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SUPREME COURT OF TEXAS
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No. 20-0644

IN THE SUPREME COURT OF TEXAS

COOK CHILDREN'S MEDICAL CENTER,
Petitioner,

v.

T.L., A MINOR, AND MOTHER, T.L., ON HER BEHALF,
Respondents.

On Petition for Review from the
Second Court of Appeals at Fort Worth, Texas
No. 02-20-00002-CV

REPLY IN SUPPORT OF PETITION FOR REVIEW

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SUMMARY OF THE ARGUMENT

The court of appeals' opinion all but declared a carefully crafted statute unconstitutional and converts private doctors and hospitals into state actors amenable to suit under §1983. *See* Pet. 1. Despite those sweeping holdings, Respondents call the opinion is "limited." Far from it. During this unprecedented time, in which a pandemic compels daily gut-wrenching conversations between doctors and families about life and death treatment decisions, the court of appeals' decision may be the most important case on this Court's docket.

The Legislature unanimously passed, and the Governor signed, a law that physicians, patients, and families have used for twenty years to resolve wrenching disputes over end-of-life care. The court of appeals' decision creates uncertainty that will prevent the statute's future use anywhere in Texas. This Court must correct the court of appeals' overreach in order that medical professionals, patients, and their families may continue to rely on the Legislature's carefully considered and time-tested framework. More broadly, the millions of Texans whose conduct comes under the ambit of the court of appeals' far-reaching holding deserve to know whether their private activities have been converted into state action, subject to federal lawsuits, against their will.

Respondents' defense of the court of appeals' state-action holding replicates the court's fundamental errors in describing the statute's provisions. Unable to

distinguish the controlling case law on this point, Respondents contend it need not be followed because of minute factual differences of the sort that would grind common-law courts to a halt. Respondents also deny that the opinion established a constitutional right to medical care, yet it is only because of the opinion that Cook Children's doctors and nurses must provide inappropriate and unethical medical care that only exacerbates T.L.'s suffering.

The Court should grant review and reverse the opinion below.

ARGUMENT

I. The court of appeals, departing from established precedent, created a new, expansive, and unworkable standard for state action.

A. TADA neither dictates any medical decisions nor delegates any state power to doctors or hospitals.

The court of appeals held that a hospital acts as *parens patriae* when it declines to provide treatment that is medically inappropriate and unethical. Yet a hospital is not *commanding* a patient to receive treatment or otherwise imposing its will; it is *refusing* to act. The patient remains free to pursue her full range of options with another willing provider. Pet. 11. Nor does a hospital exercise sovereign power to decide what is lawful; it exercises its own medical judgment regarding its own activity, as the regulatory scheme permits. *Id*. It is the Legislature, not Cook Children's, that determines the legal consequences of the hospital's actions.

Respondents' contrary position conflicts with the statute's text. Respondents assert that the statutory procedure *is* mandatory, but they cite no statutory text, *see* Resp. 12, because §166.046 is explicitly voluntary, Pet. 13 (citing TADA §166.045(c)). This failure is not remedied by Respondents' observation that without §166.046, doctors may be subject to civil and criminal liability. *See* Resp. 12. The Legislature indeed provided that a physician who withdraws artificial-life support without utilizing §166.046 *might* be liable for that decision, but the Legislature explicitly permitted physicians to take that calculated risk. Thus, the statute's text rejects Respondents' assertion that §166.046 gives doctors and hospitals authority they would not otherwise have. *See* Resp. 14. It merely provides certainty about the legal consequences.

Respondents also reason that if the statute is a safe harbor, then the court of appeals' opinion will not compel the hospital to provide care. *Id*. Respondents' conclusion does not follow. TADA provides immunity but does not impair or supersede any existing rights. TADA §§166.046, .051. By ignoring that text and governing constitutional law, the court of appeals, not TADA, imposed new and onerous duties on Cook Children's and other healthcare providers. *See infra* § I.B. The disconnect is therefore not in Cook Children's argument, but between the court of appeals' atextual construction and the Legislature's intent.

Respondents' arguments proceed from an alternate reality, divorced from the words the statute uses. Yet this Court holds that a statute's text is supreme. That text must guide this Court's analysis.

B. The opinion below explicitly requires Cook Children's to provide painful and futile medical treatment.

Respondents contend that "[t]he Opinion does not require Petitioner to perform any services" or "take any action" but merely "precludes Petitioner from withdrawing the effective life-sustaining treatment T.L. is already being provided." Resp. 7. The intention of Respondents' suit, and the import of the court of appeals' holding, belies this argument. Every day, Cook Children's doctors and nurses must take an ever-changing array of actions to keep T.L. alive. Among other things, they must administer paralytic drugs so that she cannot move, perform painful suctioning of her lungs, and inflate her lungs manually when she suffers a "dying event." 2RR137, 146-48. This is medical care that Cook Children's is providing by order of the court of appeals based on the court's misreading of the Due Process Clause and the Supreme Court's state-action doctrine. The law, state and federal, precludes this command.

C. The court of appeals opinion contravenes controlling federal authority on State action.

As the dissent observed, the opinion below contradicts controlling U.S. Supreme Court authority on state action. Pet. 14-15, 17-18. Respondents cannot

demonstrate otherwise. Their arguments fail especially in light *Blum v. Yaretsky*, which held that a nursing home that refused treatment to patients despite their objection, pursuant to a mandatory governmental procedure, was not a state actor. 457 U.S. 991, 1008, 1011-12 (1982). *Blum* is directly relevant here, where Respondents assert that Cook Children's is a state actor because it is refusing to provide care, over their objection, pursuant to a voluntary State procedure. Respondents urge the Court to ignore *Blum* based on a single factual difference: *Blum* "does not address medical decisions to take affirmative steps to end life." Resp. 17. Respondents cannot explain how that irrelevant factual distinction erases *Blum*'s bearing on this case. Their response to the multiple other cases on state action is similarly superficial. *See* Resp. 15-16.

D. Respondents cannot escape the wide sweep of the court of appeals' delegation holding.

The court of appeals' newly created legal standard converts countless private acts into state action, subjecting private conduct by private individuals to §1983 liability. *See* Pet. 18-19. The court of appeals held that §166.046 was unconstitutional because it immunized Cook Children's private decision to refrain from providing care it believes to be unethical, based on the court's (mistaken) belief that such inaction invaded T.L.'s bodily autonomy. Cook Children's thus cited several examples of statutes—like Texas's stand-your-ground statute and corporal-punishment statute—that likewise (and more directly) immunize private, personal

decisions that interfere with another person's bodily integrity. *Id.* If §166.046 is unconstitutional, so must be these statutes.

Respondents' attempt to cabin the court of appeals' extraordinary holding fails. Effectively, Respondents argue that each situation can be distinguished on the facts. Resp. 9 ("they do not . . . remove treatment that will cause a specific death"). In the first place, Respondents are mistaken: under the court of appeals' holding, a good Samaritan who ceases providing CPR or a physician who removes a person from the kidney-transplant waiting list causes another person's death, yet Texas law grants them immunity for those private decisions. *See* Pet. 18-19. The court's holding would thus make them state actors.

More important, Respondents cannot articulate a *legally significant* difference between this case and the statutes Cook Children's cited. This is because the scenarios are conceptually identical: a person acting under the castle doctrine has immunity for the affirmative killing of another person based on *his own* judgment about whether the victim posed a threat; a parent using corporal punishment has immunity for inflicting physical pain based on *the parent's* judgment that doing so is necessary to discipline the child. Likewise, §166.046 gives a hospital immunity for its decision not to perform certain medical treatments based on the hospital's medical and ethical judgment. In each of these cases, the Legislature immunized conduct driven entirely by private judgment. Yet none of these cases are delegations

of state power because it is the Legislature, not the private individual, that prescribed the private decision's legal consequences.

Respondents cannot diminish the expansive and unprecedented reach of the court of appeals' holding.

E. Cook Children's is neither constricting T.L.'s treatment options nor obstructing her transfer to another facility.

Respondents assert that Cook Children's has restricted T.L.'s treatment options and, by its refusal to perform a tracheostomy, prevented her transfer to another facility or discharge to home care. Resp. 19-20. These assertions are false.

T.L.'s mother has long believed that a tracheostomy would permit T.L. to be cared for at home. *See* 2RR198-99, 295. No medical evidence substantiates that belief, but much refutes it. The only medical testimony below confirmed that, tracheostomy or not, T.L. cannot survive outside of a CICU-like environment. 2RR96-98. The reason Cook Children's will not perform a tracheostomy is that doing so would be surgery for surgery's sake—it would provide T.L. no medical benefit. App. 1 at 4-6.[1] Cook Children's cannot ethically write medical discharge orders to permit T.L. to be treated by a home-health nurse because T.L. requires

[1] Appendix 1 is a document Cook Children's filed in the trial court. Cook Children's is requesting a supplemental record that will include this document and attaches it as an appendix to this filing for the Court's convenience.

ventilation and CICU-level care, overseen by a physician, and at home she would die in excruciating pain. *Id.* at 3-4, 8-9.

Nevertheless, as part of its extensive efforts to assist Respondents transfer T.L. to a facility willing to comply with their desired course of treatment, 2RR54-55; DX6, 7, Cook Children's has consistently stated that if a willing institution requires a tracheostomy as a condition of T.L.'s transfer—for example, because of the type of ventilator the facility uses—then Cook Children's will perform that surgery. App. 1 at 7, 10. Although a handful of physicians have offered opinions about T.L.'s treatment (often without having reviewed her entire medical record), none has offered to take over her care, and no facility has agreed to accept her. 2RR95, 170-71.

In any event, Respondents cite no case supporting the notion that their inability to find an institution willing to take over T.L.'s care makes Cook Children's a state actor. They attempt to analogize T.L.'s circumstances to the inmate's in *West v. Akins*, 487 U.S. 42 (1988), which held that a private physician to whom a prison outsourced medical care was a state actor. Resp. 20. *West*'s state-action holding resulted exclusively from the fact that *the State*—not the physician—had deprived the inmate of the freedom to choose his own doctor, and thus the state, and the physician as its agent, became responsible for the inmate's medical care. *West*, 487 U.S. 54-55. Here, *the State of Texas* has not deprived T.L. of the freedom to choose

her physician. The fact that private circumstance, rather than state power, leaves her unable to find a physician willing to provide care that Cook Children's believes unwarranted does not transform Cook Children's into the State simply because it was the last institution to treat her.

Respondents' argument that Cook Children's is a state actor because it provides T.L. care under the Medicaid Star Kids program fares no better. Respondents fail to acknowledge the substantial precedent, on which Cook Children's relied in the court of appeals, rejecting the notion that a private hospital becomes a state actor simply by providing treatment under a government-funded program.[2] Respondents' argument, if accepted, would convert almost every physician and hospital in the United States into a state actor.

II. Respondents cannot diminish the court of appeals' recognition of a constitutional right to receive medical treatment.

A. A constitutional right to medical treatment is a necessary component—and consequence—of the court of appeals' procedural due-process holding.

Respondents sweep under the rug the court of appeals' creation of a new constitutional right to medical treatment. They concede the existence of such a right

[2] *Blum* concerned a nursing home's treatment of Medicaid patients pursuant to Medicaid regulations. Yet the Court found no state action. Following *Blum*, courts have consistently rejected the argument that Respondents make here. *E.g.*, *Wheat v. Mass*, 994 F.2d 273, 275–76 (5th Cir. 1993); *Hodge v. Paoli Mem'l Hosp.*, 576 F.2d 563, 564 (3d Cir. 1978) (per curiam); *see also Rendell-Baker v. Kohn*, 457 U.S. 830, 840 (1982) (holding that private school was not state actor despite receiving most of its funding from the state).

is necessary to their substantive due process claim, but assert it is irrelevant to the procedural due-process claim that the court of appeals held was viable. Resp. 7-8. Respondents are wrong.

Every due-process claim—procedural or substantive—requires deprivation of a constitutionally protected interest. *University of Tex. Med. Sch. at Hous. v. Than*, 901 S.W.2d 926, 929 (Tex. 1995) (procedural due process); *accord Patel v. Texas Dep't of Licensing & Reg.*, 469 S.W.3d 69, 86-87 (Tex. 2015) (substantive due process). The deprivation Respondents advance is of an alleged right to command Cook Children's to perform medical treatment it believes to be unethical. The existence of this right is a necessary component of the court of appeals' holding that Respondents' procedural due-process claim can go forward.

B. Respondents barely even attempt to defend a right to medical treatment.

Respondents deny that the opinion below creates a new right to medical treatment, but they stop there. Resp. 7. That Respondents decline to defend the new constitutional right they convinced the court of appeals to create betrays their inability to overcome *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 196 (1989), which held that the Due Process Clause "confer[s] no affirmative right to governmental aid, even where such aid may be necessary to secure life." *See* Pet. 20. Respondents ignore *DeShaney* and the numerous federal appellate decisions, on which Cook Children's relied, specifically rejecting a constitutional right to

medical care. *See id.* This failure independently requires reversal of the court of appeals' judgment.

PRAYER

Petitioner respectfully requests that this Court grant its petition on an expedited basis, reverse the court of appeals' judgment, and remand the case to the trial court for further proceedings.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Based on a word count run in Microsoft Word 2016, this brief contains 2,379 words, excluding the portions of the brief exempt from the word count under Texas Rule of Appellate Procedure 9.4(i)(1).

/s/ *Wallace B. Jefferson*
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CERTIFICATE OF SERVICE

I hereby certify that on September 18, 2020, a true and correct copy of this reply, including any and all attachments, is served via electronic service through eFile.TXCourts.gov on parties through counsel of record, listed below:

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APPENDIX 1

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CASE NO. 048-112330-19

T.L., A MINOR AND MOTHER, T.L., ON HER BEHALF, Plaintiffs, v. COOK CHILDREN'S MEDICAL CENTER, Defendant.	§ § § § § § § § § § §	IN THE DISTRICT COURT TARRANT COUNTY, TEXAS 48TH JUDICIAL DISTRICT

COOK CHILDREN'S MEDICAL CENTER'S RESPONSE TO PLAINTIFFS' "MOTION TO COMPEL"/APPLICATION FOR TEMPORARY MANDATORY INJUNCTION

Cook Children's Medical Center ("Cook Children's"), Defendant, responds as follows to Plaintiffs' mistitled "Emergency Motion to Compel" as follows:

I.

INTRODUCTION

The Plaintiffs' "Motion to Compel" is a disguised application for mandatory temporary injunctive relief which asks this Court to force Cook Children's to allow – and participate in – an illegal, unnecessary, and dangerous operation on a one-year-old patient. As this Court has already found, T.L. has incurable heart and lung conditions and suffers daily due to the heroic medical efforts necessary to keep her alive. Her condition since the last hearing before this Court has only continued to deteriorate. Despite this undisputable fact, Plaintiffs now ask the Court to let them cause even more pain to this patient for no medical benefit. Not only is this Motion procedurally flawed, but it is utterly unmeritorious and presents the Court with false and unsupportable factual claims. The Court should deny the Motion in all respects.

II.

SUMMARY OF THE ARGUMENT

Plaintiffs' Motion is legally and factually without merit. Although entitled a "Motion to Compel," the Motion is actually an application for a temporary mandatory injunction and the Court must procedurally and legally treat it as such. As detailed at length below, the Motion fails for numerous reasons, including:

- Plaintiffs' Motion is procedurally deficient. A temporary injunction cannot – as Plaintiffs seek here – change the status quo or grant the ultimate relief sought by a cause of action. Moreover, the injunction sought by the Motion does not relate to a verified cause of action in the First Amended Petition. Finally, Plaintiffs have not produced any competent admissible evidence to support the Motion.

- The requested injunctive relief is unlawful. Plaintiffs ask the Court to require Cook Children's to grant Dr. Glenn E. Green privileges to perform a tracheostomy on T.L. (and to follow his treatment orders). However, Dr. Green has no Texas medical license. He has not sought a temporary license from the Texas Medical Board and is facially ineligible for such a license. Even if he obtained a temporary license, rather than directing T.L.'s care, Dr. Green would have to be supervised by a licensed Cook Children's doctor at all times. The proposed relief would mandate that Dr. Green, Cook Children's, and its staff commit a felony and violate numerous federal laws endangering Cook Children's accreditation with the Joint Commission and the Centers for Medicare and Medicaid Services.

- The proposed injunction would mandate that Cook Children's perform unethical surgery on T.L. that is unnecessary, provides T.L. no medical benefit, and is dangerous. There is no valid medical reason to perform a tracheostomy on T.L. The surgery would not in any way change her medical diagnosis, improve her condition, or provide a medical benefit. The only "evidence" to the contrary would be improper affidavits that are demonstrably inaccurate as they are based on an incomplete and inaccurate review of T.L.'s medical record. In contrast, there are real risks in performing such a surgery on T.L. – especially when performed by a surgeon with no familiarity with T.L. who intends to immediate leave after surgery – that outweigh any benefits. As this Court previously found, a patient does not have the right to compel a medical provider to provide treatment that it finds inappropriate and unethical.

- There is no possible emergent need for the relief sought in the Motion. Even if a tracheostomy was appropriate, there is no basis for temporary injunctive relief. Plaintiffs have been seeking a tracheostomy for more than seven months. Nothing has happened that justifies the seeking of emergency relief. T.L. is stable and a tracheostomy will not improve her condition. Moreover, based on the sworn

Declaration of Dr. Green, the easier solution is to transfer T.L. to his care now that C.S. Mott Children's Hospital has confirmed that ICU beds are available.

III.

BACKGROUND FACTS

The Court is familiar with the underlying dispute and testimony presented at December's temporary injunction hearing, which will not be repeated at length here. In sum, T.L. suffers from numerous heart and lung conditions that, among other things, prevent her from properly oxygenating her blood. Despite numerous surgeries and extensive medical intervention, she is terminal and her condition cannot be improved. Moreover, the medical treatments necessary to keep T.L. alive are causing her to suffer: she is kept constantly sedated and chemically paralyzed with numerous machines connected to her, including a ventilator which artificially breathes for her. Although scores have been contacted, no other hospital or doctor has been willing to accept T.L. as a transfer patient.

This Court denied Plaintiffs' application for a temporary injunction which sought to compel Cook Children's to continue life-sustaining treatment for T.L. That order has been appealed to the Second Court of Appeals (which enjoined Cook Children's from withdrawing care pending its ruling). That appeal remains pending.

A. T.L.'s Current Condition

Over the past seven months, T.L. has remained in pain with no change to her key underlying medical conditions. Declaration of Jay M. Duncan (Attached as Exhibit 1) ¶¶ 4-5. T.L. remains on a ventilator and receives more than forty medications every day to keep her alive. *Id.* ¶¶ 4-5, Attach. A. She has had several serious infections, each of which has been treated and beaten back. *Id.* ¶ 7. Working with Plaintiffs, doctors have tried to reduce her medications (particularly her paralytic), but T.L. has not tolerated such actions. *Id.* ¶ 8.

Having spent the past year paralyzed and sedated, the medical interventions have taken a toll on T.L. As she has continued to build tolerances to the various pain medications, her dosages have had to be increased. *Id.* ¶¶ 5, 7. Her muscles and ligaments have tightened due to her inability to move such that her entire body is now stiff. *Id.* ¶¶ 5, 7. Recent scans of her brain also show that T.L.'s neurological functions are being permanently impaired due her life-sustaining treatments.

The nurses and doctors who treat T.L. continue to note that she is suffering and in pain. *See, e.g.*, *Id.* ¶¶ 4-9 ("In my opinion, what is happening to T.L. is simply cruel and serves no medical purpose."). There remains no hope for recovery. *Id.* ¶ 4.

B. <u>T.L.'s Artificial Breathing – Nasal v. Tracheal Intubation</u>

Because of T.L.'s inability to oxygenate, she is on a ventilator that breathes for her. *Id.* ¶ 12; Declaration of Kaci Osenga (Attached as Exhibit 2) ¶ 7. The air is pumped into T.L.'s lungs through a tube that is inserted into her nose. Duncan Dec. ¶ 12; Osenga Dec. ¶ 7. In the medical opinion of Cook Children's doctors, nasal intubation is the most appropriate way to treat T.L. Duncan Dec. ¶ 12; Osenga Dec. ¶ 9.

At various times over the past year, Plaintiffs have raised the issue of having the ventilator be connected to T.L. through her trachea. *E.g.*, Duncan Dec. ¶ 11. Each time, Cook Children's has noted that there is no medical benefit to changing the ventilation source. T.L. does not suffer from a medical condition necessitating tracheal intubation (as some patients do) and she has responded well to her current nasal intubation. *Id.* ¶ 12; Osenga Dec. ¶ 9. She is receiving adequate and appropriate ventilatory support through her nasotracheal tube. Osenga Dec. ¶ 9. Performing a tracheostomy to change the physical location of artificial airway for ongoing mechanical ventilation does not impact the effectiveness or ongoing need for ventilatory support. *Id.* Duncan

Dec. ¶ 13. Thus, the only difference between nasal and tracheal intubation for T.L. is a few inches of tubing.

A tracheostomy does not provide medical benefit to T.L.'s underlying life limiting condition. Osenga Dec. ¶ 10; Duncan Dec. ¶ 13. It will not allow T.L. to better oxygenate her blood, reduce her reliance on a ventilator, or change her poor prognosis. Osenga Dec. ¶ 10; Duncan Dec. ¶ 13. A tracheostomy will not change the anticipated trajectory of T.L.'s congenital heart disease, severe chronic lung disease, pulmonary hypertension, or significant pulmonary infectious issues. Osenga Dec. ¶ 10; Duncan Dec. ¶ 13. With one possible exception,[1] a tracheostomy would not immediately impact the medications or dosages that T.L. receives. Osenga Dec. ¶ 10; Duncan Dec. ¶ 13.

As T.L.'s primary physician notes, "It would, in my opinion, be medically unethical [to perform a tracheostomy on T.L.] as it would cause one to perform surgery on T.L. for the sake of performing surgery." Duncan Dec. ¶ 13.

The procedure required to create tracheal intubation is normally a fairly routine surgery. Known as a tracheostomy, the surgery involves a patient placed under general anesthesia who then has a hole made through the front of the neck and into the windpipe. Osenga Dec. ¶ 8. A tracheostomy tube is placed into the hole to keep it open for breathing. *Id.* The new airway is initially fairly unstable, but a stable track gradually forms around the tube to secure it in place. Duncan Dec. ¶ 15. The first seven days are critical for tracheostomy patients. *Id.* The standard of

[1] There is a small, but unproven, chance that a tracheostomy would allow Cook Children's to reduce the amount of vecuronium that T.L. receives. Osenga Dec. ¶ 10, n.1; Duncan Dec. ¶ 13 n.1. This assumes that T.L. would find the tracheal intubation less "irritating" than the nasal intubation and there is, therefore, a small chance that her dosage could be decreased as she would be less likely to try to pull the new tube out. Osenga Dec. ¶ 10, n.1; Duncan Dec. ¶ 13 n.1. Of course, this assumes that T.L. would take no other harmful actions and that she could tolerate extra movement without adversely impacting her blood oxygen numbers. Osenga Dec. ¶ 10, n.1; Duncan Dec. ¶ 13 n.1. Cook Children's doctors have concluded that the small chance of this benefit is not worth the potential risks of the procedure such that a tracheostomy is not medically appropriate for T.L. Osenga Dec. ¶ 10, n.1; Duncan Dec. ¶ 13 n.1.

care in the medical field is that the surgeon who performed the tracheostomy must be available to resolve any issues that may arise during this early period and must be the doctor who performs the first tracheostomy tubal change. *Id.*

Unlike the average patient, T.L. presents unique issues. Because of her extraordinarily high tolerance of pain medications, a specialized cardiac anesthesiologist would be required to place her under general anesthesia. *Id.* ¶ 14; Osenga Dec. ¶ 11. Making sure that she has the appropriate level of pain medication to keep her comfortable after surgery would also require specialized care balancing her high tolerance against the danger of interfering with her other bodily functions, such as breathing. Duncan Dec. ¶ 14; Osenga Dec. ¶ 11. To be clear, it is the opinion of Cook Children's that its doctors could likely perform a tracheostomy on T.L., but such an operation would not be without risk and would need to involve doctors that were very familiar with her conditions that were prepared to closely monitor her before, during, and after the surgery.

Thus, when weighing the possible benefits of the procedure against the risks, Cook Children's doctors have concluded that it is not medically beneficial, ethical, or appropriate to T.L. to subject this surgery. Duncan Dec. ¶ 16; Osenga Dec. ¶ 12.

C. Plaintiffs' Consultant Contacts Numerous Doctors about T.L. and a Tracheostomy with an E-mail Filled with False and Incomplete Claims.

Dr. Green is an ENT specialist at C.S. Mott Children's Hospital in Michigan. In November of 2019, his hospital was contacted to see if they would accept T.L. as a transfer patient. *See* Exhibit 4, at 10. Dr. Green's hospital stated that they saw no further care as appropriate for T.L. and declined to accept her as a patient. *Id.*

In late December of 2019, Hanna Mehta, on behalf of Plaintiffs, emailed dozens of doctors seeking help. She claimed that a physician had been located that would provide heart surgery for T.L., but that the surgery could not take place until T.L. received a tracheotomy. On December

30, 2019, someone forwarded that plea to Dr. Green. *See* Ex. 5, at 4-5. That email – which is filled with falsities about T.L.'s situation and medical care – seeks someone to perform a tracheostomy on T.L. "which will allow her lungs to begin to heal and regenerate," and then write discharge orders from Cook Children's. *Id.* at 5. Dr. Green responded by noting that, simply providing a trach was not an issue, but that he was aware that any transfer hospital could perform the procedure so he suspected something else was an issue. *Id.* at 4. Nonetheless, he stated that he would be willing to look at certain records. Ms. Mehta sent Dr. Green certain limited and edited medical records and he asked for a lung CT scan. *Id.* at 2-3.

Eventually, Dr. Green reached out to Cook Children's for certain specific and limited records (and forwarded the above e-mail thread). *Id.* at 1. He also faxed a separate request on January 9, 2020. Exhibit 6. Cook Children's provided the documents requested.

Numerous physicians that had received the Mehta e-mail reached out to Cook Children's to ask questions, request access to medical records, or otherwise seek information about T.L.'s condition. After reviewing T.L.'s record, those doctors frequently noted that they felt they had been misled and each indicated that no treatment was appropriate. After receiving numerous complaints, Cook Children's reached out to Plaintiff's counsel for help and noted that, while they applauded Ms. Mehta's zeal and purpose, her emails were filled with false accusations and inaccurate medical claims. *See* Ex. 7. Among the issues raised was the fact that Ms. Mehta was sending incomplete and inaccurate records which wasted time and caused doctors to have a false impression about T.L.'s condition. *Id.* Cook Children's also stressed, again, that "if the only thing standing between [T.L.] and a transfer – whether to another hospital or palliative care at home – is a tracheotomy," Cook Children's would perform the procedure. *Id.* But, the facility needed to be located and agree to take T.L. before any tracheotomy would be appropriate. *Id.*

D. To help Plaintiffs in their Search for Home Care and Discharge Orders, Cook Children's Offers to allow Temporary Privileges to Dr. Patrick Roughneen.

As the Court may recall from the Temporary Injunction hearing, besides looking for a hospital to treat T.L., Plaintiffs also indicated a desire to have T.L. sent home under the care of a home health nurse. In that regard, Plaintiffs complained that Cook Children's would not write "discharge orders" for home health and perform a tracheotomy (which Plaintiffs thought necessary for home treatment). As nurses are not allowed to diagnose various illnesses or prescribe medication, a home health nurse must receive "orders" from a discharging doctor specifying the treatment and medications that the patient would receive. That doctor then remains in charge of the patient throughout her home care. Because the doctors at Cook Children's universally believe that T.L. cannot receive proper care in such an environment, they are unwilling to write discharge orders for home health care.

In an effort to help Plaintiffs, Cook Children's made an extraordinary offer: To the extent that Plaintiffs could locate a doctor that believed it was medically appropriate to treat T.L. at home, Cook Children's would arrange for such doctor to get privileges at Cook Children's for the purpose of writing such orders and performing such other procedures that might be needed for the home health transfer. *See* Ex. 8.

Plaintiffs emailed counsel for Cook Children's to note that a physician, Dr. Patrick Roughneen, had been located that had a different opinion about part of T.L.'s diagnoses (he believed that T.L. was not suffering from pulmonary hypertension[2]). Ex. 9. Cook Children's

[2] Cook Children's completely disagrees with Dr. Roughneen's conclusions, which not only appear to be based on an irrelevant reading of a single number, but also seeks to compare that reading against that of a healthy active child for comparison (as opposed to looking at what the proper reading would be for a child that has been sedated and paralyzed for several months. Nonetheless, Cook Children's did not allow this disagreement to impact its willingness to give privileges to Dr. Roughneen. Indeed, after having the opportunity to personally examine the patient and consult with her attending physician, Dr. Roughneen apparently abandoned his assertion that there was "no evidence" of pulmonary hypertension as this is not addressed anywhere in his consultation note.

immediately responded and repeated its earlier offer: Cook Children's would arrange for Dr. Roughneen to have emergency privileges so that he could write discharge orders – which could include a tracheostomy – allowing T.L. to move to home health. Ex. 10. Importantly, Cook Children's outlined to Plaintiffs the legal requirements for Dr. Roughneen to have temporary emergency privileges and asked for the necessary documents. *Id.* Cook Children's also offered to have T.L. transferred to Dr. Roughneen's hospital. *Id.* Plaintiff's counsel responded that they would gather the appropriate materials. Ex. 11. When Dr. Roughneen did not have the appropriate insurance as required for privileges, Cook Children's worked with him to find a workaround. See Ex. 12.

Dr. Roughneen declined to accept T.L. as a patient at his hospital and chose, instead, to come to Cook Children's to evaluate T.L. He spent less than two hours at the hospital, spoke with a few medical personnel, and examined T.L. Dr. Roughneen did not feel discharge orders were appropriate and he agreed that the treatment received to date was appropriate. As required by law, he made consultation notes in T.L.'s medical record of his conclusions that, "if feasible", T.L. might benefit from a three-step process: (1) try to wean T.L. from sedation and paralytcis; (2) then, try to wean T.L. from other heart medications, and finally (3) having decreased those medications, consider a tracheostomy for a transfer. *See* Roughneen Dec. ¶ 3. Cook Children's did not disagree with such an approach in theory as, indeed, it had already tried this treatment without success. Duncan Dec. ¶ 8. Since Dr. Roughneen's consultation, Cook Children's has tried again to institute this 3-step plan. Duncan Dec. ¶ 8. The plan, however, has never moved past step 1 as, each time, T.L. has reacted poorly and – to keep T.L. alive and to comply with the current injunction – the medications had to be continued. *Id.*

E. Plaintiffs' Plan for Dr. Green to Perform a Tracheostomy Based on False Assumptions, Incomplete Records, and Without Complying with the Law.

In early March 2020, Plaintiffs' counsel formally asked if Cook would allow "2 physicians" temporary privileges to perform a tracheotomy on T.L. Ex. 13. Cook Children's promptly explained that it could not allow that under the law BUT that "if you have a provider who is prepared to treat [T.L.] and the holdup is the type of ventilator used, Cook Children's will happily perform a tracheotomy to aid the transfer." Ex. 14. Plaintiffs did not respond.

On Tuesday, July 14, 2020, Plaintiffs' counsel called to conference on a motion seeking to compel Cook Children's to give privileges to a doctor to come in and perform a tracheostomy on T.L. Cook Children's counsel called back and an amenable discussion took place among the lawyers about the issues, problems, and possible ways to resolve the issues. Unfortunately, an agreement could not be reached and Plaintiffs filed their Motion to Compel that evening identifying Dr. Green as the doctor they wanted Cook Children's to credential.

Dr. Green is not licensed to practice medicine in Texas. *See* Declaration of Donald Beam, M.D. (Attached as Ex. 3) ¶ 6. Plaintiffs have not indicated that he has applied with the Texas Medical Board for a temporary license, and Dr. Green does not appear to meet the statutory prerequisite for such a permit. Even if he were granted a temporary license by Texas, the law mandates that he be supervised by a Cook Children's doctor for his work. Dr. Green has not provided Cook Children's with any of the materials necessary for him to be credentialed and, as noted, he would not be entitled to privileges. *Id.* ¶ 6.

Dr. Green has never spoken with a single person treating T.L. His entire theory of treatment for T.L. is based on a hypothesis that maybe – with no possible support – it is possible that T.L.'s episodic events where her blood oxygen level drops could be caused by "a collapse of the distal trachea and bronchi" and suggests that, to see if this is the cause, a bronchoscopy should be

performed. Green Dec. ¶ 10. Dr. Green then notes that "There is no mention of this in the medical records and no indication that she has been evaluated or treated for this potentially very serious condition." Green Dec. ¶ 11. Finally, Dr. Green notes that if this condition is treated and a tracheostomy is performed, he thinks there is a chance that her paralytics could be decreased and "a reduction in Baby T.L.'s medications will help facilitate her transfer to a lower level of care." Green Dec. ¶ 13. As noted in more detail below, the key problem with Dr. Green's entire declaration, is that he apparently failed to review the medical records and did not note that T.L. has received multiple bronchoscopies – starting in May of 2019 – and that Cook Children's has confirmed that T.L. does not have tracheomalacia. Duncan Dec. ¶ 21. However, T.L. was diagnosed with mild broncheomalacia, which is not a significant factor in her complex cardiopulmonary interactions and her current diseased state. Duncan Dec. ¶ 19. Her primary problem is the interaction between her severe congenital heart disease, severe chronic lung disease, pulmonary hypertension, and the inability for further palliative operations to be beneficial. Duncan Dec. ¶ 19.

Of most significance in the Motion, Dr. Green stated under oath that his team is prepared to accept and treat T.L. as soon as his facility has ICU beds available. Green Dec. ¶ 8. Cook Children's reached out to C.S. Mott Children's Hospital and confirmed that ICU beds are available and that they are accepting transfer patients. Cook Children's has formally requested transfer and, as of the moment of the filing of this Response, is awaiting a decision. Obviously, if Dr. Green is indeed prepared to accept T.L. as a transfer patient now that his hospital has available ICU beds, that could moot both this Motion and the entire lawsuit as T.L. can be transferred to C.S. Mott Children's Hospital and Dr. Green immediately.

III.

ARGUMENT & AUTHORITIES

In their Motion, Plaintiffs ask the Court for a mandatory injunction to compel Cook Children's to immediately grant emergency privileges to an unlicensed physician and to unlawfully allow such physician unfettered access to perform surgery on T.L. that Cook Children's considers medically inappropriate. Moreover, Plaintiffs ask the Court to compel Cook Children's to actively take part in the medically unnecessary procedure and then to treat T.L. after the unlicensed surgeon immediately leaves town, abandoning T.L. and leaving Cook Children's to handle any and all complications from the surgery.

Simply put, the law does not allow for the relief Plaintiffs seek. Moreover, even if it did, Plaintiffs cannot meet their burden for a mandatory injunction here as the relief sought is neither emergent nor meritorious. The Court should deny the Motion in its entirety.

A. Plaintiffs' "Motion to Compel" is a Disguised and Inappropriate Application for Mandatory Injunction.

Plaintiffs have titled their Motion "*Plaintiffs' Emergency Motion to Compel Defendant Cook Children's Medical Center to Grant Temporary Emergency Privileges to Glenn E. Green, M.D.*" That title is grossly misleading and should not allow Plaintiffs to avoid their legal burdens. No matter what the Motion is called, its true substance is an application for a mandatory injunction. Plaintiffs cannot meet – and have not even attempted to meet – their legal burdens for such relief.

When evaluating a motion, it is the "character and function" of the requested relief that determines its classification. *See, e.g., Qwest Commc'ns Corp. v. AT&T Corp.*, 24 S.W.3d 334, 336 (Tex. 2000) (per curiam). A party cannot avoid the requirements of proposed injunctive relief merely by claiming that it is seeking a "Motion to Compel" rather than a temporary injunction. *Helix Energy Sols. Group, Inc. v. Howard*, 452 S.W.3d 40, 42 (Tex. App. – Houston [14th Dist.]

2014, no pet.). The plaintiff in *Helix Energy* "filed a motion styled as Plaintiff's Motion to Compel Payment of Maintenance and Cure Benefit." *Id.* The motion asked the court to compel the defendants to pay him certain fees. *Id.* The trial court granted the motion and, on appeal, the court reversed and found that, despite the motion's title, the order granting the "motion to compel" was a temporary injunction. *Id.* ("Although styled as an order granting a motion to compel, 'it is the character and function of that order that determines its classification."); *accord Qwest Commc'ns*, 24 S.W.3d at 336 (holding that an order compelling action was a temporary injunction); *Del Valle Indep. Sch. Dist. v. Lopez*, 845 S.W.2d 808, 809 (Tex. 1992) (holding that an order compelling a school district to hold an election was an injunction regardless of the title).

Here, Plaintiffs' Motion asks this Court to require Cook Children's to "grant Dr. Green emergency privileges." Motion, at 1. Such an order would compel action by Cook Children's. As in *Helix Energy*, this is an application for a temporary injunction. Therefore, the Court can only grant the requested relief to the extent the Plaintiffs satisfy all of the elements for a temporary injunction. *Helix Energy*, 452 S.W.3d at 42; *accord Qwest Commc'ns*, 24 S.W.3d at 336; *Del Valle Indep. Sch. Dist.*, 845 S.W.2d at 809.

Not only must the Court treat the Motion as an application for injunctive relief, it must be reviewed under the heightened requirements of a mandatory injunction. "There are two general types of temporary injunctions: prohibitive and mandatory. A prohibitive injunction forbids conduct, whereas a mandatory injunction requires it." *RP&R, Inc. v. Territo*, 32 S.W.3d 396, 400 (Tex. App. – Houston [14th Dist.] 2000, no pet.). A mandatory injunction is an extraordinary remedy. *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 204 (Tex. 2002). A mandatory injunction should "never be granted unless extreme or very serious damage at least will ensue from withholding that relief." *Southwestern Tel. & Tel. Co. v. Smithdeal*, 104 Tex. 258, 265 (Tex. 1911).

Courts have consistently noted that an application for a temporary mandatory injunction presents a higher burden of proof for the Plaintiff, and such an application "should be denied absent a clear and compelling presentation of extreme necessity or hardship." *Tri-Star Petroleum Co. v. Tipperary Corp*, 101 S.W.3d 583, 592 (Tex. App. – El Paso 2003, pet. denied) (*citing Rhodia, Inc. v. Harris Cnty.*, 470 S.W.2d 415, 419 (Tex. Civ. App. – Houston [1st Dist.] 1971, no writ)); *accord Pharaoh Oil & Gas, Inc. v. Ranchero Esperanza, Ltd.*, 343 S.W.3d 875, 883 (Tex. App. – El Paso 2011, no pet.).

A mandatory injunction is only proper "to ***preserve*** the status quo of the litigation's subject matter pending a trial on the merits," *Butnaru*, 84 S.W.3d at 204 (emphasis added) (citations omitted), not to ***change*** the status quo, as Plaintiffs seek here. To obtain a mandatory injunction, "the applicant must plead and prove three specific elements: (1) a cause of action against the defendant; (2) a probable right to the relief sought; and (3) a probable, imminent, and irreparable injury in the interim." *Id.* The party seeking relief bears the burden to prove those three elements. *See Lifeguard Benefit Servs., Inc. v. Direct Med. Network Sols., Inc.*, 308 S.W.3d 102, 111 (Tex. App. – Fort Worth 2010, no pet.). Moreover, the evidence presented at the hearing in support of the motion must be "clear and compelling." *Tri-Star Petroleum*, 101 S.W.3d at 592.

In this case, Plaintiffs' Motion fails to even acknowledge they are seeking a mandatory injunction, much less prove the necessary elements to obtain such relief. As discussed in more detail below, Plaintiffs cannot meet their burden, and the Motion must be denied.

B. Plaintiffs Cannot Seek Mandatory Injunctive Relief as the Motion is Procedurally Improper.

Plaintiffs' application for injunctive relief is procedurally improper in multiple ways, each of which individually defeats the relief Plaintiffs seek.

First, the requested injunction is improper because it seeks relief that irreversibly alters the status quo. A temporary injunction is only appropriate to the extent it ***preserves*** the status quo. *Walling v. Metcalfe*, 863 S.W.2d 56, 58 (Tex. 1993); *Butnaru*, 84 S.W.3d at 204. The status quo is defined as the last, actual, peaceable, non-contested status that preceded the controversy. *State v. Southwestern Bell Tel. Co.*, 526 S.W.2d 526, 528 (Tex. 1975). Here, the status quo is that T.L. is intubated nasally, is being treated by Cook Children's medical staff, and Dr. Green has no privileges at Cook Children's. Plaintiffs' requested relief here seeks to change the status quo by (1) granting Dr. Green surgical privileges, (2) allowing Dr. Green to treat T.L. (which necessarily incorporates compelling Cook Children's doctors and staff to carry out Dr. Green's medical orders), and (3) subjecting T.L. to surgery to change the site and nature of her intubation. Changing the status quo through an injunction is not allowed. *Id.*

Second, the Motion must fail as it is not supported by competent evidence. "In the context of a request for temporary injunctive relief, a probable right to recovery and probable injury must be established by competent evidence adduced at a hearing." ***Shamoun & Norman, LLP v. Yarto Int'l Group, LP***, 398 S.W.3d 272, 282, (Tex. App. – Corpus Christi 2012, pet dism'd) (citing *Millwrights Local Union No. 2484 v. Rust Eng'g Co.*, 433 S.W.2d 683, 686 (Tex. 1968)). The applicant bears the burden of providing competent evidence in support of its request for temporary injunctive relief. *Camp v. Shannon*, 348 S.W.2d 517, 519 (Tex. 1961). "However, a sworn petition does not constitute evidence." *Shamoun & Norman, LLP*, 398 S.W.3d at 282 (citing *Millwrights Local Union No. 2484*, 433 S.W.2d at 686). And affidavits do not constitute admissible evidence. *Millwrights Local Union No. 2484*, 433 S.W.2d at 686. As Plaintiffs have indicated that they do not intend to support their motion with testimony, the Motion must be dismissed as a threshold matter.

Third, the proposed injunction fails as it is not tied to an asserted cause of action. Injunctive relief is a remedy, not a cause of action. *Cooper v. Litton Loan Servicing, LP*, 325 S.W.3d 766, 769 (Tex. App. – Dallas 2010, pet. denied) (citing *Brittingham v. Ayala*, 995 S.W.2d 199, 201 (Tex. App. – San Antonio 1999, pet. denied)). "To obtain an injunction a party must first assert a cause of action" that entitles it to the injunctive relief. *Id*. Here, there is no claim in this lawsuit that seeks injunctive relief for Dr. Green to have surgical privileges at Cook Children's. Plaintiffs cannot obtain an injunction for which they have not asserted a cause of action. *Cooper*, 325 S.W.3d at 769.

Fourth, no injunctive relief can issue unless a plaintiff has filed a petition seeking such relief that has been verified. TEX. R. CIV. P. 682. There is no verification.

Fifth, Plaintiff's Motion seeks to achieve ultimate, permanent relief. A ruling on temporary injunctive relief may not be used to obtain an advance ruling on the merits. *See Iranian Muslim Org. v. City of San Antonio*, 615 S.W.2d 202, 208 (Tex. 1981). While Plaintiffs could attempt to assert a cause of action that would seek to compel Cook Children's to provide surgical privileges to Dr. Green, they could not obtain such relief via a temporary injunction as that would improperly achieve the ultimate relief sought without the need for trial.

In sum, Plaintiffs have skipped all of the procedural requirements needed for a mandatory injunction and hope, that by calling it a "Motion to Compel," they can convince the Court to overlook this fatal defect. The Court should not accept this improper invitation.

C. Plaintiffs Cannot Show a Probable Right to the Relief Sought as the Proposed Injunction is Unlawful.

The relief sought by Plaintiffs is per se illegal. Under Texas law, a party may not perform a medical procedure without a valid Texas medical license. TEX. OCCUPATIONS CODE § 155.001.

It is undisputed that Dr. Green has no Texas medical license. If he operates on T.L. without such license, it is a third degree felony. *Id.* § 165.152(c).

Such illegal actions also subject Cook Children's and its staff and doctors to criminal and civil penalties. Not only would Cook Children's be allowing an illegal surgery under its roof, but the Motion indicates that Dr. Green would be traveling alone. Thus, Cook Children's would be required to supply an anesthesiologist and the rest of the surgical team that Dr. Green would require. Moreover, the proposed order submitted by Plaintiffs asks the Court to order Cook Children's to follow all orders written by Dr. Green for T.L.'s care. Such a series of actions would be unlawful and would endanger the professional licenses of everyone involved.[3]

As a physician licensed in another state, Dr. Green could apply for a Visiting Physician Temporary Permit. Plaintiffs do not show that he has done so. Moreover, he facially does not meet the standards for such a license. The Texas Medical Board can only issue a temporary permit for a foreign doctor if such doctor intends to "***practice under the supervision of a licensed Texas physician***" to either (a) teach, (b) provide clinical charity care for an underserved population, (c) to help with a declared disaster,[4] (d) provide forensic psychiatric examination in a criminal matter, or (e) to provide specialized medical care that is not otherwise available from a Texas physician. *See, e.g.*, TEX. ADMIN. CODE § 172.5 (emphasis added). None of those scenarios exist here. Moreover, if Dr. Green were to apply for a temporary permit, he would have to "present written verification from the [Texas] physician who will be supervising the applicant that the physician will provide continuous supervision of the applicant" and "present written verification from the [Texas] supervising physician as to the purpose for the requested permit." *Id.* § 172.5(a)(2)(D)-

[3] It would also endanger Cook Children's accreditation and its ability to participate in numerous programs, such as Medicaid and Medicare.

[4] While Governor Greg Abbott has invoked the disaster clause due to the ongoing COVID pandemic, that only allows for the temporary licensure of physicians seeking to help treat COVID patients.

(E). Finally, an application for a temporary permit must be submitted 30 days prior to the visiting physician entering the state.

Thus, even if Dr. Green were to seek a temporary Texas license – and show the Texas Medical Board that he meets a regulatory provision allowing for same – Dr. Green would have to work under the supervision of a Cook Children's doctor. By law, rather than supervising others, others would need to supervise him.

Similar standards govern Cook Children's ability to agree to grant privileges to and to supervise Dr. Green. Cook Children's is accredited by the Joint Commission and is required to comply with the standards set forth by the Joint Commission and the Centers for Medicare and Medicaid Services. *See* Beam Dec. ¶ 2. Those standards mandate that temporary privileges can only be granted in two cases: 1) where an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the professional staff executive committee and the governing body, or 2) to fulfill an important patient care need. *Id.* ¶ 3. Where the temporary privileges are requested to fulfill an important patient care need, the Cook Children's professional staff would be required to verify the current licensure and competence of the applicant. *Id.* To achieve that, the applicant must provide documentation of his/her active license to practice medicine in Texas, professional liability insurance with limits of $500,000 per occurrence/$1,000,000 aggregate that would cover his work at Cook Children's, controlled substances registration (state and federal), as well as a current copy of his/her CV. *Id.* ¶¶ 4-5. Plaintiffs have shown none of these requirements.[5]

[5] It is critical to note that Plaintiffs are well aware of these issues. When Plaintiffs requested that Dr. Patrick Roughneen be allowed to consult on T.L.'s case, Cook Children's agreed and walked Plaintiffs through the necessary steps to have Dr. Roughneen obtain temporary privileges. Unlike Dr. Green, Dr. Roughneen is licensed in Texas, provided the required materials, and was sponsored for his work.

Further, any request for temporary privileges must be initiated by an existing member of the Cook Children's Professional Staff, and the request must be approved by the President of Cook Children's, with the written concurrence of the appropriate Division Chief, the Chair of the Credentials Committee, and the President of the Professional Staff. *Id.* ¶ 5. Cook Children's administration does not have the authority to override a decision to grant or deny temporary privileges or to otherwise unilaterally grant such privileges. *Id.* No such request has been made and, if one was made, it would be denied as there are pediatric surgeons and otolaryngologists on staff at Cook Children's who have the appropriate training, expertise, and credentials to perform the procedures Dr. Green seeks to perform. *Id.* ¶ 6. Accordingly, there would be no justification for granting temporary privileges to an outside physician here. Further, Dr. Green has no Texas license and no doctor that is willing to sponsor and supervise his work.

The relief sought in the Motion, therefore, cannot be granted.

D. Plaintiffs Cannot Show a Probable Right to Relief as Plaintiffs Have No Legal Right to Mandate that Cook Children's Perform Particular Care.

In their Motion, Plaintiffs repeat their argument – as previously presented at the prior Temporary Injunction – that T.L.'s mother has the legal right to choose the medical care of T.L. However, that issue is not before the Court. No one is suggesting that T.L.'s mother cannot seek a tracheostomy or other medical treatment. ***If Dr. Green and his team are prepared to take over the treatment of T.L. – which his Declaration states that he is – then, as Cook Children's has confirmed that ICU beds are available as C.S. Mott Children's Hospital, it is prepared to transfer T.L. to Dr. Green immediately who can perform whatever treatment he and T.L.'s mother deem appropriate.*** However, the Motion presents a different question: whether Cook Children's can be compelled to provide medical treatment that it deems unnecessary and medically unethical. The law does not support this relief.

In order to grant the relief Plaintiffs are seeking, this Court would have to hold – contrary to medical ethics, common law principles, and well-established constitutional doctrine – that T.L.'s Mother has an absolute right to force Cook Children's doctors and nurses to provide T.L. with any particular medical treatment her mother chooses. Far from merely asking Cook Children's to stand aside and allow Dr. Green to perform the tracheostomy procedure, granting Plaintiffs' Motion seeks to require Cook Children's to (1) grant Dr. Green privileges, (2) have its doctors and nurses both assist Dr. Green with the surgery and provide follow-up care in order to maintain T.L.'s airway following the procedure after Dr. Green departs, and (3) continue to treat and indefinitely care a patient in a new medical situation who has been intubated against the standard of care. Thus, Cook Children's would be required to participate in – and deal with the resulting consequences of – a procedure that, in their professional medical judgment, is medically futile and will do nothing to improve T.L.'s condition. There is no legal basis for requiring them to do so.

1. Plaintiffs' Challenge to Section 166.046 of the Texas Advance Directives Act Is Not Implicated Here.

Section 166.046 of the Texas Advance Directives Act ("TADA"), whose constitutionality Plaintiffs are currently challenging before the Court of Appeals, is not implicated here. Neither the proposed tracheostomy procedure, nor Cook Children's refusal to perform it, implicates the withdrawal of "life-sustaining treatment" that is the subject of Section 166.046.[6] *See* TEX. HEALTH & SAFETY CODE § 166.046; *cf.* Pltfs. Ex. J (Jan. 3, 2020 Court of Appeals Order enjoining CCMC from taking action "intentionally designed to withdraw life-sustaining treatment" while appeal is

[6] Furthermore, TADA expressly provides by its own terms that it does not "impair or supersede any legal right or responsibility" relating to the withholding or withdrawal of life-sustaining treatment. TEX. HEALTH & SAFETY CODE § 166.051; *see also HCA. Inc. v. Miller*, 36 S.W.3d 187, 193-94 (Tex. App. Houston [14th Dist.] 2000), *aff'd*, 118 S.W.3d 758 (Tex. 2003) (noting that TADA does not change rights to withhold treatment).

pending). The tracheostomy is not "life-sustaining treatment" because T.L. is stable and the procedure will do nothing to treat T.L.'s underlying terminal condition or to improve her nonexistent chances of survival, and a refusal to perform the procedure will not cause or hasten her death. *See* Duncan Dec. ¶ 13. And Cook Children's refusal to perform the tracheostomy is not a violation of the Court of Appeals' temporary order, because it does not entail any withdrawal of the life-sustaining treatment that Cook Children's is currently providing. *Cf.* Pltfs. Mot. at 8–9 (agreeing that the proposed tracheostomy "would not run afoul" of the Court of Appeals' order). Cook Children's has already explained in its prior briefing why there is no ethical, legal, or constitutional basis for requiring its physicians and nurses to provide medically futile treatment contrary to their conscience and professional judgment, and it briefly recaps those arguments below. *See generally* Cook Children's Dec. 11, 2019 Brief in Response ("TI Resp."); Cook Children's Dec. 20, 2019 Supplemental Response ("TI Supp. Resp."). Because "life-sustaining treatment" is not at issue here, there is even less basis for imposing such an obligation.

a. *Well-Established Principles of Medical Ethics Protect Physicians' Right to Refuse to Provide Care They Deem Futile*.

Physicians have always had the ability to refuse to provide care that they deem futile. *See* TI Supp. Resp. 8–10. "Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them." Am. Med. Ass'n, Opinion E-2.035. Instead, "physicians have an affirmative obligation to transition a patient to palliative care when other treatments have no reasonable chance of providing benefit." Mary S. McCabe & Courtney Storm, *When Doctors and Patients Disagree About Medical Futility*, 4 J. ONCOLOGY PRAC. 207, 209 (2008). The reason that doctors have such a right is that "[p]roviding medically futile treatment is not consistent with [a doctor's] professional ethic." *Id.*

While a physician cannot countermand a patient's wish, the physician can abstain from providing a particular treatment. The American Medical Association's Code of Medical Ethics protects physicians' "right to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice," allowing them "considerable latitude to practice in accord with well-considered, deeply held beliefs." AM. MED. ASS'N, COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MED. ETHICS § 1.1.7 (2016). In short, "[r]especting patient autonomy does not mean that" physicians must provide "specific interventions simply because they (or their surrogates) request them." *Id.* § 5.5.

b. *A Physician's Right to Refuse to Provide Treatment is Protected at Common Law*.

While a physician may not force treatment upon a patient, the common law has always recognized a physician's right to refuse to provide treatment that offends the physician's sense of conscience, ethics, or professional judgment. *See* TI Resp. at 12; TI Supp. Resp. at 8. This right is intrinsic to the doctor-patient relationship's private, voluntary nature. Indeed, it is intrinsic to the physician's own liberty: "[n]o person can be caused, against his will, to enter into an employment contract." *N.L.R.B. v. Knoxville Pub. Co.*, 124 F.2d 875, 882 (6th Cir. 1942); *accord Texas Alcoholic Bev. Comm'n v. Live Oak Brewing Co.*, 537 S.W.3d 647, 655 (Tex. App.—Austin 2017, pet. denied) ("Among the liberty interests protected by due course of law is freedom of contract").

2. Cook Children's Is Not Infringing Any Protected Constitutional Interest.

Because Plaintiffs' pending challenge to the constitutionality of Section 166.046 does not affect their current Motion (since it does not relate to a withdrawal of life-sustaining treatment), any right to relief must be premised on Plaintiffs' underlying claim for deprivation of constitutional rights under 42 U.S.C. § 1983. To prevail on their § 1983 claim, Plaintiffs must show (1) a

violation of a constitutionally protected interest, (2) by a state actor. *See, e.g.*, *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 428 (1982); *University of Tex. Med. Sch. at Hous. v. Than*, 901 S.W.2d 926, 929 (Tex. 1995) (elements of procedural due process claim); *Patel v. Texas Dep't of Licensing & Regulation*, 469 S.W.3d 69, 86–87 (Tex. 2015); *Simi Inv. Co. v. Harris Cty., Tex.*, 236 F.3d 240, 249 (5th Cir. 2000) (elements of substantive due process claim); *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 924 (1982) (plaintiff must demonstrate that the deprivation was the result of state action). Plaintiffs have done neither.

Plaintiffs cannot point to a single case in which a court has applied either a due process "right to life" or a parent's right to make medical decisions to compel a particular hospital or physician to continue providing treatment they have determined is medically inappropriate. To the contrary, Defendant has provided ample authority making clear that no such obligation exists. *See* TI Resp. at 14–15; TI Supp. Resp. at 12–15.

Even if Cook Children's were a state hospital (which it is not), there would be no constitutional basis for requiring it to perform the procedure requested by Plaintiffs. A physician is not ***constitutionally*** obligated to provide ***any*** treatment, including life-sustaining treatment. A contrary holding would have severe consequences. If Plaintiff were correct that the Constitution requires doctors to undertake treatment that ***prevents or forestalls*** illness, then patients would have a constitutional right to have ***any and all*** ailments treated. Yet the United States Supreme Court has expressly rejected this position. *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 189, 198–99 (1989); *accord Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 710 n.18 (D.C. Cir. 2007) (en banc) ("No circuit court has acceded to an affirmative access [to medical care] claim."); *Johnson by Johnson v. Thompson*, 971 F.2d 1487, 1495–96 (10th Cir. 1992) (rejecting argument that right to life includes right to receive medical

care). Indeed, even in the unique prison context, courts have roundly rejected the notion that a patient has a right to receive "any particular type of treatment." *Long v. Nix*, 86 F.3d 761, 765 (8th Cir. 1996); *accord Jenkins v. Colo. Mental Health Inst. at Pueblo*, 215 F.3d 1337, at *1–*2 (10th Cir. 2000) (unpublished).

The due process clause has long been understood to "afford[] protection against unwarranted government interference with freedom of choice in the context of certain personal decisions," but not to confer an obligation on the government to ensure that the person "realize[s] all the advantages of that freedom." *Harris v. McRae*, 448 U.S. 297, 317–18 (1980). Accordingly, the substantive-due-process right to use contraceptives does not imply "an affirmative constitutional obligation to ensure that all persons have the financial resources to obtain contraceptives." *Id.* at 318.

An argument similar to Plaintiffs' was addressed and rejected in *Disability Rights Wisconsin v. University of Wisconsin Hospital & Clinics*, 859 N.W.2d 628 (Wisc. App. 2014) (unpublished). The *Disability Rights* plaintiffs argued that a state hospital violated their due process rights by refusing to provide them certain desired treatments. The court rejected that claim, finding no authority "that doctors have an obligation, deriving from patients' fundamental constitutional rights, to begin or continue medical treatment." *Id.* at *6. Following *DeShaney*, the court concluded that there was no "substantive due process right to medical care from the government" because such a right would "run contrary to the fundamental principle that the government is not under a constitutional duty to affirmatively protect persons or to rescue them from perils 'that the government did not create.'" *Id.* at *8 (quoting *DeShaney*, 489 U.S. at 195).

Plaintiffs have not pointed to a single authority – from Texas or anywhere else – that would give rise to an affirmative constitutional obligation for Cook Children's to perform a specific

medical treatment. Plaintiffs' citation of *Miller ex rel. Miller v. HCA, Inc.* is not on point. Pltfs. Mot. at 10; *see* 118 S.W.3d 758, 766–68 (Tex. 2003). First, *Miller* does not establish any obligation (constitutional or otherwise) for a physician to perform specific medical treatment at a parent's request, but instead simply holds that a physician is not liable for choosing to perform such treatment without the parent's consent in an emergency situation. *See id*. at 768. Second, and more importantly, *Miller* is expressly limited to "emergent circumstances" which are not present here. *See id*. ("[A] physician does not commit a legal wrong by operating on a minor without consent when the operation is performed under emergent circumstances – *i.e*., when death is likely to result immediately upon the failure to perform it."). Unlike in *Miller*, where the physician had only minutes to decide whether to perform resuscitation on a prematurely-born infant, *see id.* at 763, this is not an "emergent" situation. A tracheostomy will not improve Baby T.L.'s chances of survival, and Cook Children's refusal to perform it will not cause or hasten her death. *See* Duncan Dec. ¶ 13. Even Plaintiffs do not contend that "death is likely to result immediately" if the tracheostomy is not performed.

3. Cook Children's Is Not a State Actor.

Even if Plaintiffs could provide authority supporting an affirmative constitutional right to receive the particular medical treatment they are requesting (which they have not), Cook Children's has no obligation to provide such treatment because it is not a state actor. *See generally* TI Resp. 15–21; TI Supp. Resp. 16–18. After multiple rounds of briefing before this Court and the Court of Appeals, Plaintiffs still cannot point to any case from a medical or hospital context that supports treating Cook Children's as a state actor.

- Plaintiffs can point to no case in which a private hospital's provision or withholding of medical treatment made it a state actor. *See, e.g., Klavan v. Crozer-Chester Medical Center*, 60 F. Supp. 2d 436, 443–44 (E.D. Pa. 1999).

- Plaintiffs can point to no case in which a medical provider's action pursuant to a statutory or regulatory scheme made it a state actor. Several cases establish the contrary. *E.g.*, *Blum v. Yaretsky*, 457 U.S. 991 (1982) (transfer of patients pursuant to Medicaid utilization requirements was not state action).

- Plaintiffs can point to no case in which a private hospital was deemed to be a state actor simply because it received public funding. Many cases establish the contrary. *E.g.*, *id.* at 1008; *Hodge v. Paoli Mem. Hosp.*, 576 F.2d 563, 564 (3d Cir. 1978) (collecting cases).

- Finally, Plaintiffs can point to no case (whether in a medical context or otherwise) in which a private party's benefiting from a statutory immunity scheme made it a state actor. Many cases explicitly reach the opposite conclusion. *E.g.*, *Goss v. Memorial Hosp. Sys.*, 789 F.2d 353, 356 (5th Cir. 1986) (immunity for medical peer review committees did not make them state actors).

Because there is no legal basis supporting Plaintiffs claim for relief, Plaintiffs' Motion should be denied.

E. Plaintiffs Cannot Show a Probable Right to Relief as the Proposed Injunction Mandates Unnecessary and Medically Inappropriate Surgery.

Even if the law supported the concept of forcing a hospital to grant privileges to allow a foreign doctor to perform surgery – which it does not – such relief would not be warranted here as the surgery is not medically necessary.

A tracheostomy is a surgical procedure whereby a surgical opening is created in a patient's neck and trachea into which a specialized tube is inserted to provide an airway directly into the trachea (or windpipe). Osenga Dec. ¶ 8. The patient would then breathe or be ventilated through the tracheostomy tube rather than through the nose or mouth or an oral or nasotracheal tube. *Id.* A tracheostomy is a specialized artificial airway for patients with an obstructed upper airway, anatomical anomalies of the airway, or those who require ongoing mechanical ventilation which is achievable outside of the hospital setting. *Id.* T.L. does not fit any of those criteria.

T.L. has no medical condition for which a tracheostomy is medically necessary. *Id.* ¶ 9; Duncan Dec. ¶ 13. She is receiving adequate and appropriate ventilatory support through her nasotracheal tube. Osenga Dec. ¶ 9. Performing a tracheostomy to change the physical location of artificial airway for ongoing mechanical ventilation does not impact the effectiveness or ongoing need for ventilatory support. *Id.* Duncan Dec. ¶ 13. Indeed, claiming that the choice of intubation site would provide some benefit is equivalent to arguing that there is some benefit to having an IV inserted in attached to the left arm versus the right: medically, as long as the vein is appropriately accessed, it makes no difference.

A tracheostomy does not provide medical benefit to T.L.'s underlying life limiting condition. Osenga Dec. ¶ 10; Duncan Dec. ¶ 13. It will not allow T.L. to better oxygenate her blood, reduce her reliance on a ventilator, or change her hopeless prognosis. Osenga Dec. ¶ 10; Duncan Dec. ¶ 13. A tracheostomy will not change the downward trajectory of T.L.'s congenital heart disease, severe chronic lung disease, pulmonary hypertension, or significant pulmonary infectious issues. Osenga Dec. ¶ 10; Duncan Dec. ¶ 13. With one possible exception,[7] a tracheostomy would not impact the medications or dosages that T.L. receives. Osenga Dec. ¶ 10; Duncan Dec. ¶ 13.

Moreover, the small chance of a possible benefit (and noting that any benefit will not change the anticipated trajectory of her underlying medical conditions), must be weighed against the significant risks of a tracheostomy for T.L. Osenga Dec. ¶ 10. A tracheostomy would be

[7] There is a small, but unproven, chance that a tracheostomy might allow Cook Children's to reduce the amount of one medication, vecuronium, that T.L. receives. Osenga Dec. ¶ 10, n.1; Duncan Dec. ¶ 13 n.1. This assumes that T.L. would find the tracheal intubation less "irritating" than the nasal intubation and there is, therefore, a small chance that her dosage could be decreased as she might be less likely to try to pull the new tube out. Osenga Dec. ¶ 10, n.1; Duncan Dec. ¶ 13 n.1. Of course, this assumes that T.L. would take no other harmful actions and that she could tolerate extra movement without adversely impacting her blood oxygen numbers. Osenga Dec. ¶ 10, n.1; Duncan Dec. ¶ 13 n.1. Cook Children's doctors have concluded that the small chance of this benefit is not worth the potential risks of the procedure such that a tracheostomy is not medically appropriate for T.L. Osenga Dec. ¶ 10, n.1; Duncan Dec. ¶ 13 n.1.

performed under general anesthesia which, for T.L., mandates specialized cardiac anesthesiology. Osenga Dec. ¶ 11. But because of T.L.'s prolonged exposure and significant tolerance to sedatives and analgesics, post-operative pain would be difficult to manage and cause her to suffer. Osenga Dec. ¶ 11. Moreover, while severe complications from a tracheostomy are rare, they are possible. Osenga Dec. ¶ 11. Should any such complications occur, T.L.'s underlying serious and irreversible medical conditions would greatly limit her ability recover from the surgery. Osenga Dec. ¶ 11. She might not survive such postoperative complications. Osenga Dec. ¶ 11.

The dangers for a tracheostomy would be exacerbated if performed by a visiting surgeon, such as Dr. Green, that left after the procedure. Duncan Dec. ¶ 15. Dr. Green is unfamiliar with T.L.'s medical history and has never spoken to anyone on T.L.'s care team. Moreover, when performing surgery on such a delicate patient, it is critical that any surgeon that performs a tracheostomy remain available to treat that patient for 6-7 days. *Id.* When a tracheostomy is performed, the airway is unstable until a stable track can form from the outside of the neck to the trachea. *Id.* The standard of care for surgeons performing tracheostomies is to perform a "purse stitch" with "stay sutures" that remain out and exposed. *Id.* The stay sutures are designed to aid reinsertion of the tracheostomy tube if required. *Id.* Because the surgeon who performed the tracheostomy knows what was done and the pathway that was chosen, it is critical that such surgeon be available to aid in repairing any problems that arise as in some occasions surgical expertise is required to replace the tube. *Id.* The standard of care in the medical industry, and at Cook Children's Medical Center, is that the surgeon that performed the initial tracheostomy must remain available to the patient until the first trach tube change has taken place and that the surgeon performs the first change (usually 6-7 days after the initial surgery). *Id.* If a visiting surgeon

performs a tracheostomy and then leaves, that is against the standard of care and endangers the patient. *Id.*

The declarations provided by Plaintiffs do not support the relief they seek. Each of the declarations suffer from dramatic flaws:

Dr. Green, for example, indicates that he has only reviewed a portion of T.L.'s medical records. Green Dec. ¶ 9. He has never spoken with a single physician treating T.L. He hypothesizes – with no support – that T.L.'s episodic events where her blood oxygen level drops could be caused by "a collapse of the distal trachea and bronchi" and suggests that a bronchoscopy should be performed to test his theory. Green Dec. ¶ 10. Dr. Green then notes that "There is no mention of this in the medical records and no indication that she has been evaluated or treated for this potentially very serious condition." Green Dec. ¶ 11. Finally, Dr. Green notes that if this condition is treated and a tracheostomy is performed, he thinks there is a chance that her paralytics could be decreased and "a reduction in Baby T.L.'s medications will help facilitate her transfer to a lower level of care." Green Dec. ¶ 13. The problem with Dr. Green's entire declaration is that he apparently failed to review the medical records.

Dr. Green would like to have a bronchoscopy performed to check on possible malacia, which he claims was never done. ***However, that test was performed more than a year ago***. *See* Exhibit 15. Concerned about possible malacia, Cook Children's performed the diagnostic bronchoscopy on May 17, 2019. Duncan Dec. ¶ 19. The results showed no *tracheo*malacia. Duncan Dec. ¶ 21. However, T.L. was diagnosed with mild *broncho*malacia. Based on the exact test Dr. Green claims should be done, Cook Children's determined that the mild broncheomalacia was not a significant factor in her complex cardiopulmonary interactions and her current diseased state. Duncan Dec. ¶ 19. Her primary problem is the interaction between her severe congenital heart

disease, severe chronic lung disease, pulmonary hypertension, and the inability for further palliative operations to be beneficial. Duncan Dec. ¶ 19. Coincidentally, ***just a few days before Plaintiffs raised this issue and filed this motion, T.L. underwent another bronchoscopy*** to make sure that there were no additional or new issues. *See* Exhibit 16. On July 11, 2020, the new bronchoscopy again showed no tracheomalacia and showed that the previously diagnosed mild broncheomalacia remained the same and – still – had no significant impact on T.L.'s condition. Duncan Dec. ¶ 20.

In short, Dr. Green's entire hypothesis – which he claimed was based on a failure to perform a bronchoscopy and look for this condition – has already been tested and his theoretical diagnosis rejected.

Dr. Roughneen came to Cook Children's at Plaintiffs request to consult on T.L.'s case. The conclusions he reached mirrored Cook Children's. He concluded that a three-step process was indicated: (1) try to wean T.L. from sedation and paralytics; (2) then, try to wean T.L. from other heart medications, and finally (3) having decreased those medications, consider a tracheostomy. *See* Roughneen Dec. ¶ 3. Dr. Roughneen's concept came as no surprise to Cook Children's, as it had already tried the initial step without success. Duncan Dec. ¶ 8. Since Dr. Roughneen's consultation, Cook Children's has tried again to institute this plan. Duncan Dec. ¶ 8. The plan, however, has never moved past step 1 as, each time, T.L. has reacted poorly and – to keep T.L. alive and to comply with the current injunction – the medications had to be re-commenced. *Id.*

Again, as with Dr. Green, Dr. Roughneen appears to have only reviewed a portion of the medical records. The plan he wants has been tried and failed multiple times.

The evidence here does not begin to meet Plaintiffs' heightened burden for a mandatory injunction. Plaintiffs' incomplete and factually inaccurate declarations do not show an extreme

necessity under the "clear and compelling" standard. *Tri-Star Petroleum*, 101 S.W.3d at 592; *Rhodia, Inc.*, 470 S.W.2d at 419; *Pharaoh Oil & Gas, Inc.*, 343 S.W.3d at 883.

F. <u>Plaintiffs Cannot Show a Probable, Imminent, and Irreparable Injury as there is No Emergency Justifying a Temporary Injunction</u>.

Finally, there is no probable, imminent, or irreparable injury. T.L. is stable. Duncan Dec. ¶ 12; Osenga Dec. ¶ 9. The care T.L. is receiving through nasal intubation meets the medical standard of care for such patients. Duncan Dec. ¶ 12. T.L.'s condition will not improve with a tracheostomy and it will remain the same (barring outside issues) without one. *See* Section III(E), *supra*. There is no medically emergent need for a tracheostomy here. Osenga Dec. ¶ 10. "An injunction is not proper when the claimed injury is merely speculative, however; fear and apprehension of injury are not sufficient to support a temporary injunction." *Frequent Flyer Depot, Inc. v. Am. Airlines, Inc.*, 281 S.W.3d 215, 227 (Tex. App. – Fort Worth 2009, pet. denied)

As to the possible transfer to a lower-treatment palliative care facility, that cannot provide the basis for an injunction here. First, Cook Children's freely admits that there may be a facility that, among its conditions to take T.L. as a transfer patient, would be that T.L. be tracheally intubated. Cook Children's has repeatedly stressed that, should such a facility ever be located and the only holdup is the tracheostomy, Cook Children's would perform the surgery. The problem here is that Plaintiffs keep trying to "put the cart before the horse," and they seek a surgery with the thought that an institution can be located later. That is not medically appropriate. Plaintiffs have been searching for a transfer center for almost a year now. Not a single facility has indicated that it would take T.L. as soon as a trach is performed. Thus performing an unneeded surgery on T.L. that involves serious risks in the hope that such a facility will be located soon is inappropriate. Should Plaintiffs locate a facility, and that facility insists on a tracheostomy to complete the

transfer, Cook Children's will perform the surgery and – as it has told Plaintiffs – Cook Children's will need to keep T.L. for 7 days through the initial trach change.

More importantly, Plaintiffs can obtain the relief they seek by arranging for T.L.'s transfer to a facility that will perform the tracheostomy and assume T.L.'s care. If Drs. Green or Roughneen believe they can provide superior treatment, then Cook Children's is happy to transfer T.L. to their care. However, despite all of their statements in their declarations, the hospitals affiliated with each doctor have declined transfer. That being said, it is important to note that Dr. Green has stated under oath in his declaration before the Court that his team is prepared to accept and treat T.L. as soon as his facility has ICU beds available. Green Dec. ¶ 8. Based on that sworn statement, Cook Children's reached out to C.S. Mott Children's Hospital and confirmed that ICU beds are available and that they are accepting transfer patients. Cook Children's has formally requested transfer and, as of the moment of the filing of this Response, is awaiting a decision. The undersigned counsel has also reached out to Plaintiffs' counsel noting that – based on the sworn statement of Dr. Green – there appears to be an easy way to moot both this Motion and the entire lawsuit as T.L. can be transferred to C.S. Mott Children's Hospital and Dr. Green immediately now that his facility has confirmed beds are available. T.L.'s counsel has yet to respond.

As there is no emergency or imminent damage likely to occur – especially proven by the "clear and compelling" standard required for a mandatory injunction, the Motion must fail.

IV.

CONCLUSION

For the foregoing reason, the Court should deny the Motion in its entirety.

Dated: July 21, 2020

Respectfully submitted,

By: /s/ Geoffrey S. Harper

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ATTORNEYS FOR DEFENDANT

EXHIBIT 1

CAUSE NO. 048-112330-19

T.L., A MINOR AND MOTHER, T.L., ON HER BEHALF, Plaintiffs, v. COOK CHILDREN'S MEDICAL CENTER, Defendant.	§ § § § § § § § § § § §	IN THE DISTRICT COURT TARRANT COUNTY, TEXAS 48TH JUDICIAL DISTRICT

DECLARATION OF DR. JAY M. DUNCAN

I, Jay M. Duncan, M.D., declare as follows:

1. I am over the age of 21 and fully competent to make this declaration. I have personal knowledge of the facts and statements contained in this declaration and I declare under penalty of perjury that the following is true and correct.

2. I am an Attending Physician and the Co-Medical Director of the Cardiac Intensive Care Unit at Cook Children's Medical Center, the defendant in this case. I, and my team, have been the primary doctors treating T.L. since she was born. It is in that capacity that I have knowledge of the facts described below.

3. I graduated from the University of Missouri at Kansas City with a combined B.A. and M.D. in 1999. I did my residency at The Children's Mercy Hospital in Kansas City followed by a fellowship at Arkansas Children's Hospital. I am board certified in Pediatric Critical Care Medicine and 100% of my practice has been in the field of cardiac intensive care for the last 8-9 years.

A. **Condition of T.L.**

4. I testified at length about the medical history and condition of T.L. at the hearing on the Plaintiff's Application for Temporary Injunction. Her main diagnosis and terminal condition remains unchanged. T.L. continues to suffer from complex congenital heart disease, severe chronic lung disease, pulmonary hypertension, significant pulmonary infectious issues, and other related conditions. Among the key issues impacting T.L. is that she cannot properly oxygenate her blood. This is multifactorial given the interactions between the diagnosis listed above. She remains terminal and her diseases are incurable. T.L. remains alive today solely because of the machines and medications that artificially aid her in performing key bodily functions and such treatment is well beyond the standard of care.

5. T.L. is still suffering daily. The treatments necessary to keep her alive cause her pain and serve no medical purpose as they cannot improve her condition. In order to keep her alive, T.L. is constantly deeply sedated and pharmaceutically paralyzed. Moreover, T.L. has significant tolerance to the various sedative and analgesic medications she is administered that makes it challenging to ensure her comfort. She has developed significant contractures of her muscles due to immobility that also add to her pain and suffering.

6. Cook Children's has continued to have periodic discussions with various hospitals and doctors about treating T.L. Despite the fact that Cook Children's has now spoken with dozens of hospitals and doctors about treating T.L., no hospital or doctor has been willing to accept T.L. as a transfer patient.

7. Since the hearing, T.L.'s condition has continued to deteriorate as would be expected for someone kept sedated and paralyzed for such a long time. She has suffered from various infections, many quite serious. She has developed significant contractures of her

extremities due to prolonged immobility despite aggressive rehabilitative efforts by the Cook Children's team. She receives few visitors (there are no visitation restrictions for parents due to COVID) and spends almost all of her time alone in her bed, while connected to various wires, tubes, and machines.

8. At various times, Cook Children's has attempted to wean T.L. from her sedative medications and paralytic agents. This was tried both before and after Dr. Patrick Roughneen visited Cook Children's and provided his consulting opinion. Each time, we have been unsuccessful as T.L. has responded poorly and we were required to continue the medications.

9. In my opinion, what is happening to T.L. is simply cruel and serves no medical purpose.

10. We continue to monitor and adjust T.L.'s medications. Attached to this Declaration as Attachment A is a list of her medications that is current and accurate as of the date and time this Declaration was signed.

B. Requests for Tracheostomy

11. T.L.'s mother and/or her counsel have been asking Cook Children's to perform a tracheostomy on T.L. since at least November of 2019. It was then – and remains now – my opinion that a tracheostomy is not medically appropriate for T.L.

12. T.L.'s breathing is artificially controlled by a ventilator that pushes extra-oxygenated air into her lungs. She is intubated nasally, which is the standard of care for a patient in her condition.

13. Plaintiffs seek to have Cook Children's – or another visiting provider – perform a tracheostomy for the purpose of moving the ventilator connection from T.L.'s nose to her throat

area.[1] There is no possible medical benefit to T.L.'s key underlying condition for such an action. Nothing about a tracheostomy will allow her to better oxygenate her blood. Nothing about this procedure could improve her chances of survival or have any impact on T.L.'s congenital heart disease, severe chronic lung disease, pulmonary hypertension, or significant pulmonary infectious issues. It would, in my opinion, be medically unethical as it would cause one to perform surgery on T.L. for the sake of performing surgery. A tracheostomy would not impact her need for a ventilator and, with one possible exception,[2] would not immediately impact the medications or dosages she receives. A tracheostomy would in no way be a life-sustaining treatment for T.L.

14. Although a tracheostomy is normally considered a fairly routine surgery, it presents significant challenges with T.L. Because of T.L.'s current condition and underlying physiology, a specialized cardiac anesthesiologist would be needed to provide general anesthesia for T.L. Moreover, the pain that T.L. would suffer from the surgical incision and subsequent care would need to be treated carefully, as the medication dosage she would need for any beneficial effects would be high (and doctors would need to ensure that such medications would not interfere with her other needs). There is a chance that we would not be able to properly control her pain which would cause T.L. even more suffering. Moreover, while severe complications from a tracheostomy are rare, they are possible. Should such complications occur, T.L.'s well-documented medical conditions would greatly impact her treatment and chances of survival.

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[1] The doctors at Cook Children's perform tracheostomies regularly and the hospital has the expertise to perform such a procedure such that no outside physicians would be needed.

[2] There is a small, but unproven, chance that a tracheostomy would allow Cook Children's to reduce the amount of vecuronium that T.L. receives. This assumes that T.L. would find the tracheal intubation less "irritating" than the nasal intubation and there is, therefore, a small chance that her dosage could be decreased as she would be less likely to try to pull the new tube out. Of course, this assumes that T.L. would take no other harmful actions and that she could tolerate extra movement without adversely impacting her blood oxygen numbers. In my opinion, the small chance of this benefit is not worth the potential risks of the procedure such that a tracheosto0my is not medically appropriate for T.L.

15. The dangers for a tracheostomy would be exacerbated if performed by a visiting surgeon that left after the procedure. Putting aside the issues of having a doctor unfamiliar with T.L.'s medical history – and one who has never spoken to anyone on her care team – performing surgery on such a delicate patient, it is critical that any surgeon that performs a tracheostomy remain available to treat that patient for 6-7 days. When a tracheostomy is performed, the airway is unstable until a stable track can form from the outside of the neck to the trachea. Problems with maintaining the airway during this initial period, while rare, happen. Indeed, the standard of care for surgeons performing tracheostomies is to perform a "purse stitch" with "stay sutures" that remain out and exposed. The stay sutures are designed to aid reinsertion of the tracheostomy tube if required. Because the surgeon who performed the tracheostomy knows what was done and the pathway that was chosen, it is critical that such surgeon be available to aid in repairing any problems that arise as in some occasions surgical expertise is required to replace the tube. The standard of care in the medical industry, and at Cook Children's Medical Center, is that the surgeon that performed the initial tracheostomy must remain available to the patient until the first trach tube change has taken place and that the surgeon performs the first change (usually 6-7 days after the initial surgery). If a visiting surgeon performs a tracheostomy and then leaves, that is against the standard of care and endangers the patient.

16. In weighing the potential benefits of a tracheostomy against the risks, it is my opinion that it is not medically appropriate for T.L. to have such a surgery, especially from a visiting physician that would leave after the surgery.

17. That being said, if there was a hospital or doctor that was prepared to treat T.L. but would not take over her care until such time as she had a tracheostomy, that reason would, in my opinion, provide an extra benefit that would justify the procedure and I would make sure it was

done. Indeed, I have repeatedly stated that Cook Children's will perform a tracheostomy on T.L. should Plaintiffs locate a doctor prepared to take over her care (to the extent such doctor wants the procedure done).

18. If, for example, Dr. Glenn E. Green and his team at C.S. Mott Children's Hospital is prepared to assume the treatment of T.L., Cook Children's has always been willing to aid in the transportation of the patient. T.L. could transport to C.S. Mott Children's Hospital in her current condition. It is my opinion, that a tracheostomy would not need to be performed prior to transport.[3] Dr. Green and his colleagues could assume care of T.L., and perform the operation there to the extent that they feel such an operation is medically ethical and appropriate. I confirmed that, as of July 19, 2020, there were ICU beds available at C.S. Mott Children's Hospital, but their cardiac clinical team who has previously reviewed this case did not feel they would have anything to add to this child's management.

C. Malacia

19. I am familiar with the various forms of malacia in patients and have treated numerous patients with the condition. Cook Children's was aware of the possibility of T.L. having some form of malacia more than a year ago. A bronchoscopy was performed at that time which indicated that T.L. suffered from a mild form of bronchomalacia that is not a significant factor in her complex cardiopulmonary interactions and her current diseased state. Her primary problem is the interaction between her severe congenital heart disease, severe chronic lung disease, pulmonary hypertension, and the inability for further palliative operations to be beneficial.

[3] However, as noted above, if the failure to have a prior tracheostomy would prevent C.S. Mott Children's Hospital from accepting T.L. as a transfer patient, Cook Children's would agree to perform the surgery.

20. Within the last 14 days, T.L. underwent another bronchoscopy which showed that her mild bronchomalacia that was previously diagnosed remains unchanged and still is not a significant factor in her complex cardiopulmonary interactions and her current diseased state.

21. T.L. does not have tracheomalacia.

22. As discussed at the temporary injunction hearing, T.L. has suffered from "dying events" whereby her blood oxygen level plummeted and Cook Children's was required to medically intervene by manually inflating her lungs and other treatments. As noted above, those events appear to be under better control. They occur much less frequently than noted in my December testimony.

23. It is my professional opinion and that of T.L.'s experienced cardiac ICU team that these dying events were not the result of severe tracheomalacia.

24. If T.L. had tracheomalacia (or another form of malacia mandating treatment), Cook Children's has the expertise and experience to recognize and treat the condition.

My name is Jay M. Duncan, my date of birth is 11/05/1974, and my work address is 1500 Cooper St., Fort Worth, TX 76104. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Tarrant County, State of Texas, on the 20th day of July, 2020.

Jay M. Duncan, M.D,

EXHIBIT 2

CAUSE NO. 048-112330-19

T.L., A MINOR AND MOTHER, [redacted], ON HER BEHALF, Plaintiffs, v. COOK CHILDREN'S MEDICAL CENTER, Defendant.	§ § § § § § § § § § § §	IN THE DISTRICT COURT TARRANT COUNTY, TEXAS 48TH JUDICIAL DISTRICT

DECLARATION OF DR. KACI OSENGA

I, Kaci Osenga, M.D., declare as follows:

1. I am over the age of 21 and fully competent to make this declaration. I have personal knowledge of the facts and statements contained in this declaration and I declare under penalty of perjury that the following is true and correct.

2. I am the Medical Director of the Hospice/Palliative Care Program at Cook Children's Medical Center, the defendant in this case, and have worked at Cook Children's Medical Center since 2016. I was asked to assess the palliative care needs and possible palliative pathways that could be offered to patient T.L. It is in that capacity that I have knowledge of the facts described below.

3. I received my medical degree from University of Wisconsin-Madison ("UWM"). I completed pediatric residency followed by a fellowship in pediatric hematology and oncology at UWM. I am board certified in both Pediatrics and Hospice and Palliative Medicine, and 100% of my medical practice has been in the field of hospice and palliative medicine for the last 13 years.

A. Work for T.L. on a Palliative/Hospice Plan.

4. I was contacted about T.L. in May of 2020. I was informed that T.L.'s mother might be interested in a shift to palliative care at Cook Children's and I was asked to review her file to determine what a palliative care approach to T.L.'s care might entail. After a comprehensive review of the medical records, the plan was for me to meet with T.L.'s mother and better understand her definitions of palliative care and discuss possible palliative approaches to caring for T.L. in the future. I was asked to initially review the medical records and offer my opinion without speaking to any of the treating doctors or the family. Thus, the conclusions that I reached below were made independently without any influence by T.L.'s care team, external sources, or discourse with the family.

5. Due to a personal family emergency, my work on this matter was interrupted for several weeks. When I returned, I reviewed T.L.'s entire medical file. I completed my review within the last 14 days and, based on that review, reached the following conclusions:

a. T.L.'s condition, including but not limited to complex congenital heart disease, severe chronic lung disease, pulmonary hypertension and recurrent serious life threatening infections, is life-limiting and incurable.

b. T.L. suffers daily as a result of the medical treatment that is sustaining her life. In order to sustain her life, she requires ongoing neuromuscular blockade and deep sedation for which she has developed a significant tolerance, making a level of comfort difficult to achieve in the presence or absence of neuromuscular blockade.

c. T.L.'s condition continues to deteriorate.

d. The level of care needed to sustain T.L.'s life without greatly increasing her discomfort and suffering cannot be provided outside of an ICU setting. She is not eligible for home based palliative care or hospice services based on the complexities and demands of life-sustaining ICU level medical needs.

e. Based on my review of the medical record, there has been disagreement between family and hospital caregivers regarding T.L.'s level of suffering.

f. I believe that it is appropriate to transition to a plan of care that attends to the suffering of this patient and forgoes further interventions that are no longer beneficial.

6. Before I could meet with T.L.'s mother to discuss my conclusions and to propose a palliative plan, the instant Motion to Compel was filed.

B. Issues Regarding the Proposed Tracheostomy.

7. T.L. is artificially kept alive by a ventilator that "breathes" for her by pushing extra-oxygenated air into her lungs. She has a nasotracheal tube in place which connects her to the ventilator. This tube passes through one of her nostrils, past her posterior pharynx, through her vocal cords and into her trachea.

8. A tracheostomy is a surgical procedure whereby a surgical opening is created in a patient's neck and trachea into which a specialized tube is inserted to provide an airway directly into the trachea (or windpipe). The patient would then breathe or be ventilated through the tracheostomy tube rather than through the nose or mouth or an oral or nasotracheal tube. The surgery is usually performed in an operating room (unless done in an emergency) with the patient under general anesthesia. An artificial airway is necessary when a patient has an obstructed upper airway, serious anatomical anomalies of the airway, or another condition which prevents the patient from safely or effectively breathing or ventilating through their nose or mouth. A tracheostomy is a specialized artificial airway for patients with an obstructed upper airway, anatomical anomalies of the airway, or those who require ongoing mechanical ventilation which is achievable outside of the hospital setting.

9. T.L. has no medical condition for which a tracheostomy is medically necessary. She is receiving adequate and appropriate ventilatory support through her nasotracheal tube. Performing a tracheostomy to change the physical location of artificial airway for ongoing mechanical ventilation does not impact the effectiveness or ongoing need for ventilatory support.

In the absence of a level of care achievable outside of the ICU, and in the context of underlying life limiting conditions, I would not recommend a tracheostomy for this patient.

10. A tracheostomy does not provide medical benefit to T.L.'s underlying life limiting condition. It will not allow T.L. to better oxygenate her blood, reduce her reliance on a ventilator, or change her poor prognosis. A tracheostomy will not change the anticipated trajectory of T.L.'s congenital heart disease, severe chronic lung disease, pulmonary hypertension, or significant pulmonary infectious issues. With one possible exception,[1] a tracheostomy would not immediately impact the medications or dosages that T.L. receives. Moreover, there is no emergent need to perform a tracheostomy.

11. Compared to the small chance of a possible benefit (and noting that any benefit will not change the anticipated trajectory of her underlying medical conditions), there are significant risks with a tracheostomy for this patient. A tracheostomy would be performed under general anesthesia and due to the serious nature of her cardiopulmonary disease, she would require specialized cardiac anesthesiology. But because of T.L.'s prolonged exposure and significant tolerance to sedatives and analgesics, post-operative pain and symptom management would be expected to be difficult and cause more suffering. Moreover, while severe complications from a tracheostomy are rare, they are possible. Should any such complications occur, T.L.'s underlying serious and irreversible medical conditions would greatly impact her recovery and possibly her survival. As such, with little anticipated benefit, complications in the post-operative period, could hasten her death.

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[1] There is a small, but unproven, chance that a tracheostomy would allow Cook Children's to reduce the amount of vecuronium that T.L. receives. This assumes that T.L. would find the tracheal intubation less "irritating" than the nasal intubation and there is, therefore, a small chance that her dosage could be decreased as she would be less likely to try to pull the new tube out. Of course, this assumes that T.L. would take no other harmful actions and that she could tolerate extra movement without adversely impacting her blood oxygen numbers. In my opinion, the small chance of this benefit is not worth the potential risks of the procedure such that a tracheosto0my is not medically appropriate for T.L.

12. In weighing the potential benefits of a tracheostomy against the risks, it is my opinion that it is not medically beneficial or appropriate for T.L. to have such a surgery.

My name is Kaci Osenga, my date of birth is 19 March 1973, and my work address is 1500 Cooper St., Fort Worth, TX 76104. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Tarrant County, State of Texas, on the 20th day of July, 2020.

KOsenga, MD
Kaci Osenga, M.D.

EXHIBIT 3

DECLARATION OF DONALD BEAM, M.D.

STATE OF TEXAS §
§
COUNTY OF TARRANT §

"My name is Donald Beam, M.D. I am over the age of eighteen and otherwise competent to make this Declaration. I have personal knowledge of the facts stated in this Declaration, and hereby swear as follows:

1. I am a pediatric hematologist employed by Cook Children's Physician Network. I am triple board certified in pediatrics, internal medicine, and pediatric hematology/oncology. I hold clinical privileges at Cook Children's Medical Center ("CCMC"), and have been an active member of the Professional Staff at CCMC since 2006. I am an elected officer of the Professional Staff and currently serve as the Vice President of Credentialing. In my capacity as Chair of the Credentials Committee, I am responsible for reviewing and investigating the credentials of all applicants for appointment, reappointment, and clinical privileges at CCMC, and for making credentialing recommendations based on the standards, criteria, and qualification requirements as defined by the Professional Staff of CCMC. It is in that capacity that I have obtained the knowledge of the facts contained below, each of which is true and correct.

2. CCMC is accredited by the Joint Commission, and, in order to maintain its accreditation, CCMC must comply with the standards set forth by the Joint Commission and the Centers for Medicare and Medicaid Services. The standards and requirements for the granting of temporary privileges are defined by the Joint Commission. As mandated by the Joint Commission, those standards and requirements are incorporated into and expounded upon in the Professional Staff Bylaws of CCMC ("Bylaws"). True and correct copies of relevant sections of the Bylaws are attached as Exhibit A.

3. The Joint Commission permits the granting of temporary privileges in only two circumstances: 1) where an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the professional staff executive committee and the governing body, or 2) to fulfill an important patient care need. Where the temporary privileges are requested to fulfill an important patient care need, the professional staff is required to verify the current licensure and competence of the applicant. Further, the Joint Commission requires that all temporary privileges be granted by the chief executive officer of the hospital, based on the recommendation of the professional staff president.

4. In compliance with the Joint Commission requirements, the Bylaws require a physician seeking temporary privileges for a specific patient need to provide documentation of his/her professional licensure, required liability insurance, controlled substances registration (state and federal), as well as a current copy of his/her CV. In addition, the System Credentials Department must receive oral or written verification of the physician's current good standing at a Joint Commission-accredited hospital.

5. To meet these requirements, an applicant seeking temporary surgical privileges at CCMC would have to hold an active license to practice medicine in the state of Texas and provide proof of professional liability insurance with limits of $500,000 per occurrence/$1,000,000 aggregate. Further, the Bylaws require that the request for temporary privileges be initiated by an existing member of the Professional Staff, and the request must be approved by the President of CCMC, with the written concurrence of the appropriate Division Chief, the Chair of the Credentials Committee, and the President of the Professional Staff. CCMC administration does not have the authority to override a decision to grant or deny temporary privileges or to otherwise unilaterally grant such privileges.

6. It is my understanding the Plaintiffs are requesting CCMC be compelled to grant temporary privileges to an out-of-state physician for the purpose of performing a tracheostomy on [redacted] and scoping her airway. This request is not being initiated by an existing member of CCMC's Professional Staff, nor would such a request ever be necessary or appropriate since there are pediatric surgeons and otolaryngologists on staff at CCMC who have the appropriate training, expertise, and credentials to perform such procedures. Accordingly, there would be no justification for granting temporary privileges to an outside physician. Further, based on my review of the Texas Medical Board licensing records, this physician is not licensed to practice medicine in Texas, and would, therefore, be ineligible to exercise clinical privileges at CCMC (or any other hospital or facility in the state of Texas).

7. Given the ongoing public health crisis related to the COVID-19 pandemic, any request for temporary privileges would be subject to heightened scrutiny. Hospitals throughout the state of Texas, including CCMC, are dealing with an influx of COVID positive patients and focused on infection prevention and control efforts to protect the health and safety of patients, visitors, and staff. That is especially critical here, where the doctor is seeking to enter the hospital and be exposed to some of our most fragile patients. In this situation, considering the current risks and the lack of need for expertise, CCMC would not grant temporary privileges to Dr. Green.

My name is Donald Beam, my date of birth is April 18th, 1973, and my work address is 1500 Cooper St., Fort Worth, TX 76104. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Tarrant County, State of Texas, on the 20th day of July, 2020.

Donald Beam, M.D.

EXHIBIT 3 A

NO. 02-20-00002-CV

[redacted] A MINOR AND MOTHER, [redacted], ON HER BEHALF, Appellants,	§	IN THE SECOND
v.	§	COURT OF APPEALS
COOK CHILDREN'S MEDICAL CENTER, Appellee.	§	FORT WORTH. TEXAS

DECLARATION OF DR. PATRICK ROUGHNEEN

Pursuant to 28 U.S.C. § 1746 and Texas Civil Practice & Remedies Code §132.001, I hereby declare as follows:

1. My name is Patrick Roughneen, M.D. I am over twenty-one (21) years of age. I am of sound mind and fully competent to make this Declaration.

2. I am a cardiovascular surgeon at the University of Texas Medical Branch - Galveston. I am providing this information in my personal capacity as a cardiovascular surgeon and not associated with my position at the University of Texas Medical Branch.

3. I have reviewed the medical records of [redacted], who is a patient at Cook Children's Hospital in Fort Worth, Texas. Based on [redacted] most recent heart catheterization imaging, it is my professional judgment that there is no evidence of pulmonary hypertension in [redacted]. The results show [redacted] pulmonary artery pressures are within an acceptable range.

4. Additionally, I believe that it is reasonable to explore palliative care options in accordance with the wishes of [redacted] mother, [redacted].

5. Furthermore, I am willing to physically assess [redacted] and provide an independent second medical opinion, on or after January 19, 2020. Until January 19, I have clinical duties and then will be out of the state.

6. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Galveston County, State of Texas, on the 6th day of January 2020.

Patrick Roughneen, M.D.
Declarant

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below:

Kennon Welch on behalf of Wallace Jefferson
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Status as of 9/18/2020 4:59 PM CST

Associated Case Party: Cook Children's Medical Center

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Associated Case Party: T. L., Mother on Behalf of T.L., a Minor

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