and taking into consideration the rights of all the parties involved, found [the patient] was dead in accordance with the California statutes and ordered withdrawal of the life-support device." (*Id.* at 1280.) *Dority* more generally instructed: "The jurisdiction of the court can be invoked upon a sufficient showing that it is reasonably probable that a mistake has been made in the diagnosis of brain death or where the diagnosis was not made in accord with accepted medical standards." (*Ibid.*)

As the District Court stated: "The law requires an independent confirmation of death in the case of suspected brain death; here at least three doctors have independently determined Israel is brain dead." (Exhibit 5, 28:6-8.)

The District Court further observed that "reasonable accommodations" had been provided to Israel's parents, in accordance with Health & Safety Code section 1254.4(a) and (b), providing for a hospital to provide "with a reasonably brief period of accommodation" "to gather family or next of kin at the patient's bedside." (Exhibit 5, 27:7-28:14.) "During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required." (Health & Saf. Code, § 1254.4(a).) The District Court decided Israel's family had "been provided more than a brief period of time to gather, and the state court considered and addressed Ms. Fonseca's moral and religious concerns during the time its TRO was in effect." (Exhibit 5, 28:11-14.) "Ms. Fonseca sought and received immediate protection from the Placer County Superior Court, which entered a TRO and allowed her to present evidence and seek relief over the course of two weeks." (Exhibit 5, 28:17-19). Moreover, the District Court observed that Ms. Fonseca could have

appealed the Placer County Superior Court's order, but decided not to, for their own subjective reasons. (Exhibit 5, 28:19-24.) Since then, Ms. Fonseca filed an appeal with the Ninth Circuit, but then voluntarily dismissed it. (Exhibit 6.)

As the District Court observed, full procedural due process was afforded to Israel's family and they are not entitled to further accommodations.

No more examinations would be appropriate. The CUDDA finding was upheld by Placer County Superior Court. (Exhibit 4.) No collateral attack on death determination should be allowed.

IV. THE COURT SHOULD TAKE JUDICIAL NOTICE OF DEATH CERTIFICATE AND THE EVIDENCE PRESENTED TO THE DISTRICT COURT

With this application, Children's Hospital Los Angeles has provided a copy of the Certificate of Death, filed with the Placer County Clerk-Recorder. (Exhibit 3.)

In the District Court, Kaiser presented evidence regarding the determination of death that formed the basis for the Certificate of Death. (Exhibit 7, Opposition to Motion for Preliminary Injunction.) That evidence included: the declaration of Michael S. Myette, M.D., "the Medical Director for the Pediatric ICU at Kaiser Permanente in Roseville," describing the basis for his determination of brain death (Exhibit 8); the transcript of Dr. Myette's testimony in the Placer County Superior Court, regarding the determination of brain death (Exhibit 9); and his completion of Certificate of Death (Exhibit 10).

V. DR. SHEWMON CANNOT GIVEN CONTROL OF CHLA ADMISSIONS

A. CHLA Will Cooperate with Transport to Dr. Shewmon for Examination

Children's Hospital Los Angeles will cooperate with Israel's parents for their transport of Israel to a medical facility that D. Alan Shewmon, M.D. has available for his examinations of patients.

B. CHLA's Authority to Grant or Deny Staff Privileges

Dr. Shewmon is not on the physician staff at Children's Hospital Los Angeles. CHLA is not required to grant him any staff privileges. CHLA is not required to accept a determination by Dr. Shewmon on the issue of whether CHLA should provide medical services.

As the District Court observed, Dr. Shewmon has published "advocating for a definition of death that looks to more than the brain," and concluding that such concerns raising "a professional doubt surrounding brain death as death, legally or medically, represents a minority position" and that such doubt is insufficient to deem CUDDA substantively unconstitutional. (Exhibit 6, 25:13-28.)

Children's Hospital Los Angeles cannot be forced to grant staff privileges to Dr. Shewmon for the purpose of allowing him to assert a determination inconsistent with accepted medical standards.

In *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, the Court of Appeal held that a hospital can be held liable to a patient for negligently screening the competency of its medical staff to insure the adequacy of medical care rendered to patients. (*Id.* at 340-341.)

In *Bell v. Sharp Cabrillo Hospital* (1989) 212 Cal.App.3d 1034, plaintiff alleged wrongful death as the result of the hospital's negligent renewal of the staff privileges of a surgeon. (Id. at 1037.) The Court explained, "[b]ecause a hospital's effectiveness in selecting and periodically reviewing the competency of its medical staff is a necessary predicate to delivering quality health care, its inadequate fulfillment of that responsibility constitutes 'professional negligence.'" (*Id.* at 1051.) A hospital's selection and review of the competency of staff physicians is a "responsibility" that is "inextricably interwoven" with delivering competent quality medical care. (*Id.* at 1048-1052.)

A hospital is not required to grant privileges to physicians who would be disruptive of the hospital's mission. As explained in *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, deciding that a hospital bylaw provision assessing physicians' "ability to 'work with others," or "the ability to cooperate in the performance of hospital functions," is an appropriate subject for peer review to determine any "demonstrable nexus between the applicant's ability to 'work with' others and the effect of that ability on the quality of patient care provided." (*Id.* at 628-629.)

Miller refused to allow hospitals to impose a standard of conduct on physicians that imposes a blanket prohibition against all "disruptive or noncooperative conduct." (Ibid.) Miller observed that "a certain amount of dispute and friction" is to be expected among the physicians

working at a hospital, and accepted. (Id. at 629-630.)

C. CHLA Is Not Required to Support of Facilitate Dr. Shewmon's Views

Consistent with the First Amendment, the Hospital was not obligated to agree with Dr. Shewmon. In *Wooley v. Maynard* (1977) 430 U.S. 705, the Court decided that citizens of New Hampshire could not be required to display license plates on their vehicles stating: "Live free or die." (*Id.* at 714-715.) The Court explained: "the right of freedom of thought protected by the First Amendment against state action includes both the right to speak freely and the right to refrain from speaking at all." (*Id.* at 714.) In reaching its conclusion that citizens could not be required to display the state motto, the Court cited its precedent holding that public school students could not be compelled "to participate in daily public ceremonies by honoring the flag both with words and traditional salute gestures." (*Id.* at 714-715; citing *Board of Education v. Barnette* (1943) 319 U.S. 624, 636.)

Similarly, in *Hurley v. Irish-American Gay, Lesbian and Bisexual Group of Boston, Inc.* (1995) 515 U.S. 557, the Court implored: "'Since *all* speech inherently involves choices of what to say and what to leave unsaid' ..., one important manifestation of the principle of free speech is that one who chooses to speak may also decide 'what not to say.'" (*Id.* at 573; quoting *Pacific Gas & Electric Co. v. Public Utilities Commission of Cal.* (1986) 475 U.S. 1, 11, 16 (emphasis in original).) The right to avoid saying something is "enjoyed by business corporations generally and by ordinary people engaged in unsophisticated expression as well as by professional publishers." (*Id.* at 574.)

These principles mean that CHLA cannot be forced to support views of Dr. Shewmon.

As the District Court observed, Dr. Shewmon disagrees with the CUDDA definition of brain death. The CUDDA definition, however, is based upon accepted medical standards. (Health & Safety Code sections 7180, 7181.) CHLA cannot properly be compelled to facilitate an examination by Dr. Shewmon that is expected to defy accepted medical standards.

VI. THE DECLARATIONS OF DRS. MARKOVITZ AND LEW SUPPORT THE RIGHT OF CHLA TO WITHDRAW MEDICAL MEASURES

With this ex parte application, Children's Hospital Los Angeles has submitted the

declarations of Barry Markovitz, M.D. and Cheryl Lew, M.D.

Dr. Markovitz declaration includes

They explain the reasons for their opinions that, based upon their education, training, and experience, and based upon the legal status of death established as of April 14, 2016, there is not a medical or ethical justification to continue to impose artificial measures that force the physical body of Israel Stinson as a deceased person to function despite the absence of brain or brain stem vitality. The provision of medical services to the physical body of Israel Stinson is an act of futility and does not advance any accepted medical interests. The ongoing provision of such services is inconsistent with the standard of care, and the ethical and professional standards, applicable to reasonable and competent physicians and hospitals in the community who encounter patients who experience brain death.

VII. CONCLUSION

For the foregoing reasons, the temporary restraining order of August 18, 2016 should be dissolved.

DATED: August 25, 2016

CARROLL, KELLY, TROTTER, FRANZEN, McKENNA & PEABODY

By: _____

RICHARD D. CARROLL
DAVID P. PRUETT
Attorneys for Respondent,
CHILDREN'S HOSPITAL LOS ANGELES

DECLARATION

CARROLL, KELLY, TROTTER, FRANZEN, McKENNA & PEABODY
RICHARD D. CARROLL (SBN 116913)
DAVID P. PRUETT (SBN 155849)
111 West Ocean Boulevard, 14th Floor
Post Office Box 22636
Long Beach, California 90801-5636
Telephone No. (562) 432-5855 / Facsimile No. (562) 432-8785

Attorneys for Respondent, CHILDREN'S HOSPITAL LOS ANGELES

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ISRAEL STINSON, a minor, by Jonee Fonseca his mother, Petitioner, vs. CHILDREN'S HOSPITAL LOS ANGELES Respondent.	CASE NO.: BS164387 **DECLARATION OF BARRY P. MARKOVITZ, M.D., M.P.H. IN SUPPORT OF EX PARTE APPLICATION TO DISSOLVE TEMPORARY RESTRAINING ORDER** **DATE: AUGUST 25, 2016** **TIME: 8:30 A.M.** **DEPT: 86** ASSIGNED FOR ALL PURPOSES TO: JUDGE AMY D. HOGUE DEPARTMENT 86

DECLARATION OF BARRY P. MARKOVITZ, M.D., M.P.H.

1. I an adult and a medical doctor licensed to practice medicine in the State of California. I am making this declaration in support of the ex parte application of Children's Hospital Los Angeles seeking to dissolve the temporary restraining order of August 18, 2016.

2. Since 2006, I have been a physician on staff at Children's Hospital Los Angeles, and have had responsibility as Division Head of Critical Care Medicine, Medical Director for the Pediatric Intensive Care Unit (PICU), and Medical Director of Respiratory Care. Since 2009, I have held the academic appointment as Professor of Clinical Pediatrics and Anesthesiology at University of Southern California, Keck School of Medicine, Los Angeles, where I was a Visiting Professor from 2006 to 2009.

3. Regarding my education, I graduated from the University of Pennsylvania School of Medicine in 1983. I earned a Master's of Public Health degree from St. Louis University in 2003.

4. Relative to my medical training, from 1983 to 1986, my Internship and Residency in Pediatrics was at Children's Memorial Hospital, Northwestern University Medical Center. From 1986 to 1988, I also participated in a Residency in Anesthesiology at the University of Pennsylvania Hospital. Further, from 1988 to 1990, I participated in a Fellowship in Pediatric Anesthesiology & Critical Care Medicine, at Children's Hospital of Philadelphia.

5. I have board certification in (1) Anesthesiology and Pediatric Anesthesiology, by the American Board of Anesthesiology; and (2) Pediatrics and Pediatric Critical Care Medicine, by the American Board of Pediatrics.

6. I am a member of medical societies, including: Society of Critical Care Medicine, Pediatric Section; American Academy of Pediatrics, Section on Critical Care; Physicians for Social Responsibility; and Pediatric Cardiac Intensive Care Society.

7. From 1990 to 2006, I had academic appointments with Washington University School of Medicine, St. Louis, Missouri, concluding with Associate Professor of Anesthesiology and Pediatrics. At St. Louis Children's, from 1999 to 2006, I was the Medical Director of Respiratory Care, and from 2005 to 2006, I was the Co-director of the Pediatric Intensive Care

Unit and Chief of the Medical/Surgical ICU service.

8. At Children's Hospital Los Angeles, I have served on committees, including my current membership on the Critical Response Systems Committee (formerly CPR Committee; Co-Chair 2009-2013), Simulation Steering Committee, Action Committee for Quality Outcomes, and Physician Support Committee of the Medical Staff.

9. I am currently a member of the editorial boards for two peer review journals, the Journal of Intensive Care Medicine (section editor Electronic Journals and Resources) and Pediatric Critical Care Medicine (section editor Evidence-based Journal Club since 2004). I participate in manuscript review for other peer review journals, as follows: Intensive Care Medicine, Anesthesiology, Haematologica, Journal of Pediatrics, American Medical Informatics Association, Anesthesia and Analgesia, American Journal of Respiratory and Critical Care Medicine, Archives of Pediatric and Adolescent Medicine, New England Journal of Medicine, Critical Care Medicine, JAMA Pediatrics, Journal of Critical Care, Chest.

10. Other details of my education, training, and experience as a physician are summarized in my curriculum vitae, a copy of which is submitted as Exhibit 11.

11. On or about July 22, 2016, I became aware of a request for a lateral transfer of a patient, Israel Stinson, from a hospital in Guatemala City, Guatemala, known as "Nuestra Señora del Pilar," to Children's Hospital Los Angeles. When considering whether to accept this transfer, we understood the history of events to be that this was a two-year old, who suffered a cardiac arrest following an episode of status asthmaticus, had tracheostomy and gastrostomy tube, and was to be evaluated for possible home ventilation initiation.

12. Under these circumstances, we at Children's Hospital Los Angeles have continued the level of organ support that had been established in Guatemala, including mechanical ventilation, intravenous fluids, an antidiuretic hormone (vasopressin) for diabetes insipidus, thyroid hormone supplements, and seizure control medication.

13. However, after the transfer to Children's Hospital Los Angeles, we learned that Israel had been declared dead by neurologic criteria at Kaiser Roseville and that a death

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certificate had been filed on April 14, 2016. That information was confirmed by medical records we received from Kaiser on August 12, 2016. Specifically, the records we received included:

a. A report by Gary W. Raff, M.D., of UC Davis Medical Center, dated April 6, 2016, documenting "ECMO decannulation," is submitted as Exhibit 12. "ECMO" is a medical abbreviation that refers to "Extracorporeal Membrane Oxygenation," which uses a machine to take over the work of the lungs and sometimes the heart. It is also sometimes referred to as ECLS (Extracorporeal Life Support) or bypass. Dr. Raff's report documents that ECMO was implemented in response to an earlier event, with asthma causing cardiac arrest. On April 6, 2016, Dr. Raff's note confirms, that modality of support was stopped.

b. A note by Sara Aghamohammadi, M.D., of UC Davis Medical Center, dated April 7, 2016, documented that a cerebral blood flow study showed the absence of cerebral perfusion, and is submitted as Exhibit 13.

c. A brain death determination, including apnea test, by Dr. Aghamohammadi, dated April 8, 2016, is submitted as Exhibit 14. The findings made by Dr. Aghamohammadi constitute a determination that Israel Stinson experienced brain death.

d. A note by John Holcroft, M.D., of UC Davis Medical Center, dated April 10, 2016, is submitted as Exhibit 15. That note documented that the first brain death exam of April 8, 2016 "was consistent with brain death," that "a nuclear medicine flow study did not show evidence of cerebral perfusion," the "plan had been to do a second brain death exam today," but that the parents objected and the mother stated "under no circumstances are you to do that exam today" and "no one is allowed to do anything while I'm gone."

e. The records of Kaiser Roseville include a Pediatrics Discharge Summary/Note, by Shelly Garone, M.D., Assistant Physician in Chief, submitted as Exhibit 16. That Summary/Note documented that determinations of brain death were made at Kaiser on April 12, 2016 and April 14, 2016. Relative to the exam of April 14, 2016, Dr. Garone stated: "At the conclusion of this exam, which was consistent with brain death, I conducted a repeat apnea test, which also confirmed no brain function. The patient was declared brain dead at 12:00 noon on 4/14/16." Dr. Garone also stated: "the family is trying to get a legal injunction to

prevent us from discontinuing medical intervention. So the ventilator, the norepinephrine, .and the vasopressin have not yet been stopped." Dr. Garone's Summary/Note stated the conclusion: "30 month old with brain death after status asthmaticus."

f. An attorney for Children's Hospital Los Angeles obtained a certified copy of the "Certificate of Death" for Israel Stinson, stating the date of death as April 14, 2016, caused by "ANOXIC ENCEPHALOPATHY," referring to brain death, due to "CARDIAC ARREST," due to "STATUS ASTHMATICUS," a severe asthma attack.

g. I have been informed that two courts have rejected challenges to the death determination, the Placer County Superior Court, and the United States District Court (for the Eastern District of California). I also understand that an appeal the Ninth Circuit Court of Appeals was dismissed.

14. The prior brain death determinations appear appropriate. The Certificate of Death officially establishes the death of Israel Stinson. A formal assessment of brain death has not been done at CHLA, largely because the determination has already occurred. Additionally, the mother, Jonee Fonseca wrote a note, dated August 9, 2016, purporting to forbid physicians at CHLA from undertaking such an evaluation, a copy of which is submitted as Exhibit 17. Nevertheless, I have personally examined Israel Stinson and have not identified anything that would be contrary to the assessment of brain death. On exam, Israel Stinson continues to show no sign of central nervous system function except spinal reflexes, movements that are reflexive from the spinal cord and not evidence of brain stem function. The beating of the heart occurs by virtue of the electrical impulses of the heart and occurs without control from the brain or brain stem. During the course of my examinations of Israel Stinson, without removing the ventilator, I have on one occasion turned off the mechanical support that otherwise induce the lungs to expand and contract, while maintaining 100% oxygen flow to the lungs. In doing so, I observed the monitor for the level of carbon dioxide (CO_2) the monitor is meant to detect, over several minutes the CO_2 increased. The increase of CO_2 in a patient with brain stem function would induce respiratory effort, because the brain stem would react to the signals based upon increased CO_2 in blood. Israel Stinson's body showed no respiratory effort in response to the increased

CO_2. When I restarted the ventilator, the chest was forced by the mechanical force of the ventilator to expand, and following mechanically induced contraction of the lungs showed high CO_2, consistent with the observation that there was no respiration while the mechanical force of the ventilator had been turned off.

15. Because of those medical and ethical concerns, I asked for consultation from the Bioethics Committee of Children's Hospital Los Angeles. In response, Cheryl Lew, M.D., Chair of that Committee, made a report, dated August 15, 2016, submitted as Exhibit 18. In her report, and on behalf of the Bioethics Committee, Dr. Lew concluded: "it is morally permissible and even obligatory for the healthcare team to discontinue all mechanical and organ supportive treatments and free this child's body from inappropriate manipulation."

16. On August 13, 2016, given the child's prior determination of death and a death certificate file with the State, I informed the parents of the decision to withdraw the futile services being administered to the physical body because of the futility of it. Despite the prior determination of death, I informed the parents they would be given a reasonable period of time to accept the decision to withdraw those services or to arrange transfer to a different institution, but that the plan at Children's was to withdraw such services on August 18, 2016.

17. Based upon my education, training, and experience, and based upon the legal status of death established as of April 14, 2016, there is not a medical or ethical justification to continue to impose artificial measures that force the physical body of Israel Stinson as a deceased person to function despite the absence of brain or brain stem vitality. The provision of medical services to the physical body of Israel Stinson is an act of futility and does not advance any accepted medical interests. The ongoing provision of such services is inconsistent with the standard of care, and the ethical and professional standards, applicable to reasonable and competent physicians and hospitals in the community who encounter patients who experience brain death.

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18. Consistent with my statements herein, I have had contact with at least eight other pediatric intensive care units and the representatives of those units have stated unwillingness to accept a transfer of Israel Stinson because of his brain death.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 23rd day of August 2016, in Los Angeles, California.

BARRY P. MARKOVITZ, M.D.

DECLARATION

CARROLL, KELLY, TROTTER, FRANZEN, McKENNA & PEABODY
RICHARD D. CARROLL (SBN 116913)
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111 West Ocean Boulevard, 14th Floor
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Attorneys for Respondent, CHILDREN'S HOSPITAL LOS ANGELES

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ISRAEL STINSON, a minor, by Jonee Fonseca his mother,

Petitioner,

vs.

CHILDREN'S HOSPITAL LOS ANGELES

Respondent.

CASE NO.: BS164387

DECLARATION OF CHERYL LEW, M.D. IN SUPPORT OF EX PARTE APPLICATION TO DISSOLVE TEMPORARY RESTRAINING ORDER

DATE: AUGUST 25, 2016
TIME: 8:30 A.M.
DEPT: 86

ASSIGNED FOR ALL PURPOSES TO:
JUDGE AMY D. HOGUE
DEPARTMENT 86

DECLARATION OF CHERYL LEW, M.D.

1. I am an adult and a medical doctor licensed to practice medicine in the State of California. I am making this declaration in support of the ex parte application of Children's Hospital Los Angeles (sometimes referred to as "CHLA") seeking to dissolve the temporary restraining order of August 18, 2016.

2. I have been an Attending Physician on staff at Children's Hospital Los Angeles since 1977 and have been a member of the Division of Pediatric Pulmonology. I serve as the Chair of the Ethics Committee at Children's Hospital Los Angeles. Since 2013, I have been Leader/Director of the Respiratory Care Unit.

3. Regarding my education and training, in 1972, I graduated from the Medical School of the University of California, San Diego. From 1972 to 1975, I participated in Pediatrics Internship and Residency at Children's Hospital Los Angeles. I then had Fellowship training in Neonatology and Pulmonology, again at Children's Hospital Los Angeles, from 1975 to 1977. Since then, from 1991 to 1997 I received Bioethics post graduate education, from the Joseph & Rose Kennedy Institute of Ethics at Georgetown University. In 2003, I participated in a fellowship in Teaching & Learning, Maurice Hitchcock, Division Medical Education, Keck School of Medicine. In 2004, I participated in a fellowship in Educational Leadership, with the Division of Medical Education, Keck School of Medicine.

4. In 2010, I received a Master's of Science degree in Bioethics from the Alden March Bioethics Institute, Albany Medical College, Albany, N.Y.

5. I am board certified in (1) Pediatrics; (2) Pediatric Pulmonology; and (3) Neonatal-Perinatal Medicine. Those board certifications are by the American Board of Pediatrics.

6. Since 1975, I have had an academic appointment in Pediatrics, at the Keck School of Medicine, University of Southern California, Los Angeles. Presently, I am a Clinical Professor Pediatrics (Clinician Educator).

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7. I am a member of medical societies, including: American Thoracic Society; American Academy of Pediatrics; American Society for Bioethics and the Humanities; American Society for Law, Medicine and Ethics.

8. Since 1993, I have served as the Chair, Ethics Resource Committee at Children's Hospital Los Angeles, and have been on that committee since 1993. Since 2007, I have been a member of the Comfort, Pain Management and Palliative Care Committee.

9. Other details of my education, training, and experience as a physician are summarized in my curriculum vitae, as copy of which is submitted as Exhibit 19.

10. As the Chair of the Ethics Committee at Children's Hospital Los Angeles, I was asked by Barry P. Markovitz, M.D., to provide an Ethical Consultation, relative to Israel Stinson, in CHLA's Pediatric Intensive Care Unit. I know Dr. Markovitz from his membership on the physician staff of Children's Hospital Los Angeles, and his current roles as Chief of the Division of Critical Care Medicine and Medical Director for the Pediatric Intensive Care Unit (PICU).

11. On August 15, 2016, I provided Bioethics Consultation relative to the status of Israel Stinson and the provision of medical services to his physical body. A true and correct copy of that consultation report is submitted as Exhibit 18.

12. While I stand by the entirety of the contents of the Bioethics Consultation report, I will recount with specificity some of the main points. As described in my report, prior to the transfer of Israel Stinson to Children's Hospital Los Angeles, I was informed that Israel Stinson had been determined to be dead by neurological status, brain death, by physicians at two institutions in Northern California. I learned that since arrival at Children's Hospital Los Angeles, the child's body per the clinical evaluation of the Pediatric Critical Care Staff and Neurocritical Care consultant presented signs and findings consistent with the diagnosis of death by neurological criteria.

13. In the Discussion section of my report, at pages 2-3, I explained: "Although, the child is deceased, the moral obligations of the healthcare team continue to be of priority towards the best interests of the child as a deceased person. Health care professionals have basic and core obligations to respect the personhood of even deceased patients. In the situation of the deceased,

those obligations mean that the remains or corpse must be treated with respect, must not be subject to undue and inappropriate intrusion or to be subject to inappropriate medical interference. In this context, continued provision of organ support with mechanical ventilation, intravenous manipulation of electrolytes for the seeming severe and intractable hypernatremia-electrolyte imbalance and other therapies constitute interference with a corpse and thus is intrinsically disrespectful to the essence of this child's personhood during his past life. It is clear at this point that there is no possibility that this child's brain will recover to the extent that one could argue that he could resume his personhood. This latter point is demonstrated by the lack of any, even minimal recovered neurological function over an extended period of time."

14. Further, my discussion included: "the primary moral obligation remains towards providing appropriate respect to the child who has died. This most important obligation means that the healthcare team ought to remove and discontinue the un-natural medical interventions currently in place which are of no benefit to a dead child and serve only as unnecessary intrusions on his corpse." (Exhibit 18, p. 3.)

15. In conclusion, on behalf of the Ethics Resource Committee, my report recommended:

1. The current plan to offer to the parents' time-limited opportunity to obtain an alternative venue of care is appropriate. The time-frame which has already been offered by the PICU staff is also appropriate.

2. Since death has already occurred, the members of the healthcare team ought not to offer any further "attempts" at resuscitative efforts for occurrence of any cardiopulmonary instability. Occurrence of problems with gas exchange, cardiac rhythm or circulation are signs of death and attempts to reverse these problems represents inappropriate intrusion and interference with the corpse.

3. The other medical issues such as electrolyte imbalance are also reflections of whole brain death and need not be treated.

4. Laboratory studies: blood work, etc. are also sources of intrusiveness and constitute a form of disrespect since none of the abnormalities can be corrected in a dead body. These studies need not be continued.

5. Once the time-frame for seeking alternatives for care elsewhere has elapsed, it is morally permissible and even obligatory for the healthcare team to discontinue all mechanical and organ supportive treatments and free this child's body from inappropriate manipulation. (Exh. 18, p. 3.)

16. Based upon my education, training, and experience, and based upon the legal status of death, and based upon the reasons stated in my Bioethics Consultation report, there is not a medical or ethical justification to continue to impose artificial measures that force the physical body of Israel Stinson as a deceased person to function despite the absence of brain or brain stem vitality. The provision of medical services to the physical body of Israel Stinson is an act of futility and does not advance any accepted medical interests. The ongoing provision of such services is inconsistent with the standard of care, and the ethical and professional standards, applicable to reasonable and competent physicians and hospitals in the community who encounter patients who experience brain death.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 23rd day of August 2016, in Los Angeles, California.

CHERYL D. LEW, M.D., MS BIOETHICS

DECLARATION

CARROLL, KELLY, TROTTER, FRANZEN, McKENNA & PEABODY
RICHARD D. CARROLL (SBN 116913)
DAVID P. PRUETT (SBN 155849)
111 West Ocean Boulevard, 14th Floor
Post Office Box 22636
Long Beach, California 90801-5636
Telephone No. (562) 432-5855 / Facsimile No. (562) 432-8785

Attorneys for Respondent, CHILDREN'S HOSPITAL LOS ANGELES

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ISRAEL STINSON, a minor, by Jonee Fonseca his mother,

Petitioner,

vs.

CHILDREN'S HOSPITAL LOS ANGELES

Respondent.

CASE NO.: BS164387

DECLARATION OF DAVID P. PRUETT IN SUPPORT OF EX PARTE APPLICATION TO DISSOLVE TEMPORARY RESTRAINING ORDER

DATE: AUGUST 25, 2016
TIME: 8:30 A.M.
DEPT: 86

ASSIGNED FOR ALL PURPOSES TO:
JUDGE AMY D. HOGUE
DEPARTMENT 86

DECLARATION OF DAVID P. PRUETT

1. I am an attorney licensed to practice law in the State of California. I am a certified appellate specialist. I am a partner with the firm of Carroll, Kelly, Trotter, Franzen, McKenna & Peabody, attorneys for Children's Hospital Los Angeles in the above-captioned action pertaining to Israel Stinson. I am making this declaration in support of the ex parte application of Children's Hospital Los Angeles to dissolve the temporary restraining order of August 18, 2016.

2. On August 23, 2016, at 8:41 a.m. I left a voicemail for Jonee Fonseca, at (707)450-6900, the telephone number on her "Verified Ex Parte Petition for Temporary Restraining Order," and at 9:06 a.m. I sent to her an email to her address at joneefonseca@yahoo.com, give you notification that Children's Hospital Los Angeles will make an ex parte application to the Court, at 8:30 a.m. on August 25, 2016, in Department 86 of the Los Angeles Superior Court, located at 111 North Hill Street, Los Angeles, California, for an order to dissolve the temporary restraining order entered by the Court on August 18, 2016 and to permit Children's Hospital Los Angeles to take actions, including withdrawal of mechanical support of the physical body of Israel Stinson, based upon the fact that Israel Stinson has been medically and legally determined to be dead. Alternatively, Children's Hospital Los Angeles will seek an order expediting the proceedings, to hear the issue of whether the Court should enter a preliminary injunction, to be heard by the Court on August 29, 2016, or as soon thereafter as the matter can be heard. A copy of my email is submitted as Exhibit "X."

3. On August 24, 2016, at about 10:30 a.m., I spoke to Ms. Fonseca, and she informed me that she or an attorney would appear at the ex parte hearing. Later that day, at about 2:30 p.m., I received a call from attorney Dan Woodard, stating that he would be appearing at the ex parte hearing. He gave me phone numbers of (626)485-3589 and (626)584-8000, and email of djw@woodardlaw.net.

4. True and correct copies of documents have been submitted with this declaration and the ex parte application, including:

- Exhibit 1: Temporary Restraining Order of August 18, 2016;

- Exhibit 2: Verified Ex Parte Petition For Temporary Restraining Order/Injunction: Request For Order Of Independent Neurological Exam; Request For Order To Maintain Level Of Medical Care, filed August 18, 2016;
- Exhibit 3: Copy of Certificate of Death, which I obtained from the State of California on August 12, 2016;
- Exhibit 4: Order Of Dismissal of the Placer County Superior Court, dated April 29, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889;
- Exhibit 5: Order of United States District Court, Eastern District of California, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889, filed May 13, 2016, dissolving temporary restraining order and denying preliminary injunction, obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system;
- Exhibit 6: Order of Ninth Circuit, Fonseca v. Kaiser Permanente, Case: 16-15883 (appealing District Court Case 2:16-cv-00889), filed May 26, 2016, obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system;
- Exhibit 7: Kaiser Roseville and Dr. Michael Myette's Opposition To Motion For Preliminary Injunction, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889, filed May 10, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California;
- Exhibit 8: The declaration of Michael S. Myette, M.D., filed with Kaiser Roseville and Dr. Michael Myette's Opposition To Motion For Preliminary Injunction, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889, filed May 10, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California;
- Exhibit 9: The transcript of Placer County Superior Court testimony of Michael S. Myette, M.D., filed with Kaiser Roseville and Dr. Michael Myette's Opposition To Motion For Preliminary Injunction, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889,

filed May 10, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California;

- Exhibit 10: Certificate of Death documentation prepared by Michael S. Myette, M.D., filed with Kaiser Roseville and Dr. Michael Myette's Opposition To Motion For Preliminary Injunction, Fonseca v. Kaiser Permanente, Case 2:16-cv-00889, filed May 10, 2016, and obtained from the Court's Case Management/Electronic Case Filing (CM/ECF) system for United States District Court, Eastern District of California.

5. Exhibits 5 through 19 are true and correct copies of the documents described in the declarations of Barry Markovitz, M.D. and Cheryl D. Lew, M.D.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 25th day of August 2016, in Long Beach, California.

DAVID P. PRUETT

EXHIBIT X

Baker, Laurie

From: Pruett, Dave
Sent: Tuesday, August 23, 2016 9:06 AM
To: 'joneefonseca@yahoo.com'
Cc: Baker, Laurie
Subject: CHLA Notice L.A. Superior Court action, "Israel Stinson, a minor, by Jonee Fonseca his mother v. Children's Hospital Los Angeles"

Dear Ms. Fonseca:

I am an attorney for Children's Hospital Los Angeles in the Los Angeles Superior Court proceedings, entitled "*Israel Stinson, a minor, by Jonee Fonseca his mother v. Children's Hospital Los Angeles*," case no. BS164387.

This email is to give you notification that Children's Hospital Los Angeles will make an ex parte application to the Court, at 8:30 a.m. on August 25, 2016, in Department 86 of the Los Angeles Superior Court, located at 111 North Hill Street, Los Angeles, California, for an order to dissolve the temporary restraining order entered by the Court on August 18, 2016 and to permit Children's Hospital Los Angeles to take actions, including withdrawal of mechanical support of the physical body of Israel Stinson, based upon the fact that Israel Stinson has been medically and legally determined to be dead. Alternatively, Children's Hospital Los Angeles will seek an order expediting the proceedings, to hear the issue of whether the Court should enter a preliminary injunction, to be heard by the Court on August 29, 2016, or as soon thereafter as the matter can be heard.

This email will also confirm that, at 8:41 a.m., on August 23, 2016, I notified you of the above stated plan for ex parte application by leaving you a voicemail at (707)450-6900, the telephone number you put on the "Verified Ex Parte Petition for Temporary Restraining Order."

This notice is given in accordance with Rule 3.1204(a)(1), California Rules of Court, based upon the contact information available from the Court file.

We request that you or any attorney representing you inform us whether you will appear to oppose the ex parte application. (Rule 3.1204(a)(2).) Thus far, we have not been informed of any attorney on your behalf.

Sincerely,

David P. Pruett
dppruett@cktfmlaw.com | www.cktfmlaw.com
CKTFM&P
Carroll, Kelly, Trotter, Franzen, McKenna & Peabody
111 W. Ocean Boulevard, 14th Floor
P.O. Box 22636
Long Beach, California 90801
Telephone: (562) 432-5855
Facsimile: (562) 432-8785

EXHIBIT 1

Israel Stinson, a minor, by Jonee Fonseca his mother, Petitioner, v. Children's Hospital Los Angeles, Respondent.	Case No.: BS164387 Judge Amy D. Hogue Hearing Date: August 18, 2016 Time: 11:15 a.m. Dept.: 86 TEMPORARY RESTRAINING ORDER AND ORDER TO SHOW CAUSE RE PRELIMINARY INJUNCTION

Jonee Fonseca, appearing on behalf of her son, Petitioner, seeks a temporary restraining order and an order permitting independent neurological examination of Petitioner Israel Stinson. Fonseca states in her Verified Ex Parte Application and Declaration that Respondent Children's Hospital Los Angeles (Hospital") advised her on August 16 that it intends "to remove Israel's ventilator which will almost certainly result in [her] son's death." Fonseca states that Israel suffered severe brain damage as a result of an asthma attack and has been comatose ever since. Although his condition was stable while hospitalized in Guatemala, it has deteriorated since his transfer to the Hospital in July.

As the court noted in *Dority v. Superior Court* (1983) 145 Cal.App.3d 273, 280, "The jurisdiction of the court can be invoked upon a sufficient showing that it is reasonably probable that a mistake has been made in the diagnosis of brain death or where the diagnosis was not made in accord with accepted medical standards." Under Health & Safety Code §§ 7181, a pronouncement of death based on "irreversible cessation of all functions of the entire brain including the brain stem" requires "independent confirmation by another physician."

Fonseca avers that Respondent has violated section 7181 by failing to obtain or permit an independent evaluation. She asserts that the Hospital has an inherent conflict of interest because it may be responsible to provide ongoing care if he is not declared dead. She also advises that

EX1

Dr. Alan Shewman, a neurologist with UCLA Medical Center, is willing to examine Israel for purposes of an independent evaluation.

This Court finds that Fonseca has made a sufficient showing of emergency and the possibility of irreparable harm to justify the issuance of a temporary restraining order requiring the Hospital to (1) refrain from removing Israel from the ventilator, (2) take reasonable measures necessary to maintain Israel in a stable condition pending a hearing before this court, and (3) cooperate with Fonseca to facilitate an independent evaluation of Israel by Dr. Shewman.

The Court further orders the Hospital to show cause, at 9:30 a.m. on September 9, 2016, why a preliminary injunction to the same effect shall not issue. The Hospital is ordered to file any written opposition on or before September 1, 2016. Any reply memorandum must be filed on or before September 6, 2016.

Petitioner is order to personally serve the Hospital with the Petition and all supporting papers in accordance with California Code of Civil Procedure 413.10 et seq.

Petitioner is hereby appointed guardian ad litem for her minor child, Israel, based on her sworn statement to the court that she is his natural mother. In all further proceedings, the guardian ad litem must be represented by counsel and cannot represent the minor child as a self-represented litigant.

Dates: August 18, 2016

SUPERIOR COURT LOS ANGELES COUNTY CALIFORNIA

Amy D. Hogue
Judge of the Superior Court

EXHIBIT 2

Jonee Fonseca
Mother of Israel Stinson
P.O. Box 2105
Napa, CA 94558
707.450.6900
joneefonseca@yahoo.com

IN THE SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF LOS ANGELES

UNLIMITED CIVIL JURISDICTION

Israel Stinson, a minor, by Jonee Fonseca his mother.

Petitioner,

v.

Children's Hospital Los Angeles.

Respondent.

Case No. BS164887

VERIFIED EX PARTE PETITION FOR TEMPORARY RESTRAINING ORDER/INJUNCTION: REQUEST FOR ORDER OF INDEPENDENT NEUROLOGICAL EXAM; REQUEST FOR ORDER TO MAINTAIN LEVEL OF MEDICAL CARE;

D 86

I, Jonee Fonseca, am the mother of Israel Stinson, who on August 7 was admitted to Children's Hospital of Los Angeles ("Children's) for treatment and care pending transfer to home care. Israel suffered an asthma attack while at UC Davis Children's Hospital in Sacramento that resulted in a temporary lack of oxygen to Israel's brain. Israel was placed on a ventilator and has needed ventilator support since the injury.

EX 2

Because Israel is a Medi-Cal patient with Kaiser Permanente, Israel was transferred to Kaiser Permanente Medical Center in Roseville ("Kaiser") for treatment on April 12, 2016. Dr. Michael Myette, a pediatric intensivist at Kaiser, did not treat Israel, but instead performed a brain death exam. On April 13, I was told Israel would be removed from his ventilator. I obtained a court order keeping Israel alive while I sought a physician who could perform an independent examination. I found several physicians willing to examine Israel, but Kaiser refused to allow the independent exam.

After doing much research on caring for patients with serious brain injuries, I decided that I wished for Israel to be cared for at home. However, in order for Israel to be transferred to home care, he required a breathing tube and feeding tube ("g-tube"). Kaiser refused to perform these procedures. Dr. Myette said that Israel's digestive system was "dead" and that trying to feed him would be "catastrophic." Dr. Myette also said the only reason Israel was alive is because he was continually adjusting Israel's blood pressure through medication. These statements were later proved to be inaccurate.

I began looking for another hospital that would accept Israel as a patient in order to provide the procedures needed for Israel to be cared for at home.

Dr. Juan Zaldana, a pediatric specialist at Sanatorio Nuestra Señora del Pilar ("del Pilar") in Guatemala City, Guatemala, agreed to admit Israel and provide the breathing tube and g-tube. On May 21, 2016, Israel was transported to Guatemala City and was admitted to del Pilar.

Because Kaiser refused to feed my son, Israel had not received any nutrition in almost six weeks. He was on dextrose (sugar water) for hydration.

Shortly after Israel was transferred to del Pilar, Dr. Zaldana performed a tracheotomy and gastrostomy to provide Israel with a breathing tube and feeding tube. Israel responded very well

to the procedures and to receiving nutrition. Within one week, he was off of the blood pressure medication and was able to regulate his blood pressure on his own. He was also able to regulate his body temperature on his own. Israel also increased his movements in response to my voice and touch. He is able to move his upper body and his arms and legs. He recently started to squeeze his hands and make a fist.

Dr. Zaldana, and Dr. Francisco Montiel, a pediatric neurologist at del Pilar, performed numerous exams on Israel, including two EEGs. Both doctors concluded that Israel's condition was inconsistent with the criteria for brain death (see attached). They determined that Israel is in a "persistent vegetative state." This was confirmed by Dr. Rubén Posadas, a neurologist at del Pilar (see attached).

We remained in Guatemala with Israel for approximately 2 1/2 months. During that time we made arrangements for Israel's return to the U.S.

In July, I was told that Children's Hospital of Los Angeles (Children's) consulted with Dr. Zaldana regarding Israel's condition. After speaking with Dr. Zaldana, Children's agreed to accept Israel as a transfer patient for treatment.

On Saturday, August 6, Israel was transported by air ambulance from Guatemala City to Children's. He was admitted to Children's the morning of August 7. That same day, Dr. Ashraf Abou-Zamzam, Israel's attending physician at Children's, told me that Israel's sodium levels were high.

Over the next few days, Israel's face and torso became increasingly red and swollen. I was shocked by his appearance, as Israel had never had this reaction before. Israel was able to maintain proper sodium levels, blood pressure, and temperature without medication while at del

Pilar (see attached). On August 9, I was told that Children's stopped feeding Israel because of his sodium levels. On August 15, limited feeding was reinstated.

On August 16, Children's informed me that it intended to remove Israel's ventilator, which will almost certainly result in my son's death.

MEMORANDUM OF POINTS AND AUTHORITIES

California Health and Safety Code Section 7180 (a) (The Uniform Determination of Death Act) provides for a legal determination of brain death as follows; "(a) An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."

Health and Safety Code Section 7181 provides for an "independent" verification of any such determination stating; "When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be ***independent confirmation*** by another physician."

As established by the Court in *Dority v Superior Court* (1983) 145 Cal.App.3d 273, 278, this Court has jurisdiction over the issue of whether a person is "brain dead" or not pursuant to Health and Safety Code Sections 7180 & 7181. Acknowledging the moral and religious implications of such a diagnosis and conclusion, the *Dority* court determined that it would be "unwise" to deny courts the authority to make such a determination when circumstances warranted.

Here, Kaiser performed a brain death exam and declared that Israel was brain dead, but refused to allow for an independent examination. Kaiser also said that as a result of Israel's brain

injury, his condition would deteriorate. Dr. Myette said that Israel's digestive system was "dead." Not only did Israel's condition not deteriorate, but he began improving. After Israel began receiving nutrition at del Pilar, he no longer required medication to stabilize his blood pressure, heart rate, or sodium levels. He was also able to regulate his own body temperature without artificial devices (i.e., "Bare Hugger"). Only Kaiser physicians have examined Israel is regards to possible brain death.

Israel received an independent examination by three physicians—Dr. Juan Zaldana, a pediatric specialist; Dr. Francisco Montriel, a pediatric neurologist; and Dr. Ruben Posadas, a neurologist. All three have determined that while Israel has a serious brain injury, he is not brain dead. Israel's EEGs show brain activity. This is not consistent with brain death.

Children's accepted Israel for treatment based on reports by these physicians. The admitting physician personally talked with Dr. Zaldana about Israel's condition and prognosis. Israel's condition has significantly worsened since being under the care of Dr. Abou-Zamzam at Children's. Now Children's wants to remove Israel's ventilator, which will most likely cause Israel's death by suffocation.

I had Israel transferred to Children's, as I believed the medical staff would provide him with care and treatment, while I made arrangements for Israel to be cared for at home. Instead, Children's is planning to put Israel to death.

My son responds to treatment. He is able to move his upper body, turn his head, and move his arms and legs in response to my voice and touch. The fact that he responds to my voice indicates, at the very minimum, brain stem activity. Section 7180, requires the cessation of *all* functions of the brain, including the brain stem.

At this time, I do not trust Children's to provide an independent evaluation of Israel. Because Israel's condition has worsened since being admitted to Children's, the hospital has a conflict of interest in determining his condition. If Children's can make a finding of brain death, they no longer have to pay for any of his care, while if he is severely brain damaged, but not brain dead, they may be legally liable to provide his ongoing care and treatment at Children's or elsewhere.

Only one other case of this type is on record in California, namely the case of Jahi McMath which was heard in Alameda County in December of 2013. That case, one of first impression, where Nailah Winkfield challenged Children's Hospital Oakland's determination of brain death after they negligently treated her daughter, Jahi, led to an Order, issued by Hon E. Grillo, holding that an independent determination is one which is performed by a physician with no affiliation with the hospital facility (in that case Children's Hospital Oakland) which was believed to have committed the malpractice which led to the debilitating brain injuries Jahi suffered. A true and correct copy of Judge Grillo's Order is attached to this Petition. In the *McMath* case, the Trial Court rejected the Hospital's position that the Court had no jurisdiction over the determination of whether not Jahi McMath was "brain dead" or not.

In *McMath*, Judge Grillo stated that the Section 7180's language regarding "accepted medical standards" permitted an inquiry into whether the second physician (also affiliated with Children's Hospital Oakland) was "independent" as that term was defined under Section 7181. Judge Grillo determined that the petitioner's due process rights would be protected by a focused proceeding providing limited discovery and the right to the presentation of evidence.

The Court determined that, under circumstances which are strikingly similar to those which present themselves here, the conflict presented was such that the court found that the

Petitioner was entitled to have an independent physician, unaffiliated with Children's Hospital Oakland, preform neurological testing, an EEG and a cerebral blood flow study. Indeed, the Court Ordered Children's Hospital Oakland to permit the Court's own court appointed expert to be given temporary privileges and access to the Hospital's facilities, diagnostic equipment, and technicians necessary to perform an "independent" exam.

In a Nevada Supreme Court case with similar facts, the court unanimously questioned whether the American Association of Neurology guidelines that are used to determine brain death in both Nevada and California, "adequately measure all functions of the entire brain, including the brain stem." *In re Guardianship of Hailu*, 131 Nev. Adv. Op. 89. (Nov. 16, 2015). In that case, Aden Hailu, a young college student, went into cardiac arrest during emergency surgery for severe stomach pain and subsequently suffered a brain injury. The hospital performed three EEGs, which showed some brain activity, yet doctors still proceeded to declare her brain dead pursuant to Nevada's brain death statute, which is identical to California's. Both states use the same guidelines to determine brain death, namely those developed by the American Association of Neurology.

In this case, Children's wants to remove my son from his ventilator, even though three separate independent examinations have concluded that he is not brain dead and two EEGs show brain activity.

As in *Dority* and *McMath*, the unique circumstances of this case invoke the Court's jurisdiction and due process considerations require that this Court grant my Petition for a Temporary Restraining Order and order that Children's Hospital of Los Angeles recognize the independent examinations performed by Drs. Zaldana, Montriel, and Posadas, or permit Dr. Alan

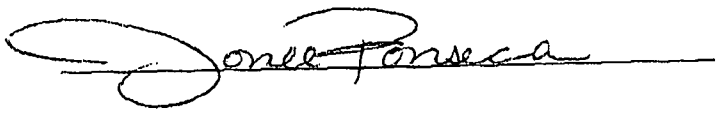
Shewmon to conduct another independent examination with the assistance of Children's diagnostic equipment and technicians necessary to carry out a repeat EEG.

In order to provide the requisite physical conditions for a reliable set of tests to be performed, Israel Stinson should continue to be treated so as to provide his optimum physical health and in such a manner so as to not interfere with the neurological testing (such as the use of sedatives or paralytics).

WHEREFORE, petitioner prays:

1) That a Temporary Restraining Order be issued precluding Respondents from performing any apnea tests on Israel Stinson be issued;
2) That an Order be issued precluding Respondents from removing Israel Stinson from respiratory support, or removing or withholding medical treatment;
3) That an Order be issued that Respondents are to provide Israel Stinson treatment to maintain his optimum physical health, including nutrition and thyroid hormone as needed, in such a manner so as to not interfere with the neurological testing (such as the use of sedatives or paralytics in such a manner and/or at such time that they may interfere with the accuracy of the results).
4) That an Order be issued that Petitioner is entitled to an independent neurological examination, by Dr. Alan Shewmon with the assistance of Childrens diagnostic equipment and technicians necessary to carry out a repeat EEG.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on August 17, 2016, at Los Angeles, California.



Jonee Fonseca

Jonee Fonseca
Mother of Israel Stinson
P.O. Box 2105
Napa, CA 94558
707.450.6900
joneefonseca@yahoo.com

IN THE SUPERIOR COURT OF CALIFORNIA

IN AND FOR THE COUNTY OF LOS ANGELES

UNLIMITED CIVIL JURISDICTION

Israel Stinson, a minor, by Jonee Fonseca his mother. Petitioner, v. Children's Hospital Los Angeles Dr. Ashraf Abou-Zamzam Respondent.	Case No. DECLARATION OF JONEE FONSECA IN SUPPORT OF EX-PARTE PETITION FOR TEMPORARY RESTRAINING ORDER/ INJUNCTION: REQUEST FOR ORDER OF INDEPENDENT NEUROLOGICAL EXAM; REQUEST FOR ORDER TO MAINTAIN LEVEL OF MEDICAL CARE ; REQUEST FOR ORDER TO FACILITATE TRANSFER TO ANOTHER FACILITY OR TO HOME CARE

I, Jonee Fonseca, declare that I am the mother of petitioner Israel Stinson.

1. On April 2, 2016, my son Israel Stinson suffered an asthma attack while being treated at UC Davis Children's Hospital in Sacramento, CA. It took several minutes for a doctor to

respond to my calls for help and by that time, Israel had stopped breathing. Doctors were able to resuscitate him, but he suffered a brain injury due to lack of oxygen.

2. Israel is insured through Medi-Cal with Kaiser Permanente so he was transferred to Kaiser Permanente Medical Center ("Kaiser") in Roseville, CA for treatment.

3. Within 24 hours of his arrival at Kaiser, the admitting physician, Dr. Michael Myette, performed a brain death exam. I was told my son would be removed from life support on April 14.

4. I then sought an independent evaluation of Israel's condition and obtained a court order to keep my son on the ventilator until another doctor could be found.

5. Although I found several doctors who were willing to provide an independent examination, Kaiser refused to allow them to examine Israel.

6. My intention was—and is—to have Israel cared for at home. In order for Israel to be cared for at home, Israel needed a breathing tube and feeding tube ("g-tube").

7. I asked Kaiser to perform the procedures, but Doctor Myette said that Israel's digestive system was not functional and that trying to feed him would be "catastrophic." He also said that Israel would not survive the tracheotomy procedure to provide him with a breathing tube.

8. During the nearly six weeks that Israel was at Kaiser, the hospital refused to provide him with any nutrition. He was only on a dextrose solution for hydration.

9. Kaiser also refused to do the two procedures necessary for Israel to be transferred to home care.

10. Dr. Myette told me the only reason Israel was alive was because he was making continual adjustments to his blood pressure medication, primarily vasopressin.

11. Dr. Juan Zaldana, a pediatric specialist at Sanatorio Nuestra Señora del Pilar ("del Pilar") in Guatemala City, Guatemala, agreed to admit Israel and provide the breathing tube and g-tube.

12. On May 21, Israel was transported by air ambulance (AirCARE One) to Guatemala City and admitted to del Pilar.

13. It took about five days for Israel to become stable enough to have the procedures. Both the tracheotomy and the gastrostomy were performed on the same day.

14. Israel responded very well to finally receiving nutrition. Within one week, he was off of all of the vasopressors and was able to regulate his blood pressure on his own. He was also able to regulate his body temperature on his own. Israel also increased his movements in response to my voice and touch. He is able to move his upper body and his arms and legs. He recently started to squeeze his hands and make a fist.

15. Dr. Zaldana, and Dr. Francisco Montiel, a pediatric neurologist at del Pilar, performed numerous exams on Israel, including two EEGs. Both doctors concluded that Israel's condition was inconsistent with the criteria for brain death (see emails, attached). They determined that Israel is in a "persistent vegetative state." This was confirmed by Dr. Rubén Posadas, a neurologist at del Pilar (see email, attached).

16. We remained in Guatemala with Israel for approximately 2 1/2 months. During that time we made arrangements for Israel's return to the U.S.

17. In July, I was told that Children's Hospital of Los Angeles (Children's) consulted with Dr. Zaldana regarding Israel's condition. After speaking with Dr. Zaldana, Children's agreed to accept Israel as a transfer patient.

18. On Saturday, August 6, Israel was transported by air ambulance from Guatemala City to Children's.

19. On Sunday, August 7, Dr. Ashraf Abou-Zamzam, Israel's attending physician at Children's told me that Israel's sodium levels were high. Israel's face and torso were red and swollen. This had never occurred at del Pilar.

20. On August 9, I was told that Children's stopped feeding Israel because of his sodium levels. On August 15, limited feeding was reinstated.

21. I have requested that Israel be examined by an independent physician. Dr. Alan Shewmon, a neurologist with UCLA Medical Center, is willing to examine Israel (see attached). Dr. Shewmon is a highly qualified and respected neurologist who serves as Professor Emeritus of Neurology and Pediatrics at UCLA's David Geffen School of Medicine. Children's refused to allow Dr. Shewmon temporary admitting privileges for the purpose of examining Israel.

22. I have also been informed that Totally Kids, a long-term care facility for children with severe brain injuries, is expecting to have a bed open for Israel early next month. If Israel cannot be transferred to home care, I would like him to go to a facility that specializes in children with special needs.

23. On August 16, I was told that Children's is planning to remove Israel from ventilator support tomorrow, August 18.

24. I am hereby asking that Children's Hospital of Los Angeles be prevented from removing my son, Israel Stinson, from the ventilator.

25. If Children's removes Israel from the ventilator and he stops breathing, they will have ended his life as well as their responsibility to provide care for the harm their negligence caused. For this reason I hereby request that an independent examination be performed, including the use of an EEG.

26. I also request that Children's be prevented from performing an "apnea test" on Israel during which he would be removed from the ventilator.

27. I also request that Children's be ordered to continue to provide such care and treatment to Israel that is necessary to maintain his physical health and promote any opportunity for healing and recovery of his brain and body, including nutrition and thyroid hormone as needed.

28. I also request that Children's Hospital of Los Angeles be ordered to facilitate Israel's transfer to either a long-term care facility or home care as soon as possible.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on August 17, 2016, in Los Angeles, California.

_____

Jonee Fonseca

26. I also request that Children's be ordered to continue to provide such care and treatment to Israel that is necessary to maintain his physical health and promote any opportunity for healing and recovery of his brain and body, including nutrition and thyroid hormone as needed.

27. I also request that Children's Hospital of Los Angeles be ordered to facilitate Israel's transfer to either a long-term, subacute care facility or home care as soon as possible.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on August 17, 2016, in Los Angeles, California.

Jonee Fonseca

Jonee Fonseca

Paul A. Byrne, M.D.
577 Bridgewater Drive
Oregon, Ohio 43616
(419) 698-8844
e-mail:pbyrne@toast.net

August 18, 2016

1. I have personal knowledge of all the facts contained herein and if called to testify as a witness I would and could competently testify thereto.

2. I am a physician licensed in Missouri, Nebraska and Ohio. I am Board Certified in Pediatrics and Neonatal-Perinatal Medicine. I have published articles on "brain death" and related topics in the medical literature, law literature and the lay press for more than thirty years. I have been qualified as an expert in matters related to central nervous system dysfunction in Michigan, Ohio, New Jersey, New York, Montana, Nebraska, Missouri, South Carolina, Virginia and the United States District Court for the Eastern District of Virginia.

3. I have reviewed the medical records of Israel Stinson, a 2-year-old boy, when he was a patient in Kaiser Permanente, Roseville Hospital. I visited Israel Stinson several times. On April 22 when I visited him, he was in the arms of his mother. A ventilator was in place.

4. I have continued to be in touch with Israel's parents. I have reviewed the videos that have been sent to me. Israel does move in these videos. If Israel were a cadaver, this is not possible, Thus Israel is alive.

5. The Guidelines of the AAN that the hospital claims to have been following were not fulfilled. The Guidelines require that "Patients must lack all evidence of responsiveness." Israel is responsive.

6. Israel was transferred to Guatemala on May 18, 2016 for treatment. There he received nutrition, tracheostomy and gastrostomy. His condition improved so he no requires vasopressors. He was continued on thyroid medication while in Guatemala.

7. Three doctors in Guatemala (an intensivist and 2 neurologist) stated that Israel is alive and does not fulfill criteria for death. I have been in touch with these doctors.

8. Israel was transferred back to USA to Children's Hospital Los Angeles (CHLA) on August 8,2016.

9. Israel receives treatment for diabetes insipidus.

9. On April 4, Cranial Doppler showed "Near total absence of blood flow into the bilateral cerebral hemispheres." "Near total absence" is not evidence of no blood flow.

10. An apnea test was done on Israel 3 times. Every time he was made acidotic and hypercapneic (increase in carbon dioxide). These tests could not have helped Israel. Further, the third time was after Israel's parents requested that such testing not be done again.

11. Endocrine abnormalities including hypothyroidism preclude any reliable evaluation of functioning of the brain. Thyroid blood studies were done on April 18. Results showed that Israel has

hypothyroidism. Thyroid was started on thyroid medication on April 18. He continues on thyroid medication.

12. The results of test of thyroid function of Israel Stinson are:

4/17/16 TSH: 0.07 (normal 0.7-5)

4/17/16: T4: 0.4 (Normal .8-1.7)

Israel's brain (hypothalamus) produces thyroid stimulating hormone (TSH), but not enough for normal thyroid function, thus he needs thyroid medication.

14. T4 was low and brain edema turned into brain myxedema. When thyroid is given, brain circulation can increase and resume normal levels, thereby restoring normal neurological and hypothalamic function.

15. With proper medical treatment Israel is likely to continue to live, and may find limited to full recovery of brain function, and may possibly regain consciousness.

16. Israel has a beating heart without support by a pacemaker or medications. Israel has circulation and respiration and many interdependent functioning organs including liver, kidneys and pancreas. Israel healed after his surgeries in Guatemala. Israel Stinson is a living person who is on a ventilator, passes urine, digests food and has bowel movements. These do not occur in a cadaver after true death. These are indications that Israel is alive.

17. The criteria for "brain death" are multiple and there is no consensus as to which set of criteria to use (Neurology 2008). The criteria supposedly demonstrate alleged brain damage from which the patient cannot recover. However, there are many patients who have recovered after a declaration of "brain death." (See below.)

18. The latest scientific reports indicate that patients deemed to be "brain dead" are actually neurologically recoverable. I recognize that such treatments are not commonly done. Further it is recognized that the public and the Court must be wondering why doctors don't all agree that "brain death" is true death. Israel, like many others, continues to live. Many persons are on thyroid hormone because they would die without it.

19. The questions presented here refer to (1) the unreliability of methods that have been used to identify death and (2) the fact that no therapeutic methods that would enable brain recovery have been used so far.

20. Israel Stinson's brain is probably supplied by a partially reduced level of blood flow, insufficient to allow full functioning of his brain, such as control of respiratory muscles and production of a hormone controlled by the brain itself. This is called thyroid stimulating hormone, TSH, which then stimulates the thyroid gland to produce its own hormones. With insufficient amount TSH Israel has hypothyroidism.

21. On the other hand, partially reduced blood flow to his brain, despite being sufficient to maintain vitality of the brain, is too low to be detected through imaging tests currently used for that purpose. Employing these methods currently used for the declaration of "brain death" confounds NO EVIDENCE of circulation to his brain with actual ABSENCE of circulation to his brain.

22. Israel had electrical activity on 2 EEG's while in Guatemala.

23. In 2013, Jahi McMath was in hospital in Oakland, CA. When I visited her in the hospital in Oakland, Jahi was in a condition similar to Israel. A death certificate was issued on Jahi on December 12, 2013. Jahi was transferred to New Jersey where tracheostomy and gastrostomy were done and thyroid medication was given. Multiple neurologists recently evaluated Jahi and found that she no longer fulfills any criteria for "brain death. Since jahi has been in New Jersey, she has had her 14th and 15th birthdays. The doctors in Oakland declared Jahi dead and issued a death certificate. Jahi's mother said no to taking Jahi's organs and no to turning off her ventilator. Israel's parents are saying no to taking Israel's organs and to taking away his life support. Just like Jahi's mother!

24. Israel Stinson needs continued treatment with ventilator, thyroid medication and proper nutrition. These can be done in a long term care facility or his home.

Paul A. Byrne, M.D., FAAP

References to some of those who have recovered after a declaration of "brain death":

Hospital staff began discussing the prospect of harvesting her organs for donation when she squeezed her mother's hand. **Kopf was mistakenly declared dead in hospital but squeezed her mother's hand in 'breathtaking miracle.'**
https://www.dropbox.com/s/dtti4hkkx89ikyg/Uber%20Shooting%20Victim%20Abigail%20Kopf%20Going%20From%20Victim%20to%20Survivor%20_%20NBC%20Nightly%20News.mp4?dl=0

Zack Dunlap from Oklahoma. Doctors said he was dead, and a transplant team was ready to take his organs — until a young man came back to life
http://www.msnbc.msn.com/id/23768436/;http://www.lifesitenews.com/ldn/2008/mar/08032709.html, March 2008

Rae Kupferschmidt: http://www.lifesitenews.com/ldn/2008/feb/08021508.html, February 2008.

Frenchman began breathing on own as docs prepared to harvest his organs
www.msnbc.msn.com/id/25081786

Australian woman survives "brain death" http://www.lifesitenews.com/news/brain-dead-woman-recovers-after-husband-refuses-to-withdraw-life-support UTM source=LifeSiteNews.com+Daily+Newsletter&utm_campaign=231fd2c2c9-LifeSiteNews_com_US_Headlines05_12_2011&utm_medium=email

Val Thomas from West Virginia
WOMAN WAKES AFTER HEART STOPPED, RIGOR MORTIS SET IN
http://www.foxnews.com/story/0,2933,357463,00.html

http://www.lifesitenews.com/ldn/2008/may/08052709.html, May 2008.

An unconscious man almost dissected alive:
http://www.lifesitenews.com/ldn/2008/jun/08061308.html, June 2008

Gloria Cruz: http://www.lifesitenews.com/news/brain-dead-woman-recovers-after-husband-refuses-to-withdraw-life-support/,May 2011

Madeleine Gauron: http://www.lifesitenews.com/news/brain-dead-quebec-woman-wakes-up-after-family-refuses-organ-donation,July 2011

References that "brain death" is not true death include:

Joffe, A. Brain Death is Not Death: A Critique of the Concept, Criterion, and Tests of Brain Death. Reviews in the Neurosciences, 20, 187-198 (2009), and Rix, 1990; McCullagh, 1993; Evans, 1994; Jones, 1995; Watanabe, 1997; Cranford, 1998; Potts et al., 2000; Taylor, 1997; Reuter, 2001; Lock, 2002; Byrne and Weaver, 2004; Zamperetti et al., 2004; de Mattei, 2006; Joffe, 2007; Truog, 2007; Karakatsanis, 2008; Verheijde et al., 2009. Even the President's Council on Bioethics (2008), in its white paper, has rejected "brain death" as true death.

NEUROLOGICAL EVALUATION

I evaluated patient: Israel Stinson

1. Ischemic hypoxic encelapathy, the motive is to determine if there are signs of irreversal cerebral lesions.

- I evaluated the depth of the eye: atrophy of the bilateral optic nerve.
- Slight venous pulsation, without hemorrhage
- Negative oculovestibulary test
- Negative maneuvers of the doll of the wrist
- Pupils: two millimeters on the left, one millimeter on the right

There are primitive reflexes of defense and rejection, of position in both superior and inferior, members, there are osteotendinoses reflexes present.

He maintains cardiac frequency and arterial pressure without pharmaceutical assistance. The head has temperature, it feels warm.

CONCLUSION

1. Deep coma state
2. Persistent vegetative state, due to serious brain lesion
3. Does not belong to the encephalic criteria of brain death (warm head temperature, keeps blood pressure and cardiac frequency without medication).

The prognosis is reserved, he will be a patient dependent on mechanical ventilation.

Dr. Rubén Posadas
Neurologist
Col 3842

EVALUACION POR NEUROLOGIA

*Evalué paciente conocido por

1. Encefalopatía hipoxico isquémica, el motivo es determinar si existen signos de lesión cerebral irreversible.

*Efectué fondo de ojo: atrofia del nervio óptico bilateral

*Pulsación venosa leve, sin hemorragia

*Pruebas oculovestibulares negativas

*maniobras ojos de muñeca negativa

*pupilas: dos milímetros izquierdos, derechos un milímetro

Hay reflejos primitivos de defensa y rechazo, de posición en ambos miembros superiores e inferiores, reflejos osteotendinosos presentes.

Mantiene frecuencia cardiaca y presión arterial sin ayuda de medicamentos. La cabeza tiene temperatura, se palpa tibia

CONCLUSION:

1. Estado coma profundo
2. Estado vegetativo persistente por lesión cerebral grave
3. No cumple con criterios encefálicos de muerte cerebral (cabeza tibia, mantiene presión y frecuencia cardiaca sin fármacos)

El pronóstico es reservado, será un paciento dependiente de ventilación mecánica.

Dr. Rubén Posadas

Neurólogo

Col. 3842

Subject: Re: Israel

From: Alexandra Snyder (asnyder@lldf.org)

To: ashewmon@socal.rr.com;

Cc: joneefonseca@yahoo.com;

Date: Wednesday, August 17, 2016 1:40 PM

Thank you!

Alexandra Snyder
Executive Director
Life Legal Defense Foundation
O: 707.224.6675
C: 202.717.7371

On Aug 17, 2016, at 1:40 PM, D. Alan Shewmon, MD <ashewmon@socal.rr.com> wrote:

Dear Ms. Snyder,

As I told Ms. Fonseca, I would be willing to examine Israel Stinson if the hospital were to grant temporary privileges for me to do so.

Best regards,
D. Alan Shewmon, MD

Subject: Re: Israel

From: Alexandra Snyder (asnyder@lldf.org)

To: pbyrne@bex.net;

Cc: joneefonseca@yahoo.com;

Date: Wednesday, August 17, 2016 1:27 PM

Thank you! I'm hoping to have the documents finished in the next hour as Jonee needs to file them today.

On Aug 17, 2016, at 12:56 PM, Paul A Byrne MD <pbyrne@bex.net> wrote:

No. I will ask

From: Alexandra Snyder [mailto:asnyder@lldf.org]
Sent: Wednesday, August 17, 2016 3:51 PM
To: Paul Byrne, MD <pbyrne@bex.net>
Cc: Jonee Fonseca <joneefonseca@yahoo.com>
Subject: Re: Israel

Do you happen to have a CV from Dr. Zalanda and/or Dr. Montiel?

On Aug 17, 2016, at 11:37 AM, Paul A Byrne MD <pbyrne@bex.net> wrote:

From: Juan Zaldana [mailto:zaljua@yahoo.com.mx]
Sent: Monday, June 13, 2016 12:11 PM
To: Paul A. Byrne MD <pbyrne@bex.net>
Subject: Rv: Israel

The Neurologist wrote it.

El Lunes, 13 de junio, 2016 9:01:42, Francisco Montiel <fmontielguate@gmail.com> escribió:

To whom it may concern:

I, Francisco Montiel, paediatric neurologist, have had the opportunity to evaluate Israel who was tranfered from an intensive care unit in the USA with a medicl history already known.

Upon evaluation Israel shows no spontaneous respiratiry effort, oculocepalic, oculovestibular and ciliospinal relfexes are absent, he shows no reaction to vocal stimulii, however upon physical stimulii he does show movement of his 4 limbs, more right thna left movement, this movments appearnto be spinal in nature.

He has had 2 EEG tests both of which show slowmwaves of ver low amplitude, neither of them being isoelectric.

Given the findings and history, the clinical picture appearnto be one of persistent vegetative state.

Francisco Montiel
Medical license 6932

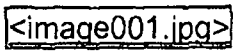


EXHIBIT 3

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

OFFICE OF THE CLERK-RECORDER
COUNTY OF PLACER
AUBURN, CALIFORNIA

CERTIFICATE OF DEATH

State File Number: 3052016139219
Local Registration Number: 3201831002021

Decedent's Personal Data

Field	Value
1. Name of Decedent – First (Given)	ISRAEL
2. Middle	–
3. Last (Family)	STINSON
AKA, Also Known As	- - -
4. Date of Birth (mm/dd/ccyy)	10/05/2013
5. Age Yrs.	2
6. Sex	M
7. Birth State/Foreign Country	CA
8. Social Security Number	[redacted]
9. Ever in U.S. Armed Forces?	[ ] YES [X] NO [ ] UNK
10. Marital Status/SRDP (at Time of Death)	NEVER MARRIED
11. Date of Death (mm/dd/ccyy)	04/14/2016
12. Hour (24 Hours)	1200
13. Education	00
14/15. Was Decedent Hispanic/Latino(a)/Spanish?	[ ] YES [X] NO
16. Decedent's Race	BLACK, AFRICAN AMERICAN
17. Usual Occupation	CHILD
18. Kind of Business or Industry	–
19. Years in Occupation	

Usual Residence

Field	Value
20. Decedent's Residence (Street and number, or location)	545 MARKHAM AVE APT. #3
21. City	VACAVILLE
22. County/Province	SOLANO
23. Zip Code	95688
24. Years in County	UNK
25. State/Foreign Country	CA

Informant

Field	Value
26. Informant's Name, Relationship	TERRY JENKINS, DECEDENT AFFAIRS COORD.
27. Informant's Mailing Address	1600 EUREKA ROAD, ROSEVILLE, CA 95661

Spouse/SRDP and Parent Information

Field	Value
28. Name of Surviving Spouse/SRDP – First	-
29. Middle	-
30. Last (Birth Name)	-
31. Name of Father/Parent – First	NATHANIEL
32. Middle	–
33. Last	STINSON
34. Birth State	UNK
35. Name of Mother/Parent – First	JONEE
36. Middle	–
37. Last (Birth Name)	FONSECA
38. Birth State	UNK

Funeral Director / Local Registrar

Field	Value
39. Disposition Date (mm/dd/ccyy)	05/21/2016
40. Place of Final Disposition	OUT OF THE COUNTRY -, SOUTH AMERICA
41. Type of Disposition(s)	TR
42. Signature of Embalmer	NOT EMBALMED
43. License Number	-
44. Name of Funeral Establishment	KAISER FOUNDATION HOSPITAL
45. License Number	NONE
46. Signature of Local Registrar	[redacted]
47. Date (mm/dd/ccyy)	07/14/2016

Place of Death

Field	Value
101. Place of Death	KAISER FOUNDATION HOSPITAL- ROSEVILLE
102. If Hospital, Specify One	[X] IP [ ] ER/OP [ ] DOA
103. If Other Than Hospital, Specify One	[ ] Hospice [ ] Nursing Home/LTC [ ] Decedent's Home [ ] Other
104. County	PLACER
105. Facility Address or Location Where Found	1600 EUREKA ROAD
106. City	ROSEVILLE

Cause of Death

Line	Cause	Time Interval Between Onset and Death
Immediate Cause (A)	ANOXIC ENCEPHALOPATHY	DYS.
(B)	CARDIAC ARREST	DYS.
(C)	STATUS ASTHMATICUS	DYS.
(D)		

Field	Value
108. Death Reported to Coroner?	[X] YES [ ] NO
Referral Number	1405220
109. Biopsy Performed?	[ ] YES [X] NO
110. Autopsy Performed?	[ ] YES [X] NO
111. Used in Determining Cause?	[ ] YES [ ] NO
112. Other Significant Conditions Contributing to Death but Not Resulting in the Underlying Cause	HISTORY OF ASTHMA
113. Was Operation Performed for Any Condition in Item 107 or 112?	NO
113A. If Female, Pregnant in Last Year?	[ ] YES [ ] NO [ ] UNK

Physician's Certification

Field	Value
114. Decedent Attended Since (mm/dd/ccyy)	04/12/2016
Decedent Last Seen Alive (mm/dd/ccyy)	04/14/2016
115. Signature and Title of Certifier	[redacted]
116. License Number	A73633
117. Date (mm/dd/ccyy)	04/18/2016
118. Type Attending Physician's Name, Mailing Address, Zip Code	MICHAEL STEVEN MYETTE M.D. 1600 EUREKA ROAD, ROSEVILLE, CA 95661

Coroner's Use Only

Field	Value
119. Manner of Death	[ ] Natural [ ] Accident [ ] Homicide [ ] Suicide [ ] Pending Investigation [ ] Could not be determined
120. Injured at Work?	[ ] YES [ ] NO [ ] UNK
121. Injury Date (mm/dd/ccyy)	
122. Hour (24 Hours)	
123. Place of Injury	
124. Describe How Injury Occurred	
125. Location of Injury	
126. Signature of Coroner/Deputy Coroner	
127. Date (mm/dd/ccyy)	
128. Type Name, Title of Coroner/Deputy Coroner	

State Registrar: A B C D E | FAX AUTH # | CENSUS TRACT

0100010032243741

INFORMATIONAL
NOT A VALID DOCUMENT
TO ESTABLISH IDENTITY

RYAN RONCO effective 5/17/2016
PLACER COUNTY CLERK-RECORDER

CERTIFIED COPY OF VITAL RECORDS
STATE OF CALIFORNIA, COUNTY OF PLACER

00020561 8

This is a true and exact reproduction of the document officially registered and placed on file in the office of the Placer County Clerk-Recorder.

DATE ISSUED 08/12/2016

JIM McCAULEY
PLACER COUNTY CLERK-RECORDER

This copy is not valid unless prepared on an engraved border displaying the date, seal and signature of the Clerk-Recorder

PRNCO (Rev) 12/15

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

EX 3

EXHIBIT 4

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF PLACER

ISRAEL STINSON by and through JONEE FONSECA, his mother Petitioner; v. UC DAVIS CHILDREN'S HOSPITAL; KAISER PERMANENTE ROSEVILLE MEDICAL CENTER-WOMEN AND CHILDREN'S CENTER, Respondent	Case No.: S-CV-0037673 ORDER OF DISMISSAL

Petitioner and applicant Jonee Fonseca has applied for a temporary restraining order directed to Kaiser Permanente Roseville Medical Center—Women and Children's Center concerning medical care and intervention provided to her son Israel Stinson. TRO proceedings were previously heard April 14, 15, 22 and 27, 2016.

A continued hearing was held April 29, 2016, in Department 43, the Hon. Michael W. Jones, presiding. Ms. Fonseca and Nathaniel Stinson, minor's father, appeared with Alexandra M. Snyder, Esq. Jason J. Curliano, Esq., and Madeline L. Buty, Esq., appeared for Kaiser Foundation Hospitals.

At the prior hearing, the court extended the restraining order to implement the Health and Safety Code section 1254.4 reasonably brief period of accommodation for Israel's family, and found that the extension of orders to April 29, 2016, 9:00 a.m., satisfies the statutory requirement for a reasonably brief accommodation period. The court finds that Health and Safety Code sections 7180 and 7181 have been complied with.

Having considered the argument and representations of counsel, the court orders as follows, and for reasons set forth in the record throughout these proceedings, the court orders as follows:

The temporary restraining order previously issued and most recently extended is dissolved by its own terms and this matter is DISMISSED.

The court notes that a separate federal action has been filed and the parties are pursuing relief there.

IT IS SO ORDERED.

DATED: April 29, 2016

Hon. Michael W. Jones
Judge of the Superior Court

EXHIBIT 5

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA,

Plaintiff,

v.

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, et al.,

Defendants.

No. 2:16-cv-00889-KJM-EFB

ORDER

Approximately one month ago, doctors at a Kaiser Permanente hospital in Roseville, California determined that two-year-old Israel Stinson had suffered the irreversible cessation of all functions of his entire brain, including the brain stem. Under California law, this determination means Israel has suffered brain death and is no longer alive. But because Israel's heart is still beating and he is still breathing, with the support of a ventilator and careful, ongoing medical intervention, Israel's mother, Jonee Fonseca, asks this court to prohibit Kaiser from ending its life-support efforts. She argues California's definition of "death" violates the United States Constitution and deprives both her and Israel of due process. She also claims the defendants' actions have violated the California Constitution and the federal Emergency Treatment and Active Labor Act. She names Kaiser, one of its physicians, and the Director of the California Department of Health as defendants, and she requests a preliminary injunction to

maintain and improve Israel's condition during this lawsuit. Although Kaiser and Ms. Fonseca have been attempting to reach a mediated resolution to accomplish Ms. Fonseca's goal of transporting Israel to a different location, there currently is no concrete proposal identifying either a location that will receive Israel or a method of transport. The court therefore is called to resolve the parties' legal disputes.

To this end, the court held a hearing on the preliminary injunction request on May 11, 2016. Kevin Snider, Matthew McReynolds, and Alexandra Snyder appeared for Ms. Fonseca, and Jason Curliano appeared for Kaiser and Michael Myette, M.D. Ashante Norton and Ismael Castro appeared and observed on behalf of Karen Smith, M.D., the Director of California's Department of Public Health.

I. DETAILED BACKGROUND

On April 1, 2016, Ms. Fonseca took Israel to a local emergency room. Fonseca Decl. ¶ 1, ECF No. 3-2. He had displayed symptoms of an asthma attack. *Id.* He was transferred to the pediatric unit at the hospital for the University of California, Davis, and his condition stabilized at least somewhat. *Id.* ¶¶ 1–2. Later the same day, however, after arriving at U.C. Davis, his condition worsened, he went into cardiac arrest, and he fell unconscious. *See id.* ¶¶ 3-5. Doctors attempted to revive him, and then used an extracorporeal membrane oxygenation (ECMO) machine to provide cardiac and respiratory support. *Id.* ¶¶ 5–7. Within a few days, his heart and lungs were functioning again on their own, but he requires a ventilator to breathe. *See id.* ¶¶ 9–14. A doctor determined Israel had suffered brain death; he was therefore no longer alive within the meaning of the California Uniform Determination of Death Act (CUDDA), Cal. Health & Safety Code § 7180 *et seq.*[1] *See id.* ¶ 14; First Am. Compl. ¶¶ 14, 19, ECF No. 1. Israel was then transported to the Kaiser hospital in Roseville, where he has been attended to since April 11,

[1] *See* Cal. Health & Safety Code § 7180(a) ("An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."); *see also id.* § 7181 ("When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be independent confirmation by another physician.").

2016. Doctors at Kaiser have twice independently confirmed he is brain dead. Fonseca Decl. ¶ 13; *see also* Myette Decl., ECF No. 43-1. The hospital completed its portion of a death certificate, which identifies the date of Israel's death as April 14, 2016, but other portions of the certificate remain incomplete. *See* Myette Decl. Ex. B, ECF No. 43-3 (incomplete portions include parents' names and information about the disposition). In light of its doctors' determinations, Kaiser intends to end life support efforts.

Ms. Fonseca believes Israel is not dead because his heart is beating and he is breathing, but if he no longer receives life support, he will then die. First Am. Compl. ¶ 3. She perceives that he responds to her voice and touch, and at times he appears to have taken breaths on his own. *See* Fonseca Decl., ECF No. 35. She therefore feels an imperative moral and spiritual obligation to ensure life support efforts for her son do not end. *Id.* ¶ 62.

Dr. Michael Myette, M.D. is the Medical Director for the Pediatric Intensive Care Unit at Kaiser in Roseville, the doctor ultimately responsible for Israel's care, and a defendant in this action. He explains his understanding of Israel's condition in basic terms: "Israel's brain is not telling his organs how to function." Myette Decl. ¶ 5. This means doctors must meticulously monitor and support his condition by adjusting his blood pressure and hormone levels pharmaceutically, providing support with a ventilator, and keeping his body warm with blankets. *Id.* ¶¶ 5–7. He is receiving only dextrose—sugar—for nutrition, but has not lost weight over the three to four weeks since he was admitted. *Id.* ¶ 9. Dr. Myette worries that if he fed Israel internally, complications would likely arise, including infection, which would be difficult to detect and combat. *Id.* ¶ 8. Israel does not respond to any stimulus. *Id.* ¶¶ 10, 12. Dr. Myette opines that although Ms. Fonseca believes Israel has taken breaths on his own, this is a misreading of the ventilator, which can be artificially triggered. *Id.* ¶ 14. The movements Israel makes in response to his mother's touch or voice are reflexes that originate in his spine; they also are triggered by more innocuous and lighter contact, for example, a bump on the side of his bed. *Id.* ¶¶ 10–12.

On April 14, 2016, after Kaiser completed its portion of the death certificate, Ms. Fonseca sought relief from the Placer County Superior Court on Israel's behalf. *See Fonseca*

ex rel. *Stinson v. U.C. Davis Children's Hosp.*, No. S-CV-0037673 (Placer Cty. Super. Ct. filed Apr. 14, 2016).[2] The superior court entered a temporary restraining order (TRO) requiring Kaiser to continue life support, and over a period of about two weeks during which the order was extended twice, Ms. Fonseca and Israel's biological father, Nathaniel Stinson, attempted unsuccessfully to arrange for Israel's transfer to another medical facility. *See generally* Curliano Decl. Exs. A–G, J–K, ECF No. 14-2 to -8 & -11 to -12. On April 29, the state court dismissed Ms. Fonseca's petition for relief and dissolved the TRO. ECF No. 19-1. The state court found California Health and Safety Code sections 7180 and 7181 had "been complied with." *Id.* at 2.

On April 28, 2016, the day before the Superior Court's restraining order was set to finally expire, Ms. Fonseca filed this lawsuit. *See* Compl., ECF No. 1. Her original complaint alleged claims directly under the U.S. Constitution, the federal Rehabilitation Act, and the Americans with Disabilities Act. The court granted a temporary restraining order until a hearing could be held on Monday, May 2, 2016. ECF No. 9. At the May 2 hearing, the court dismissed the original complaint by bench order, as the complaint's allegations did not show the court had jurisdiction. Minutes, ECF No. 22; Minute Order, ECF No. 23. The court ordered Ms. Fonseca to file a first amended complaint the next day. Kaiser did not object to an extension of the TRO through May 11, and a hearing was set for that day on a motion for a fully briefed preliminary injunction. The matter was also referred to emergency mediation before a magistrate judge of this court, but as noted the parties have been unable to reach an agreement so as to moot the current motion. Minutes, ECF No. 28.

Ms. Fonseca timely filed a first amended complaint, which includes five claims. First, she claims under 42 U.S.C. § 1983 that CUDDA is unconstitutional on its face under the Fifth and Fourteenth Amendments. First Am. Compl. ¶¶ 51–59. CUDDA provides that "death" is not just the cessation of breath and a heartbeat—the prior, historical conception—but also the absence of all functions of the brain and brain stem. *Id.* ¶ 56. Because the CUDDA provision is

[2] The court may take judicial notice of the filings in the state case. *See* Fed. R. Evid. 201(b) (governing judicial notice); *Asdar Grp. v. Pillsbury, Madison & Sutro*, 99 F.3d 289, 290 n.1 (9th Cir. 1996) (court filings and orders in related litigation may be subject to judicial notice).

broader than the historical conception and because it allows for no specific appeal of a death determination, Ms. Fonseca alleges it deprives Israel of due process. *Id.* ¶¶ 56–57. She asserts this claim against all the defendants: Kaiser, Dr. Myette, and Dr. Smith. *See id.* ¶¶ 5–6. Ms. Fonseca asks the court to declare CUDDA unconstitutional on its face, *id.* ¶ 59, and requests Kaiser be ordered to take certain steps to maintain and improve Israel's condition, *id.* ¶¶ 47–50.

Second, Ms. Fonseca alleges under 42 U.S.C. § 1983 that CUDDA deprives her of due process as Israel's parent. *Id.* ¶¶ 60–67. For this independent reason, she claims CUDDA is unconstitutional on its face. *Id.* ¶ 67. She alleges this claim against all the defendants.

Third, Ms. Fonseca alleges Kaiser violated the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd *et seq.* First Am. Compl. ¶¶ 68–79. Under EMTALA, hospitals with emergency departments must perform appropriate medical screening to determine whether those who come to the hospital asking for treatment have an emergency medical condition. 42 U.S.C. § 1395dd(a). If the hospital discovers a medical emergency, it must examine, treat, and "stabilize" the patient's condition or, alternatively, transfer the person to another medical facility. *See id.* § 1395dd(b), (e). Ms. Fonseca alleges Kaiser has not and will not appropriately stabilize Israel's condition if it removes life support, and she alleges Kaiser has not otherwise made an appropriate effort to transfer Israel to another facility. First Am. Compl. ¶¶ 71–75. She asks for declaratory relief, money damages, and an injunction ordering Kaiser to comply with EMTALA and stabilize Israel's condition. *Id.* ¶¶ 77–79.

Fourth, Ms. Fonseca alleges under 42 U.S.C. § 1983 that Kaiser and Dr. Myette have deprived her and Israel of their rights to privacy under the Fourth Amendment. *Id.* ¶¶ 80-84. She refers specifically to her right and Israel's right to have control over Israel's healthcare.

Fifth, Ms. Fonseca alleges Kaiser and Dr. Myette have violated her right and Israel's right to privacy and autonomy under Article I of the California Constitution. *Id.* ¶¶ 85-88.

Ms. Fonseca's motion for a preliminary injunction was filed on May 6, 2016. *See* Mot. Prelim. Inj., ECF No. 33. She requests relief at this stage on the basis of her claims under the EMTALA and federal Constitution, but not under her California constitutional claim. Kaiser

and Dr. Myette filed an opposition on May 10, 2016, ECF No. 43, and the court allowed reply argument at the hearing on May 11, 2016.

II. JURISDICTION

Federal courts are courts of limited jurisdiction. Therefore, as in every case, the court first asks whether it has jurisdiction to hear and decide the dispute before it. As explained below, the court is satisfied it has jurisdiction over the claims and defendants, although federal question jurisdiction does not adhere to Kaiser and Dr. Myette based on the civil rights claims.

A. Rooker-Feldman

As a preliminary matter, in the May 2 hearing, the court voiced its concern that it lacks jurisdiction over this action under *Rooker v. Fidelity Trust Co.*, 263 U.S. 413 (1923), and *District of Columbia Court of Appeals v. Feldman*, 460 U.S. 462 (1983), two cases that form the basis of what courts call the *Rooker-Feldman* doctrine. On further review and in light of the allegations in the First Amended Complaint, the court is satisfied this doctrine does not deprive it of all jurisdiction over this case.

Under the *Rooker-Feldman* doctrine, federal district courts are without jurisdiction to hear direct and de facto appeals from the judgments of state courts. *Cooper v. Ramos*, 704 F.3d 772, 777 (9th Cir. 2012); *Noel v. Hall*, 341 F.3d 1148, 1155 (9th Cir. 2003). To determine whether an action functions as a de facto appeal, the court "pay[s] close attention to the relief sought by the federal-court plaintiff." *Id.* at 777–78 (quoting *Bianchi v. Rylaarsdam*, 334 F.3d 895, 900 (9th Cir. 2003)) (emphasis omitted). "It is a forbidden de facto appeal under *Rooker–Feldman* when the plaintiff in federal district court complains of a legal wrong allegedly committed by the state court, and seeks relief from the judgment of that court." *Id.* (quoting *Noel*, 341 F.3d at 1163). However, the *Rooker-Feldman* doctrine does not preclude a plaintiff from bringing an "independent claim" that, though raising similar or even identical to issues, was not the subject of a previous judgment by the state court. *Id.* at 778.

A review of *Feldman* itself is instructive here. In *Feldman*, two graduates of unaccredited law schools petitioned a local court for a waiver to permit them to sit for the bar. 460 U.S. at 466. After the local court rejected their claims, the graduates filed suit in federal

court. *Id.* at 468. The Supreme Court deemed the action a de facto appeal to the extent it sought review of the local court's denial. *Id.* at 482. On the other hand, as recounted by the Ninth Circuit in *Noel*, the Supreme Court allowed the "challenge to the local court's legislative act of promulgating its rule" prohibiting the graduates from sitting for the bar. *Noel*, 341 F.3d at 1157. This aspect of the lawsuit "was a challenge to the validity of the rule rather than a challenge to an application of the rule." *Id.*; *see also Feldman*, 460 U.S. at 487.

In some instances, the independent constitutional claims a plaintiff asserts in federal court may not be possible to disentangle from a state court's earlier decision. *See Feldman*, 460 U.S. at 482 n.16. If that is the case, then the federal district court may not review the state court decision. *Id.* This was true of only some of the claims before the *Feldman* Court; other claims could be separated from the de facto appeal, for example the graduates' claims that the District of Columbia's law-school requirement discriminated against them and impermissibly delegated authority to the American Bar Association to regulate the bar. *Id.* at 487–88.

Here, Ms. Fonseca challenges CUDDA's constitutionality generally. For the most part, she does not challenge CUDDA's particular application. *See* Mot. Prelim. Inj. at 12 ("At this stage of the proceedings, Plaintiff is not asserting that [Kaiser] has misread or misapplied CUDDA."); *but see, e.g.*, First Am. Compl. ¶ 32; Byrne Decl. ¶¶ 5, 12–15, ECF No. 36. Her constitutional claims here were not presented to the state superior court and except for the mandatory aspects of the injunction she proposes, discussed toward the end of this order, the relief she now seeks does not undermine the factual or legal conclusions the state court reached. The same is true of her non-constitutional claims; none was before the superior court. Ms. Fonseca neither asserts legal error by the state court nor seeks relief from a state court judgment. If Ms. Fonseca can otherwise establish this court's subject matter jurisdiction over her claims, the *Rooker–Feldman* doctrine does not prevent her case from going forward.

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B. Standing

Next is the question of standing. Given Ms. Fonseca's status as Israel's mother and general guardian, she may litigate here on his behalf. *See* Fed. R. Civ. P. 17(c) (a general guardian may sue on behalf of a minor or incompetent person); *Doe* ex rel. *Sisco v. Weed Union Elementary Sch. Dist.*, No. 13-01145, 2013 WL 2666024, at *1 (E.D. Cal. June 12, 2013) ("Rule 17(c)(1)(A) permits a 'general guardian' to sue in federal court on behalf of a minor, and a parent is a guardian who may so sue." (citation and quotation marks omitted)). This presupposes that the rules of parental guardianship govern equally the relationship between a parent and a child whose death is disputed. Whatever the correct procedural method of representation, for purposes of this motion Ms. Fonseca may represent Israel's interests in this case. *See, e.g.*, *Lopez v. Cty. of L.A.*, No. 15-01745, 2015 WL 3913263, at *9 (C.D. Cal. June 25, 2015) (survival claims under Constitution by parent); *see also Williams v. Bradshaw*, 459 F.3d 846, 848 (8th Cir. 2006) ("Federal courts are to apply state law in deciding who may bring a § 1983 action on a decedent's behalf."); Cal. Civ. Proc. Code § 377.10, .20, .30 (governing survival claims); Cal. Prob. Code §§ 6401–02 (who may bring a survival action). She has standing. Her request to be appointed as Israel's guardian *ad litem* is therefore denied as moot. *See* Pet., ECF No. 31.

C. Federal Question Jurisdiction and Action Under Color of Law

Turning now to the complaint's substantive claims, Ms. Fonseca proposes three jurisdictional pillars to support her action in federal court.

1. EMTALA and § 1331

First, she cites her EMTALA claims and 28 U.S.C. § 1331, the latter of which establishes this court's jurisdiction over all claims arising under the Constitution, laws, and treaties of the United States. This court's jurisdiction to evaluate her EMTALA claim, which arises under a federal statute, is beyond dispute, as is this court's supplemental jurisdiction to consider any state-law claims that are a part of the same case or controversy. *See* 28 U.S.C. § 1367(a).

2. 42 U.S.C. § 1983

This leaves Ms. Fonseca's claims under § 1983, a broad federal civil rights statute. Any claim under that section must concern the defendants' actions under color of law. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 946 (1982). State action is a "jurisdictional requisite" in any claim under § 1983. *Polk Cty. v. Dodson*, 454 U.S. 312, 315 (1981). In this regard, Ms. Fonseca notes her addition of Dr. Smith as a defendant. Dr. Smith is alleged to be the Director of the California Department of Public Health and is sued in her official capacity under 42 U.S.C. § 1983. First Am. Compl. ¶ 6.

a. Dr. Smith

"Claims under § 1983 are limited by the scope of the Eleventh Amendment."[3] *Doe v. Lawrence Livermore Nat. Lab.*, 131 F.3d 836, 839 (9th Cir. 1997). Specifically, states and state governmental entities are not "persons" within the meaning of § 1983. *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 70 (1989). The Supreme Court has, however, interpreted the Eleventh Amendment as allowing federal courts to grant prospective injunctive relief against state officials acting "under color of law." *Va. Office for Prot. & Advocacy v. Stewart*, 563 U.S. 247, 255 (2011); *Ex parte Young*, 209 U.S. 123, 159–60 (1908). In short, "the Eleventh Amendment does not generally bar declaratory judgment actions against state officers." *Nat'l Audubon Soc'y, Inc. v. Davis*, 307 F.3d 835, 847 (9th Cir. 2002), *opinion amended on denial of reh'g*, 312 F.3d 416 (2002). This court therefore has jurisdiction to consider Ms. Fonseca's request for prospective declaratory relief against Dr. Smith, which targets an allegedly ongoing violation of federal constitutional law in the form of her application of CUDDA in the provision of procedures related to issuance of death certificates.

b. Kaiser and Dr. Myette

Kaiser and Dr. Myette, by contrast, have not in any way supported by the record acted "under color of law." Kaiser is a private hospital, and Dr. Myette is a private person.

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[3] "The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state, or by citizens or subjects of any foreign state." U.S. Const. amend. XI.

"[P]rivate parties are not generally acting under color of state law," *Price v. State of Haw.*, 939 F.2d 702, 707–08 (9th Cir. 1991), "no matter how discriminatory or wrongful" their actions may be, *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 50 (1999) (citation and quotation marks omitted). But "[u]nder familiar principals, even a private entity can, in certain circumstances, be subject to liability under section 1983." *Villegas v. Gilroy Garlic Festival Ass'n*, 541 F.3d 950, 954 (9th Cir. 2008) (en banc). The basic question a court must answer is whether the private person's conduct "may be fairly characterized as 'state action'" or "fairly attributable to the State." *Lugar*, 457 U.S. at 924, 937. The phrase "under color of law" for purposes of a § 1983 claim has the same meaning as the phrase "state action" for purposes of the Fourteenth Amendment. *Id.* at 928.

At the outset, the Supreme Court has taken care to distinguish two related elements of "fair attribution" in a § 1983 claim: the plaintiff must show both that a "state action" has occurred and that the defendants acted "under color of law." *Id.* at 937; *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 156 (1978). Here, a state has acted: California passed CUDDA, and the California Department of Public Health imposes procedural requirements related to the issuance of a death certificate, including for people who have suffered brain death under CUDDA. *See* First Am. Compl. ¶¶ 6, 21; *see also Am. Mfrs.*, 526 U.S. at 50 (a private person's actions "with the knowledge of and pursuant to" a statute shows "state action" occurred (citation and quotation marks omitted)). But these facts do not establish Kaiser's and Dr. Myette's action under color of law.

Federal courts have often been called on to decide whether doctors and hospitals have acted under color of law. In general, private doctors and hospitals are more commonly found not to be state actors. *See, e.g.*, *Babchuk v. Indiana Univ. Health, Inc.*, 809 F.3d 966, 970-71 (7th Cir. 2016); *McGugan v. Aldana-Bernier*, 752 F.3d 224, 229–31 (2d Cir. 2014), *cert. denied*, 135 S. Ct. 1703 (2015); *Wittner v. Banner Health*, 720 F.3d 770, 775–81 (10th Cir. 2013); *Briley v. State of Cal.*, 564 F.2d 849, 855–56 (9th Cir. 1977) (noting that "private hospitals and physicians have consistently been dismissed from § 1983 actions for failing to come within the

color of state law requirement of this section" and collecting authority).[4] This is likely the result of two rules of thumb. First, the Supreme Court has "consistently held that '[t]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment." *Am. Mfrs.*, 526 U.S. at 52 (quoting *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 350 (1974), and citing *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982)) (alteration in original). On a related note, even though doctors' services are "affected with a public interest," the same may be said of many professions, and this does not automatically convert their every action into an action of the state. *See Jackson*, 419 U.S. at 354. Second, although doctors and hospitals are often the beneficiaries of state and federal funding, receipt of government funding alone does not make for action under color of law. *See Chudacoff v. Univ. Med. Ctr. of S. Nev.*, 649 F.3d 1143, 1149–50 (9th Cir. 2011) (collecting authority).

In addition, the choices a doctor or a hospital must make are often matters of discretion, informed by expertise, training, and the specifics of the patient presented to them, and for this reason, courts often hesitate to find a doctor's actions fairly attributable to the state. *See, e.g.*, *Blum*, 457 U.S. at 1008 (decisions that "ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State" undercut claims of action under color of law); *Collyer v. Darling*, 98 F.3d 211, 232–33 (6th Cir. 1996) (noting the absence of any contractual relationship between the doctors and the state and the "independence with which the doctors completed their tasks"); *Pinhas v. Summit Health, Ltd.*, 894 F.2d 1024, 1034 (9th Cir. 1989) (a decision that "ultimately turned on the judgments made by private parties according to professional standards that are not established by the State," but flowed from a peer-review process created by statute, was not an action under color of law), *aff'd on unrelated question*, 500 U.S. 322 (1991).

At the same time, no categorical rule prevents the mixture of professional judgment and action under the color of law. *See, e.g.*, *West v. Atkins*, 487 U.S. 42, 51 (1988)

[4] Kaiser previously has been found by another district court not to be a state actor, in a case challenging California's statutory scheme governing medical peer review proceedings. *See generally Safari v. Kaiser Found. Health Plan*, No. 11-05371, 2012 WL 1669351 (N.D. Cal. May 11, 2012).

(explaining the court below misread Supreme Court precedent "as establishing the general principle that professionals do not act under color of state law when they act in their professional capacities"). Nevertheless, private doctors and hospitals do not even act under color of state law when they participate in the civil commitment of mentally ill patients. *See, e.g.*, *Bass v. Parkwood Hosp.*, 180 F.3d 234, 243 (5th Cir. 1999) (collecting authority).

By contrast, a doctor or hospital is much more likely to have acted under color of law when the hospital is a public hospital, or if it assumed that role for all practical purposes, for example when a doctor contracts with a state to provide medical services to the inmates of a state prison. *See generally West*, 487 U.S. 42; *see also Chudacoff*, 649 F.3d at 1150 (citing, *inter alia*, *Woodbury v. McKinnon*, 447 F.2d 839, 842 (5th Cir. 1971)). In these situations, the doctor or hospital has "exercised power possessed by virtue of state law and made possible only because the wrongdoer is clothed with the authority of state law." *West*, 487 U.S. at 49 (citation and quotation marks omitted).

The Ninth Circuit case of *Sutton v. Providence St. Joseph Medical Center*, 192 F.3d 826 (9th Cir. 1999), provides a helpful framework. In *Sutton*, the Circuit considered in detail the potential liability of a private defendant under § 1983. It concluded "the mere fact that the government compelled a result does not suggest that the government's action is "fairly attributable" to the private defendant. *Id.* at 838. To find otherwise "would be to convert every employer—whether it has one employee or 1,000 employees—into a governmental actor every time it complies with a presumptively valid, generally applicable law, such as an environmental standard or a tax-withholding scheme." *Id.* The court emphasized the importance of "something more" between the state and private person: Did the defendant perform a public function? Did the government and defendants act together? Did the government compel or coerce the defendants? Or is there some other "nexus" between the government and the defendants? *See id.* at 835. The Circuit cited three cases as examples of this nexus: (1) *Adickes v. S.H. Kress & Co.*, 398 U.S. 144 (1970), where the Supreme Court relied on an alleged conspiracy between private and public actors; (2) *Lugar*, 457 U.S. 922, where the Court relied on official cooperation between the private and public actors; and (3) *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163

(1972), where the Court relied on the state's enforcement and ratification of the private person's actions. *See Sutton*, 192 F.3d at 839–41.

Here, Ms. Fonseca cites four facts to argue Kaiser's and Dr. Myette's determination of death is fairly attributable to the state: (1) "declarations of death are essentially a state-prescribed function"; (2) the defendants acted as "willful participants" in the State's determination of death; (3) the defendants had "no discretion to entertain independent medical judgment inconsistent with CUDDA's definition" and participated in a specific, state-defined protocol; and (4) Kaiser received Israel from one public institution, U.C. Davis, and is attempting to transfer him to another public official, the coroner. *See* Mot. Prelim. Inj. at 6–9.

These facts do not show Kaiser and Dr. Myette are state actors. Several relate to the question of whether a "state action" occurred, but not whether the defendants here acted "under color of law." In other words, it may be that a state normally prescribes the exact criteria for a doctor to check when deciding whether a patient is living, and it may be that Kaiser and Dr. Myette willfully complied with state laws and regulations, but these facts suggest only that a "state action" has occurred, not that Kaiser and Dr. Myette acted under color of law.

At most it can be said that California passed a law and that the defendants willfully complied with the law. *See, e.g.*, Cal. Health & Safety Code §§ 102800, 102825 (physicians' obligations related to a death certificate). As *Sutter* teaches, state compulsion does not establish a private defendant's actions under color of law; "something more" is necessary. *Sutton*, 192 F.3d at 835. If the facts here were enough to show Kaiser and Dr. Myette had acted under color of law, then a private person would act under color of law every time he or she obeyed laws or regulations of his or her own accord, which cannot be. *See Am. Mfrs.*, 526 U.S. at 52. Consider a lawyer who studies the California Code of Civil Procedure, or a driver who fills out the paperwork to apply for a driver's license. California defines its rules of procedure and a state agency creates the forms the driver fills out, but the lawyer is not a state actor when he follows the rules, and a driver is not a state actor when he fills out and turns in the form. Something more is required. The defendants suggest an analogy to a priest who completes a marriage license,

Opp'n at 1, which, though unsupported by citation to a specific authority, illustrates the same point.

The fact that Kaiser received and would transfer Israel to and from a state institution does not show the private defendants acted under color of law. It is a coincidence that Israel was transferred from a university hospital, and the presence of state entities in this respect cannot make for action under color of law.

Professional expertise, training, and discretion also show California played at most a minor role in Kaiser's and Dr. Myette's actions. CUDDA describes brain death in general terms—the "irreversible cessation of all functions of the entire brain, including the brain stem"—and it specifically refers to "accepted medical standards." *See* Cal. Health & Safety Code § 7180. California has not dictated which tests must be performed, how, when, or by whom. These specifics are all matters of private medical expertise and discretion. They are the subject of guidelines published by professional medical organizations. *See, e.g.*, Am. Acad. Pediatrics, *Clinical Report—Guidelines for the Determination of Brain Death in Infants and Children* (2011), ECF No. 36-1. The determination of Israel's brain death "ultimately turn[ed] on medical judgments made by private parties according to professional standards" that California did not establish. *Blum*, 457 U.S. at 1008.

Upon close review, this case contrasts with the others in which doctors and hospitals have been found to act under color of law. For example, drawing from those cited above, in *West v. Atkins*, the Supreme Court held that a doctor employed part-time by the state acted under color of law when he treated inmates in a state prison. *See generally* 487 U.S. 42. In *Chudacoff v. University Medical Center of South Nevada*, the Ninth Circuit described the defendant hospital as public "through and through," because it was "controlled and managed" by the state and the defendants' authority "flow[ed] directly from the state." 649 F.3d at 1150.

This case also contrasts with the general body of decisions based on action under color of law that occurred outside the hospital context. In the *Lugar* case on which plaintiff has relied, for example, the Supreme Court considered whether a private defendant who used an *ex parte* state procedure to obtain an order sequestering the plaintiff's property could be liable as a

state actor. 457 U.S. at 924–25. The Court reaffirmed that a private person could be held liable as a state actor in that situation, noting that the state's involvement was "overt" and "official" and that the private person participated jointly with the state in a seizure of property. *Id.* at 927–28, 941; *see also Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 290–91 (2001) ("[T]he association in question here includes most public schools located within the State, acts through their representatives, draws its officers from them, is largely funded by their dues and income received in their stead, and has historically been seen to regulate in lieu of the State Board of Education's exercise of its own authority.").

Ms. Fonseca has not cited any case where a private doctor working at a private hospital providing treatment to a private person was found to have acted under color of law. The court's independent research has likewise produced no example. This is a case of private action, not public action. The § 1983 claims against Kaiser and Dr. Myette cannot support Ms. Fonseca's request for a preliminary injunction.

In determining whether an injunction should issue, therefore, the court considers only the EMTALA claim against Kaiser, which appears to be the claim on which plaintiff primarily relies, as well as the § 1983 claims against Dr. Smith.

III. LEGAL STANDARD

A preliminary injunction preserves the relative position of the parties until a trial is completed on the merits or the case is otherwise concluded. *See Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981). It is an extraordinary remedy awarded only upon a clear showing that the plaintiff is entitled to relief. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008). The plaintiff must show she is "likely to succeed on the merits," "likely to suffer irreparable harm in the absence of the preliminary relief," "the balance of equities tips in [her] favor," and "an injunction is in the public interest." *Id.* at 20. Alternatively, if a plaintiff cannot demonstrate she is likely to succeed on the merits of her claims, but can show at least (1) that "serious questions" go to the merits of her claims, (2) that the "balance of hardships tips *sharply*" in her favor, and (3) that the other two parts of the *Winter* test are satisfied, then a preliminary injunction may be proper nonetheless. *Shell Offshore, Inc. v. Greenpeace, Inc.*, 709 F.3d 1281, 1291 (9th Cir. 2013)

(quoting *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1134–35 (9th Cir. 2011)) (emphasis in *Shell*).

But if the plaintiff cannot show she has even a "fair chance of success on the merits," then it does not matter how the other parts of the *Winter* test may be resolved; "at an irreducible minimum the moving party must demonstrate a fair chance of success on the merits, or questions serious enough to require litigation." *Pimentel v. Dreyfus*, 670 F.3d 1096, 1111 (9th Cir. 2012) (quoting *Guzman v. Shewry*, 552 F.3d 941, 948 (9th Cir. 2009)) (internal quotation marks omitted).

When deciding whether to issue a preliminary injunction, the court may rely on declarations, affidavits, and exhibits, among other things, and this evidence need not conform to the standards that apply at summary judgment or trial. *Johnson v. Couturier*, 572 F.3d 1067, 1083 (9th Cir. 2009); *see also Flynt Distrib. Co. v. Harvey*, 734 F.2d 1389, 1394 (9th Cir. 1984) ("The trial court may give even inadmissible evidence some weight, when to do so serves the purpose of preventing irreparable harm before trial"); *Rubin* ex rel. *N.L.R.B. v. Vista Del Sol Health Servs., Inc.*, 80 F. Supp. 3d 1058, 1072 (C.D. Cal. 2015) ("It is well established that trial courts can consider otherwise inadmissible evidence in deciding whether or not to issue a preliminary injunction."). "A credibility determination is well within the court's province when ruling on a preliminary injunction motion . . . ." *N.E. England Braiding Co. v. A.W. Chesterton Co.*, 970 F.2d 878, 884 (Fed. Cir. 1992); *accord Oakland Tribune, Inc. v. Chronicle Pub. Co., Inc.*, 762 F.2d 1374, 1377 (9th Cir. 1985); 11A Charles A. Wright, et al., Federal Practice & Procedure § 2949 (3d ed. 2013). A district court may also hear oral testimony at a hearing. *Stanley v. Univ. of S. Cal.*, 13 F.3d 1313, 1326 (9th Cir. 1994). Oral testimony is unnecessary, however, if the parties had an adequate opportunity to submit written testimony and argue the matter. *Id.*

IV. DISCUSSION

A. EMTALA Claim Against Kaiser

Ms. Fonseca argues that under EMTALA, Kaiser is required to provide "stabilizing treatment" to Israel until he can be transferred. Mot. Prelim. Inj. at 10–11. She relies

heavily on the Fourth Circuit's decision in *In re Baby K*, 16 F.3d 590 (4th Cir. 1994), discussed below.

Congress enacted EMTALA over concerns that "hospitals were dumping patients who were unable to pay for care, either by refusing to provide emergency treatment to these patients, or by transferring the patients to other hospitals before the patients' conditions stabilized." *Jackson v. East Bay Hosp.*, 246 F.3d 1248, 1254 (9th Cir. 2001); *see* H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985), reprinted in 1986 U.S. Code Cong. & Admin. News 579, 605. EMTALA provides,

> In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

42 U.S.C. § 1395dd(a).

If the hospital determines that the individual has an emergency medical condition, then the hospital must provide either

> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> (B) for transfer of the individual to another medical facility . . . .

Id. § 1395dd(b). An "emergency medical condition" is defined as

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . . .

Id. § 1395dd(e)(1)(A). "To stabilize" and "stabilized" are also specifically defined:

> (A) The term "to stabilize" means, with respect to an emergency medical condition . . . , to provide such medical treatment of the

> condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility . . . .
>
> (B) The term "stabilized" means, with respect to an emergency medical condition . . . , that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility . . . .

Id. § 1395dd(e)(3).

It appears there is no binding or persuasive authority on all fours with this case. As noted, Ms. Fonseca analogizes her case to that of the child in *Baby K*. Mot. Prelim. Inj. at 11. The patient in *Baby K* was an anencephalic[5] infant suffering from respiratory distress. 16 F.3d at 592–93. The hospital physicians informed Baby K's mother that most anencephalic infants die within a few days of birth due to breathing difficulties and other complications, and recommended that Baby K be provided only with supportive care in the form of nutrition, hydration and warmth. *Id.* at 592. Baby K's mother and physicians were not able to reach an agreement as to the appropriate care for Baby K; thus, Baby K's mother transferred her to a nursing home. *Id.* at 593. After the transfer, Baby K was readmitted to the hospital three times due to breathing difficulties. *Id.* Each time, after breathing assistance was provided and Baby K was stabilized, she was discharged to the nursing home. *Id.* Following Baby K's second admission, the hospital sought a declaratory judgment that it was not required to provide respiratory support to anencephalic infants. *Id.* The district court denied that relief, and the Fourth Circuit affirmed, observing:

> Congress rejected a case-by-case approach to determining what emergency medical treatment hospitals and physicians must provide and to whom they must provide it; instead, it required hospitals and physicians to provide stabilizing care to any individual presenting an emergency medical condition. EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more

[5] Anencephaly is a congenital malformation where a major portion of the patient's brain, skull and scalp are missing. *Baby K*, 16 F.3d at 592. The presence of a brain stem supported Baby K's autonomic functions and reflex actions, but, without a cerebrum, the patient was permanently unconscious and had no cognitive abilities or awareness. *Id.* She could not see, hear, or interact with her surroundings. *Id.*

> than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy—all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death.

Id. at 598. EMTALA was therefore applicable and required the hospital to provide stabilizing care to Baby K when her mother sought emergency care. *Id.*

Two years later, the Fourth Circuit clarified its holding in *Baby K* and provided a narrowed reading of EMTALA. *See Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996). In *Bryan*, the plaintiff argued that the hospital defendant violated EMTALA when, after treating the adult patient for an emergency condition for twelve days, it decided that no further efforts to prevent the patient's death should be made. *Id.* at 350, 352. The hospital refused to follow instructions from the patient's husband and family, and entered a "do not resuscitate" order against the family's wishes. *Id.* at 350. As a result, the patient's condition worsened, and she died a few days later. The Fourth Circuit found EMTALA did not apply and distinguished *Baby K*:

> Under the circumstances [in *Baby K*], the requirement was to provide stabilizing treatment of . . . respiratory distress, without regard to the fact that the patient was anencephalic or to the appropriate standards of care for that general condition.
>
> The holding in *Baby K* thus turned entirely on the substantive nature of the stabilizing treatment that EMTALA required for a particular emergency medical condition. The case did not present the issue of the temporal duration of that obligation, and certainly did not hold that it was of indefinite duration.

Id. at 352. The *Bryan* court went on to affirm the district court's order dismissing the case because the plaintiff had conceded that the patient received stabilizing treatment in accordance with EMTALA for twelve days. *Id.* at 353. The plaintiff's claim rested only on the "ultimate cessation of that or any further medical treatment upon entry of the anti-resuscitation order," which did not violate EMTALA. *Id.*

The Fourth Circuit further noted that EMTALA is "a limited 'anti-dumping' statute, not a federal malpractice statute." *Id.* at 351. It echoed the decisions of other circuit

courts, noting that EMTALA was enacted to prevent patients from being turned away from emergency rooms for lack of insurance or other non-medical reasons. *Id.*; *see also, e.g.*, *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 796 (10th Cir. 2001) (Congress enacted EMTALA to regulate emergency room care to prevent the dumping" of the uninsured); *Cherukuri v. Shalala*, 175 F.3d 446, 448 (6th Cir. 1999) (same). The Ninth Circuit, in finding EMTALA provides no private right of action against physicians, has characterized the law's purpose in the same way: "Congress enacted [EMTALA] in response to a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured." *Eberhardt v. City of L.A.*, 62 F.3d 1253, 1255 (9th Cir. 1995) (citation and quotation marks omitted). "Congress was concerned that hospitals were 'dumping' patients who were unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their conditions were stabilized." *Id.*

Ultimately, the Fourth Circuit held in *Bryan* that once stabilizing treatment has been provided for a patient who arrives with an emergency condition, "the patient's care becomes the legal responsibility of the hospital and the treating physicians," and the legal adequacy of the subsequent care is no longer governed by EMTALA. 95 F.3d at 351. A hospital is not obligated to provide "stabilizing treatment" for a particular "emergency medical condition" for an indefinite duration, at least in terms of its liability under EMTALA. *See id.* at 352.

Here, after Israel's first admission to a local hospital for an asthma attack, then his loss of consciousness, intubation and transfer to U.C. Davis, followed by a brain death examination and apnea tests[6] at U.C. Davis, Israel was transferred to Kaiser on the eleventh day after his asthma attack. At Kaiser, stabilizing treatment was provided, another apnea test was performed, and after another three days, two doctors performed tests independently to determine whether Israel's brain was still functioning. Each doctor determined Israel had suffered brain

[6] In performing an apnea test, a doctor removes the ventilator and allows the carbon dioxide levels within a patient to rise in order to provoke a respiratory response. The First Amended Complaint appears to allege that Israel was not comatose at the time of this testing, but does not provide further clarification as to his actual state. FAC ¶ 19.

death as provided by CUDDA on April 14, 2016.[7] Kaiser completed a portion of a Certificate of Death for Israel soon afterward. ECF No. 43-3. Nonetheless, Kaiser has continued to provide support for Israel pending the parties' efforts at mediation and court decisions.

As a practical matter, after stabilizing Israel, Kaiser determined Israel's condition was no longer an emergency medical condition because it found Israel had suffered brain death. This determination distinguishes this case from *Baby K*, where the patient, despite breathing difficulties, was stabilized and discharged. Also, unlike *Baby K*, this is not a case where the patient still "seek[s] emergency stabilizing treatment for [medical] distress." *Baby K*, 16 F.3d at 598. Rather, Ms. Fonseca requests that Israel remain on a ventilator with additional treatment so he can be in his current condition once she has a plan for transfer. The dispute here, as in *Bryan*, raises at best a question of long-term care. *See id.* EMTALA does not obligate Kaiser to maintain Israel on life support indefinitely. Plaintiff identifies no date by which she would agree Kaiser's obligations cease. This case raises no serious questions under EMTALA.

B. Substantive Due Process Claim Against Dr. Smith

The complaint alleges generally that CUDDA deprives Ms. Fonseca of liberty and privacy and Israel of life without due process. *See* First Am. Compl. at 11–15. In her moving papers, Ms. Fonseca clarifies that she challenges CUDDA both as a matter of substance and with respect to the procedures CUDDA establishes. *See* Mot. Prelim. Inj. at 11–12. The court considers first, here, her substantive challenge. As explained below, the court does not enjoin CUDDA, and therefore does not provide Dr. Smith time to brief her position on plaintiff's claims against her.

The Due Process Clause of the Fourteenth Amendment prohibits states from making or enforcing laws that deprive a person of life, liberty, or property without due process. U.S. Const. amend. XIV, § 1. The Clause has been construed to "protect[] individual liberty against certain government actions regardless of the fairness of the procedures used to implement them." *Collins v. City of Harker Heights, Tex.*, 503 U.S. 115, 125 (1992) (citation and quotation

[7] As the state court found, Kaiser thus provided the "independent confirmation" required by CUDDA. Cal. Health & Safety Code § 7181.

marks omitted). It "provides heightened protection against government interference with certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). Among these rights is a person's liberty interest in making certain decisions about medical treatment. *See id.* at 724–25 (citing *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 279 (1990)).

1. Rights at Stake

When presented with a due process challenge, the court must take care to understand what right or liberty interest is at stake. *See id.* at 721 (referring to a "careful description" of the asserted fundamental liberty interest). Ms. Fonseca would define the interests in question here as Israel's right to live and her right to make decisions about his care; that is, she alleges CUDDA deprives her of a right to make healthcare decisions for Israel. *See* Mot. Prelim. Inj. at 11–16. For all practical purposes, these claims are the same: they are both challenges to California's decision to place brain death on equal footing with the prior legal understanding of death, as linked to breath and heartbeat. Although the court agrees Ms. Fonseca has a fundamental liberty interest "in the care, custody, and control of [her] children," *Troxel v. Granville*, 530 U.S. 57, 65 (2000), it does not follow that any person, parent or not, has a right to demand healthcare be administered to those who are not alive in the eyes of the state. Nevertheless, Ms. Fonseca's fundamental interests in the care of her son likely encompass her challenge to California's determination that he is not alive. For purposes of this motion, the court finds Ms. Fonseca may challenge CUDDA in her own right as well as on Israel's behalf. *But see Pickup v. Brown*, 740 F.3d 1208, 1235–36 (9th Cir.) (finding a parent has no fundamental right "to choose for a child a particular type of provider for a particular treatment that the state has deemed harmful"), *cert. denied*, 134 S. Ct. 2871, *and cert. denied sub nom. Welch v. Brown*, 134 S. Ct. 2881 (2014).

It goes without saying that the right to life is fundamental. The fundamental rights of parents have also been unquestioned for the better part of a century at least. *See, e.g., Troxel*, 530 U.S. at 65. This does not end this court's inquiry; whether a constitutional right has been violated is determined by balancing that right or liberty interest against the "relevant state

interests." *Cruzan*, 497 U.S. at 279 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)). In other words, "[i]n determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance the liberty of the individual and the demands of an organized society." *Youngberg*, 456 U.S. at 320 (citation and quotation marks omitted).

2. Balancing of Interests

The particulars of the required balancing exercise are difficult to describe generally. The Supreme Court has engaged in balancing in three cases that are instructive here. In *Cruzan*, the Court balanced a competent person's "constitutionally protected liberty interest in refusing unwanted medical treatment" against Missouri's decision to require clear and convincing evidence that a person in a persistent vegetative state would have wanted to terminate treatment. 497 U.S. at 278–85. The Court considered the State's interests in safeguarding the deeply personal choice between life and death. *See id.* at 281. In *Youngberg*, the Court balanced a civilly committed person's interests in safety and freedom against the state's interests, for example in protecting others from violence, and concluded that the state was constitutionally required to ensure that the commitment decision was not made in reliance on a "substantial departure from accepted professional judgment, practice, or standards." 457 U.S. at 321–23. And in *Bell v. Wolfish*, 441 U.S. 520 (1979), the Court balanced the rights of pretrial detainees to be free from punishment against the state's interest in ensuring a defendant is present at trial, the state's "operational concerns," and other related interests. *Id.* at 539–40. Similarly, as the Ninth Circuit has observed, a parent's fundamental liberty interest in maintaining the family relationship is not absolute; when the state interferes with that relationship, the parents' interests must be balanced against those of the state. *See, e.g.*, *Woodrum v. Woodward Cty., Okl.*, 866 F.2d 1121, 1125 (9th Cir. 1989); *see also Pickup*, 740 F.3d at 1235 ("Parents have a constitutionally protected right to make decisions regarding the care, custody, and control of their children, but that right is not without limitations." (citation and quotation marks omitted)).

While the historical, common-law understanding, that death occurred after the permanent cessation of breath and blood flow, was generally in effect in this country for many years prior to the late 1900s, *see, e.g.*, *People v. Mitchell*, 132 Cal. App. 3d 389, 396–97 (1982)

(citing *Commonwealth v. Golston*, 373 Mass. 249 (1977)), the understanding of the human body's functioning is different today than it was when death was defined without reference to the brain. The previous legal understanding of death fit within a context when the heart, lungs, and other organs could not be sustained artificially. In the face of changing technology, California has a broad range of legitimate interests in drawing boundaries between life and that reflect current understanding. These interests include: for purposes of criminal law (has a murder occurred and when?), tort liability (has a doctor caused a death and when?), probate and the law of estates (what rights do heirs possess and when?), general healthcare and bioethics (how must the state and private medical providers allocate scarce resources among the ill and injured?), and as relevant here regulation of the medical profession (when may a doctor refuse treatment, and when must a doctor provide treatment?). *Cf. Glucksberg*, 521 U.S. at 731 (recognizing a state's interest in protecting "the integrity and ethics of the medical profession" opposite an asserted fundamental right); *Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975) ("States have a compelling interest in the practice of professions within their boundaries . . . ."); *Varandani v. Bowen*, 824 F.2d 307, 311 (4th Cir. 1987) (recognizing a state's "compelling interest in assuring safe health care for the public").

Nothing before the court suggests CUDDA is arbitrary, unreasoned, or unsupported by medical science. Kansas was the first to adopt a statutory definition of death in 1970, including brain death. *See State v. Shaffer*, 223 Kan. 244, 249 (1977). Other states followed this lead, and the Uniform Determination of Death Act was adopted in 1980 by the National Conference of Commissions on Uniform Laws. David B. Sweet, *Homicide by Causing Victim's Brain-Dead Condition*, 42 A.L.R.4th 742 (orig. pub. 1985). The current version of the Act is the product of a long-debated agreement between the American Medical Association and the American Bar Association. *See id.*; 14 Witkin, Summary 10th, Wills, § 11, p. 69 (2005). Thirty-three states and the District of Columbia have formally adopted the Act. *See* U.L.A., Unif. Determination of Death Act, Refs. & Annos.; *see also In re Guardianship of Hailu*, 361 P.3d 524, 528 (Nev. 2015) ("The UDDA and similar brain death definitions have been uniformly accepted throughout the country."). California adopted the Act in 1982. *See* 1982 Cal. Stat. 3098.

Brain death itself is a widely recognized and accepted phenomenon, including in children and infants. *See, e.g.*, Am. Acad. Pediatrics, *Clinical Report—Guidelines for the Determination of Brain Death in Infants and Children* (2011), ECF No. 36-1 (affirming "the definition of death," the same definition used in CUDDA, which "had been established by multiple organizations including the American Medical Association, the American Bar Association, the National Conference of Commissioners on Uniform State Laws, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research and the American Academy of Neurology"); James L. Bernat, *The Whole-Brain Concept of Death Remains Optimum Public Policy*, 34 J.L. Med. & Ethics 35, 36 (2006) ("The practice of determining human death using brain tests has become worldwide over the past several decades. The practice is enshrined in law in all 50 states in the United States and in approximately 80 other countries . . . .").

At the same time, the court recognizes the unease with which some regard brain death. *See, e.g.*, Bernat, *supra*, at 36 (referring to a "persistent group of critics"); Seema K. Shah, *Piercing the Veil: The Limits of Brain Death as a Legal Fiction*, 48 U. Mich. J. L. Reform 301, 302 (2015) (recognizing the "tremendous value of the legal standard of brain death in some contexts" but arguing brain death is a legal fiction and should not be recognized in certain cases, including where religious and moral objections are raised); D. Alan Shewmon, *"Brainstem Death," "Brain Death" and "Death": A Critical Re-Evaluation of the Purported Equivalence*, 14 Iss. L. & Med. 125 (1998) (advocating for a definition of death that looks to more than the brain). A California Court of Appeal has suggested "[p]arents do not lose all control once their child is determined brain dead," but also expressed uncertainty whether this right was born of the common law, the Constitution, logic, or simple decency. *Dority v. Superior Court*, 145 Cal. App. 3d 273, 279–80 (1983). Ms. Fonseca has presented the declaration of Dr. Paul Byrne, M.D., who believes Israel may recover some cognitive function with time and treatment. *See generally* Byrne Decl., ECF No. 36. Dr. Myette disagrees. *See* Myette Decl. ¶ 15. On balance, a professional doubt surrounding brain death as death, legally or medically, represents a minority position. Such doubt is unlikely to render CUDDA substantively unconstitutional on its face.

C. Procedural Due Process Claim against Dr. Smith

"A procedural due process claim has two elements: deprivation of a constitutionally protected liberty or property interest and denial of adequate procedural protection." *Krainski v. Nev.* ex rel. *Bd. of Regents of Nev. Sys. of Higher Educ.*, 616 F.3d 963, 970 (9th Cir. 2010). Here, as discussed, California is alleged to have deprived Israel of life and Ms. Fonseca of her fundamental interests in the care, custody, and control of her children. These are fundamental rights and interests the Constitution protects. Ms. Fonseca still must demonstrate she is likely to succeed in showing the process provided to Israel and herself has been inadequate.

"Due process, unlike some legal rules, is not a technical conception with a fixed content unrelated to time, place and circumstances. It is compounded of history, reason, the past course of decisions." *Cafeteria & Rest. Workers Union v. McElroy*, 367 U.S. 886, 895 (1961) (citation, alteration, and quotation marks omitted). "The fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner." *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976) (citation and quotation marks omitted). What process is due generally depends on three factors: (1) "the private interest that will be affected by the official action"; (2) "the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards"; and (3) "the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail." *Id.* at 335.

CUDDA and other provisions of the Health and Safety Code provide several procedural safeguards:

(1) Health & Safety Code section 7180 allows a determination of death only "in accordance with accepted medical standards."

(2) "When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be independent confirmation by another physician." Cal. Health & Safety Code § 7181.

(3) Physicians involved in the determination of death must not participate in any procedures to remove or transplant the deceased person's organs. *Id.* § 7182.

(4) "Complete patient medical records required of a health facility pursuant to regulations adopted by the department in accordance with [California Health and Safety Code] Section 1275 shall be kept, maintained, and preserved" with respect to CUDDA's requirements in the case of a brain death. *Id.* § 7183.

(5) Hospitals must "adopt a policy for providing family or next of kin with a reasonably brief period of accommodation . . . from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem . . . through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required." *Id.* § 1254.4(a). "[A] 'reasonably brief period' means an amount of time afforded to gather family or next of kin at the patient's bedside." *Id.* § 1254.4(b). "[I]n determining what is reasonable, a hospital shall consider the needs of other patients and prospective patients in urgent need of care." *Id.* § 1254.4(d).

(6) The hospital must "provide the patient's . . . family or next of kin, if available, with a written statement of the [policy regarding a reasonably brief period of accommodation described in section 1254.4(a)], upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent." *Id.* § 1254.4(c)(1). "If the patient's . . . family . . . voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns." *Id.* § 1254.4(c)(2).

(7) Section 1254.4 provides for no private right of action, as plaintiff stresses. *Id.* § 1254.4(e). But a state court may hear evidence and review a physician's determination that brain death has occurred. *See Dority*, 145 Cal. App. 3d at 280 ("The [trial] court, after hearing the medical evidence and taking into consideration the rights of all the parties involved, found

[the patient] was dead in accordance with the California statutes and ordered withdrawal of the life-support device. The court's order was proper and appropriate.").

Ms. Fonseca is unlikely to show the available protections are inadequate. Whether a person has suffered brain death is a medical determination that should involve a doctor, as CUDDA foresees. CUDDA creates a procedure that allows a determination to be verified quickly; false positives may mean a patient in critical condition receives no care. The law requires an independent confirmation of death in the case of suspected brain death; here at least three doctors have independently determined Israel is brain dead. Doctors who make the determination of death cannot be involved in any related transplant procedures; here the doctors are not. Family may gather at a patient's bedside, and hospitals must make reasonable accommodations for the religious or moral concerns of the patient's family or next of kin. The family has been provided more than a brief period of time to gather, and the state court considered and addressed Ms. Fonseca's moral and religious concerns during the time its TRO was in effect.

In addition, although section 1254.4 creates no private right of action, a California appellate court has determined that an interested person has some recourse to judicial review. Ms. Fonseca sought and received immediate protection from the Placer County Superior Court, which entered a TRO and allowed her to present evidence and seek relief over the course of two weeks. Although Ms. Fonseca has not appealed the state court's dismissal of her case, *Dority* signals she could. At hearing, her counsel in this case -- who is not counsel in her state case – suggested that a state appeal would be burdensome or unproductive, and exclaimed that taking that route generally is a "death knell for California working class families." While the full impact of his statement is not clear to this court, nothing in the record before it supports the conclusion that full procedural due process is unavailable with respect to CUDDA.

V. RELIEF SOUGHT

Ms. Fonseca has not borne her burden to show she is likely to succeed on the merits of the claims she relies on at this stage, and she has not presented sufficiently serious

questions to justify a preliminary injunction. This conclusion is bolstered by the fact that her claims do not appear to fit with the relief she seeks.

While Ms. Fonseca requests maintenance of ventilation, she also requests a mandatory injunction. *See* First Am. Compl. ¶¶ 48 (requesting an injunction that requires Kaiser to provide nutrition to Israel); Proposed Order, ECF No. 33-1 at 3. A mandatory injunction "orders a responsible party to take action." *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015) (citation and quotation marks omitted). This type of relief "goes well beyond simply maintaining the *status quo pendente lite* and is particularly disfavored." *Id.* (citation, quotation marks, and alterations omitted). Mandatory injunctions are incompatible with doubtful cases like this one. *Id.* Moreover, it seems unlikely this court would have jurisdiction to consider the specifics of what care Israel must receive. This question, among others, was the subject of the Placer County Superior Court's orders and hearings last month. The *Rooker-Feldman* doctrine or standard preclusion rules would likely apply. *See, e.g.*, *Cooper*, 704 F.3d at 777; *cf. Exxon Mobil Corp. v. Saudi Basic Indus. Corp.*, 544 U.S. 280, 284, 292–94 (2005) (referring to independent doctrines of preclusion, stay, and dismissal that may arise in the presence of parallel state court proceedings).

As noted, it appears the court lacks subject matter jurisdiction over the § 1983 claims against Kaiser and Dr. Myette, and EMTALA does not provide a basis for enjoining Kaiser on the facts here. Dr. Smith may be the only viable defendant in this action. An order requiring Kaiser to maintain Israel's condition could not properly be issued against Dr. Smith. If indeed CUDDA is facially unconstitutional, the court could at most declare that the certificate of Israel's death is void. Kaiser and its physicians would then remain subject to other provisions of California law that are not before this court. *See, e.g.*, Cal. Prob. Code §§ 4735 ("A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."); *id.* § 4654 ("[Division 4.7 of the Probate Code] does not authorize or require a

health care provider or health care institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or health care institution.").

While Ms. Fonseca's maternal instincts and moral position are completely understandable, the concerns reviewed here suggest she is unlikely to obtain the relief she seeks, and weigh against a preliminary injunction based on the law this court is sworn to apply and uphold.

VI. CONTINUING TEMPORARY RELIEF

To date, the TRO the court previously issued has remained in effect. *See* Order Apr. 28, 2016, ECF No. 9; Minutes, ECF No. 22; Minutes, ECF No. 45. At the May 11, 2016 hearing, Ms. Fonseca indicated she would ask the court stay the effect of an order denying her request for a preliminary injunction to allow her to seek emergency relief from the Ninth Circuit Court of Appeals. The defendants expressed no objection to this request.

"While an appeal is pending from an interlocutory order . . . that . . . denies an injunction, the court may . . . grant an injunction on terms for bond or other terms that secure the opposing party's rights." Fed. R. Civ. P. 62(c). Under this rule, the court considers generally the same factors as in the context of a temporary restraining order or preliminary injunction. *See, e.g.*, *Protect Our Water v. Flowers*, 377 F. Supp. 2d 882, 883 (E.D. Cal. 2004). Nevertheless, when a court has attempted to answer a question of first impression, and when the practical consequences of its decision suggest caution, a plaintiff's likely success on the merits may not play so central a role. *See, e.g., id.*; *Yamada v. Kuramoto*, 744 F. Supp. 2d 1075, 1087 (D. Haw. 2010). And in a case such as this one, "[a]n erroneous decision. . . is not susceptible of correction." *Cruzan*, 497 U.S. at 283.

The court therefore provides that this order will not take effect, and the temporary restraining order will remain in place, until the close of business on Friday, May 20, 2016, to allow Ms. Fonseca time to seek emergency relief from the Ninth Circuit Court of Appeals.

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VII. CONCLUSION

The temporary restraining order currently in effect REMAINS IN PLACE until the close of business on Friday, May 20, 2016, at which point it will be dissolved. The motion for a preliminary injunction is DENIED.

This order resolves ECF Nos. 31 & 33.

IT IS SO ORDERED.

DATED: May 13, 2016.

UNITED STATES DISTRICT JUDGE

EXHIBIT 6

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JONEE FONSECA, an individual parent and guardian of I.S., a minor, Plaintiff - Appellant, v. KAISER PERMANENTE MEDICAL CENTER ROSEVILLE; et al., Defendants - Appellees.	No. 16-15883 D.C. No. 2:16-cv-00889-KJM-EFB Eastern District of California, Sacramento ORDER

Appellant's motion for voluntary dismissal of this appeal is granted. Fed. R. App. P. 42(b). Costs shall be allocated pursuant to the terms of the motion.

This order shall act as and for the mandate of the Court.

FOR THE COURT:

MOLLY C. DWYER
CLERK OF COURT

Cole Benson
Supervising Deputy Clerk
Ninth Circuit Rules 27-7 and 27-10

ER 6

EXHIBIT 7

JASON J. CURLIANO [SBN 167509]
DREXWELL JONES [SBN 221112]
BUTY & CURLIANO LLP
516 16th Street
Oakland, CA 94612
Tel: (510) 267-3000
Fax: (510) 267-0117

WALTER DELLINGER (pro hac motion pending)
O'MELVENY & MYERS LLP
1625 Eye Street, NW
Washington, DC 20006
Tel: (202) 383-5300
Fax: (202) 383-5414

Attorneys for Defendants:
KAISER PERMANENTE MEDICAL CENTER
ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA,

Plaintiff,

v.

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, DR. MICHAEL MYETTE M.D., KAREN SMITH, M.D. in her official capacity as Director of the CALIFORNIA DEPARTMENT OF PUBLIC HEALTH and DOES 1 THROUGH 10, INCLUSIVE,

Defendants.

Case No: 2:16-CV-00889-KJM-EFB

KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

Date: May 11, 2016
Time: 3:30 p.m.
Courtroom: 3
Hon. Kimberly J. Mueller

Complaint Filed: April 28, 2016

EX7

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BUTY & CURLIANO LLP
ATTORNEYS AT LAW
516 16TH STREET
OAKLAND CA 94612
510.267.3000

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BUTY & CURLIANO LLP
ATTORNEYS AT LAW
516 18th STREET
OAKLAND CA 94612
510.267.3000

I. INTRODUCTION

A consensus opinion has existed in the medical community for well over thirty years that an individual who has sustained irreversible cessation of all functions of the entire brain, including the brain stem, is dead.[1] During two separate examinations the physicians at Kaiser Roseville[2] exercised their sound clinical judgment and followed well established medical guidelines in concluding that Israel Stinson had experienced irreversible brain death. These guidelines were formulated and adopted by professional medical organizations and they have become well accepted in the medical community.[3] [4] The determinations made by the physicians at Kaiser Roseville were consistent with a separate, clinical diagnosis of brain death that had been made earlier by physicians at the University of California Davis Medical Center in Sacramento ("UCD Medical Center").

Having unsuccessfully challenged these determinations before a California state court, Plaintiff Jonee Fonseca now seeks to have a second legal forum adjudicate many of the same issues, under the premise that California's Uniform Determination of Death Act ("CUDDA") violates her rights, as Israel's mother, to procedural and substantive due process under the Fourteenth Amendment. Plaintiff's claims must be rejected. First, neither Kaiser Roseville nor its physicians are state actors subject to constitutional attack. Just as a priest does not become a state actor when he signs a marriage license, neither do Kaiser Roseville or its doctors become state actors when they attest to the medical fact of death on a death certificate pursuant to CUDDA.

Second, plaintiff's constitutional claims are without factual or legal support. Plaintiff's procedural due process claim disregards the extensive process CUDDA affords, and which plaintiff

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[1] The determination of death by neurological criteria, e.g., "brain death", has been determined to constitute death in all jurisdictions in the United States and in most other developed countries. *See* J.L. Bernat, The Whole-Brain Concept of Death Remains Optimum Public Policy, 34(1) J.L. Med. & Ethics 35-43 (2006), Dec. Curliano, Ex. M; D. Gardner, *et al.*, International Perspective on the Diagnosis of Death, 108 British J. Anesthesia i14-i28 (2012), Dec. Curliano, Ex. N.

[2] The use of "Kaiser Roseville" in the brief refers to the specific Kaiser Permanente medical facility where Israel was transferred.

[3] See Nakagawa, TA. *Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations –Executive Summary*, Annals of Neurology, 2012, Vol. 71, pp. 573-585 9 (hereinafter referred to as "Guidelines"). Dec. Curliano, Ex. L.

[4] Israel met the clinical criteria for brain death as laid out and accepted by the medical community, including the: 1) Pediatric Section of the Society of Critical Care Medicine, Mount Prospect, IL; 2) Section on Critical Care Medicine of the American Academy of Pediatrics, Elk Grove Village, IL; 3) Section on Neurology of the AmericanAcademy of Pediatrics, Elk Grove Village, IL; and 4) Child Neurology Society, St. Paul, MN.

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ATTORNEYS AT LAW
516 16TH STREET
OAKLAND CA 94612
510.267.3000

was given in state court. During the state court proceedings, plaintiff was provided a full evidentiary hearing, the ability to present witnesses and evidence, and continuances by the trial court to locate and retain qualified physicians competent to testify that Israel had not experienced brain death. [5] At the end of these proceedings, the state court concluded there was no factual or legal basis for calling into question the findings made by the physicians at two separate medical facilities. In fact, plaintiff failed to present a single live witness to dispute the detailed testimony from Dr. Myette, Israel's primary physician at Kaiser Roseville, regarding his medical determination that Israel had an irreversible cessation of all brain functions such that in his opinion, and the opinion of his colleagues, Israel had experienced irreversible brain death. [6]

Plaintiff's substantive due process claim is equally weak. Plaintiff cannot point to a single case or constitutional provision that would justify an extraordinary judicial action overriding the considered judgment of the California Legislature, the larger medical community, and the medical professionals at Kaiser Roseville. The Constitution and the court system are not appropriate vehicles for seeking to overrule the medical judgment of physicians at two separate medical facilities, as well as the determination made in the state court case that this clinical judgment was exercised appropriately, professionally, and in conformity with well-established standards in the medical community.

Plaintiff also asserts that Kaiser Roseville and Dr. Myette violated the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd. EMTALA mandates that hospitals treat living patients with "emergency conditions." It does not require doctors to disregard

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[5] The Reporter's Transcript from the state court proceedings is attached as Exs. C, E, G and K to the Declaration of Jason J Curliano ("Dec. Curliano") filed on May 1, 2016 (DOC. #14). The relevant portions of the filings in state court are attached as Exs. A, B, D, F, H, I, and J to Dec. Curliano. The record from the state court action shows that Kaiser Roseville was ready to provide medical privileges at its facility to an appropriately qualified physician identified by plaintiff. The record also shows that Kaiser Roseville worked with plaintiff and her attorneys in putting the staffing in place to assist in transferring Israel to a medical facility that agreed to accept him. Plaintiff was apparently unable to obtain confirmation from an appropriate medical facility that it would accept Israel.

[6] The only "medical" evidence presented by plaintiff in the state court action was in the form of a declaration from D. Paul Byrne, a retired pediatrician and neonatologist. This same declaration was submitted by plaintiff as part of the papers she filed in federal court. Dr. Byrne is not licensed to practice in the State of California and he has no specialty in neurology. Additionally, his opinions are essentially that California law, the law of other states, and the medical community in general, are all wrong in using brain death as a medical definition of death. He believes there can be no finding of death if a patient still breaths and has a beating heart. In Israel's case, these functions are being sustained by artificial means.

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ATTORNEYS AT LAW
516 16TH STREET
OAKLAND CA 94612
510.267.3000

their own clinical opinions and ethical obligations by performing unnecessary and invasive procedures on a deceased patient. Indeed, as many courts have made clear, EMTALA does not impose the type of unlimited duty to provide medical treatment that plaintiff seeks in this case.

Finally, plaintiff's claims essentially ask this Court for a redo of the state court proceedings. Despite plaintiff's assurances that "this Court is not being asked [by plaintiff] to reconsider or reverse any aspect of the [California] Superior Court's actions," the vast majority of plaintiff's amended complaint, motion, and the accompanying declarations simply attack the medical determinations made by the physicians at Kaiser Roseville and UCD Medical Center, and thus the ruling made by the state court accepting those determinations as sound and in compliance with California law. The *Rooker-Feldman* doctrine precludes relitigation of these questions.

For this reason, and those discussed above, plaintiff's request for a preliminary injunction should be denied and the temporary restraining order that is currently in place dissolved.

II. STATEMENT OF RELEVANT FACTS AND PROCEDURAL HISTORY

A. Chronology of medical treatment.

Israel presented to the emergency room at Mercy Hospital on April 1, 2016. Given the severity of his condition, Mercy Hospital transferred Israel to the Pediatric Intensive Care Unit at UCD Medical Center. While undergoing care at UCD Medical Center, Israel suffered a severe respiratory attack, which progressed to a cardiac arrest. While Israel's caregivers struggled to save his life, his lungs were so weak, and his health so poor, that he could not adequately respond to medical treatment. After more than 40 minutes of CPR, UC Davis physicians managed to restore cardio-pulmonary functioning with mechanical support. Given the length of time Israel was without oxygen, UC Davis physicians were concerned the anoxic episode had resulted in brain death. The physicians performed an examination to determine his neurological status. The results were consistent with brain death. In addition, a nuclear medicine flow study showed no evidence of cerebral profusion.

UC Davis physicians advised Israel's parents they intended to perform a second brain death examination. They explained an unfavorable result in a second brain death examination would result

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510.267.3000

in Israel being declared legally dead. Prior to UC Davis physicians performing a second brain death examination, Israel's parents arranged to have him, while on mechanical cardio-pulmonary support, transferred to Kaiser Roseville for a second opinion.

On April 12, Kaiser Roseville admitted Israel with his parent's consent to perform a second brain death examination. That evening, Kaiser Roseville performed a brain death examination, which included a clinical exam, neurological evaluation and apnea test. The results indicated brain death.[7] On April 14, the physicians at the hospital performed yet another examination, Israel's third determination for brain death. The third examination once again confirmed brain death. The family was notified, and the "reasonably brief period of accommodation" under Health and Safety Code § 1254.4, which is intended to allow the family and next of kin time to gather at the patient's bedside, began.

In accordance with well-accepted medical standards, a declaration of death was issued. Israel's primary attending physician, Dr. Myette, identified the primary causes of death, then fulfilled his administrative duties as a physician by filling out the State's preprinted Certification of Death form. Dr. Myette had no interaction with anyone from the State and his determination of Israel's cause of death was based upon his own education, training, experience and clinical judgment. The Certification was then transmitted to the California Department of Public Health on April 18 by Decedent Affairs, a department at Kaiser Roseville that handles issues relating to the passing of a patient at the facility. Although a medical determination of brain death has been made, the Certification is not completed. Israel's parents have not completed the remaining part of the form identifying their wishes with respect to the transfer of Israel's body. The Certification remains with the Department of Public Health until such time as the parents complete the form or a final decision is rendered in state or federal court.

B. Plaintiff's state court action.

Shortly after Israel was declared brain dead on April 14, plaintiff petitioned a California Superior Court for a temporary restraining order preventing Kaiser Roseville from withdrawing

[7] Sedative medication was last administered on April 2, 2016.

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510.267.3000

cardio-pulmonary support. Plaintiff also requested time for an independent neurological exam and requested that Kaiser Roseville maintain the level of care Israel had been receiving prior to being declared dead. The court granted plaintiff's request for a temporary restraining order and set the matter for a full hearing on April 15. The order required Kaiser Roseville to continue providing cardio-pulmonary support and to continue providing medications currently administered, with necessary adjustments to maintain his condition.

On April 15, the parties, including plaintiff and Israel's father, appeared for the hearing in state court. Represented by counsel, plaintiff requested a two-week continuance of the TRO in order to have an independent brain death determination performed. Counsel represented that the family was being advised by an out-of-state physician who would find a physician licensed in California to perform an independent examination. During the proceeding, Kaiser Roseville offered testimony from Dr. Myette, Israel's attending physician. Dr. Myette described Israel's clinical course starting from April 1, 2016, explained that a determination of brain death in children is a clinical diagnosis based on the absence of neurologic function, and testified that the Guidelines recommend two examinations, including apnea testing, with each examination separated by an observation period.

The neurological examination described by Dr. Myette during the hearing involves a finding of complete loss of consciousness, vocalization, and volitional activities. The patient must lack evidence of responsiveness with an absence of eye opening or moving in response to noxious stimulant.[8] The examination also assesses for the loss of all brainstem reflexes including: no response by the pupils to light, the absence of movement of bulbar musculature including facial and oropharyngeal muscles, no grimacing or facial movements in response to deep pressure on the condyles and supraorbital ridge, the absence of gag, cough, sucking and rooting reflex, the absence of corneal reflexes, and the absence of oculovestibular reflexes. The apnea test measures the existence or absence of a patient's breathing drive (the ability to draw a breath) by challenging the respiratory system with CO2. Taken together, the clinical evaluation, neurological examination and

[8] Even in brain death, certain non-purposeful muscular movements may occur. These movements do not negate the diagnosis of brain death. Plaintiff has not identified any California licensed physician who will provide competent medical testimony to the contrary. No such testimony or evidence was provided in the state court case

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516 16TH STREET
OAKLAND CA 94612
510.267.3000

apnea test evaluate for brain death. After listening to Dr. Myette and giving plaintiff the opportunity to present any competent evidence or testimony in support of her case (an opportunity plaintiff did not take advantage of), the court issued an order continuing the restraining order for one week to April 22, 2016. The additional time was to provide plaintiff with an opportunity to have an independent examination performed.

On April 22, plaintiff's counsel advised the court that the family intended to transfer Israel to Sacred Heart Medical Center in Spokane, Washington. To facilitate the transfer, the parties entered into a detailed stipulation, which the court incorporated into an order. The restraining order and related conditions were to stay in effect until April 27, 2016. The parties agreed and were ordered to work together to facilitate the transfer, which they did. Ultimately, Sacred Heart declined Israel's admission. Israel continued to remain at Kaiser Roseville.

On April 27, plaintiff's counsel requested an additional two-week continuance to continue her efforts to find a suitable facility to transfer Israel to and to find a physician who would perform another brain death evaluation. Plaintiff also requested that Kaiser Roseville be ordered to install a percutaneous endoscopic gastrostomy tube or "PEG tube" and a tracheostomy tube. Plaintiff represented that these procedures would help to facilitate transfer to another facility or to home care. Plaintiff only provided declarations from Dr. Byrne (see ft. nt. 6) and a critical care coordinator to support her request for an additional continuance. The court denied plaintiff's request and found that plaintiff failed to present competent medical evidence showing a mistake in the determination of brain death or a failure to use accepted medical standards in making that determination. The court ordered that the TRO would remain in effect until April 29, in order to fulfill Kaiser Roseville's obligation to provide the family with a reasonable period of time under Health & Safety Code § 1254.4 to gather at Israel's bedside.

On April 29, the parties appeared in state court again. At this final hearing, the court dissolved the TRO and ruled that "Health and Safety Code sections 7180 and 7181 have been complied with" by Kaiser Roseville and its physicians. Plaintiff made no request to keep the TRO in place so that plaintiff could file an appeal in state court, nor has she since requested the state

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ATTORNEYS AT LAW
516 16TH STREET
OAKLAND CA 94612
510.267.3000

appellate court to keep it in place until such an appeal could be heard.

Although there is no winner in a case like this, plaintiff's claim that she "did not lose in state court" is clearly not supported by the record and the state court's rulings. The determinations of brain death made by physicians at UCD Medical Center and Kaiser Roseville that are being challenged by plaintiff were found by the state court to have been made in conformity with accepted medical standards and protocol.

C. The inaccurate factual claims in plaintiff's motion.

In her motion, plaintiff makes a number of factual assertions and claims against Kaiser Roseville that have no evidentiary support and in most instances are simply wrong. For example, plaintiff asserts that "KPRMC has refused to provide such treatment [nutrition, including protein and fats] stating that they do not treat or feed brain dead patients." Putting aside the fact this statement overlooks the exemplary care that has been provided by physicians, nurses and caregivers at Kaiser Roseville since Israel was admitted on April 12, it fails to acknowledge that the physicians have been using their clinical judgment in managing what is admittedly a difficult situation for all involved. This includes the administration of medications needed to keep Israel's heart and lungs working. It also includes clinical management of the ventilator, without which Israel would be unable to breathe. In state court, plaintiff requested that the court direct the physicians to do more, including introducing protein and fats into Israel's non-functioning gut. The court found there was no medical or legal basis for directing physicians at Kaiser Roseville to take these steps. The court also acknowledged that given the medical determination of brain death, certain procedures that were being requested by plaintiff raised serious medical ethical concerns in the court's mind since the court was being asked to direct physicians to provide treatment they felt was not medically warranted or appropriate.

Plaintiff states in her motion that Israel "has taken breath[s] off of the ventilator" and that he "has also begun moving his upper body in response to his mother's voice and touch." Although it is understandable that a parent in plaintiff's position would want to look for any signs of improvement or brain function, in the case of Israel, what plaintiff may be noticing has nothing to do with Israel's

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516 16TH STREET
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510.267.3000

brain function. The injury to his brain and brain stem is irreversible. As Dr. Myette explains in his declaration, the "breath[s]" that plaintiff believes she sees are not Israel breathing on his own, but rather they are caused by an artificial triggering of the reading on the ventilator given the sensitivity of the settings. Dec. Dr. Myette, Para. 14. Approximately a week ago when plaintiff first pointed out what she believed were signs Israel was breathing on his own, Dr. Myette suggested he could perform another apnea test that would confirm what the three (one at UCD Medical Center and two at Kaiser Roseville) previous apnea tests had confirmed—which is that Israel's lungs cannot inhale or exhale without being hooked up to a ventilator. Plaintiff stated she did not want the test to be done. Dec. Dr. Myette, Para. 14. With respect to any movement seen on the videos, these involuntary movements are spasms that emanate from the spine. Dec. Dr. Myette, Para. 10, 11, 12. They do not indicate that his brain is responding to external stimuli. Dec. Dr. Myette, Para. 10, 11, 12.

D. The process associated with completing and filing a death certificate.

California has developed a statutory framework that covers the administrative act of completing and recording a Death Certificate once a medical determination has been made that an individual is deceased. The California Department of Public Health is required to maintain birth, marriage, and death certificates. Health & Safety Code § 102100. Pursuant to Health & Safety Code § 102755, within eight days of death, each death must be registered with the local registrar of births and deaths "in the district in which the death was officially pronounced or the body was found." A funeral director, or person acting in lieu of a funeral director, is required to prepare the death certificate. A certification by a physician is required to be completed within fifteen hours of death, if completed by the attending physician, or within three days of the examination of the body if completed by the coroner. Health & Safety Code § 102800. An attending physician must notify the coroner's office of the death in cases in which the death occurs without medical attendance; during the continued absence of the treating physician or surgeon, where the attending physician cannot determine cause of death; where suicide is suspected; following an injury or accident; or under any circumstances as to afford a reasonable ground to suspect the death was caused by a

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516 16TH STREET
OAKLAND CA 94612
510.267.3000

criminal act. Health & Safety Code § 102850; Govt. Code § 27491. The local registrar is required to accept the registration of the death certificate and note the date of acceptance. Health & Safety Code § 102875(a)(8).

A coroner is charged with determining the cause of death in a variety of circumstances, none of which are present in this case. Health & Safety Code § 102850. In any case in which the coroner performs an inquest into cause of death, the coroner shall sign the death certificate. Govt. Code § 27491(a). In cases in which a coroner is not involved, a funeral director prepares the death certificate. The death certificate is registered with the local county registrar and then maintained by the California Department of Public Health Vital Records.

IV. LEGAL ANALYSIS

A. Plaintiff is unable to establish a substantial likelihood of success on the merits or that there are serious questions going to the merits of her claims.

A plaintiff moving for injunctive relief "must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20 (2008), citing *Munaf v. Geren,* 553 U.S. 674, 689-690 (2008); *Amoco Production Co. v. Gambell,* 480 U.S. 531, 542 (1987); *Weinberger v. Romero–Barcelo,* 456 U.S. 305, 311–312 (1982).

a. Kaiser Roseville and Dr. Myette are not state actors.

Plaintiff argues that Kaiser Roseville and Dr. Myette are state actors given the "coercive nature of the challenged statute and the degree to which the state and KPRMC are entwined in these types of life-and-death decisions." In addition, plaintiff alleges in her amended complaint that "KPRMC receives funding from the state and federal government which is used to directly and indirectly to provide healthcare services to individuals including but not limited to Israel Stinson."

Neither of plaintiff's claims establishes that Kaiser Roseville or Dr. Myette is a state actor. First, the mere fact a hospital or private institution receives funds from the state or federal government does not turn a private party into a state actor. In *Jackson v. East Bay Hospital,* 980 F. Supp. 1341, 1357-58 (N.D. Cal. 1997), the Court ruled that a private hospital "cannot be deemed a

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ATTORNEYS AT LAW
516 18TH STREET
OAKLAND CA 94612
510.267.3000

state actor merely because they are recipients of state or federal funding . . . such as Medicare, Medicaid, or Hill-Burton funds." *See also Taylor v. St. Vincent's Hospital,* 523 F.2d 75, 77 (9th Cir. 1975) [receipt of public funds under the Hill-Burton Act was not proper grounds for finding a private hospital to be a state actor for purposes of 42 U.S.C. § 1983]; *Rendell-Baker v. Kohn,* 457 U.S. 830, 840 (1982) [privately operated school not deemed to be a state actor even though "virtually all of the school's income was derived from government funding"].

Nor has plaintiff established that the involvement of an admittedly private medical facility like Kaiser Roseville and a private citizen like Dr. Myette with the state on issues of "life-and-death" transform either private party into state actors. *See Blum v. Yaretsky,* 457 U.S. 991, 1004 (1982). Plaintiff argues that defendants made a medical determination that Israel was dead, they completed the necessary paperwork after this medical determination was made, and that this medical decision was based upon the definition of death contained in CUDDA.

But, as plaintiff concedes, state regulation of the medical profession, including promulgating guidelines that must be followed, does not make a private party a state actor. Instead, where, as here, a private party exercises their judgment according to professional standards not dictated by the state, that party cannot be said to be a state actor. In *Pinhas v. Summit Health, Ltd.,* 894 F.2d 1024 (9th Cir.1989), the plaintiff filed suit claiming the medical facility violated his right to due process under the Fourteenth Amendment by revoking his medical privileges. As here, the plaintiff argued in *Pinhas* that the statutory scheme followed by the hospital in terminating his privileges, including its submission of a report to the state, made the hospital a state actor. The court rejected that argument, stating that "[t]he central inquiry in determining whether a private party's actions constitute 'state action' under the fourteenth amendment is whether the party's actions may be 'fairly' attributed to the State." *Id.* at 1033. Because the decision in question "ultimately turned on the judgments made by private parties according to professional standards that are not established by the State," the Court held that plaintiff had not demonstrated that the regulated party had been converted into a state actor. *Id.* 1034, quoting *Blum v. Yaretsky,* 457 U.S. at 1004 (1982).

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510.267.3000

The same is true in this case. As in *Pinhas*, licensed physicians, like those caring for Israel at UCD Medical Center and Kaiser Roseville, exercise their own clinical judgment in making a medical determination that an individual has experienced brain death. This determination was made on three separate occasions in Israel's case. No one from the State was involved in the medical decision making process at either facility.. Additionally, CUDDA, and in particular Health & Safety Code § 7180(a)(2), defers to physicians in determining whether death has occurred by providing that "A determination of death must be made in accordance with accepted medical standards." CUDDA and the California Legislature have not defined those standards, nor have they coerced private parties into adopting or using a particular set of standards mandated by the State. *See* ft. nt. 1, 3 and 4. Under such circumstances, it simply cannot be said that Kaiser Roseville or Dr. Myette's actions are "fairly attributed to the state." *See also Safari v. Kaiser Foundation Health Plan,* 2012 WL166935 (N.D. Calif. 2012).

The Supreme Court in *Blum, supra,* addressed a claim similar to the one plaintiff is making in this case: Does a state's implementation and enforcement of certain regulatory requirements covering healthcare facilities makes the actions of the private facilities those of the state for purpose of creating liability under 42 U.S.C. § 1983? The Court in *Blum* held that regulations imposed by the state, including the use of particular forms in making decisions regarding the level of care to be provided under Medicare (42 U.S.C. § 1396 *et seq.*), did not make the state liable for the actions of the private medical facilities. The Court rejected the argument that healthcare providers were "affirmatively commanded" by the State to make medical decisions regarding the discharge or transfer of patients. The Court noted that, "the physicians, and not the forms, make the decision about whether the patient's care is medically necessary....We cannot say that the State, by requiring completion of a form, is responsible for the physicians decision." *Id.* at 1006. The Court also found it significant that the decisions by the providers that were alleged to be state action "ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State." *Id.* at 1008, citing to and quoting *Polk County v. Dodson,* 454 U.S. 312, 318 (1981).

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Plaintiff makes an unsubstantiated assertion that CUDDA "coerces" California physicians to practice medicine in a particular manner and that it prevents them from exercising their own clinical judgment in accordance with well accepted medical standards. There is absolutely no legal analysis to support this argument, nor is there any evidence that the Legislature in enacting CUDDA dictates or intended to dictate to physicians how they should practice medicine or exercise their clinical judgment in caring for patients. The fact CUDDA provides very general procedural guidelines for the testing associated with determining whether there is brain death does not convert the actions of a private party into those of the state. *See Blum*, 457 U.S. at 1006, 1008 (1982). Nor is it true that "CUDDA defines death," for it is clear that physicians and professional organizations, of which California physicians are members, establish when brain death occurs. These organizations also promulgate medical guidelines that are used by physicians when making this determination. See ft. nts. 1, 3 and 4.

Accepting plaintiff's argument that the State, through CUDDA, has allegedly "defined" death (as opposed to simply adopting the definition developed by the medical community) such that all medical institutions and physicians making this determination become state actors would expand the definition of a state actor beyond constitutional limits. Would plaintiff also argue that a pastor or priest who performs a marriage and signs the marriage license pursuant to state law is a state actor? Does the fact that the state sets parameters for issuing birth certificates transform the medical care a hospital and its doctors provide during birth, and the later administrative functions of issuing a birth certificate, mean that the hospital and doctors are state actors? Although birth, marriage and death are all regulated and defined by states, the actions of private parties in complying with these statutory guidelines does not convert those actions into actions of the state. In the context of this case, plaintiff's argument, taken to its logical conclusion, would mean that almost all medical treatment and services provided by a private medical facility is conduct by the state. Every procedure and treatment, including the exercise of clinical judgment by physicians, would carry with it potential constitutional implications. Plaintiff has not provided any legal support for such an expansive definition of what constitutes a state actor.

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b. Plaintiff has not established a likelihood of success that Fourteenth Amendment Due Process is implicated by the medical decisions made in this case.

Plaintiff's due process claims are wholly without merit. Kaiser Roseville and Dr. Myette respect plaintiff's sincerely held beliefs and do not seek to change or override them in any way. But those beliefs do not create any affirmative obligation on the part of the hospital and its dedicated medical professionals to act contrary to medical science and their own — and their profession's — ethical standards. *Cf. Pickup v. Brown*, 42 F. Supp. 3d 1347, 1373 (E.D. Cal. 2012) ["[W]hile parents have a fundamental right to decide whether to avail themselves of state-regulated mental health professionals, they do not have a fundamental right to direct the state's regulation of those professionals."].

Plaintiff points to nothing in the Constitution or in case law that would justify an extraordinary judicial action overriding the considered judgment of the California Legislature, the larger medical community, and the medical professionals involved in this case. Nothing plaintiff cites supports the novel proposition that there is a constitutional right to force medical providers to impose treatment on a deceased individual—treatment that is unwarranted, futile and unethical.

Plaintiff is unable to point to a single state or federal court decision that holds or even suggests that a parent's right to make medical decisions for her child includes the right to tell the state and the physicians practicing in the state how they must define death. And understandably so, as all fifty states (and the District of Columbia) have adopted some statutory definition of death like the one contained in CUDDA. Recognizing plaintiff's argument in this case would render all of those statutes facially unconstitutional. *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997) [refusing to strike down Washington's ban on physician assisted suicide on substantive due process grounds where to do so would have invalidated "the considered policy choice of almost every State"].

Accepting plaintiff's position would leave states and medical professionals without any way to determine when, as a legal matter, one of its citizens has died. That is not and cannot be the law. Determining when an individual has died is a fundamental obligation of the medical community and the states in which the community practices. Fulfilling that obligation serves many

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516 16TH STREET
OAKLAND CA 94612
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important functions including (1) protecting the dignity of a state's citizens; (2) promoting public health; (3) upholding the integrity of the medical profession by not forcing physicians to provide treatment and perform invasive procedures on deceased individuals; and (4) providing for the orderly administration of estates and death benefits. *See Glucksberg*, 521 U.S. at 731 ["The State . . . has an interest in protecting the integrity and ethics of the medical profession"]; *Rubin v. Coors Brewing Co.*, 514 U.S. 476, 485 (1995) ["[T]he Government has a significant interest in protecting the health, safety, and welfare of its citizens."]; *Cunnuis v. Reading School District*, 198 U.S. 458 (1905) [upholding state statute relating to the administration of estates of persons presumed to be dead]. Plaintiff's procedural due process claim fares no better. Under CUDDA, a patient can only be declared legally brain dead upon the independent determination of two physicians, according to accepted medical standards. Health and Safety Code §§ 7180 and 7181. If there is still a dispute as to those independent determinations, a party can seek review in state court. *Dority v. Superior Court*, 145 Cal. App. 3d 273, 280 (1983). As plaintiff was afforded here, the party seeking review can obtain a full evidentiary hearing, has the ability to present their own witnesses and evidence, including the ability to retain qualified physicians to testify on her behalf. This type of pre-deprivation, court adjudication is the gold standard of procedural due process.

c. Plaintiff is unable to establish a likelihood of success on her EMTALA claim.

The plain language of EMTALA makes clear that it does not apply to the administration of medications and artificial mechanical support to maintain Israel's physiological condition. He is not presenting to an emergency department in need of "medical screening" or "stabilizing" medical treatment. *See* EMTALA, 42 U.S.C. § 1395dd. Israel has been determined to have suffered brain death, an irreversible condition that medicine cannot stabilize or cure. Nothing in EMTALA covers the treatment of a patient like Israel who was transferred to Kaiser Roseville almost a month ago.

It is undisputed that Israel was admitted to Kaiser Roseville on April 12. It is also undisputed that Israel has been at the facility since that time. He has not been transferred or moved to any other medical facility, but rather has received exemplary care from the physicians, nurses and caregivers at Kaiser Roseville. Plaintiff disregards the reality of the admission and care that has been provided

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in making an unsubstantiated and factually meritless claim in her complaint and motion that Kaiser Roseville has not complied with EMTALA.

In support of its EMTALA claim, plaintiff erroneously relies on *In the Matter of Baby K,* 16 F.3d 590 (4th Cir.1994) to argue that Kaiser Roseville and its physicians are required to perform procedures on Israel in contravention of their medical opinion and ethics. *Baby K* is easily distinguishable from this case and no longer even good law for the principle for which plaintiff cites to it. In *Baby K*, the Fourth Circuit held that EMTALA required the hospital to continue to stabilize and, if necessary, admit an anencephalic child presented to the emergency department. There was no suggestion that Baby K was brain dead. To the contrary, in support of its decision, the Court noted the hospital admitted that "Baby K [had] reside[d] at [a] nursing home for months at a time without requiring emergency medical attention." *Id.* at 596. In other words, when the child presented to the emergency department she was in need of treatment to stabilize her condition simply so she could return to the nursing home.

Subsequent to its decision in *Baby K*, the Fourth Circuit revisited the reach of EMTALA as it relates to a patient that was admitted to a hospital where she resided for twenty days before passing away. *Bryan v. Rectors and Visitors,* 95 F.3d 349 (4th Cir. 1996). In *Bryan*, the District Court found that EMTALA did not apply once the patient was stabilized and admitted to the hospital. The Fourth Circuit affirmed the lower court's ruling. The Court rejected plaintiff's argument that once admitted, EMTALA required the hospital to continue to "stabilize" the patient for an indefinite period of time. In reviewing a number of cases interpreting EMTALA, the Court recognized that EMTALA is "a limited 'anti-dumping' statute, not a federal malpractice statute." *Id.* at 351. This means that "[o]nce EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition . . . the legal adequacy of that care is then governed not by EMTALA but by the state malpractice law.. . " *Id.*

The clear statutory language in EMTALA and Court's decision in *Bryan* supports the conclusion that EMTALA simply does not apply where, as here, the patient has experienced irreversible brain death. Accordingly, there is no likelihood that plaintiff will prevail on this claim

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516 19th STREET
OAKLAND CA 94612
510.267.3000

or her request for injunctive relief premised on an alleged violation of the statute.

B. Plaintiff's request that defendants do more than maintain the status quo while the legal issues are decided should be denied.

a. Under California law, physicians are not required to participate in medical procedures they believe would not improve the condition of the patient.

Plaintiff provides no legal support for her request to have physicians perform invasive medical procedures on Israel who has been declared legally dead. There is nothing in the language of Health & Safety Code § 1254.4 that requires this to be done. California enacted a detailed statutory framework governing when a physician may refuse to provide medical care that the physician believes would not improve the condition of the patient. Probate Code § 4735 provides: "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution." In addition, Probate Code § 4654 provides, "This division does not authorize or require a health care provider or health care institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or health care institution." Finally, Probate Code § 4736 provides guidelines for the transfer of a patient with respect to pain medication and palliative care.

In *Barber v. Superior Court*, 147 Cal.App.3d 106, 1018 (1983), a criminal case against two physicians, the court affirmed the general principle that a physician has no duty to continue treatment that is ineffective:

> A physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless.... If the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery. (Horan, Euthanasia and Brain Death: Ethical and Legal Considerations (1978) 315 Annals N.Y.Acad. **217 Sci. 363, 367, as quoted in President's Commission, supra, ch. 5, p. 191, fn. 50.)

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516 16TH STREET
OAKLAND CA 94612
510.267.3000

b. Plaintiff has not provided any legal authority to support her argument that defendants can be ordered to do more than maintain the status quo for a patient that has been declared to be legally brain dead.

Plaintiff suggests that her request for a preliminary injunction is one that only concerns enjoining the removal of cardiopulmonary "life-support." See Pltf's Notice of Motion, pg.2:12-13. However, her motion and amended complaint clearly indicate that plaintiff is seeking to require Kaiser Roseville and Dr. Myette to affirmatively undertake certain medical actions. An injunction which "'affirmatively require[s] the nonmovant to act in a particular way, is mandatory and disfavored." *Newland v. Sebelius,* 881 F.Supp.2d 1287, 1293 (D. Colo. 2012).) "When a mandatory preliminary injunction is requested, the district court should deny such relief ' "unless the facts and law clearly favor the moving party." ' " *Stanley v. University of California,* 13 F.3d 1313, 1320 (9th Cir. 1994). Mandatory injunctions are not granted in doubtful cases. Rather, it must be shown the plaintiff has a strong likelihood of success on the merits. *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009). The Ninth Circuit has concluded that a mandatory injunction "goes well beyond simply maintaining the status quo Pendente lite." *Anderson v. U.S.*, 612 F.2d 1112, 1112 (1980). The status quo is ''the last, uncontested status which preceded the pending controversy." *Regents of Univ. of California v. Am. Broad. Companies, Inc.*, 747 F.2d 511, 514 (9th Cir. 1984), quoting *Tanner Motor Livery, Ltd. v. Avis, Inc.*, 316 F.2d 804, 809 (9th Cir. 1963).

The terms of the proposed preliminary injunction requires Kaiser Roseville and its physicians to perform medical procedures and treatment that go far beyond that needed to maintain the status quo. Moreover, these procedures and treatment will not change Israel's irreversible medical condition. As Dr. Myette explained in the state court action, Israel's organs, such as his kidneys, "are not receiving the signals [from the brain] to do their job." Dec. Curliano , Ex. C, pg. 24:18-26:20. Dr. Myette also testified that they are required to constantly micro adjust Israel's vasopressin infusion, to prevent sodium levels from becoming out of balance, and microadjust norepinephrine, "a synthetic cousin to our own adrenaline that our own body secretes." "Israel's body does not secrete [adrenaline] anymore." Dec. Curliano, Ex. C, pg. 31:1-17. The constant adjustments require "moment-to-moment, minute-to-minute, and hour-to-hour management of his

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510.267.3000

blood pressure, and that moment-to-moment, hour-to-hour management of his salt and free water levels in his body are something that requires a physician be present virtually all the time." Dec. Curliano, Ex. C, pg. 32:10-14. As Dr. Myette explained, he is "working very hard, but we're on top of this. But the notion that he is stable and sitting in a corner and everything is running on autopilot is -- is a notion that is not grounded in reality. He is aggressively, acutely managed moment to moment." Decl. of Curliano, Ex. C, pg. 33:15-19.

Plaintiff has not provided any legal support or competent medical opinion to support her request that this Court direct Kaiser Roseville, Dr. Myette, and the doctors, nurses and caregivers working with Israel to perform medical procedures and treatment that are medically unnecessary and that go beyond providing the level of support necessary to maintain the status quo. Israel has been determined to be brain dead. There is nothing medically that can be done to change this unfortunate fact. Controlling case law supports a finding that other than maintaining the status quo, in the event further injunctive relief is granted, defendants should not be required to engage in acts of medical futility or provide care and treatment that are at odds with their medical and ethical beliefs.

C. The *Rooker-Feldman* doctrine precludes this Court from effectively reviewing the state court's determination.

Much of plaintiff's complaint and motion effectively ask this Court to review the state court's approval of the procedures followed by Kaiser Roseville and the considered medical judgment of its physicians in this case. For example, plaintiff cites the declaration of Dr. Paul Byrne to support the statement in her motion that "the facts are that a physician believes that the child is not dead and Israel's condition can improve with further treatment." This is nothing but a direct attack on the medical determinations made by physicians at Kaiser Roseville and UCD Medical Center, and thus also an attempted end-run around the state court's ruling accepting those determinations as sound and in compliance with California law. Indeed, Dr. Byrne was present at the state court proceeding – plaintiff just elected not to call him as a witnesses to testify or to contradict the testimony that was given by Israel's primary physician, Dr. Myette.

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OAKLAND CA 94612
510.267.3000

The Rooker-Feldman doctrine precludes relitigation of these questions. See *Exxon Mobil Corp. v. Saudi Basic Indus. Corp.*, 544 U.S. 280, 283 (2005) [Rooker-Feldman doctrine bars plaintiffs from "essentially invit[ing] federal courts of first instance to review and reverse unfavorable state-court judgments."] It is "immaterial" that plaintiff "frames [her] federal complaint as a constitutional challenge" to the state court's determinations, "rather than as a direct appeal of those determinations." *Bianchi v. Rylaarsdam*, 334 F.3d 895, 900 n.4 (9th Cir. 2003); *Cooper v. Ramos*, 704 F.3d 772, 781 (9th Cir. 2012).

V. CONCLUSION

For all the foregoing reasons, the requested injunctive relief should be denied. In the alternative, the Court should abstain from taking any action, and instead require that plaintiff litigate her claims in state court.

DATED: May 10, 2016

BUTY & CURLIANO LLP

By: _____
JASON J. CURLIANO
Attorneys for Defendants
KAISER PERMANENTE MEDICAL CENTER ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

BUTY & CURLIANO LLP
ATTORNEYS AT LAW
516 16TH STREET
OAKLAND CA 94612
510.267.3000

CERTIFICATE OF SERVICE

I am employed in the County of Alameda, State of California. I am over the age of eighteen years and not a party to the within entitled cause; my business address is 516 16th Street, Oakland, CA 94612.

On May 10, 2016, I caused to be served the following document:

KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

on the interested parties in said cause, by causing delivery to be made by the mode of service indicated below:

Kevin T. Snider, State Bar No. 170988 Michael J. Peffer, State Bar. No. 192265 Matthew B. McReynolds, State Bar No. 234797 PACIFIC JUSTICE INSTITUTE P.O. Box 276600 Sacramento, CA 95827 Tel. (916) 857-6900 Fax (916) 857-6902 Email: ksnider@pji.org	Ashante L. Norton Ismael A. Castro Office of the Attorney General 1300 I. Street, Suite 1101 Sacramento, CA 94244-2550 Tel. (916) 323-82013 Fax (916) 324-5567 Email: Ashante.Norton@doj.ca.gov Email: Ismael.Castro@doj.ca.gov
Alexander M. Snyder (SBN 252058) Life Legal Defense Foundation P.O. Box 2015 Napa, CA 94558 Tel: (707) 224-6675 asnyder@lldf.org	

X I caused a true and correct copy of the aforementioned document(s) to be transmitted electronically to all parties designated on the United States Eastern District Court CM/ECF website.

___ (By Email): On May 10, 2016 I caused a copy of the document(s) described on the attached document list, together with a copy of this declaration, to be emailed listed on the attached service list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on May 10, 2016, at Oakland, California.

SUSAN TRUAX

BUTY & CURLIANO LLP
ATTORNEYS AT LAW
516 16TH ST.
OAKLAND CA 94612
510.267.3000

8

EXHIBIT 8

JASON J. CURLIANO [SBN 167509]
DREXWELL M. JONES [SBN 221112]
BUTY & CURLIANO LLP
516 16th Street
Oakland, CA 94612
Tel: (510) 267-3000
Fax: (510) 267-0117

Attorneys for Defendants:
KAISER PERMANENTE MEDICAL CENTER
ROSEVILLE (a non-legal entity) and DR. MICHAEL MYETTE

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JONEE FONSECA,

Plaintiff,

v.

KAISER PERMANENTE MEDICAL CENTER ROSEVILLE, DR. MICHAEL MYETTE M.D., and DOES 1 THROUGH 10, INCLUSIVE,

Defendants.

Case No: 2:16-CV-00889-KJM-EFB

DECLARATION OF DR. MICHAEL S. MYETTE IN SUPPORT OF KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO PRELIMINARY INJUNCTION AND FURTHER INJUNCTIVE RELIEF

Date: May 11, 2016
Time: 1:30 p.m.
Courtroom: 3
Hon. Kimberly J. Mueller

Complaint Filed: April 28, 2016

I, Michael S. Myette, M.D., hereby declare:

1. I am a physician employed by The Permanente Medical Group, Inc. I have practiced medicine for over ten years. As the Medical Director for the Pediatric ICU at Kaiser Permanente in Roseville ("Kaiser Roseville"), I oversee and care for the most critically ill and unstable children admitted to the facility. I am Board Certified in Pediatrics and Pediatric Critical

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ATTORNEYS AT LAW
516 16TH STREET
OAKLAND CA 94612
510.267.3000

Care Medicine. All of the facts stated herein are within my personal knowledge and if called as a witness, I could competently testify thereto.

2. On April 12, 2016, I received and admitted Israel Stinson as an inpatient at Kaiser Roseville from U.C. Davis Medical Center ("U.C. Davis"). I have reviewed Israel's medical records from U.C. Davis, his Kaiser Roseville medical records, and continue to follow and oversee his cardio-pulmonary support at Kaiser Roseville.

3. On April 15, 2016, I testified in Placer County Superior Court regarding Israel's condition and clinical course. I reviewed the transcript of the state court proceeding and determined the information I provided regarding Israel's condition and the circumstances surrounding his anoxic event were accurate and correct. A true and correct copy of relevant portions of the April 15, 2016 transcript taken in the Superior Court are attached hereto as Exhibit A.

4. Since April 15, 2016, I have found no clinical change in Israel's condition. Pursuant to various court orders, Israel's cardio-pulmonary functioning has been maintained through a variety of medications, glucose, hormones, water, electrolytes and mechanical support.

5. As Israel's brain is not telling his organs how to function, medical intervention is required for all critical metabolic functions. His blood pressure is wholly dependent on the administration of dopamine and norepinephrine at constantly changing levels. Without these drugs and a ventilator, his heart would cease to function within minutes.

6. Israel's hypothalamus and pituitary gland are dead. The hypothalamus is a portion of the brain that maintains the body's internal balance (homeostasis). It releases or inhibits hormones controlling the body's heart rate, temperature, fluid and electrolyte balance, weight, glandular secretions, pituitary gland and thyroid. Israel has no functioning of internal neuro-endocrine regulation. Absent the administration of artificial hormones and a warming blanket, Israel's body temperature would fall to the ambient level.

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OAKLAND CA 94612
510.267.3000

7. Israel is receiving exogenous temperature regulation, exogenous thyroid hormone, exogenous anti-diuretic hormone, and exogenous catecholamines. Still, he demonstrates no signs of recovery. His serum thyroid hormone level is normal due to exogenous replacement. The argument Israel's current state was caused by hypothyroidism (as opposed to hypothyroidism resulting from brain death) is completely unfounded and disproven given the fact his serum thyroid level is now at a normal level (again due to exogenous replacement) with no improvement. Moreover, since Israel is not hypothyroid, the argument endocrine abnormalities preclude a reliable evaluation of brain functioning is medically unsound.

8. Israel's gastrointestinal system shows no signs of any functionality. As a result, complications are likely to arise if enteral feeding were attempted. Enteral feeding refers to the delivery of a nutritionally complete supplement, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach, duodenum or jejunum. If Israel's GI system is not functioning, enteral feeding could result in infection. Since Israel's body would not respond to an infection with a fever, we would likely not know of an infection until he was septic.

9. Since his admission at Kaiser Roseville, Israel has received dextrose for nutrition. Despite getting only dextrose calories, he has not lost weight in over 23 days since his admission. Israel has not had a bowel moment since being in the hospital.

10. Israel's pupils are fixed, dilated and unresponsive. He does exhibit a single, stereotypic spinal reflex. The movement is always the same. A spinal reflex is a reflexive action mediated by cells in the spinal cord, bypassing the brain altogether. The kneejerk or patellar reflex, where the leg jerks when the kneecap is struck with a brisk tap, is a classic example of a reflex. Reflexes allow the body to respond quickly to threats and hazards without the time delay involved when the brain is consulted about how to respond to a stimulus. In a spinal reflex, a sensation is felt at the site and relayed to neurons in the spinal cord via a sensory pathway. The spinal cord returns a signal along a motor pathway, signaling a movement in response to the sensation. This happens in fractions of a second, allowing people to jerk away before the brain is even aware of a problem.

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510.267.3000

11. Unfortunately, Israel's mother, family, and attorneys, all non-medical professionals, interpret Israel's spinal reflex as a sign his brain may be functioning or even that he is recovering. They are incorrect. The videos offered by Israel's mother merely show the single, stereotypic spinal reflex.

12. Aside from the spinal reflex, Israel is unresponsive to any stimuli. He does not respond to his mother's voice, or the voice of anyone else. Israel's stereotypic spinal reflex occurs due to very light touch, including bumping the side of his bed.

13. Israel's heart rate does not increase in response to stimulation. His heart rate and blood pressure increase and decrease as a result of medical intervention with drugs and hormones. His heart rate and blood pressure increase and decrease throughout the day. Israel's heart rate dropped to 70 beats per minute on May 5, 2016. A child of Israel's age typically has a heart rate of 110 to 120 beats per minute. Unfortunately, we are approaching the maximum effective dosage of beta-stimulating medications.

14. Israel's mother told me she believes he took a breath on one or more occasions when she was holding him. Sadly, Israel lacks the ability to take a breath because the portion of his brain designed to draw a breath is dead. An apnea test, as described in my previous testimony on April 15, 2016, is designed to test a person's ability to take a breath. Physicians have administered three apnea tests on Israel. Israel failed to draw a breath in each of these tests. When I recently offered Israel's mother another apnea test to see whether Israel was breathing, she declined. The so-called spontaneous breaths his mom claims to have seen are due to a well-known and well-understood artificial triggering of the ventilator. Israel has been given ample opportunities to demonstrate he can breathe and has repeatedly and consistently failed to do so.

15. The argument Israel, with proper medical treatment, is likely to continue to live, and may find limited to full recovery of brain function, and may possibility regain consciousness is medically unsound. Absent from this view is any explanation of the MRI/CT scans showing diffuse cerebral edema, global hypoxemic injury and transforaminal herniation through the foramen magnum (a portion of his brain moved through the hole in the base of his skull through

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OAKLAND CA 94612
510.267.3000

which the spinal cord connects to the brain). Neurological recovery from a transforaminal herniation through the Foramen Magnum due to this process is unprecedented.

16. Since his admission at Kaiser Roseville, Israel shows absolutely no improvement in his condition, despite the aggressive medical intervention and cardio-pulmonary support provided to date. In fact, he continues to slowly deteriorate from a cardiovascular standpoint and we are reaching the effective limits on medications used to keep his heart beating.

17. Brain death is widely accepted in the medical community. While there are different tests used to determine brain death, multiple tests are considered proper and accepted by the medical community. The protocol I used to determine Israel is brain dead is widely accepted among medical professionals who specialize in neurology and pediatric critical care. My determination of brain death for Israel was made in accordance with accepted medical standards. Israel would be considered brain dead by any medically recognized and accepted criteria for making such a determination.

18. As my determination that Israel is brain dead was made according to accepted medical standards, no personnel or agents of the State of California (or any other governmental body) influenced, affected or contributed to my determination. In fact, I had no interactions with anyone from the State of California or any government body in order to arrive at my determination of brain death. Filling out paperwork for a death certificate is an administrative task performed after I have made a determination of death. Such an administrative function merely documents my medical determination of death, which was made based solely on my training, observations and examination, and is completely independent of the State of California or any governmental body. A true and correct copy of Israel's certificate of death is attached hereto as Exhibit B.

I declare under penalty of perjury that the foregoing is true and correct. Executed on May 10, 2016, in Roseville, California.

MICHAEL S. MYETTE, M.D.

BUTY & CURLIANO LLP
ATTORNEYS AT LAW
516 16TH STREET
OAKLAND CA 94612
510.267.3000

CERTIFICATE OF SERVICE

I am employed in the County of Alameda, State of California. I am over the age of eighteen years and not a party to the within entitled cause; my business address is 516 16th Street, Oakland, CA 94612.

On May 10, 2016, I caused to be served the following document:

DECLARATION OF DR. MICHAEL S. MYETTE IN SUPPORT OF KAISER ROSEVILLE AND DR. MICHAEL MYETTE'S OPPOSITION TO PRELIMINARY INJUNCTION AND FURTHER INJUNCTIVE RELIEF

on the interested parties in said cause, by causing delivery to be made by the mode of service indicated below:

Kevin T. Snider, State Bar No. 170988 Michael J. Peffer, State Bar. No. 192265 Matthew B. McReynolds, State Bar No. 234797 PACIFIC JUSTICE INSTITUTE P.O. Box 276600 Sacramento, CA 95827 Tel. (916) 857-6900 Fax (916) 857-6902 Email: ksnider@pji.org	Ashante L. Norton Ismael A. Castro Office of the Attorney General 1300 I. Street, Suite 1101 Sacramento, CA 94244-2550 Tel. (916) 323-82013 Fax (916) 324-5567 Email: Ashante.Norton@doj.ca.gov Email: Ismael.Castro@doj.ca.gov
Alexander M. Snyder (SBN 252058) Life Legal Defense Foundation P.O. Box 2015 Napa, CA 94558 Tel: (707) 224-6675 asnyder@lldf.org	

X I caused a true and correct copy of the aforementioned document(s) to be transmitted electronically to all parties designated on the United States Eastern District Court CM/ECF website.

___ (By Email): On May 10, 2016 I caused a copy of the document(s) described on the attached document list, together with a copy of this declaration, to be emailed listed on the attached service list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on May 10, 2016, at Oakland, California.

SUSAN TRUAX

BUTY & CURLIANO LLP
ATTORNEYS AT LAW
516 16TH ST.
OAKLAND CA 94612
510.267.3000

SUPERIOR COURT OF CALIFORNIA

COUNTY OF PLACER

DEPARTMENT NO. 43 HON. MICHAEL W. JONES, JUDGE

ISRAEL STINSON,

Plaintiff,

vs. Case No. S-CV-0037673

U.C. DAVIS CHILDREN'S HOSPITAL,

Defendant,

---o0o---

REPORTER'S TRANSCRIPT

Friday, April 15, 2016

PETITION HEARING

---o0o---

APPEARANCES:

FOR THE PLAINTIFF:
LIFE LEGAL DEFENSE FOUNDATION
BY: ALEXANDRA M. SNYDER, Attorney at Law
P.O. Box 2015
Napa, CA 94558

FOR THE DEFENDANT:
BUTY & CURLIANO LLP
BY: DREXWELL JONES, Attorney At Law
516 16th St
Oakland, CA 94612

Court Reporter: Jennifer F. Milne, CSR NO. 10894

EX 9

So, Dr. Myette, I'm going to ask that you please stand, sir, and be sworn.

(Whereupon the witness was sworn.)

THE WITNESS: I do.

THE CLERK: Please state your full name for the record.

THE WITNESS: Michael Steven Myette.

THE CLERK: Please be seated.

THE COURT: All right. You can just remain there for this purpose, sir.

Go ahead

DIRECT EXAMINATION

BY MR. JONES:

Q. Doctor, first off, what is your title?

A. I am a pediatric intensivist, and I'm board-certified in pediatrics and in pediatric critical care medicine. And I'm the medical director for the pediatric ICU at Kaiser Permanente in Roseville.

Q. And how long have you practiced medicine?

A. I have -- I have worked at Kaiser for -- it will be 11 years this July. Prior to that, I did my critical care in fellowship at U.C. San Francisco. And prior to that, I did a pediatric residency at U.C. Davis.

MR. JONES: Your Honor, I'd like to qualify this witness as an expert witness as well as a treating

physician.

MS. SNYDER: Excuse me. I'm sorry, Your Honor. But I was under the -- we were under the understanding that we would not be calling witnesses, specifically medical witnesses, because of the short time frame, that there would be no time for us to call a witness.

In fact, Kaiser asked us if we would call a medical witness, and we said we would not. And the understanding was that they would not either because their witness is ten minutes from here and ours is 2,000 miles from here. So -- and we had 15 hours to prepare for this hearing this morning.

THE COURT: I understand.

MS. SNYDER: Okay.

THE COURT: What I'm doing at this point in time is Kaiser wants to present some further information for the Court on these issues. And in terms of me receiving that information, since we have the doctor here, I might as well receive it in a proper fashion under oath.

MS. SNYDER: Okay.

THE COURT: Would you agree with that, that if he is going to say something, it might as well be --

MS. SNYDER: I do agree with that, yes.

THE COURT: Okay. Thank you. Go ahead, sir.

BY MR. JONES:

Q. And have you been involved with the care of Israel Stinson?
A. Yes. I received him in transfer from U.C. Davis Medical Center on April 12th and cared for him through yesterday. I -- I documented his time of death yesterday at 12:00 noon.
Q. Have you had an opportunity to review the medical records from U.C. Davis?
A. Yeah. I -- I extensively reviewed the medical records at U.C. Davis, the course of his care there, which I can summarize, if you want me to.
THE COURT: That's okay.
BY MR. JONES:
Q. Can you summarize the care.
A. Okay. Israel presented with a condition called status asthmaticus to an outside hospital in the Mercy system.
The emergency physicians treating him were concerned at the severity of his asthma. He was initially treated with medicines to take care of that. Ultimately, it was determined that he required assistance with a ventilator.
THE COURT: How old is Israel?
THE WITNESS: Israel is a 30-month-old boy. He is 2 1/2 years old.

THE COURT: Okay.

THE WITNESS: So he had an intratracheal tube placed in his trachea and was put on a ventilator. This intervention placed the child beyond the scope of care of the facility in the Mercy system. So they contacted U.C. Davis Medical Center who agreed to accept the patient in transfer.

BY MR. JONES:

Q. And what date was that, Doctor?

A. April 1st.

Q. And the transfer was April 2nd?

A. The transfer was April 1st.

Q. Okay.

A. The patient was cared for overnight in the pediatric ICU at U.C. Davis Medical Center.

On the 2nd of April, the physicians determined that he had improved and the intratracheal tube, breathing tube, was removed.

He was continued to be treated for his asthma at that point with Albuterol and other medications.

A few hours after excavation, he began to develop a very acute respiratory distress. The doctors attempted to treat that with rescue medications, but he developed a condition called a bronchospasm where his airway squeezes down so tight that air can't pass through

it.

The U.C. Davis doctors did multiple rescue attempts including replacing the intratracheal -- the breathing tube.

Even with the intratracheal breathing tube in place, they could not adequately force air into the portion of his lung where oxygen is exchanged.

During this episode, Israel's heart stopped. He was resuscitated with cardiopulmonary resuscitation, chest compressions, and continued attempts to force air into his lungs through the intratracheal tube.

Q. For how long?

A. 40 minutes this went on.

I spoke directly with one of the physicians of record who told me that they had a terrible time trying to get air in his lungs.

As hard as they pushed, they could not seem to bypass this -- the spastic airway and get air into the portion of his lung where it would be life sustaining.

After 40 minutes of cardiopulmonary resuscitation, he was cannulated for a machine called ECMO. It's spelled E-C-M-O. It is a machine. It stands for Extracorporeal Membrane Oxygenation.

ECMO is a machine that is analogous to a heart-lung bypass machine when somebody is getting heart

surgery. But unlike that machine, it is used in an intensive care unit to act in lieu of a heart and lungs when the heart and lungs aren't functional but the physicians believe that the condition is reversible.

He remained on the ECMO circuit for four days at U.C. Davis Medical Center.

The asthma and the subsequent cardiac arrest were, in fact, reversible. And his heart functioned -- started to function on its own after -- after a time as did the -- the bronchospasm in his lungs improved also over time with medication.

He was decannulated, which is to say taken off of the ECMO circuit on April 6th.

On April 7th, he had a procedure, a nuclear medicine procedure at U.C. Davis, called radionuclide. It's spelled r-a-d-i-o-n-u-c-l-i-d-e, I believe.

Radionuclide scan, which is a scan which measures uptake of oxygen and nutrients, glucose and such, into the brain. That is often used as an ancillary test. It is not a test that you can use to determine brain death in and of itself. It doesn't substitute for a brain death exam. But in cases where a complete brain death exam is not -- is not able to be done, it can be an ancillary piece of information. That's why I bring it up because it's supporting information.

The radionuclide scan was read by a radiologist and confirmed as showing no -- no uptake of oxygen or nutrients by Israel's brain.

On the 8th of April, one of the U.C. Davis Medical Center pediatric intensivists, somebody who is trained in the same manner and board-certified in the same manner that I am, performed an initial neuro exam attempting to see if there is any evidence of brain function.

That exam, including an apnea test, suggested that there was -- that there was no -- no brain activity. It was consistent with brain dead -- brain death.

Q. What's an apnea test?

A. An apnea test is a test whereby you take a patient off of a ventilator. You get them physiologically into a -- into a normal state as possible, normal oxygen in their blood, normal CO2 in their blood.

And you cease blowing air into their lungs. You place them on ambient, 100 percent oxygen, so that they are still able to deliver oxygen to their body during this test.

But the human body doesn't -- doesn't use oxygen or lack of oxygen to drive our desire to breathe. Our desire to breathe is driven by carbon dioxide in the

blood.

So this test is a test whereby we -- without letting a patient become dangerously deoxygenated, we allow the carbon dioxide to increase to a point where the portion of their brain that regulates carbon dioxide and tells the body to take a breath will respond. We actually go way beyond that.

The specifics of that test are available in the paper, and I can -- I can go into more detail if you want.

But the apnea test went on for -- I don't remember exactly how long she documented, but I think it was somewhere in the neighborhood of six to eight minutes, which is fairly typical for an apnea test.

The recommendations, as put forth by the American Academy of Pediatrics, the Society of Child Neurology, and the Society of Critical Care Medicine, who have issued a joint statement on how to go about these things states that you need to have normal CO2 at the beginning of the test. And you need to have a jump of at least 20 millimeters of mercury during the course of the test for the test to be valid.

The test was done -- was documented blood gasses before and after the apnea, the period of nonbreathing, were done and confirmed that there was an adequate reason

in Israel's CO2 that should have triggered his body to take a breath if that portion of his brain that -- that regulates when to take a breath was -- was functional.

On the 8th, the clinical neuro exams were conducted.

It is customary and it is recommended somebody -- somebody that is Israel's age you have to wait a minimum of 12 hours in between two separate exams of this nature.

The first exam establishes that there is no function. The second exam is supposed to confirm that whatever caused the first exam results to be what they are is -- was not, in fact, reversible.

In terms of Israel, he has not received any medications for pain or sedation since April 2nd.

He has not received any -- anything that would depress brain function since April 2nd.

Q. Was there a second test conducted at U.C. Davis?

A. There was not a second test done at U.C. Davis. The family -- well, the family requested some scans be done.

They asked for -- on the 9th or 10th -- I don't remember which day. But on the 9th or 10th, they requested a CT scan of the head be done and an MRI of the

brain be done.

U.C. Davis complied with this request and actually did both scans. The CT scan of the brain, which they sent to us also with his medical records, was read as showing diffused brain swelling, effacement of the basal cisterns, and herniation of the brain stem out the foramen magnum.

The foramen magnum is the hole at the base of the skull where the spinal cord comes out. And if the brain swells enough, then a portion of the brain, just by the pressure from all that swelling, can be forced down through that hole.

While that is not part of a brain death exam, per se, that is an unsurvivable event.

Q. Irreversible?

A. Irreversible.

Q. Then what happened?

A. The MRI also confirmed severe global injury to the brain and also confirmed the transforaminal, across the foramen herniation of brain tissue of the brain stem.

Q. Did the parents object to a second test at U.C. Davis?

A. The U.C. Davis doctors document that there was objection to doing a confirmatory brain death test.

The family requested that Israel be transferred

to U.C. Davis -- excuse me -- to Children's Hospital and Research Center in Oakland -- or now, I guess, the UCSF Benioff Children's Hospital in Oakland is the current name.

The physicians at U.C. -- or at UCSF Benioff Oakland Children's Hospital refused the transfer. They declined to take the patient in transfer.

Then -- I don't know -- the circumstances aren't 100 percent clear to me, but I came into the -- into the fold when I received a call from our outside services and asking me if I would be willing to take -- to take Israel in transfer.

Realizing that this was a difficult and tragic set of circumstances and understanding that probably the family had mistrust of the physicians at U.C. Davis because that's where the initial event, the initial cardiopulmonary arrest occurred, was likely to make it very difficult for them to accept whatever U.C. Davis was going to tell them, I agreed to transfer the patient to my intensive care unit and to evaluate him on my own.

Q. For brain death?

A. For brain death, correct.

Understand that I -- I evaluate a patient not looking for brain death, per se, but looking for absence of brain death. It is a vital part of information for me

to be able to figure out what the nature of care I need to deliver to this boy.

Had I done my initial exam on him and discovered that there was some activity in his brain, we wouldn't be here. I'd be -- we'd be -- we would not have declared him dead, and we would be attempting to facilitate whatever recovery he would have been capable of.

Q. When was he transferred to Kaiser?

A. He was transferred to Kaiser on April 12th. He arrived in the early afternoon.

Q. When was -- when was the first test conducted?

A. The first test done at Kaiser -- I did that test, but it wasn't done until about 11:00 o'clock p.m. that night.

The delay was that, as I had mentioned earlier, a patient has to be in a normal physiologic state for a brain death exam to be valid.

And Israel is unstable. The portions of his brain that autoregulate all the things that we take for granted, his brain is not doing that.

So illustration: When he came to me, his body temperature was 33 degrees centigrade. Normal body temperature is 37 degrees centigrade. He doesn't regulate his body temperature. If he gets cold, he doesn't shiver. If he gets cold, his body won't alter

its metabolic rate to increase heat production.

And so he is not -- if left alone, he will drift to ambient temperature, room temperature.

So when he got there, he had dropped from 36 to 37 degrees at U.C. Davis. The transfer, being in the ambulance and being in a -- in that environment was enough to drop his temperature four degrees centigrade.

So I had to spend several hours gently warming his body back up, which we instituted shortly after arrival. This is not something you want to do quickly because you can overshoot. And somebody who has a brain injury who gets a fever is likely to have a worsening of that brain injury. So we have to be very careful not to cause a fever.

So at that point, I began gentle warming. Another problem that had occurred when he arrived was that -- our pituitary gland in our brain regulates our water and salt balance in our body. To simplify, sodium and free water.

A hormone called vasopressin secreted by the pituitary gland keeps all of us in -- in normalcy for water and sodium. Well, his brain doesn't -- isn't doing that now. His pituitary gland is not functioning. So he was placed on an infusion of -- of manufactured -- of pharmaceutical vasopressin, which we have. And that is a

hormone that the body has this variable sensitivity to. And so you have to monitor him very closely.

When he had his brain death exam at U.C. Davis, his sodium was in the normal range. But by virtue of time, when he got to me, his sodium level was elevated, also elevated to a point at which I couldn't have done a valid brain death exam. So I had to -- I had to manage that level of sodium by altering the level of vasopressin I was infusing into his body to get his sodium into a physiologic range.

Q. Doctor, let me just ask this: Is the function of those organs not occurring because the brain is just not sending any signals of how organs have to operate?

A. That's correct. The kidneys regulate sodium and water based on signals they receive from the brain.

So while -- while Israel's kidneys in and of themselves are fine, they are not receiving the signals to do their job.

So that was the problem. He has wild fluctuations in his level of free water in his body, which can drive his sodium dangerously low or if we take away -- if we don't supplement that hormone, then he will pee out -- for lack of a better word, will urinate all the free water in his body and will go into cardiovascular collapse and die, and we will see that --

we would see that based on his sodium drifting up into levels that are not physiologic.

Q. So what test did you perform on the 12th?

A. So after getting his body warmed up to physiologic temperature, between 36 and 37 degrees centigrade, and after readjusting his vasopressin infusion to make sure that his sodium was between 130 and 145, I achieved that physiologic state at about 11:00 o'clock p.m., and then I performed a comprehensive neurologic exam looking for evidence of brain function.

I can go into the specifics of that test, if you want.

Q. What were the results of the test?

A. The results of my tests were consistent with no brain function. There was no evidence of his brain receiving any signals from his body, nor was there any evidence that his brain was regulating any organs in his body.

Q. And you performed an apnea test as well?

A. Correct. My apnea test lasted for seven and a half minutes with Israel on 100 percent oxygen. And his carbon dioxide in his blood at the beginning of the test was in the normal range, between 35 and 45. And at the end of the test, his carbon dioxide was 85. So there was a significant increase in that -- a level of increase

that would, in anybody with any function of their brain stem, cause them to draw a breath. And we -- we had a monitor on his intratracheal tube looking for any CO2, any exhale or there were -- there were sensors on his body sensing any inhale of breath.

Q. Did you also repeat that test yesterday?

A. Yes. So I did not do -- I want to be clear, I didn't do the confirmatory brain death exam. The recommendations by National is for two separate physicians to do the two different exams so that you have a fresh set of eyes.

And one of my colleagues, Dr. Masselink, spelled M-a-s-s-e-l-i-n-k, who is a board-certified pediatric neurologist performed the confirmatory neurologic test yesterday at 11:00 o'clock in the morning. That was a full 36 hours after the first test.

In the room accompanying and witnessing that test with him was Israel's great aunt and one of his grandmothers. And also Dr. Shelly Garone, who is one of -- one of my bosses -- one of the -- they're called at Kaiser -- they're called APIC. It stands for Associate Physician In Chief. And she -- she was also present for that.

Q. What were the results of the tests?

A. The results of that test, as documented by

Dr. Masselink, were that there was no -- no evidence of any brain function, that the exam was consistent with brain death.

Q. And was there a declaration of death made?

A. Yeah. Well, let me add one more thing.

A second apnea test was done as is -- as is in the recommendations put forth by the National Societies, as I previously mentioned.

So I did a second apnea test. The rules of brain death say that the same physician can do both apnea tests because it's appropriate that either a pediatric critical care doctor or a pediatric anesthesiologist, somebody with advanced airway skills, perform the apnea test. That's the one part of the exam that is beyond the scope of a pediatric neurologist.

So after Dr. Masselink completed his exam, the final piece was a confirmatory apnea test, and I did a confirmatory apnea test. This time I actually let it go for a full nine minutes, waiting to see if Israel would [Witness makes a descriptive sound] -- would draw a breath.

And after nine minutes, and CO2 that went above 90, he did not draw a breath.

At that point, I terminated the apnea test, and it met requirements for a valid test.

Q. And at that point --
A. At that point, I documented -- I wrote a death note and documented Israel's time of death at 12:00 noon, yesterday.
Q. How difficult is it to maintain, essentially, the body -- now that there's been a declaration of death, what efforts are required in order to keep Israel in the condition that he currently is, which I understand is not very stable?
A. Yeah. That's -- that's a good question. I mentioned earlier that the brain sends the signals that regulate our salt and free water.

And try as we might, doctors are not as good as a working brain at doing this. We're certainly doing our best.

But I can tell you that between Israel's arrival on the 12th and when I signed off to my colleague, another pediatric intensivist last night at 8:00 o'clock p.m., that I did not leave the hospital. I was always either in -- in the ICU, in the room with Israel, or over in my office, which is in the same building right around the corner. I took a couple of two- or three-hour naps in the sleep room, which is within 30 feet of the intensive care unit.

The reason being that throughout the night, from

the time he arrived until the time I signed him off, I was microadjusting his vasopressin infusion, making sure that his sodium did not drift too high or too low. I was adjusting another infusion that I hadn't mentioned yet, a medicine called norepinephrine or noradrenaline. It is a synthetic cousin to our own adrenaline that our body secretes.

Israel's body doesn't secrete that anymore. As a result, his blood pressure without this medicine will drift low to the point where he will not perfuse his coronary arteries, and his heart will stop. He is absolutely 100 percent dependent on this infusion of norepinephrine to keep that heart beating.

So if you give too much of that medicine, again, people have varying sensitivities to it. It's not a simple dose, and you get a blood pressure. You have to see what dose will produce a blood pressure.

He has an invasive arterial line in his femoral artery that gives us a moment-to-moment reading of his blood pressure. And using that catheter and transducing that pressure onto a monitor continuously, I adjust the norepinephrine.

He has -- I can't tell you exactly how many times, but I can tell you it's more than 20 that I've adjusted that medicine. Okay. I am trying to keep his

main arterial pressure, which is somewhere between the systolic and diastolic. I can get more specific than that if you need but that's probably adequate. I want to keep that main at least 60 and not above 100.

Below 60, and I don't adequately perfuse his kidneys or his heart.

Above 100, and the pressure in the arteries is high enough that I run the risk of him having a bleeding -- a bleeding episode or a hemorrhage.

So that moment-to-moment, minute-to-minute, and hour-to-hour management of his blood pressure, and that moment-to-moment, hour-to-hour management of his salt and free water levels in his body are something that requires a physician be present virtually all the time.

Q. Are Israel's organs essentially beginning to atrophy? Are they failing?

A. The -- this is what we normally see happen. There are exceptions to this. I think there's a -- Mom and Dad mentioned a case where somebody who had seen total cease of brain function has continued for a long time to have a beating heart. I don't know the specifics of that case.

But I can tell you in my experience -- I have precedent for trying to keep the heart beating after somebody has been declared dead. The specific situation

where we do this is when a family wishes organ donation. Because if the heart keeps beating and keeps delivering oxygen and glucose to the organs that are still functional, then those organs can be transplanted into somebody who needs them.

And so in situations where families wish organ donation, often when somebody has been declared brain dead, we, intensivists, as a bridge to get these organs to transplant, will work very hard to keep a patient alive or -- that's not -- scratch that. Not to keep -- to keep a patient's organs functioning and keep a patient's heart beating. And it does get more challenging the longer we do it.

Now, we're on top of this right now with Israel. We're working very hard, but we're on top of this. But the notion that he is stable and sitting in a corner and everything is running on autopilot is -- is a notation that is not grounded in reality. He is aggressively, acutely managed moment to moment.

THE COURT: And is nutrition an aspect of that?

THE WITNESS: So nutrition is a little bit problematic. So I can tell you -- we are providing him with a constant infusion of glucose to make sure that his blood sugar remains in normal range.

His intestines -- and intestines in situations

where there's a prolonged resuscitation often suffer a pretty significant injury.

And before we put nutrition into the gut, into the intestines, we need to know that those intestines have healed. If you put a bunch of sugar and protein and fat into a gut that is severely injured, that sets up a situation where pathological bacteria can grow in that nonfunctioning gut. And you can have catastrophic complications.

So we are not feeding him into his intestine right now because his intestines have not yet indicated to us that they are capable of handling and absorbing nutrition and putting -- putting nutrition into the intestines at this point is -- would be a very risky thing to do.

Now -- I guess I'll leave it at that.

So the short answer is beyond IV glucose infusions and IV infusions of salts and electrolytes, that's the only nutrition he is getting right now.

THE COURT: Okay. Mr. Jones, anything further?

BY MR. JONES:

Q. What -- what is the likelihood that you would be able to maintain Israel's body in this state for a two-week period of time?

A. It will be difficult. I guess that's the best I

can say. I don't -- I don't know, you know. I don't know what he is going to do. I can tell you that last night that Israel's sodium dropped to a level that in somebody with a functioning brain would have caused seizures. And the doctor who was taking care of him last night had to stop the vasopressin infusion altogether because his sensitivity to it suddenly went up.

And the sodium is coming back up now because the body is starting to get rid of that free water that was holding on, was diluting the sodium in his body.

So we are -- we are monitoring him very closely. But as I said earlier, no physician is as good as a functioning brain at regulating the physiology of a human body. And anyone who thinks they are is naive or arrogant. But, you know, we'll try. We're going to keep trying, but I can tell you that those kinds of fluctuations are going to happen. And it may be that one of them happens and his body just shuts down.

Often what I see in kids who go on to transplant is that at some point their body stops responding to the adrenaline that we infuse and their blood pressure starts to drop. And that also can be problematic. That has not happened yet with Israel, but it could happen today. It could happen tomorrow, and we could pour more and more into him and try our best to keep that blood pressure up.

In my experience, sooner or later, our efforts to mimic the brain starts to fall short.

THE COURT: I understand. Anything further, Mr. Jones?

MR. JONES: Just with that background -- I just want to point out to the Court that -- so we're here to determine whether or not the temporary order should be continued.

And my comment is that under Health and Safety Code Section 7180 and 7181, Israel has been found to be dead.

THE COURT: And, therefore, the parent should not have the opportunity to have an independent evaluation?

MR. JONES: They had. We are the independent --

THE COURT: They're not entitled to have their own independent evaluation at this point in time, somebody outside of Kaiser?

MR. JONES: I think if they -- if you look at the Dority case --

THE COURT: Just answer my question. Are the parents entitled to have an independent evaluation outside of Kaiser at this point in time?

MR. JONES: No. No. Because there's no --

THE COURT: Your position is no?

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF PLACER

---o0o---

ISRAEL STINSON,
Plaintiff,
vs. Case No. S-CV-0037673
U.C. DAVIS CHILDREN'S HOSPITAL,
Defendant,

I, JENNIFER F. MILNE, Certified Shorthand Reporter of the State of California, do hereby certify that the foregoing pages 1 through 42, inclusive, comprises a true and correct transcript of the proceedings had in the above-entitled matter held on April 15, 2016.

I also certify that portions of the transcript are governed by the provisions of CCP237(a)(2) and that all personal juror identifying information has been redacted.

IN WITNESS WHEREOF, I have subscribed this certificate at Roseville, California, this 19th day of April, 2016.

JENNIFER F. MILNE, CSR
License No. 10894

EXHIBIT 10

2016-04-18 14:08 DECEDENT AFFAIRS 9167845410 >> CA-EDRS P 1/1

CERTIFICATE OF DEATH

ISRAEL

STINSON

M

04/14/2016 1200

Physician Attestation Copy

If the form is correct, sign field 115 and fax this page to 1-916-668-5400.

DO NOT ALTER. NO COVERSHEET

Alterations invalidate the signature. If you require changes, additions, or corrections, contact the sender to re-fax a corrected form.

KAISER FOUNDATION HOSPITAL ROSEVILLE

PLACER | 1600 EUREKA ROAD | ROSEVILLE

(A) ANOXIC ENCEPHALOPATHY — DYS.

(B) CARDIAC ARREST — DYS.

(C) STATUS ASTHMATICUS — DYS.

HISTORY OF ASTHMA

NO

A73633

MICHAEL STEVEN MYETTE M.D.

04/12/2016 | 04/14/2016 | 1600 EUREKA ROAD, ROSEVILLE, CA 95661

0280658205

0280658205-02

Enlarge Cancel

EX 10

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11(REV 3/06)

STATE FILE NUMBER | LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT- FIRST (Given)	2. MIDDLE	3. LAST (Family)
ISRAEL	--	STINSON

AKA. ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)

4. DATE OF BIRTH mm/dd/ccyy	5. AGE Yrs.	IF UNDER ONE YEAR Months	IF UNDER ONE YEAR Days	IF UNDER 24 HOURS Hours	IF UNDER 24 HOURS Minutes	6. SEX
10/05/2013	2					M

9. BIRTH STATE/FOREIGN COUNTRY	10. SOCIAL SECURITY NUMBER	11. EVER IN U.S. ARMED FORCES?	12. MARITAL STATUS/SRDP* (at Time of Death)	7. DATE OF DEATH mm/dd/ccyy	8. HOUR (24 Hours)
		☐ YES ☐ NO ☐ UNK		04/14/2016	1200

13. EDUCATION – Highest Level/Degree (see worksheet on back)

14/15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet on back) ☐ YES _____ ☐ NO

16. DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)

17. USUAL OCCUPATION – Type of work for most of life. DO NOT USE RETIRED	18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	19. YEARS IN OCCUPATION

USUAL RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number, or location)

21. CITY	22. COUNTY/PROVINCE	23. ZIP CODE	24. YEARS IN COUNTY	25. STATE/FOREIGN COUNTRY
	--			

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP	27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)

SPOUSE/SRDP AND PARENT INFORMATION

28. NAME OF SURVIVING SPOUSE/SRDP*-FIRST	29. MIDDLE	30. LAST (BIRTH NAME)
[illegible]	[illegible]	[illegible]

31. NAME OF FATHER/PARENT-FIRST	32. MIDDLE	33. LAST	34. BIRTH STATE
[illegible]	[illegible]	[illegible]	[illegible]

35. NAME OF MOTHER/PARENT-FIRST	36. MIDDLE	37. LAST (BIRTH NAME)	38. BIRTH STATE

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy	40. PLACE OF FINAL DISPOSITION

41. TYPE OF DISPOSITION(S)	42. SIGNATURE OF EMBALMER	43. LICENSE NUMBER
--	▶	

44. NAME OF FUNERAL ESTABLISHMENT	45. LICENSE NUMBER	46. SIGNATURE OF LOCAL REGISTRAR	47. DATE mm/dd/ccyy
		▶	

PLACE OF DEATH

101. PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE	103. IF OTHER THAN HOSPITAL, SPECIFY ONE
KAISER FOUNDATION HOSPITAL- ROSEVILLE	☒ IP ☐ ER/OP ☐ DOA	☐ Hospice ☐ Nursing Home/LTC ☐ Decedent's Home ☐ Other

104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)	106. CITY
PLACER	1600 EUREKA ROAD	ROSEVILLE

CAUSE OF DEATH

107. CAUSE OF DEATH — Enter the chain of events --- diseases, injuries, or complications --- that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Time Interval Between Onset and Death	108. DEATH REPORTED TO CORONER?
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(A) ANOXIC ENCEPHALOPATHY	(AT) DYS.	☒ YES ☐ NO REFERRAL NUMBER 0
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(B) CARDIAC ARREST	(BT) DYS.	109. BIOPSY PERFORMED? ☐ YES ☒ NO
	(C) STATUS ASTHMATICUS	(CT) DYS.	110. AUTOPSY PERFORMED? ☐ YES ☒ NO
	(D)	(DT)	111. USED IN DETERMINING CAUSE? ☐ YES ☐ NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107
HISTORY OF ASTHMA

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)	113A. IF FEMALE, PREGNANT IN LAST YEAR?
NO	☐ YES ☐ NO ☐ UNK

PHYSICIAN'S CERTIFICATION

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. Decedent Attended Since (A) mm/dd/ccyy	Decedent Last Seen Alive (B) mm/dd/ccyy	115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy
04/12/2016	04/14/2016	▶MICHAEL STEVEN MYETTE M.D.	A73633	04/18/2016

118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE MICHAEL STEVEN MYETTE M.D.
1600 EUREKA ROAD, ROSEVILLE, CA 95661

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. MANNER OF DEATH	120. INJURED AT WORK?	121. INJURY DATE mm/dd/ccyy	122. HOUR (24 Hours)
☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Pending Investigation ☐ Could not be determined	☐ YES ☐ NO ☐ UNK		

123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)

124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)

125. LOCATION OF INJURY (Street and number, or location, and city, and zip)

126. SIGNATURE OF CORONER / DEPUTY CORONER	127. DATE mm/dd/ccyy	128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
▶		

STATE REGISTRAR	A	B	C	D	E	Printed on: 04/21/2016 10:44 AM By JENKINS, TERRY (TJENKINS1)	FAX AUTH.#	CENSUS TRACT

EXHIBIT 11

09/02/2016

CURRICULUM VITAE
BARRY P. MARKOVITZ, MD, MPH, FAAP
DECEMBER 23, 2015

PERSONAL INFORMATION:

Work
Department of Anesthesiology
Critical Care Medicine
4650 Sunset Blvd, MS#12
Los Angeles, CA 90027
Phone: 23-361-8673
Fax: (323) 361-1022
Work Email: bmarkovitz@chla.usc.edu

Home
2263 Ronda Vista Dr
Los Angeles CA 90027

Citizenship: USA

EDUCATION AND PROFESSIONAL APPOINTMENTS

EDUCATION:

1975	High School, Taylor Allderdice, Pittsburgh Scholars Program, Pittsburgh PA
1979	B.A., Washington and Jefferson College, Washington PA
1983	M.D., University of Pennsylvania School of Medicine Philadelphia PA
2003	M.P.H., St. Louis University, St. Louis MO

POST-GRADUATE TRAINING:

1983 – 1986	Internship/Residency, Pediatrics, Children's Memorial Hospital, Northwestern University Medical Center, Chicago IL (Currently Ann & Robert H. Lurie Children's Hospital of Chicago)
1986 – 1988	Residency, Anesthesiology, Hospital of the University of Pennsylvania, Philadelphia PA
1988 – 1990	Fellowship, Pediatric Anesthesiology and Critical Care Medicine, Children's Hospital of Philadelphia, Philadelphia PA

HONORS, AWARDS:

1979	Phi Sigma, Biology Honorary	Washington & Jefferson College, Washington PA
1979	Phi Beta Kappa	Washington & Jefferson College, Washington PA
1979	Edwin Scott Linton Prize in Biology	Washington & Jefferson College, Washington PA
2003	The Alumni Association Academic Achievement Award	St. Louis University School of Public Health, St. Louis MO
2006	Recognition Award	Society of Critical Care Medicine, San Francisco CA
2014	Distinguished Career Award	American Academy of Pediatrics Section on Critical Care, San Diego Ca

ACADEMIC APPOINTMENTS:

EX 11

Year-Year	*Appointment*	*Department, Institution, City, Country*
1990 – 1992	Instructor in Anesthesiology and Pediatrics	Washington University School of Medicine, St. Louis MO USA
1992 – 2000	Assistant Professor of Anesthesiology and Pediatrics	Washington University School of Medicine, St. Louis MO USA
2000 – 2006	Associate Professor of Anesthesiology and Pediatrics	Washington University School of Medicine, St. Louis MO USA
2006 – 2009	Visiting Professor of Clinical Pediatrics and Anesthesiology	University of Southern California, Keck School of Medicine, Los Angeles CA USA
2009 - current	Professor of Clinical Pediatrics and Anesthesiology	University of Southern California, Keck School of Medicine, Los Angeles CA USA

ADMINISTRATIVE APPOINTMENTS:

1999 – 2006	Medical Director, Respiratory Care	St. Louis Children's Hospital, St. Louis MO USA
2005 – 2006	Co-director, Pediatric Intensive Care Unit, Chief, Medical/Surgical ICU service	St. Louis Children's Hospital, St. Louis MO USA
2006 – current	Division Head, Pediatric Critical Care Medicine	Department of Pediatrics, USC Keck School of Medicine and Department of Anesthesiology Critical Care Medicine, Children's Hospital Los Angeles, Los Angeles CA USA
2006 – current	Medical Director, Pediatric Intensive Care Unit	Children's Hospital Los Angeles, Los Angeles CA USA
2006 – current	Physician Lead for VPS, LLC database quality benchmarking. Pediatric Intensive Care Unit	Children's Hospital Los Angeles, Los Angeles CA USA
2007 – 2008	Physician leader, CHCA Collaborative: Eliminating Code and Associated Mortality	Children's Hospital Los Angeles, Los Angeles CA USA
2009 – current	Medical Director, Respiratory Care	Children's Hospital Los Angeles, Los Angeles CA USA

TEACHING

DIDACTIC TEACHING:

Washington University School of Medicine

Year-Year	*Course Name*	*Units/Hrs*	*Role*
1998 – 2006	Humanities in Medicine	n/a	Small group facilitator
1999 – 2006	Clinical Epidemiology and Biostatistics	n/a	Small group facilitator and lecturer
2002 – 2006	Core Course in Pediatrics – Ethics and the Minor Child	n/a	Lecturer

USC Keck School of Medicine, Children's Hospital Los Angeles, Department of Anesthesiology Critical Care Medicine

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2007 – current	Leadership & Professionalism Curriculum	n/a	Small group facilitator

CME Courses Developed

n/a

Undergraduate, Graduate and Medical Student (or Other) Mentorship:

n/a

Graduate Student Thesis, Exam and Dissertation Committees:

n/a

Postgraduate Mentorship:

Year-Year	*Trainee Name*	*If past trainee, current position and location*
2014 – current	Dana Mueller	
2006 – current	Multiple fellows in Pediatric Critical Care Medicine	

Mentorship of Faculty:

Year-Year	*Mentee Name*	*Mentee Department*
2006 – current	All junior faculty in Pediatric Critical Care Medicine	Anesthesiology Critical Care Medicine, Children's Hospital Los Angeles

Service

Department Service:

Year-Year	*Position, Committee*	*Organization/Institution*
1991 – 1992	Member, Clinical Competency Committee	Washington University School of Medicine, Department of Anesthesiology
1991 – 1992	Member, Education Committee	Washington University School of Medicine, Department of Anesthesiology
1991 – 1994	Member, Housestaff Education Committee	Washington University School of Medicine, Department of Pediatrics
1996 – 2006	Member, Information Systems Steering Committee	Washington University School of Medicine, Department of Anesthesiology
2002 – 2006	Member, Appointments & Promotions Committee	Washington University School of Medicine, Department of Anesthesiology
2010 – 2013	Chair, search committee for division director of Infectious Disease	USC Keck School of Medicine, Department of Pediatrics
2012 – current	Member, Pediatric Clinical Advisory Council	USC Keck School of Medicine, Department of Pediatrics
2014 – 2015	Co-chair, search committee for division director of Neurology	USC Keck School of Medicine, Department of Pediatrics
2015 – current	Member, search committeefor division director of Neonatology	USC Keck School of Medicine, Department of Pediatrics

Medical School Service:

Year-Year	*Position, Committee*	*Organization/Institution*
2005 – 2006	Member, Disclosure Review Committee	Washington University School of Medicine
2015 – current	Member, search committee for Chair, Department of Anesthesiology	USC Keck School of Medicine

HOSPITAL OR MEDICAL GROUP SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
1991 – 1992	Member, Search Committee for Anesthesiologist-in-Chief	St. Louis Children's Hospital
1991 – 1992	Member, Pediatric Intensive Care Unit Expert Panel, Work Redesign Project	St. Louis Children's Hospital
1991 – 1993	Member, St. Louis Children's Hospital, Medical Staff Transfusion Subcommittee	St. Louis Children's Hospital
1993 – 2006	Member (Chair, effective 7/2000), Medical Staff Ethics Committee	St. Louis Children's Hospital
1995 – 2006	Member, Information Systems Physician Advisory Committee	St. Louis Children's Hospital
1995 – 1996	Physician leader, Reengineering Medical Records/Discharge Team	St. Louis Children's Hospital
1996 – 2000	Chair, St. Louis Children's Hospital, Medical Records Committee	St. Louis Children's Hospital
2001 – 2004	Member, Clinical Outcomes and Process Steering Committee	St. Louis Children's Hospital
2001 – 2003	Member, Patient Safety Steering Committee	St. Louis Children's Hospital
2007 – 2013	Member, Quality Improvement Committee	Children's Hospital Los Angeles
2007 – 2009	Physician leader, Rapid Response Team Taskforce	Children's Hospital Los Angeles
2007 – 2010	Member, Safety Council	Children's Hospital Los Angeles
2009 – 2012	Member, Clinical Informatics Operations Council	Children's Hospital Los Angeles
2009 – 2011	Member, "iAware" (Cerner EMR) implementation, New Patient Tower	Children's Hospital Los Angeles
2009 – current	Member, Critical Response Systems Committee (formerly CPR Committee) (co-chair 2009-2013)	Children's Hospital Los Angeles
2010 – current	Member, Simulation Steering Committee	Children's Hospital Los Angeles
2013 – current	Member, Action Committee for Quality Outcomes	Children's Hospital Los Angeles
2014 – current	Member, Physician Support Committee of the Medical Staff	Children's Hospital Los Angeles

UNIVERSITY SERVICE:

n/a

PROFESSIONAL SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
1991 – 1992	Member, Committee on Pediatric Anesthesia	American Society of Anesthesiologists
1994 – 1995	Member, Scientific Committee	8th Annual Pediatric Critical Care Colloquium, Sea Island GA, October 8-11, 1995
1995 – 1996	Member, Scientific Committee	9th Annual Pediatric Critical Care Colloquium, Milwaukee WI, September 25-28, 1996
1996 – 2006	Co-chair, Pediatric Internet Working Group	Society of Critical Care Medicine, Pediatric Section
1999 – 2000	Chair, Electronic Communications Committee	Society of Critical Care Medicine
1998 – current	Founding member, vPICU	The Virtual Pediatric Intensive Care Unit (http://www.vpicu.org)
2002 – 2008	Elected member, Section on Critical Care Executive Committee	American Academy of Pediatrics
2002 – current	Elected member, Scientific Advisory Committee	Pediatric Acute Lung Injury and Sepsis Investigators (PALISI) Network (re-elected 2011)
2003 – current	Chair, Scientific Review Committee	VPS (Virtual PICU Performance System, VPS© LLC), Children's Hospital Los Angeles and Children's Hospital Association (formerly National Association of Children's Hospitals and Related Institutions)
2003 – 2008	Member, sub-board on Pediatric Critical Care Medicine	American Board of Pediatrics

CONSULTANTSHIPS AND ADVISORY BOARDS:

Year	*Position, Board*	*Organization/Hospital/School, Institution*
2006 – 2009	Member, Scientific Advisory Board	Protocol KL4-AHRF-01 (A Pilot, Randomized Controlled Clinical Trial of Lucinactant, a Peptide-Containing Synthetic Surfactant, in Infants with Acute Hypoxemic Respiratory Failure), Discovery Labs, Warrington, PA
2008 – 2014	Member, Data Safety Monitoring Board	ARDSnet and RESTORE studies, NIH/NHLBI
2013 – current	Chair, Data Safety Monitoring Board	Randomized Order Safety Trial Evaluating Resident Schedules (ROSTERS), NIH/NHLBI

PROFESSIONAL SOCIETY MEMBERSHIPS:

Year- Year	*Society*
1986 – current	Physicians for Social Responsibility
1989 – current	Society of Critical Care Medicine
1990 – current	American Academy of Pediatrics
2009 – current	Pediatric Cardiac Intensive Care Society

ADMINISTRATIVE SERVICE:

n/a

COMMUNITY SERVICE:

Year-Year	*Position*	*Organization/Institution, City,*	*Role or Activity*
2007 – current	Physician volunteer	International Children's Heart Foundation and The Novick Global Cardiac Alliance, Memphis TN	Volunteer as a pediatric cardiac intensivist on two week cardiac surgery mission trips to developing countries including Dominican Republic, Honduras, Belarus, Ukraine, Macedonia

RESEARCH AND SCHOLARSHIP

EDITORSHIPS AND EDITORIAL BOARDS:

Year-Year	*Position*	*Journal/Board Name*
1995 – current	Editor	PedsCCM.org: The Pediatric Critical Care Medicine Website (http://www.pedsccm.org)
1997 – current	Editor	The PedsCCM Evidence-based Journal Club (edited 800+ critical appraisals of critical care research papers)
1999 – 2003	Editor	Critical Care Section, Medical Matrix (formerly at medmatrix.org)
1999 – current	Member	Journal of Intensive Care Medicine (section editor Electronic Journals and Resources)
2003 – current	Member	Pediatric Critical Care Medicine (section editor Evidence-based Journal Club since 2004)

MANUSCRIPT REVIEW:

Year-Year	*Journal*
1996 – current	Intensive Care Medicine, Anesthesiology, Haematologica, Journal of Pediatrics, American Medical Informatics Association, Anesthesia and Analgesia, American Journal of Respiratory and Critical Care Medicine, Archives of Pediatric and Adolescent Medicine, New England Journal of Medicine, Critical Care Medicine, JAMA Pediatrics, Journal of Critical Care, Chest

GRANT REVIEWS:

Year	*Description*	*Awarding agency, City, State, Country*
2007 – current	Small grant reviewer	Section on Critical Care, American Academy of Pediatrics, Elk Grove Village IL USA

MAJOR AREAS OF RESEARCH INTEREST

Research Areas

1. Jan-June, 1992: Characterization of integrin-associated protein in hematopoietic cells: laboratory research training program supervised by Dr. Eric Brown, Washington University School of Medicine, Department of Medicine
2. April 2002- December 2004: Economic evaluation of intensive care services for pediatric traumatic brain injury patients. Prospective, multi-center observational study. John Tilford, principal investigator, Arkansas Center for Health Sciences. Contracted support: $1,196.35
3. July 2002 – December 2005: Xigris Phase IV Trial for Pediatric Sepsis, Eli Lily and Co. Multicenter trial; local PI. Contracted support: $52,600.
4. March 2003 – June 2004: Prone positioning in pediatric respiratory failure. NIH contracted multicenter trial; local PI. Contracted support: $3,750.
5. August 2004 – December 2006: Transfusion practice in the PICU. Multicenter observational study. Johnson & Johnson. local PI. Funded support: $76,760.
6. January 2005 – June 2006: Hemofiltration for Respiratory Failure Following Hematopoietic Stem Cell Transplantation. International prospective multicenter trial. local PI. Leukemia and Lymphoma Society.
7. March 2005 – June 2006: Critical Pertussis in U.S. Children: Severe Morbidity, Sequelae, and Mortality. Prospective multicenter NICHD/CDC study. PI liaison for the PALISI network.
8. July 2006 – 2010: A Multicenter, Randomized, Masked, Placebo-Controlled Trial to Assess the Safety and Efficacy of Lucinactant in Acute Hypoxemic Respiratory Failure in Children up to Two years of Age, local PI and member, Scientific Advisory Board. Discovery Labs, Inc.
9. November 2009 – April 2011: H1N1 Surveillance Registry, Massachusetts General Hospital and Children's Hospital Boston, PALISI and ARDSnet networks, NIH funded, local PI
10. October 2010 – 2012: Influenza Vaccine Effectiveness in High- Risk Children, PALISI network, CDC funded, local PI
11. August 2011 – 2014: SAFE-EPIC (Saline vs. Albumin Fluid Evaluation – Extrapolation to Pediatric Intensive Care), multicenter cross-sectional study, local PI
12. November 2013 – December 2014: PlasmaTV (Indications and effects of plasma transfusions in critically ill children); international point prevalence study, local PI
13. November 2009 – 2015: A Phase III Trial of Calfactant for acute lung injury (ALI) in pediatric leukemia and hematopoietic stem cell transplant (HSCT) (CALIPSO) patients, PALISI network, FDA funded, local PI
14. September 2011 – 2014: PANGEA (Prevalence of Acute critical Neurologic disease in children: a Global Epidemiological Assessment), multicenter point-prevalence study, local PI
15. October 2009 – current: Genetic Epidemiology of Life-Threatening Influenza Infection in Children and Young Adults. A multicenter prospective observational study; NIH funded; PALISI network; local PI.
16. June 2009 – current: Relationship of PICU volumes and severity-adjusted outcomes, PI
17. October 2012 – current: SPROUT (Sepsis Prevalence Outcomes and Therapies), multicenter, cross sectional study, local PI
18. October 2014 – current: ABC-PICU (Age of Blood in Children), multinational randomized controlled trial of standard issue vs. fresh blood in the PICU, local PI

GRANT SUPPORT - CURRENT:

Grant No. GS-10F-0086K, PI: Randolph *Dates of Award: 2010 – current*

Agency: Centers for Disease Control *5% effort*

Title: Evaluation of Novel H1N1 Influenza A Virus Vaccine Effectiveness among Two High Risk Populations at Priority for Early Receipt of Vaccine

Description: The objective of this study is to evaluate the effectiveness of influenza vaccination in preventing laboratory-confirmed influenza infection associated with admission to an intensive care unit among children aged 6 months to 17 years.

Role: Local PI

Total Direct Costs: $32,593

Grant No. 5R01AI084011-02, PI: Randolph *Dates of Award: 2009 - current*

Agency: National Institutes of Health *5% Effort*

Title: Genetic Epidemiology of Life-Threatening Influenza in Children

Description: The objective of this study is to test the hypothesis that infection with the influenza virus triggers hypercytokinemia and innate immunosuppression in a genetically susceptible host leading to very severe and sometimes fatal infection. We will test this hypothesis in critically ill children with influenza LRTI

Role: Local PI

Total Direct Costs $2,800/patient enrolled

Grant No. 5U01HL116383-02, PI: Spinella *Dates of Award: 2013 - current*

Agency: NIH/NHLBI *5% Effort*

Title: Age of Blood in Children in Pediatric Intensive Care Units

Description: ABC PICU is a randomized clinical trial that will compare the clinical consequences of RBC storage duration in 1538 critically ill children

Role: Local PI

Total Direct Costs $3,850/patient enrolled

GRANT SUPPORT - PAST:

Grant No. 1R01FD003410-01A1, PI: Tamburro and Thomas *Dates of Award: 2010 - 2015*

Agency: Food and Drug Administration *5% Effort*

Title: Calfactant for Acute Lung Injury in Pediatric Stem Cell Transplant and Oncology Patients

Description: The objective of this study is to determine the impact of exogenous surfactant replacement using calfactant on mortality, oxygenation, duration of mechanical ventilation, PICU length of stay, and hospital length of stay in children with acute lung injury who have leukemia or lymphoma or who have undergone HSCT.

Role: Local PI

Total Direct Costs $5,000/patient enrolled

ISSUED AND PENDING PATENTS:

n/a

INVITED LECTURES, SYMPOSIA, KEYNOTE ADDRESSES

Year	*Type*	*Title, Location*
2000	Plenary	CyberSchool 2000:Finding the Fast Lane on the Critical Care Information Superhighway, Society of Critical Care Medicine Annual Scientific and Educational Symposium, Orlando, Florida, February 15, 2000
2002	Symposium	Caught in the Middle: Children in Clinical Trials: Ethical Issues in Pediatric Clinical Research, Washington University School of Medicine, St. Louis MO, October 15, 2002, Chair.
2003	Workshop	Evidence-based Pediatric Critical Care Practice, 4th World Congress of Pediatric Critical Care, Boston MA, June 8, 2003, Co-director.
2003	Symposium	Utilizing IT to Improve Patient Care, 4th World Congress of Pediatric Critical Care, Boston MA, June 8-12, 2003, Chair.
2004	Colloquium	The eRecord and Order Entry Systems. Pediatric Critical Care Colloquium, New York, NY, October 1, 2004
2006	Workshop	Basic Tools and Techniques of Evidence-Based Medicine, Pediatric Academic Societies' Annual Meeting, San Francisco CA, April 29, 2006, Co-director
2007	Symposium	Case Reviews: Trauma tales and lessons learned. 2007 Annual Pediatric Trauma Critical Care Conference, Children's Hospital Los Angeles, Los Angeles, CA. June 7, 2007
2008	Symposium	Critical Care Surge Capacity, Pediatric Disaster & Emergency Services National Summit, Los Angeles, CA, September 12, 2008
2008	Symposium	From crayfish to clinical trials: A peripatetic journey. The Trelka Scientific Symposium: A celebration of the life and career of Dennis G. Trelka, Ph.D. Washington & Jefferson College, Washington, PA. October 16, 2008
2010	Lectures	Early signs of deterioration of the hospitalized child, and Best use of the rapid response team, at Contemporary Forums' Nursing Care of the Hospitalized Child, May 14, 2010, San Francisco, CA
2012	Colloquium	19th Pediatric Critical Care Colloquium, Santa Monica CA September 6-9, 2012, Co-director
2014	Symposium	What can pediatricians learn from airplane pilots? and The new pediatric acute respiratory distress syndrome. 3rd China-US (Xiaoxiang) Symposium of Pediatrics, September 25-27, 2014, Changsha, China
2015	Lectures	Updates from PALISI, The VPS Research Process, and Is there a volume-outcome relationship in pediatric critical care? at the 2015 VPS User Group Meeting, New Orleans, LA, March 26, 2015
2015	Panel	Protocols and Checklists, 12th Congress of the World Federation of Societies of Intensive and Critical Care Medicine, August 31, 2015, Seoul, Korea, Co-chair
2015	Lecture	Rapid Response Teams Save Lives! At the 12th Congress of the World Federation of Societies of Intensive and Critical Care Medicine, August 31, 2015, Seoul, Korea
2016	Symposium	Lecturer, faculty and small group facilitator, Pediatric Critical Care Medicine Regional Boot Camp, St. Louis Children's Hospital/Washington University School of Medicine and Children's Hospital of Philadelphia, St. Louis MO, July 15-17, 2016

INVITED GRAND ROUNDS, CME LECTURES

Year	*Type*	*Title, Location*
1993	Grand rounds	Mechanics and Energetics of Pediatric Respiratory Failure, Washington University School of Medicine, Department of Anesthesiology, St. Louis, MO, April 21, 1993
1998	Grand rounds	Evidence-Based Anesthesiology? Washington University School of Medicine, Department of Anesthesiology, St. Louis, MO, April 22, 1998
1998	Grand rounds	Bringing Evidence to Patient Care: Is the Internet Helping Yet? Washington University School of Medicine, Department of Pediatrics, St. Louis MO, October 9, 1998
2000	Grand rounds	eHealthcare and Evidence-based Pediatrics: Are We There Yet? Pediatric Grand Rounds. Maimonides Medical Center, Brooklyn, New York. April 18, 2000
2002	Grand rounds	Ventilator-Induced Lung Injury, Washington University School of Medicine, Department of Anesthesiology, St. Louis, MO, February 21, 2002
2002	Grand rounds	Evidence-based Pediatrics: Hype or Hope? Pediatric Grand Rounds, Cleveland Clinic Children's Hospital, Cleveland OH. May 21, 2002
2003	Grand rounds	Dr. McCoy Meets Stanley Kubrick: The Intersection of Medical Ethics and Informatics, Washington University School of Medicine, Department of Pediatrics, St. Louis MO, August 29, 2003
2005	Grand rounds	Is Pediatrics Ready for Computerized Diagnostic Decision Support? Twelfth Annual DiCerbo Foundation lecturer in Pediatric Critical Care Medicine at North Shore University Hospital, Manhasset NY. December 7, 2005
2006	Grand rounds	She's Really Most Sincerely Dead:" Death and Organ Donation in the 21st Century, Washington University School of Medicine, Department of Anesthesiology, St. Louis, MO, May 10, 2006
2007	Grand rounds	Can (and should) computers help pediatricians make diagnoses? Computerized diagnostic decision support in pediatrics, Children's Hospital Los Angeles Department of Pediatrics, March 30, 2007 and at LAC+USC Medical Center, Women's & Children's Hospital, Department of Pediatrics, May 29, 2007.
2010	Grand rounds	Rapid Response Teams. Children's Hospital Los Angeles, Department of Anesthesiology, June 24, 2010
2012	Lecture	Strategies for Reviewing the Literature. PALISI Fellow Course. PALISI Research Network Meeting, Chicago IL, October 3, 2012
2013	Grand rounds	Diagnostic errors as systems failures: can computerized decision support help? Visiting Professorship, Boston Children's Hospital, Department of Anesthesia Critical Care, Boston MA, June 4, 2013
2013	Lecture	Strategies for Reviewing the Literature. PALISI Fellow Course. PALISI Research Network Meeting, New Orleans LA, October 2, 2013
2014	Lecture	Strategies for Reviewing the Literature. PALISI Fellow Course. PALISI Research Network Meeting, Montreal, Canada, October 8, 2014
2016	Lecture	Critically Reviewing a Manuscript: Learning from Others, at Comprehensive Approach to Clinical Research for the Junior Investigator, World Congress in Pediatric Critical Care, Toronto, Ontario, Canada, June 4, 2016.
2016	Lecture	Respiratory System 1 & 2, Miami Children's Hospital 4th Annual Pediatric Critical Care Self-Assessment course, Miami Beach FL, April 15, 2016
2016	Lecture	Critically Reviewing a Manuscript: Learning from Others, at Comprehensive Approach to Clinical Research for the Junior Investigator, PALISI Research Network Meeting, Washington DC, September 28, 2016

THESIS:

n/a

PUBLICATIONS:

REFEREED JOURNAL ARTICLES:

1. Larsen, P.R., Dick, T.E., Markovitz, B.P., Kaplan, M.M., Gard, T.G. Inhibition of Intrapituitary Thyroxine to 3,5,3'-Triiodothyronine Conversion Prevents the Acute Suppression of Thyrotropin Release by Thyroxine in Hypothyroid Rats. *Journal of Clinical Investigation* 64: 117-28, 1979
2. Markovitz, B.P., Duhaime, A., Sutton, L., Schreiner, M.S., Cohen, D.E. Effects of Alfentanil on Intracranial Pressure in Children Undergoing Ventriculo-peritoneal Shunt Revision *Anesthesiology*, 76: 71-6, 1992
3. Markovitz BP, Randolph AG. Corticosteroids for the prevention and treatment of post-extubation stridor in neonates, children and adults (Cochrane Review). In: *The Cochrane Library*, Issue 1, 2000. Oxford: Update Software.
4. Markovitz, B.P., Randolph, A.G. Corticosteroids for the Prevention of Reintubation and Post-extubation Stridor in Pediatric Patients: A Meta-Analysis. *Pediatric Critical Care Medicine* 2002; 3:223-226.
5. Hooten WM, Markovitz BP. General anaesthesia for adults receiving electroconvulsive therapy. *The Cochrane Database of Systematic Reviews*: Protocols 2003 Issue 3.
6. Markovitz BP, Bertoch D, Goodman D, Watson S, Zimmerman J. A retrospective cohort study of prognostic factors associated with outcome in pediatric severe sepsis; What is the role of steroids? *Pediatr Crit Care Med.* 2005; 6:270-274.
7. Willson DF, Thomas NJ, Markovitz BP, Bauman LA, DiCarlo JV, Pon S, Jacobs BR, Jefferson LS, Conaway MR, Egan EA; Pediatric Acute Lung Injury and Sepsis Investigators. Effect of Exogenous Surfactant (Calfactant) in Pediatric Acute Lung Injury. *JAMA* 2005;293 470-476.
8. Checchia PA, McCollegan J, Kolovos NS, Levy FH, Markovitz B. The effect of surgical case volume on outcome following the Norwood procedure. *J Thorac Cardiovasc Surg.* 2005; 129:754-9.
9. Markovitz BP, Cook R, Flick LH, Leet TL. Socioeconomic factors and adolescent pregnancy outcomes: distinctions between neonatal and post-neonatal deaths? *BMC Public Health* 2005, 5:79. Available at: http://www.biomedcentral.com/1471-2458/5/79
10. Markovitz BP, Andresen EM. Lack of insurance coverage and urgent care use for asthma: A retrospective cohort study. *BMC Public Health* 2006, 6:14.
11. Tamburro RF, Thomas NJ, Pon S, Jacobs BR, Dicarlo JV, Markovitz BP, Jefferson LS, Willson DF; Pediatric Acute Lung Injury and Sepsis Investigators (PALISI) Network. Post hoc analysis of calfactant use in immunocompromised children with acute lung injury: Impact and feasibility of further clinical trials.. *Pediatr Crit Care Med* 2008; 9:459-464.
12. Bateman ST, Lacroix J, Boven K, Forbes P, Barton R, Thomas N, Jacobs B, Markovitz B, Goldstein B, Hanson J, Randolph AG, for the Pediatric Acute Lung Injury and Sepsis Investigator's (PALISI) Network. Anemia, Blood Loss, and Blood Transfusion in North American Children in the Intensive Care Unit. *Am J Respir Crit Care Med.* 2008; 178(1):26-33.
13. Typpo KV, Petersen NJ, Hallman M, Markovitz BP, Mariscalco MM. Day 1 multiple organ dysfunction syndrome is associated with poor functional outcome and mortality in the pediatric intensive care unit.. *Pediatr Crit Care Med* 2009 Sep;10(5):562-70..
14. Markovitz BP, Randolph AG, Khemani RG. Corticosteroids for the prevention and treatment of post-extubation stridor in neonates, children and adults. *Cochrane Database of Systematic Reviews* 2008, Issue 2. Art. No.: CD001000. DOI: 10.1002/14651858.CD001000.pub2.
15. Khemani RG, Markovitz BP, Curley MAQ. Characteristics of Intubated and Mechanically Ventilated Children in 16 Pediatric Intensive Care Units (PICUs). *Chest* 2009; 136:765-771 ;DOI 10.1378/chest.09-0207

16. Epstein D, Wong CF, Khemani RG, Moromisato DY, Waters K, Kipke MD, Markovitz BP. Race/ethnicity is not associated with mortality in the pediatric intensive care unit. *Pediatrics* 2011; 127: e581-587.
17. Khemani RG, Randolph A, Markovitz B. Corticosteroids for the prevention and treatment of post-extubation stridor in neonates, children and adults. *Cochrane Database Syst Rev.* 2009 Jul 8;(3):CD001000.
18. Shibata S, Khemani RG, Markovitz B. Patient Origin Is Associated With Duration of Endotracheal Intubation and PICU Length of Stay for Children With Status Asthmaticus. *J Intensive Care Med.* 2013 Feb 11. [Epub ahead of print] PMID: 23753230 [2014; 29(3):154-159]
19. Ingaramo O, Khemani RG, Markovitz BP, Epstein D. Effect of Race on the Timing of the Glenn and Fontan Procedures for Single-Ventricle Congenital Heart Disease. *Pediatr Crit Care Med* 2012; 13:174 –177
20. Hayes LW, Dobyns EL, DiGiovine B, Brown AM, Jacobson S, Randall KH, Wathen B, Richard H, Schwab C, Duncan KD, Thrasher J, Logsdon TR, Hall M, Markovitz B. A Multicenter Collaborative Approach to Reducing Pediatric Codes Outside the ICU. *Pediatrics* 2012; 129:e785.
21. Edwards JD, Houtrow AJ, Rehm R, Markovitz BP, Graham RJ, Dudley RA. Stratifying chronic conditions by complexity aids in defining PICU populations and estimating their risk of in-PICU mortality and prolonged length of stay. *Crit Care Med* 2012; 40(7):2196-203.
22. Thomas JN, Guardia CG, Moya FR, Cheifetz I, Markovitz B, Cruces P, Barton P, Segal R, Simmons P, Randolph A, for the PALISI Network. A Pilot, Randomized, Controlled Clinical Trial of Lucinactant, a Peptide-Containing Synthetic Surfactant, in Infants with Acute Hypoxemic Respiratory Failure. *Pediatr Crit Care Med* 2012; 13(6):646-653.
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n/a

CLINICAL COMMUNICATION: (PUBLISHED CLINICAL TRIAL COMMUNICATIONS)

n/a

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Panel presentations

1. Pain in the PICU – Measurement and Therapy, panel discussant, Eighth Annual Pediatric Critical Care Colloquium, Sea Island, GA, October 8-11, 1995
2. Pediatric Critical Care Medicine in the Information Age, presentation and panel discussant, Ninth Annual Pediatric Critical Care Colloquium, Milwaukee, WI, September 25-8, 1996
3. Introduction to Evidence-Based Practice in Pediatric Critical Care, moderator and speaker, Tenth Annual Pediatric Critical Care Colloquium, Hot Springs, AR, September 17-20, 1997

4. Pediatrics and the Internet, presenter and panelist, Symposium on Computer Technology in Critical Care and Transport Medicine, American Academy of Pediatrics Annual Meeting, New Orleans, LA, October 31 - November 3, 1997
5. Evidence-Based Care in the Pediatric Intensive Care Unit, presenter/discussant, Northwest Pediatric Critical Care Cooperative Conference, Seattle, WA, October 27, 1997.
6. The Virtual Pediatric ICU (VPICU): An Overview and Vision for the Future, presenter/discussant, 12th Annual Pediatric Critical Care Colloquium, Portland, Oregon, September 22-26, 1999
7. New Frontiers of Communication, in plenary session: The Technology of the New Millennium: Transference of Knowledge to a Smaller World. 3rd World Congress on Pediatric Intensive Care, Montreal, Canada, June 28, 2000.
8. How Will Scientists, Funding Agencies and Employers Measure "Quality" of Publication in the Open Environment? plenary session, Freedom of Information - The Impact of Open Access on Biomedical Science. New York, New York, July 7, 2000. Conference proceedings available at http://www.biomedcentral.com/meetings/2000/foi/editorials/markovitz
9. Ethical Issues in Living Lobar Lung Transplantation, plenary session, 14th Annual North American Cystic Fibrosis Conference, Baltimore, Maryland, November 13, 2000.
10. Pediatrics Year in Review. Society of Critical Care Medicine Annual Scientific and Educational Symposium, San Francisco, CA, February 10-14, 2001
11. Preparing for a Life in Academics, faculty panel member. American Academy of Pediatrics National Conference & Exhibition, October 26, 2007.
12. Developing a patient safety/quality improvement research agenda for the PALISI network. 11th International PALISI (Pediatric Acute Lung Injury and Sepsis Investigators) Meeting, Snowbird, UT, March 8, 2008.
13. "Advise on Transitioning to the First Job After Fellowship," panel discussant, SCCM In-training section, Society of Critical Care Medicine's 40th Annual Congress, San Diego, CA, January 17, 2011.
14. "Advise on Transitioning to the First Job After Fellowship," panel discussant, SCCM In-training section, Society of Critical Care Medicine's 42st Annual Congress, Houston TX, February 5, 2012.
15. Integrating the NP Role into the PICU Team and Environment, 19th Pediatric Critical Care Colloquium, Santa Monica, CA, September 8, 2012

Scientific oral or poster presentations

1. Effects of Alfentanil on Intracranial Pressure in Children Undergoing Ventriculo-peritoneal Shunt Revision, American Society of Anesthesiologists Annual Meeting, Las Vegas, NV, October 22, 1990
2. Transtracheal Doppler cardiac output in pediatric patients: Comparison with the Fick method, Society of Critical Care Medicine Annual Scientific and Educational Symposium, San Antonio, TX, May 27-8, 1992
3. Partitioning the Power of Breathing of Infants with Severe Bronchiolitis, Society of Critical Care Medicine Annual Scientific and Educational Symposium, San Francisco, CA, January 31-February 4, 1995
4. Relationship Between Whole Body Oxygen consumption and Spontaneous Breathing in Infants with Respiratory Failure, Eighth Annual Pediatric Critical Care Colloquium, Sea Island, GA, October 8-11, 1995
5. A Cost Analysis of Continuous vs. Intermittent Opioids and Benzodiazepine Therapy in Critically Ill Children, Society of Critical Care Medicine Annual Scientific and Educational Symposium, San Diego, CA, February 6-10, 1997.
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7. Ethics Online: Is Confidentiality Being Respected on Medical Websites? presenter/ discussant, American Medical Informatics Association Annual Symposium, Orlando, FL, November 8, 1998
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MEDIA AND TELEVISION APPEARANCES:

n/a

EXHIBIT 12

Author	Status	Last Editor	Updated	Created
Gary Wayne Raff, MD	Signed	Gary Wayne Raff, MD	4/6/2016 3:09 PM	4/6/2016 3:02 PM

Assoc. Orders	Procedures
SURGICAL CASE REQUEST	DECANNULATION EXTRACORPOREAL MEMBRANE OXYGENATION

Pre-Op Dx	Post-Op Dx
Asthma, severe persistent, with acute exacerbation	Asthma, severe persistent, with acute exacerbation

INPATIENT OPERATION RECORD

PATIENT: Israel Stinson
MR #: 7154507
DOB: 10/5/2013
SEX: male
AGE: 2yr
OPERATION DATE: 4/6/2016

Preoperative diagnosis: Asthma s/p acute exacerbation and cardiac arrest, s/p placement on ECMO via R neck
Posteroperative diagnosis: Same
Procedure: ecmo decannulation
Surgeon: Raff

Anesthesia: PICU staff

STINSON,ISRAEL ELIJAH
10/05/13
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What was done:

A preprocedure pause was carried out. The previous dressing over the right neck was removed and the neck and chest prepped and draped. The previous incision was reopened and the right common carotid artery was controlled proximally and distally with silk ties. The cannula was removed and the ties secured. A similar procedure was used to remove the venous cannula from the internal jugular vein. There was good hemostasis. The wound was irrigated and closed with full thickness skin sutures. Sterile dressing was placed. The patient remains in critical condition in the PICU.

Report electronically signed by:

Gary W. Raff, M.D.08755, Attending Physician.

Status of Other Orders

EX 12

EXHIBIT 13

Sara Aghamohammadi MD	PHYSICIAN FACULTY	Signed	At Peds CL	Progress Notes	04/07/16 1700

UPDATE

Israel returned from nuclear medicine following cerebral blood flow study. Radiologist called to inform me of results: there was no evidence of cerebral perfusion. I viewed the images myself as well. I approached Israel's mother and father, who were in the room, and asked if they would like to know the results. I shared the results with them. Father asked "is there anything you can do to fix it?" and I said unfortunately there was not. I explained that we would still proceed with brain death exams as we had discussed before, with the first exam tomorrow (unless they want one sooner). I offered to call chaplain, additional family members, or support staff at that time. They were tearful and asked to be alone for now.

Time spent: 15 minutes

Electronically signed by:
Sara Aghamohammadi MD (PI# 14633)
Attending Physician
Pediatric Critical Care
Pager: 816-0086

STINSON,ISRAEL ELIJAH
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EXB

(14)

Sara Aghamohammadi MD | PHYSICIAN FACULTY | Signed | A Peds CU | Progress Notes | 04/08/16 0951

Physician's Progress Record

PATIENT EVALUATION FOR DETERMINATION OF BRAIN DEATH
FIRST EXAMINATION AND APNEA TEST

Patient's Name: Israel Stinson

First Exam. Date: 4/8/16 Time: 935 Temp: 36.9 B/P: 106/69 (78)

A. Preliminary Determination

1. Patient in coma: no
   - A. Cause of coma: n/a
   - B. Method by which coma diagnosed: n/a

2. The following reversible conditions were excluded:
   - A. Sedation: no
     Basis of exclusion: no sedative or anti-epileptic given in over 72 hours
   - B. Neuromuscular blockage: no
     Basis of exclusion: no neuromuscular blockade given in over 72 hours

B. Absence of Brain Stem Reflexes and Responses

All of the following must be evaluated at the time of examination and documented by the initials of the evaluating physician in the appropriate space.

FIRST EXAM

1. Pupils: a) Size: OD 5 OS 5 b) Response to light absent Initials: SA
2. Corneal reflex: absent Initials: SA
3. Ocular response to head turning: absent Initials: SA
4. Ocular response to irrigation of ears with ice water: absent Initials: SA
5. Gag reflex: absent Initials: SA
6. Spontaneous breathing: absent Initials: SA
7. Motor response to painful stimuli:absent Initials SA
8. Apnea test:
   Time 923 Baseline ABG: 7.4/37/154/23/-1
   Time 948 ABG at test end: 7.13/76/172/25/-6
   respiratory effort absent Initials SA

STINSON,ISRAEL ELIJAH
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Electronically signed by:
Sara Aghamohammadi MD (PI# 14633)
Attending Physician
Pediatric Critical Care
Pager: 816-0086

If any of the above are not done, it must be documented in the "Comments" section below:
COMMENTS: none

EX14

EXHIBIT 15

John James Holcroft, MD | PHYSICIAN FACULTY | Signed | (A) Pedis ICU Progress Notes | 04/10/16 1319

PCICU PROGRESS NOTE
4/10/2016 13:19
This note reflects plans made during multidisciplinary rounds unless otherwise indicated.

I have personally seen and evaluated this critically ill patient. I have reviewed the overnight events with Dr.Marcin. I have reviewed the flowsheets and any relevant available laboratory values and radiographic studies with the multidisciplinary team. Consult and recommendations noted from: n/a.

Major Overnight Events:
CT and MRI completed overnight. Transitioned to PRVC as well.

Continuous Infusions
Nicardipine (stopped at 8am)

Scheduled Medications
Albuterol
DDAVP (being held)
Pepcid
Ceftriaxone

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Physical Exam:
GEN: Intubated, flaccid
HEENT: Oral ETT. Midline trachea
RESP: Unlabored respirations. Good air exchange bilaterally.
CV: Regular rate and rhythm. No murmur.
GI: Absent bowel sounds. Soft, non-distended.
EXT: Slightly cool extremities. Capillary refill 3 seconds.
NEURO: Pupils 4 mm and fixed bilaterally. No response to voice or pain.
SKIN: Warm, dry

INTAKE/OUTPUT
I/O Last 2 Completed Shifts:
In: 1313 [Crystalloid:966; Lipid:107.1]
Out: 1239 [Urine:1220; Gastric:19]

Current:Weight: 11.7 kg (25 lb 12.7 oz) (04/01/16 2152) Admit:Weight: 11.7 kg (25 lb 12.7 oz) (04/01/16 2152)
Diet: TPN 10 ml/hr

Indwelling devices present and necessary: ETT, central line, arterial line

Assessment:
Critically ill 2yr old male, past medical history of asthma who was admitted with respiratory failure due to status asthmaticus and s/p ECLS after cardiopulmonary collapse. His exam has been concerning for brain death, and his first brain death exam was consistent with brain death. He also had a nuclear medicine flow study that did not show evidence of

cerebral perfusion. Mother and father have refused the second brain death evaluation. After lengthy discussions with administrative and medical leadership, the plan will be for a family meeting with all involved parties to determine the best course of action. Mother is working on a list of people that she would like to attend the meeting.

Plan:

- support perfusion as best as possible with goal normal sodium, magnesium levels
- titrate ventilator for normal ventilation/oxygenation; now on PRVC so should require less titration
- titrate nicardipine for normal blood pressure (currently off)
- absent bowel sounds, so will continue TPN, but will increase rate to 25 ml/hr since weaning off 3% NaCl
- will discontinue DDAVP; would resume once not requiring NaCl supplementation and large urine output (or start vasopressin infusion)
- continue ceftriaxone for respiratory infection

Family Update: Family updated on patient status
Critical Care Time (excluding procedures): <2 years: 50 minutes

Electronically signed by:
John Holcroft, MD
PICU Attending
Pager: 816-8804; PI#: 12085

STINSON,ISRAEL ELIJAH
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EXHIBIT 16

Garone, Shelly Rene (M.D.) Physician Signed Palliative Care 4/13/2016 4:59 PM PDT

PALLIATIVE CARE CONSULTATION 4/13/2016

CONSULT RECEIVED FROM: Dr. Myette

REASON FOR CONSULT: goals of care and advance care planning

CURRENT ACTIVE MEDICAL PROBLEMS AND DECLINE:
30 month old boy taken to an outside hospital on April 1 with status asthmaticus. He has history of asthma and poor compliance with therapies. He was at UCDMC and doing well enough April 2 to be extubated. However, later that day he developed abrupt bronchospasm and was coded for 40 minutes with initiation of ECMO. This code was devastating and he was found to have profound anoxic injury at UCDMC. His first exam for brain death was April 8. Family refused to allow another exam and wanted him transferred. Due to him being a KP member, we repatriated him. He had his first brain death exam with us last pm (confirmed brain death). He was due for a second exam today but family again is trying to refuse to allow the exam to be done. I was asked to help work with the family on their goals and long term planning.

PERTINENT PHYSICAL EXAM:
Flaccid unresponsive child on a vent. Pupils fixed and dilated. Requiring pressors due to hypotension, vasopressin due to pituitary infarct, and baer hugger due to inability to regulate body temp.

DISCUSSION:
I have had three meetings with Mom today. The first was at 10:45 this morning just with her in the room. The second meeting was by phone at 3:10 today with her and baby's dad. The third meeting was in person with Dr. Myette, Mom and maternal aunt and grandma.

This morning, Mom was very guarded, and asked me first if I'm a mom. She stated that as a mom I should understand that she's just needing time. I asked her to tell me more and she stated that "the next exam will confirm he's gone, so what's the rush? Why do I have to hear that alone and cry and wait for my family to come here?" She went on to say that UCDMC gave them 24 hours between brain death exams, even though she understands protocol is 12 hours. "If I could just get my family here tonight, it would be better." She had a moment of magical thinking and told me "I think he could be better with time" but then acknowledged that the last time he did anything that could be construed as purposeful was Sunday 4/3. She went on to say that she understands why the medical team is making the recommendations they're making and asks again, "If I'm losing him for good, what's the harm of determining that tonight or tomorrow." We also talked briefly about what his death might look like and how gently or quickly the equipment would be removed from his body.

I met with the team and we determined that the next brain death exam could wait past the 12 hour window, provided mom was truly gathering family to the bedside. The team was hopeful we could perform the brain death exam tonight at 7pm because mom would have several family members here.

I called Mom at 3:10 because she had told me she would text me with the plans for family arrival. I spoke with her and Dad on the phone. Explained that the team was hoping to do the brain death exam tonight at 7pm and that this was due to our fear of his organs failing, **not** due to her belief that we're "trying to save money." Explained that if his organs shut down prior to the exam, she will find herself in a second code blue situation, and I worry about the trauma of going through that again on her wellbeing. She was distraught in this conversation and said that she would want him coded. She also stated that she will have some family here tonight, but the rest will be picked up at the airport tomorrow at 10am. She again asked if the exam could be delayed to tomorrow. Dad then got on the phone with me and told me he's waiting for forms from an attorney to "make you delay the test." Explained to both that we must continue the medical evaluation of the patient, and that I will work with the team on whether the timing of the evaluation can be delayed one more time. Explained to Dad that he's free to seek any outside counsel he needs to seek.

EX 16

Then Dr. Myette and I met with Mom and maternal aunt and maternal grandma at the bedside. Aunt and Grandma are both very kind ladies who are as devastated by the situation as Mom. Mom asked pointed questions about evaluations done yesterday and what she needed to hear from the treating team. We were able to get to an agreement of what information she needs to receive and how she would like to receive it. She and MGM and Aunt thanked Dr. Myette for his compassion and being "real people."

We then discussed that we will perform the second and final brain death exam tomorrow at 11am. We discussed that Israel's organs may fail tonight and that Mom will be updated as to his progress throughout the night. Mom had good questions about what the brain death exam will look like and what parts of Israel's brain will be evaluated. Mom also had good questions about how to ensure Israel does not suffer, if declared dead, and machines are stopped. I agreed with Dr. Myette that it makes sense to stop the pressors first and allow Israel's heart and blood pressure to drop on their own time. However, if mom would like the tube out of his mouth and nose, we will do that, too. Explained to all how to know that Israel is comfortable.

Mom asked if Israel could hear her talking to him. We explained that we have no reason to think his ears are on now, as we believe his brain has died. However, his spirit is connected to hers and she should definitely talk to him in that way. MGM and Aunt were grateful for this acknowledgment of baby's spirit, though both deferred chaplaincy referral at this time. Mom agreed to allow me to come back tomorrow at 11am for the exam.

Outside of the room, Dad asked me to recap this meeting. After I did, he again said, "but you know I'm getting a lawyer to stop this, right?" I acknowledged that he's working the legal path and that this is okay with us. Medically, we need to continue doing the work of evaluating Israel as we are. Dad then asked me if they could just take Israel to another hospital. I explained that I did not think so, but asked if I could send the social worker to talk with him about the transfer process. He agreed. (He apparently was not in the room when SW arrived, though.)

IMPRESSION/RECOMMENDATION:
1. Probable brain death in a 30M old child - Mom is grieving as expected, and preparing for final brain death exam 4/14/16. Dad is coping less well and continues to try and find a way to avoid doing the next exam. Continue psychological support of both parents and extended family.
2. Mom and Dad and MGM have my cell phone number for any questions or concerns.
3. I will f/u tomorrow.

Thank you,

Shelly Garone, MD, FACP
Assistant Physician in Chief, Continuum
North Sacramento Valley
Cell 916-813-1068

Routing History

EXHIBIT 17

8-9-16

To the Drs of Israel E. Stinson

I will be stepping away today but I will leave my contact number please do not hesitate to call me if anything happens with my son. In my absence Please DO NOT perform any tests or exams on Israel without my consent or presence.

Thank you so much,

Jonee Fonseca (510) 575-5314

Jonee Fonseca

P.S. I decline of any apnea test that may be performed on Israel Stinson.

EKG

EXHIBIT 18

Result Type:	Event Note
Result Date:	August 15, 2016 17:52
Result Status:	Auth (Verified)
Result Title:	Bioethics Consultation
Performed By:	Lew (Attending) MD,Cheryl on August 15, 2016 17:53
Verified By:	Lew (Attending) MD,Cheryl on August 15, 2016 17:53
Encounter info:	1621601529, CHLA, Inpatient, 08/07/2016 -

* Final Report *

Event Note

re: Israel Stinson
DOB: 10-15-2013
CHLA # 4124720
DOA: 08-07-2016

Date of ERC review: 08-15-2016

Referred by: Barry Markovitz, MD
PICU attending and Clinical Director

History:

This is the case of a 2 ½ year old boy who had a cardiac arrest in April, 2016 in association with an asthma episode. He had undergone two independent determinations of neurological status at two institutions in Northern California. Pediatric specialists at both institutions determined that this child had met all criteria for death by neurological status and he was declared dead by neurological criteria. The family did not accept this diagnosis and after seeking a court injunction to continue mechanical sustaining of biological function of the child's body, his body was then transferred for further care to Guatemala where tracheostomy and feeding gastrostomy were placed surgically. Approximately one week ago, the child's body on mechanical organ support was referred for consideration for the home mechanical ventilation program through the Division of Pediatric Pulmonology here at Children's Hospital.

On arrival here, the child's body per the clinical evaluation of the Pediatric Critical Care Staff and Neurocritical Care consultant presented signs and findings consistent with the diagnosis of death by neurological criteria. Further, there are additional signs and findings of diffuse multi-organ system

EXB

dysfunction due to absence of neurocortical and subcortical regulation; these include but not limited to: temperature dysregulation; complete apnea; absent electrolyte regulation; complete neurocognitive unresponsiveness.

Per Dr. Markovitz, the PICU team has presented the results of its clinical assessment confirming the diagnosis of death by neurological criteria to the parents, who again do not accept this diagnosis. The Pulmonary service has declined to accept the sustained body of this child to the home mechanical ventilation program—both due to the diagnosis of death, but also because of the diffuse, severe organ dysregulation that the body of this dead child continues to manifest. For both these reasons, use of long term mechanical ventilation is not considered an appropriate treatment either in hospital or at home. The family has been advised of potential options, which are time-limited: to attempt to seek care at an accepting institution. The management plans of the PICU team are to continue to sustain organ function (as best possible) by mechanical means out of respect for the parents but that should the child's body remain at CHLA more than a few days more, mechanical ventilation and other medical interventions will be discontinued.

Dr. Markovitz introduced me and informed the parents of my consultation re the ethical issues and I informed the parents that my involvement pertained only to the bioethics domains and that I am not involved in the clinical care of their child. Dr. Markovitz has also contacted numerous California PICU directors at other institutions and at least one director of a pediatric subacute care facility and all have declined to accept in transfer the body of this child.

Discussion:

I have been asked to provide an analysis of the bioethical domains in this case and to comment on the obligations of the healthcare team in the physical care of the body of a deceased child. That the child is deceased by the criteria of death on a neurological basis is not in doubt, in that at least two previous teams of pediatric physicians, including pediatric neurologists have conducted the necessary studies and tests to demonstrate whole brain death. Further, there has apparently been no change in clinical condition which would suggest that brain function has improved over the last 4 months.

The question, then, concerns the obligations of the healthcare team to both respect the remains of the dead child as well as the child's past personhood/moral status, while attempting to honor the wishes of the parents.

Although, the child is deceased, the moral obligations of the healthcare team continue to be of priority towards the best interests of the child as a deceased person. Healthcare professionals have basic and core obligations to respect the personhood of even deceased patients. In the situation of the deceased, those obligations mean that the remains or corpse must be treated with respect, must not be subject to undue and inappropriate intrusion or to be subject to inappropriate medical interference. In this context, continued provision of organ support with mechanical ventilation, intravenous manipulation of electrolytes for the seeming severe and intractable hypernatremia/electrolyte imbalance and other

therapies constitute interference with a corpse and thus is intrinsically disrespectful to the essence of this child's personhood during his past life. It is clear at this point that there is no possibility that this child's brain will recover to the extent that one could argue that he could resume his personhood. This latter point is demonstrated by the lack of any, even minimal recovered neurological function over an extended period of time.

Therefore, although the healthcare team has obligations to attempt to honor the feelings and opinions of the parents in this matter, still the primary moral obligation remains towards providing appropriate respect to the child who has died. This most important obligation means that the healthcare team ought to remove and discontinue the un-natural medical interventions currently in place which are of no benefit to a dead child and serve only as unnecessary intrusions on his corpse. This latter action is a strong moral obligation for the healthcare team.

Although the scientific and medical evidence for death in this child is clear, the healthcare team does owe compassion towards the family who does not acknowledge or accept the evidence. Therefore, the offer of reasonable assistance in seeking an alternative venue of care for their child's body is appropriate. However, it is also appropriate to establish a fixed time limit for the effort to arrange for transfer to a venue whose staff might share the parents' beliefs. Further prolongation of inappropriate and intrusive treatment to this child's body represents accumulating disrespect to the child and cannot be justified. Therefore, the obligation to respect the parents' wishes is present but of considerably less moral weight than those obligations owed to the deceased child.

The ERC makes the following recommendations:

I can speak on behalf of the full ERC that the committee acknowledges the heartbreak and emotional difficulty experienced by the parents/family in the wake of this child's unfortunate and untimely death. However, I and ERC are morally obligated to make recommendations on behalf of the person this child was in life and to honor his death in a respectful way.

1. The current plan to offer to the parents' time-limited opportunity to obtain an alternative venue of care is appropriate. The time-frame which has already been offered by the PICU staff is also appropriate.

2. Since death has already occurred, the members of the healthcare team ought not to offer any further "attempts" at resuscitative efforts for occurrence of any cardiopulmonary instability. Occurrence of problems with gas exchange, cardiac rhythm or circulation are signs of death and attempts to reverse these problems represents inappropriate intrusion and interference with the corpse.

3. The other medical issues such as electrolyte imbalance are also reflections of whole brain death and need not be treated.

4. Laboratory studies: blood work, etc. are also sources of intrusiveness and constitute a form of disrespect since none of the abnormalities can be corrected in a dead body. These studies need not be continued.

5. Once the time-frame for seeking alternatives for care elsewhere has elapsed, it is morally permissible and even obligatory for the healthcare team to discontinue all mechanical and organ supportive treatments and free this child's body from inappropriate manipulation.

The healthcare team's compassionate care demonstrated towards the bereaved parents is to be lauded as well as the careful and respectful attitude towards the deceased child's body.

Thank you for requesting the participation of myself and the ERC in considering the moral dimensions of this extremely difficult situation. Please do not hesitate to contact me if further questions arise.

Cheryl D. Lew, MD, MSBioethics
Chair, on behalf of the ERC

Completed Action List:
* Perform by Lew (Attending) MD,Cheryl on August 15, 2016 17:53
* Sign by Lew (Attending) MD,Cheryl on August 15, 2016 17:53
* VERIFY by Lew (Attending) MD,Cheryl on August 15, 2016 17:53

19

CURRICULUM VITAE

CHERYL D. LEW

APRIL 1, 2016

PERSONAL INFORMATION:

Work

Children's Hospital Los Angeles
Div. Pediatric Pulmonology
Mailstop 83
P.O. Box 54700
4650 Sunset Blvd.
Los Angeles, California 90027
Phone: 323-361-2101
Fax: 323-361-1355
Work Email: clew@chla.usc.edu

Home

20615 Callon Drive
Topanga, California 90290

Citizenship: United States

EDUCATION AND PROFESSIONAL APPOINTMENTS

EDUCATION:

Year	*Degree, Field, Institution, City*
1964	Dorsey High School, Los Angeles
1968	B.A. Zoology, University of California, Los Angeles
1972	M.D., University of California, San Diego
2004	M.S.Ed., Rossier School of Education, University of Southern California, Los Angeles
2010	M.S.Bioethics, Alden March Bioethics Institute, Albany Medical College, Albany, N.Y.

POST-GRADUATE TRAINING:

Year-Year	*Training Type, Field, Mentor, Department, Institution, City*
1972-1973	Pediatric Internship, James Apthorp, Pediatrics, Children's Hospital Los Angeles
1973-1975	Pediatric Residency, James Apthorp, Pediatrics, Children's Hospital Los Angeles
1975-1977	Fellowship, Neonatology & Pediatric Pulmonary, Arnold Platzker, Pediatrics, Children's Hospita Los Angeles
1991-1997	Bioethics post graduate education, various directors, Joseph & Rose Kennedy Institute of Ethic Georgetown University
2003	Fellowship in Teaching & Learning, Maurice Hitchcock, Division Medical Education, Keck Scho of Medicine, University of Southern California, Los Angeles
2004	Fellowship in Educational Leadership, Maurice Hitchcock, Division of Medical Education, Keck School of Medicine, University of Southern California, Los Angeles

HONORS, AWARDS:

Year	*Description*	*Awarding agency, address, city*
1968	Honors in Zoology Department	Dept. of Zoology, University of California, Los Angeles
1972	Frances Nunnally Windsor Sch Award	Children's Hospital Los Angeles, Los Angeles
2002	25 years of Service	Keck School of Medicine, University of Southern California, Los Angeles
2003	25 years of Service	Professional Staff, Children's Hospital Los Angeles
2012	35 years of Service	Department of Pediatrics, Keck School of Medicine, Children's Hospital Los Angeles

ACADEMIC APPOINTMENTS:

EX 19

Year-Year	*Appointment*	*Department, Institution, City, Country*
1975-1977	Postdoctoral Associate	Pediatrics, Keck School of Medicine, University of Southern California, Los Angeles, USA
1977-1987	Assistant Professor, Clinical Pediatrics	Pediatrics, Keck School of Medicine, University of Southern California, Los Angeles, USA
1987-2015	Associate Professor, Clinical Pediatrics	Pediatrics, Keck School of Medicine, University of Southern California, Los Angeles, USA
2015-present	Associate Professor, Clinical Pediatrics (Clinician Educator)	Pediatrics, Keck School of Medicine, University of Southern California, Los Angeles, USA
1996-2002	Adjunct Associate Professor of Pediatrics	Pediatrics, School of Medicine, University of California, Los Angeles, USA
2016-present	Clinical Professor of Pediatrics (Clinician Educator)	Pediatrics, Keck School of Medicine, University of Southern California, Los Angeles, USA

ADMINISTRATIVE APPOINTMENTS:

Year	*Description*	*Institution, City, State, Country*
2004-2010	Assoc. Training director, Pediatric Pulmonology	Children's Hospital Los Angeles, Dept. Pediatrics, USC, Los Angeles, California

TEACHING

DIDACTIC TEACHING:

Institution: Keck School of Medicine, Healthcare Minor, USC

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2012-present	MEDS 260 "Challenges in the forefront of Biomedical Ethics"	2	**Course designer, rector/coordinator** and lecturer

Institution: Children's Hospital Los Angeles, Saban Research Institute

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2006-present	Integrity in Scientific Research	9	**Course designer, rector/coordinator** and lecturer

Institution: Children's Hospital Los Angeles, Department of Pediatrics

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2004-2011	Proficiency in Teaching and Professional Academic Development. Core Curriculum. Clinical Research Fellowship Education and Training Program	12	**Course designer, rector/coordinator** and lecturer

Institution: Children's Hospital Los Angeles, Department of Pediatrics

Year-Year	*Course Name*	*Units/Hrs*	*Role*
1977-present	Clinical supervision of housestaff, medical students, clinical fellows	Not applicable	Attending teaching physician

Institution: Children's Hospital Los Angeles, Department of Pediatrics/Division of Ped. Pulmonology

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2004 - 2006	Medical Humanities Seminar for enhancing reflection for Pediatric Pulmonary Fellows	Monthly, 2 hours	**Course designer, rector/coordinator**

Institution: Children's Hospital Los Angeles, Department of Pediatrics/Division of Ped. Pulmonology

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2005-2008	Educational Leadership curriculum for Pediatric Pulmonary Fellows	8 hours	**Course designer, rector/coordinator**

CME Courses Developed

Institution

Year-Year	*Course Name*	*Units/Hrs*	*Role*

Undergraduate, Graduate and Medical Student (or Other) Mentorship:

Year-Year	*Trainee Name*	*Trainee Type*	*Dissertation/Thesis/Project Title*
1983-1985	Jeanene Laegried	Graduate Student, School of Physical Therapy, USC	Neuromotor behavior and cardiorespiratory responses of premature infants with bronchopulmonary dysplasia.
2015-present	Sheila Kun, RN, MN	Advance Practice Nurse	Assessment of safety of strollers as vehicles for portable ventilator systems.
2013-present	Josephine Ellashek, RN, MN	Advance Practice Nurse	Home Mechanical Ventilation MAP project
2012-present	Brenda Barnum, RN, MA	Nurse; Bioethicist	Bioethics consultation project

Graduate Student Thesis, Exam and Dissertation Committees:

Year-Year	*Trainee Name*	*Committee Type*	*Student Department*

Postgraduate Mentorship:

Year-Year	*Trainee Name*	*If past trainee, current position and location*
2009-2011	Sabrina Derrington, MD	Asst. Prof. Clin. Pediatrics, Lurie Children's Hospital, Chicago
2012-2013	Cyrus Heydarian	Hospital Medicine Pediatrician in Virginia
2014-present	Mark Selleck, MD PhD	

Mentorship of Faculty:

Year-Year	*Mentee Name*	*Mentee Department*
2011-2013	Sabrina Derrington, MD	Anesthesiology and Critical Care Medicine (CHLA)
2014-present	Manvi Bansal, MD	Pediatrics (Pulmonology)(CHLA)
2014-present	Narayan Iyer, MD	Pediatrics (Neonatology)(CHLA)

Service

Department Service:

Year-Year	*Position, Committee*	*Organization/Institution*
2001-2013	Member, Institutional Review Board	CHLA
2005-2011	Member, Stem Cell Research Oversight Committee	CHLA/Saban Research Institute
2011-present	**Chair, Stem Cell Research Oversight Committee**	CHLA/Saban Research Institute
2006-present	Member, Conflicts of Interest in Research Committee	CHLA/Saban Research Institute
2013-present	**Director, CHLA-chILD Research Group**	CHLA Division Pediatric Pulmonology
2013-present	**Site Director**, CHLA satellite research center for **chILDRN** (Childhood Diffuse Lung Disease Research Center)	CHLA Division Pediatric Pulmonology & Childhood Diffuse Lung Disease Research Center, Denver Colorado (Dir. R. Deterding, MD)

MEDICAL SCHOOL SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
2012-2013	Member, Cardiovascular & Pulmonary Committee. SC CTSI Pilot Funding review Committee	Keck School of Medicine/USC/CHLA

HOSPITAL OR MEDICAL GROUP SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
1983-2001	Member, Hospital Infection Control	CHLA
1990-2001	Member, Antibiotics Subcommittee of Pharmacy & Therapeutics Committee	CHLA
1987-1989	Member, Utilization Management Committee	CHLA
1986-1990	Member, Morbidity, Mortality, Medical Records Committee	CHLA
1986-1988	Member, Patient Care applications Team, Hospital Information System Project	CHLA
1989-1994	Member, Critical Care Committee	CHLA
1993-1994	Member, Continuing Medical Education	CHLA
1986-2000	Member, ECMO Coordinating Committee	CHLA
1986-1994	Member, ECMO Clinical Standards and Research Group	CHLA
1988-1990	Member, Patient Care Implementation Committee, Medical Information System	CHLA
1987-1990	Member, Steering Committee, Medical Information System Project	CHLA
1988-1990	Member, Physician Task Force, Medical Information System Project	CHLA
1990-1993	Member, Clinical Systems Committee, Medical Information System Project	CHLA
1985-1994	Member, Transport Operations Committee	CHLA
1987-1995	**Chair, Quality of Care and Standards for Neonatology**	CHLA
1985-1994	Member, NICU Task force on Nosocomial Infections	CHLA
1986-present	Member, Ethics Resource Committee	CHLA
1993-present	**Chair, Ethics Resource Committee**	CHLA
2007-present	Member, Comfort, Pain Management and Palliative Care Committee	CHLA
2013-present	**Leader/Director, Respiratory Care Unit**	CHLA
2013-present	Member, Pneumonia Variant Study Group	CHLA
1998-present	Spiritual Care Advisory Board	CHLA

UNIVERSITY SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*

PROFESSIONAL SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
1977-1995	Attending Physician, Neonatology	CHLA
1977-present	Attending Physician, Pediatric Pulmonology	CHLA
1996-2010	Medical Director, Pediatric Subacute Unit, All Saints Healthcare Facility	CHLA All Saints Healthcare, North Hollywood, CA

CONSULTANTSHIPS AND ADVISORY BOARDS:

Year	*Position, Board*	*Organization/Hospital/School, Institution*
1992-1994	Member, Pediatrics Testing Committee	National Board of Medical Examiners/U.S. Medical Licensing Examination

PROFESSIONAL SOCIETY MEMBERSHIPS:

Year- Year	*Society*
1976-2000	California Thoracic Society
2015-present	
1976-present	American Thoracic Society
1978-present	Fellow, American Academy of Pediatrics
1981-2001	Society of Critical Care Medicine
1982-present	American Society of Law and Medicine
1986-2003	American College of Chest Physicians
2010-2015	
2005-present	American Society for Bioethics and the Humanities

ADMINISTRATIVE SERVICE:

Year	*Position*	*Narrative listing Accomplishments- or add appendix*

COMMUNITY SERVICE:

Year-Year	*Position*	*Organization/Institution, City,*	*Role or Activity*

RESEARCH AND SCHOLARSHIP

EDITORSHIPS AND EDITORIAL BOARDS:

Year-Year	*Position*	*Journal/Board Name*

MANUSCRIPT REVIEW:

Year-Year	*Journal*

GRANT REVIEWS:

Year	*Description*	*Awarding agency, City, State, Country*

MAJOR AREAS OF RESEARCH INTEREST

Research Areas

1. Diffuse lung disease and other rare pulmonary diseases in children
2. Conflicts of interest in clinical and research medicine
3. Policy and ethics issues around human embryonic stem cell research and application
4. Bioethical issues around new research pertaining to prognostication.
5. Neuroethical considerations around pediatric neuroimaging.
6. Longterm ventilatory assistance in childhood

GRANT SUPPORT - CURRENT:

Grant No. (PI) *Dates of Award*

Agency *Percent Effort*

Title
Description
Role:
Total Direct Costs

Grant No. (PI) *Dates of Award*

Agency *Percent Effort*

Title
Description
Role:
Total Direct Costs

GRANT SUPPORT - PAST:

Grant No. (PI) *Dates of Award*

Agency *Percent Effort*

Title
Description
Role:
Total Direct Costs

Grant No. (PI) *Dates of Award*

Agency *Percent Effort*

Title
Description
Role:
Total Direct Costs

INVITED LECTURES, SYMPOSIA, KEYNOTE ADDRESSES

Year	*Type*	*Title, Location*

INVITED GRAND ROUNDS, CME LECTURES

Year	*Type*	*Title, Location*

THESIS:

Year	*Degree*	*Institution*	*Title*
2010	M.S. Bioethics	Alden March Bioethics Institute, Albany Medical College	Sources of bioethical conflict at the pediatric bedside: emotionality vs. rationality

PUBLICATIONS:

* INDICATES TRAINEES

REFEREED JOURNAL ARTICLES:

1. Richards W, CD Lew, J Carney, ACG Platzker: Review of ICU admissions for asthma. Clin Pediatr 18:345-352, 1979.

2. Warburton D, CD Lew, ACG Platzker: Primary hyperinsulinemia reduces surface active material flux in tracheal fluid of fetal lambs. Pediatr Res 15:1422, 1982.
   Role: performed the surgical implantation techniques for fluid collection; collected and prepared for processing the fluid samples.

3. Bader D, AD Ramos, CD Lew, ACG Platzker, MW Stabile and TG Keens: Childhood sequelae of infant lung disease: Exercise and pulmonary function abnormalities after bronchopulmonary dysplasia. J Pediatr 110:693-699, 1987.

4. Laegreid JM, CD Lew, JM Walker: Neuromotor behavior and cardiorespiratory responses of premature infants with bronchopulmonary dysplasia. Physical & Occupational Therapy in Pediatrics 8:15-42, 1988.
   Role: Clinical research mentor to the first author; direct assistance in patient recruitment, testing, data analysis and supervision of all clinical aspects of the project.

5. Garg M, SI Kurzner, DB Bautista, CD Lew, AD Ramos, ACG Platzker, TG Keens: Pulmonary sequelae at six months following extracorporeal membrane oxygenation. Chest 101:1086-1090, 1992.

6. Garg M, CD Lew, AD Ramos, ACG Platzker, TG Keens: Serial measurement of pulmonary mechanics assists in weaning from extracorporeal membrane oxygenation in neonates with respiratory failure. Chest 100:770-774, 1991.
   Role: participated in research measurements on study subjects.

7. Atkinson JB, EG Ford, B Humphries, H Kitagawa, C Lew, M Garg, K Bui: The impact of extracorporeal membrane support in the treatment of congenital diaphragmatic hernia. J *Pediat Surg* 26:791-793, 1991.

8. Bui K, B Humphries, H Kitagawa, M Kosi, R Dorio, C Lew, J Atkinson, A Platzker: Extracorporeal membrane oxygenation in lambs through umbilical vessel perfusion: Cardiac and hepatic complications. *Biol Neonate* 61:351-357, 1992.

9. DeWitt PK, MT Jansen, SLD Ward, CD Lew, CM Bowman, ACG Platzker, TG Keens: Obstacles to discharge of ventilator assisted children from the hospital to home. (Submitted)

10. Makhoul IR, KC Bui, TC Fung, CD Lew, C Barrett, M Chung, J Mapp, E Gangitano: Predictors of neonatal mortality in 1500-1999 grams premature infants: Basis for ECMO

therapeutic trial. *ASAIO J.* 40: 27-32, 1994.

Role: supervised the design of this retrospective review, facilitated access to patient records and contributed to data analysis.

11. Makhoul IR, A Kugelman, M Garg, JE Berkeland, CD Lew, KC Bui: Intratracheal pulmonary ventilation versus conventional mechanical ventilation in a rabbit model of surfactant deficiency. Pediatr Res 38: 878-885, 1995.

Role: mentor to the first two authors; direct supervision of the construction of the research equipment for this project and conduct of the experiments; direct supervision of the data analysis and review of the discussion in the manuscript.

12. Makhoul, IR, A Kugelman, KC Bui, JE Berkeland, K Saiki, **CD Lew**, M Garg: Reduction of respiratory system resistance of rabbits with surfactant deficiency using a novel ultra thin walled endotracheal tube. ASAIO J. 42: 1000-1005, 1996.

Role: mentor to the first two authors; direct supervision of the construction of the research equipment for this project and conduct of the experiments; direct supervision of the data analysis and review of the discussion in the manuscript.

13. Derrington S, **Lew CD**, Gold JI, Stavroudis TA, Bart RD: The process and purpose of prognostication: opinions and experience of pediatric specialists. In Submission, 2011

Role: mentor of the first author and direct supervision of data collection as well as direct participation in data analysis, review and formulation of the concept of the discussion

14. Derrington S, Bates PD, Hinsch K, Doyle M, Galloway-Gilliam L, **Lew CD**: Webs of Constraint, Windows of Opportunity: communities and capabilities in addressing child health disparities. In preparation, 2011

Role: mentor of first author; supervised development of the concept of this symposium and recruited the participation as well as conceptualization of 3 of the authors.

15. Derrington S, Hester DM, Campbell A, **Lew CD**: Pediatric Forum—Case Commentaries. *J Clinical Ethics,* Spring 2012, 23 (1): 38-46.

Role: author of commentary on case presented.

16. Swota A, Goldhagen J, **Lew CD**. Advancing the synergy between pediatric bioethics and child rights. Perspectives in Biology and Medicine. **58 (3)** (Summer 2015): 247-251.

Role: co-author, contributing specific sections to this introductory commentary.

17. Da Silva M, **Lew C**, Lundy L, Lang KR, Melamed I, Zlotnik-Shaul R. The potential value of the United Nations Convention on the rights of the Child in pediatric bioethics settings. Perspectives in Biology and Medicine. **58 (3)** (Summer 2015): 290-305.

Role: co-author, contributing specific sections to this paper pertaining to the role of the United States in the Child Rights movement. Contributed additional research.

18. Swota A, **Lew C**, Hester DM. Case: What is a parent to do? The Case of Baby G. Perspectives in Biology and Medicine. **58 (3)** (summer 2015): 320-321.

Role: co-author; provided clinical details to the case construction and the abstract.

19. Hester DM, **Lew C**, Swota A. When rights just won't do: ethical considerations when making decisions for severely disabled newborns. Perspectives in Biology and Medicine. **58 (3)** (summer 2015): 322-327.
Role: co-author; provided clinical ethics commentary re management of case.

20. Lang K & **Lew C**. Actions speak louder than words: the U.N. Convention on the Rights of the Child and U.S. pediatric bioethics. Perspectives in Biology and Medicine. **58 (3)** (Summer 2015): 281-289.
Role: Framed and structured the paper; contributed research.

Format: Authors, Title. *Journal.* Volume #(Suppl ##):Page-Page, Year. PMID#, PMCID#, *Narrative describing personal contribution.*

REFEREED JOURNAL ARTICLES IN PRESS:

1. Su JA, Cheng AL, Ing FF, Kumar SR, **Lew CD**, Szmuszkovicz JR. Left Bronchial Compression and Pulmonary Hypertension Related to Anomalous Right Pulmonary Artery. Submitted. 2015.
Role: provided clinical commentary and information re the respiratory system physiology associated with this defect.

Format: Authors, Title. *Journal.* Volume #(Suppl ##):Page-Page, Year. PMID#, PMCID#, *Narrative describing personal contribution.*

REFEREED REVIEWS, CHAPTERS, AND EDITORIALS:
Format: Authors, Title. *Publication.* Volume #(Suppl ##):Page-Page, Year. PMID#, PMCID#

REFEREED ON-LINE PUBLICATIONS:
Format: Authors. Title. *Publication*, URL, Year. PMID#, PMCID#

CLINICAL COMMUNICATION: (CASE REPORTS, LETTERS)
Authors. Title. *Journal* Volume(Suppl ##):Page-Page, Year. PMID#, PMCID#

CLINICAL COMMUNICATION: (PUBLISHED CLINICAL TRIAL COMMUNICATIONS)
Authors. Title. *Journal* Volume(Suppl ##):Page-Page, Year. PMID#, PMCID#

NON-REFEREED JOURNAL ARTICLES, REVIEWS, OR OTHER COMMUNICATIONS:
Format: Authors, Title. *Journal.* Volume #(Suppl ##):Page-Page, Year. PMID#, PMCID#, *Narrative describing personal contribution.*

BOOKS, MONOGRAPHS, AND TEXT BOOKS:
Authors. Title. *Publication* Volume(Suppl ##):Page-Page, Year.

LETTERS TO THE EDITOR:
Authors. Title. *Publication* Volume(Suppl ##):Page-Page, Year. PMID#, PMCID#

ABSTRACTS AND PRESENTATIONS:

1. Platzker ACG, CD Lew, P Ballard, B Landing, K Freshman, A Lewis: Delayed secretion of pulmonary surfactant into tracheal fluid in fetal lambs with hydranencephaly. Clin Res 24: 198A, 1976.

   Role: conducted surgical implantations and participated in sample collection as well as data analysis.

2. Lew CD, KA Smith, CV Sedelmeier, D Nelson, ACG Platzker: Morphine sulfate and/or pancuronium improves gas exchange in ventilation of infants with severe respiratory distress. Clin Res 28:A, 1980.

   Role: conceived of the study; conducted retrospective review of medical records, collection of data, analysis of data and principal writing.

3. Lew CD, D Nelson, CV Sedelmeier, ACG Platzker: Roles and responsibilities of personnel utilized for neonatal transport in California. Clin Res 28:A, 1980.

   Role: conceived of the study; conducted retrospective review of medical records, collection of data, analysis of data and principal writing.

4. McComb JG, AD Ramos, TG Keens, C Lew, ACG Platzker: Neurosurgical management of intraventricular hemorrhage in the pre-term infant. Clin Res 28: 124A, 1980.

5. Lew C, T Keens, MH O'Neal, A Ramos, A Platzker, D Lam, C Scott, B Nickerson, A van der Hal, F Sinatra, D Thomas, R Merritt: Gastroesophageal reflux prevents recovery from bronchopulmonary dysplasia. Clin Res 29: 145A, 1981.

   Role: conceived of the study; conducted retrospective review of medical records, collection of data, analysis of data and principal writing.

6. Warburton D, CD Lew, ACG Platzker: Primary hyperinsulinemia reduces surface active material flux in tracheal fluid of fetal lambs. Pediatr Res 15:145, 1982.

7. Keens T, P Dennies, CD Lew, ACG Platzker: Risk of subsequent apnea in infants surviving near-miss sudden infant death syndrome. Clin Res 30(1)151, 1982; Pediatr Res 16(4):352, 1982. Presented at the Western Society for Pediatric Research, February 16-19, 1982.)

8. Fineberg M, MW Stabile, CD Lew, ACG Platzker, TG Keens: Bronchial hyperreactivity in parents of infants with bronchopulmonary dysplasia. Am Rev Resp Dis 131(4):265, 1985.

9. Laegreid JM, CD Lew, JM Walker: Movement abnormalities in infants with bronchopulmonary dysplasia. Clin Res 33(1):11OA, 1985.

   Role: Clinical research mentor to the first author; direct assistance in patient recruitment, testing, data analysis and supervision of all clinical aspects of the project.

10. Laegreid JM, CD Lew, JM Walker: Motor activity of infants with chronic respiratory distress. Physical Therapy 65:690, 1985.(Poster presentation, Am Physical Therapy Association National Conference, New Orleans *6-18-85).*

Role: Clinical research mentor to the first author; direct assistance in patient recruitment, testing, data analysis and supervision of all clinical aspects of the project.

11. Laegreid JM, CD Lew, JM Walker: Movement disturbances in infants with bronchopulmonary dysplasia. Pediatr Res 19(4):408, 1985.
    Role: Clinical research mentor to the first author; direct assistance in patient recruitment, testing, data analysis and supervision of all clinical aspects of the project.

12. Laegreid JM, CD Lew, JM Walker: Motor Activity of infants with chronic respiratory distress. Physiotherapy Canada 37:113, 1985 (presented *1985* Physiotherapy Conference, Vancover, B.C., *6-14-85).*
    Role: Clinical research mentor to the first author; direct assistance in patient recruitment, testing, data analysis and supervision of all clinical aspects of the project.

13. Oldham RL, CD Lew: Psychiatric Care of the Post-NICU child. Submitted to American Academy of Child Psychiatry, Annual Meeting, October, 1985, San Antonio, Texas.

14. Oldham RL, CD Lew: Comprehensive Care of Children with Congenital Myopathy. Submitted to American Academy of Child Psychiatry, Annual Meeting, October, 1985, San Antonio, Texas.

15. Bader D, AD Ramos, CD Lew, ACG Platzker, MW Stabile, TG Keens. Persistent exercise and pulmonary dysfunction in late childhood following bronchopulmonary dysplasia. Clinical Research 35(1): 240A, 1987 and Am Rev Resp Dis 135:126A, 1987.

16. Diaz RP, ACG Platzker, CM Bowman, CD Lew, SLD Ward, JA Church, TG Keens. Outcome of chronic interstitial pneumonitis in children. Am Rev Resp Dis 137: 184A, 1988.

17. Keens TG, MT Jansen, SL Davidson Ward, CD Lew, CM Bowman. Home care of ventilator-dependent infants and children. Clin Res 26: 242A, 1988 and Am Rev Resp Dis 137:506A, 1988.

18. Ortega M, ACG Platzker, AD Ramos, 3 Atkinson, CD Lew, CM Bowman. Prediction of outcome by mean airway pressure in newborns undergoing' extracorporeal membrane oxygenation. Pediatr Res 23:518A, 1988.

19. Ortega M, ACG Platzker, AD Ramos, J Atkinson, CD Lew, CM Bowman. Survival & risk of bronchopulmonary dysplasia in newborns undergoing extracorporeal membrane oxygenation. Pediatr Res 23:518A, 1988.

20. Kurzner SI, M Garg, DB Bautista, CD Lew, AD Ramos, ACG Platzker, CM Bowman, JB Atkinson, TG Keens. Improved pulmonary function following ECMO. Pediatr Res 23:414A, 1988.

21. Diaz RP, ACG Platzker, CD Lew, CM Bowman, SLD Ward, Ja Church, TG Keens. Pulmonary function patterns in children with chronic interstitial pneumonitis. Pediatr Res 23:562A, 1988.

22. Diaz, R.P., A.C.G. Platzker, C.D. Lew, C.M. Bowman, S.L. Davidson Ward, J.A. Church, and T.G. Keens. Outcome of chronic interstitial pneumonitis in children. *American Review of Respiratory Disease, 137(4):* 184A, 1988

23. Ramos A, T Nield, M Garg, ACG Platzker, CD Lew, CM Bowman, D Ashley. Neurodevelopmental outcome of extracorporeal membrane oxygenation (ECMO) patients in relation to cranial computed tomography (CT) findings. Clin Res 37: 172A, 1989.

24. Garg M, SI Kurzner, DB Bautista, CD Lew, AD Ramos, ACG Platzker, TG Keens, Chronic lung disease following extracorporeal membrane oxygenation (ECMO). Clin Res 37:202A, 1989. and Pediatric Res 25(4): 215A, 1989.

25. Garg M, SI Kurzner, DB Bautista, CD Lew, AD Ramos, ACG Platzker, TG Keens. Pulmonary compliance predicts successful weaning from ECMO in neonates with respiratory failure. Clin Res 37:202A, 1989.

26. Garg, M., D.B. Bautista, C.D. Lew, A.D. Ramos, A.C.G. Platzker, and T.G. Keens. Pulmonary compliance predicts successful decannulation in neonates with respiratory failure. *Clinical Research, 37(1):* 202A, 1989. and *Pediatric Research, 25(4):* 215A, 1989.

27. Horton EJ, WD Goldie, CD Lew, AD Ramos, KC Bui, ACG Platzker, M Garg, DG Ashley, TA Nield: Risk of neurologic sequelae in patients suffering focal seizures while on ECMO (extracorporeal membrane oxygenation). Presented at Child Neurology Society, San Antonio, Texas, October, 1989.

28. Horton EJ, WD Goldie, CD Lew, AD Ramos, KC Bui, ACG Platzker, M Garg, DG Ashley, TA Nield: Comparison of acute EEG patterns and CT fmdings in neonates treated with ECMO (extracorporeal membrane oxygenation). Presented at XII International Congress of Electroencephalography and Clinical Neurophysiology, Rio de Janeiro, January, 1990.

29. Nield TA, M Hallway, C Fodera, K Bui, M Garg, C Lew, A Platzker, A Ramos: Outcome in problem feeders post ECMO. Presented at Childrens Hospital National Medical Center ECMO Symposium, Breckenridge, Colorado, February, 1990.

30. Horton EJ, WD Goldie, CD Lew, AD Ramos, KC Bui, ACG Platzker, M Garg, DG Ashley, TA Nield: Anticonvulsant therapy and ECMO graduates. Presented at Childrens Hospital National Medical Center ECMO Symposium, Brechkenridge, Colorado, February, 1990.

31. Garg M, AD Ramos, CD Lew, KC Bui, ACG Platzker: Role of high PEEP in ECMO. Submitted to APS-SPR, 1990.

32. Atkinson JB, BD Humphries, H Kitagawa, AD Ramos, M Garg, CD Lew, K Bui, ACG Platzker: Congenital diaphragmafic hernia (CDH) survival benefit with extracorporeal membrane support (ECMO). Submitted to APS-SPR, 1990.

33. DeWitt PK, MT Jansen, SL Davidson Ward, CD Lew, CM Bowman, ACG Platzker, TG Keens: Obstacles to discharge of ventilator dependent children from the hospital to home. Am Rev Resp Dis 139: A196, 1989.

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Format: Authors, Title. *Publication.* Volume #(Suppl ##):Page-Page, Year. PMID#, PMCID#

MEDIA AND TELEVISION APPEARANCES:

Format: Date, Title of presentation, Venue