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10 Attorneys for Plaintiff,
MELISSA KAY COOK Individually and
11 MELISSA KAY COOK as *Guardian ad*
Litem of Baby A, Baby B and Baby C

12 UNITED STATES DISTRICT COURT
13 CENTRAL DISTRICT OF CALIFORNIA
14 LOS ANGELES DIVISION

15 MELISSA KAY COOK Individually and
16 MELISSA KAY COOK as *Guardian ad*
Litem of Baby A, Baby B, and Baby C,

17 Plaintiffs,

18 vs.

19 EDMUND G. BROWN, JR., Governor of
20 the State of California, et al.,

21 Defendants.

Case No. 2:16-cv-00742 ODW(AFMx)

DECLARATION OF ALMA L.
GOLDEN, M.D., F.A.A.P.
PURSUANT TO 28 U.S.C. §1746

(Fed. R. Evid. 201)

Date: May 23, 2016
Time: 1:30 p.m.
Courtroom: 11
Judge: Hon. Otis D. Wright, II
Trial Date: None Set
Action Filed: 2/2/16

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23
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25 ALMA L. GOLDEN, M.D., F.A.A.P., being of full age, deposes and says:

26 QUALIFICATIONS

27 1. I am a Pediatrician, recently retired from my position as Associate
28

1 Professor of Pediatrics at Texas A&M Health Science Center where I trained
2 medical students and residents regarding child development and child care in a
3 family-centered system from 2006-2015. I also served as Vice Chair for
4 Community Initiatives at McLane Children's Hospital, Baylor Scott and White
5 Health through which I coordinated community health education and implemented
6 health interventions from 2009-2015. I served as the faculty representative to the
7 Curriculum Committee for the Texas A&M Health Science Center in 2014-2015
8 and as a member of the Pediatric Operations Committee overseeing strategic
9 operations and planning between 2008-2014. As Associate Professor of Pediatrics
10 and Vice Chair of the Pediatric Department, I was responsible for policy,
11 development, and implementation for collaboration between Specialty and General
12 Pediatrics for indigent care and trained medical students and resident physicians on
13 Adolescent Health, Patient Education, Public Health and Policy, and Clinical
14 Intervention Methods. I previously served as the Director of Pediatrics, Scott and
15 White Round Rock Health System from 2006-2008. Throughout my career, I have
16 written about, provided training, and held administrative and policy roles in the
17 areas of Pediatrics, Family Medicine, Obstetrics and Gynecology, Ethics, Public
18 Health, and Adolescent Communication. My Curriculum Vitae is attached to this
19 Declaration and marked as Exhibit A.

20 2. I obtained my M.D. from University of Texas Medical Branch
21 (UTMB) in 1975. Following my internship, I cared for my family and served my
22 four children as my primary responsibility from 1977 to 1986. I completed my post-
23 doctoral training in Pediatrics in 1988 and was Board Certified in Pediatrics in
24 1990. From 1988-1991, I was a general pediatrician in private practice in Alvin,
25 Texas while serving as a teaching physician with UTMB. I then accepted the
26 position of Director of Pediatric Services for the Regional Maternal Child Health
27 Program of the Department of Obstetrics and Gynecology at UTMB from 1991-
28 2000. In that role as Clinical Assistant Professor of Pediatrics, I strategically

1 developed programs for pediatric care in underserved and indigent communities
2 and oversaw administrative management of pediatric services in 16 Maternal and
3 Child Health Clinic sites. Services in these clinics included family planning,
4 prenatal care, identification and management of high risk pregnancies, prenatal and
5 parental education, post-natal services and pediatric routine care including health
6 screenings, immunizations and acute care for illness. Through UTMB and the
7 Maternal Child Health program, I also taught all levels of medical students and
8 residents from the Pediatrics, Family Medicine, and Obstetrics and Gynecology
9 Departments, and nurses, nurse practitioner students, and physician assistant
10 students. Beginning in 1996, and continuing through 2000, I also served as the
11 Associate Medical Director for UTMB Health Plan, where I was responsible for the
12 development of the Medicaid managed care program, provider network and the
13 Children's Health Insurance Program implementation. As Medical Director, I
14 helped develop the range of medical services available to underserved patients and
15 families, assure that qualified providers were available to provide the necessary
16 range of health care services, and monitored the quality and adequacy of care.

17 3. During this same time period (1997-2002), I founded and served as
18 Medical Director of the SAGE Advice Council, which offered health education
19 training programs for health professionals. SAGE provided presentations on
20 adolescent risk behaviors to physicians, nurses, social workers, and educators. The
21 focus of SAGE was to equip youth professionals with the knowledge and skills to
22 both interview and intervene with youth and family members to improve health
23 choices and decrease risk behaviors, especially the risks of youth drugs, alcohol,
24 violence and sexual involvement. From 1999-2002, I served as the first Editor-In-
25 Chief of a new multidisciplinary journal regarding adolescent risk behaviors and
26 interventions: Adolescent and Family Health, associated with the Institute for
27 Youth Development. The journal published original research regarding teen risks,
28 health interventions and youth and family outcomes.

1 4. In 2002, I was appointed by President George W. Bush to be the
2 Deputy Assistant Secretary for Population Affairs at the U.S. Department of Health
3 and Human Services. In that role, I was the senior executive administrator for three
4 major programs: the nation's Title X (Family Planning) program, Title XX
5 (Adolescent Family Life) programs, and the Embryo Adoption Awareness
6 Program. The Title X (Family Planning) program funded \$289 million of grants to
7 89 state and non-profit entities which supported family planning services in 4,600
8 clinics, serving approximately 5 million clients annually. The Title XX (Adolescent
9 Family Life) program oversaw \$30 million of grants to 104 community agencies
10 which provided abstinence education and care for pregnant and parenting teens.
11 The Embryo Adoption Awareness Program addressed the approximately 400,000
12 embryos which were unused by biological parents and potentially available for
13 adoption. The complex ethical, biological and legal environment of these embryos
14 demonstrated the challenges of fertility treatments and the need for compassionate
15 adoption by loving families. One million dollars in funds were delegated through
16 competitive grants to assist fertility and adoption organizations to improve
17 awareness and adoption of stored embryos. As Deputy Assistant Secretary for
18 Population Affairs, I also served as a policy advisor to the White House Domestic
19 Policy Council, the Secretary of Health, and the Department of State on issues
20 relating to reproductive health and family planning, HIV prevention, teen
21 pregnancy, and statutory rape. In that role, I also provided policy advice to the
22 Department of Justice on matters of sexual assault, exploitation, rape, and coercion
23 of young teens by older individuals.

24 5. For over 25 years, in addition to my practice of pediatrics and faculty
25 teaching responsibilities, I have made scores of presentations to health educators,
26 school teachers and coaches, social work professionals, nurses and community
27 groups on topics such as risk-avoidance programming, HIV prevention, public
28 health approaches, family-focused health care, and teen interview and intervention

1 techniques. In 2005-2007 I conducted a series of lectures at the University of
2 Beijing, School of Public Health and other agencies in China regarding adolescent
3 behavioral interventions and public health. In 2010, in collaboration with the
4 Centers for Disease Control and Center for Relationship Education, I served as
5 primary author of the SMARTool, a reference source for assessing effective
6 interventions for adolescent risk avoidance programs.

7 6. Throughout my career, I have also served in numerous capacities on
8 Committees and Task Forces, as demonstrated by the following emblematic
9 examples. From 1995 – 2001, I contributed to the Work Group on Unintended
10 Pregnancy convened by the National Association of County and City Health
11 Officials. This Work Group reviewed data and outcomes related to teen and
12 unplanned pregnancy and made recommendations in their report, Preparing for
13 Healthy Pregnancy, for which I served as primary author. I served on the American
14 Academy of Pediatrics (AAP) Task Force on the Family from 1998-2003. The Task
15 Force reviewed extensive research and expert opinion regarding the impact of
16 family structure and function on child health. A Task Force Report was released by
17 the AAP in 2004. From 2000-2004 I served as a committee member on the AAP
18 Bright Futures Committee, reviewing recommendations for pediatric screening,
19 patient education, family involvement, anticipatory guidance, and routine well-child
20 care. From 2002 – 2006, I participated in the Health and Human Services
21 Workgroup on Prevention of the Sexual Exploitation of Young Teens reviewing the
22 prevalence of sexual exploitation, the legal framework for protecting young teens,
23 and current and needed programs to reduce exploitation and abuse of youth. In
24 2012, I participated in a CDC Expert Panel on Youth HIV/STI/Sexual Health
25 Review, collaborating with national leaders regarding programs and interventions
26 pertinent to HIV in youth. For Baylor University School of Education's Dean
27 Advisory Committee, I served as a committee member and consultant from 2012-
28 2015.

1 child C.M. does not want. This is an important fact, if true, because, as I discuss
2 below, it would not disrupt the mother-child bond and relationship. The First
3 Amended Complaint also states that there are serious reasons to believe that C.M.
4 cannot care for any of the children, and that Melissa wants to take custody of any or
5 all of the children if the court concludes that to do so is in the children's best
6 interest.

7 **OPINIONS EXPRESSED AND THE REASONS AND BASIS FOR THEM¹**

8 **I. The practices around surrogacy pose risks to the neonates that are**
9 **lessened by an ongoing relationship with his or her birth mother.**

10 11. All of the opinions I express are within a reasonable degree of medical
11 certainty.

12 12. In vitro fertilization and embryo transfer, used in surrogacy, are
13 associated with increased risks to the pregnant woman and baby. Although
14 frequently multiple embryos are implanted in order to increase the likelihood that at
15 least one embryo will implant and survive, even singletons conceived through IVF
16 are at increased risk. Compared with spontaneously conceived singleton neonates,
17 those conceived through in vitro fertilization are more at risk for preterm birth, very
18 low birth weight, and intrauterine growth retardation (McDonald et al, 2009;
19 Sunderam et al, 2015). When multiple embryos implant or implanted embryos split
20 and begin to grow, additional challenges may ensue. Complications of multiple
21 pregnancies include increased risk of perinatal mortality (death), preterm birth, low
22 birth weight, gestational diabetes, fetal growth restriction, pre-eclampsia, placental
23 abruption, and placenta previa (Kamphius et al, 2014; Allen et al, 2006; Sunderam
24 et al, 2015). Prematurity is a common outcome for a pregnancy with multiple
25 infants. Preterm infants often struggle to survive. Respiratory distress, infections,
26 neurologic damage and feeding challenges are generally the most emergent

27 _____
28 ¹ I do not include the full citations in the body of my Declaration. Full citations are
found in alphabetical order in the Addendum attached hereto.

1 concerns noticed by pediatricians and neonatologists (Patel, 2016; Genzel-
2 Boroviczeny O et al, 2006; Stoll et al, 2015). The brain damage of periventricular
3 leukomalacia seen in premature infants is well correlated with the potentially
4 irreparable harm of developmental delays, cerebral palsy and learning difficulties
5 (Linsell et al, 2016; Luu et al, 2009).

6 13. Touch has been studied as a factor in decreasing stress and pain.
7 Premature infants benefit from frequent soothing “tactile kinesthetic stimulation,”
8 (or stroking) (Ahmed et al, 2015) and acoustical stimulation with mother’s voice
9 (Wirth et al, 2016; Rand et al, 2014). Both intervention reduce heart and respiratory
10 rates, improve weight gain, and diminish irritable motion (Diego et al, 2014; Smith
11 et al, 2013; Piccolini et al, 2014). A mother’s touch and voice reduce the stress of
12 prematurity and adverse outcomes, and a calm and comfortable premature infant is
13 less likely to have additional damage to the brain than one who is very stressed.

14 14. The birth mother’s breast milk has unique value for the children to
15 whom she gives birth (Montjaux-Regis, 2011; AAP, 2012; Schanler et al, 2005;
16 Rogier et al, 2014). I am advised that C.M. refuses to permit the hospital personnel
17 to use Melissa Cook’s breast milk despite the fact she has offered it. It is my
18 understanding that C.M. has declined Melissa’s offer, and his attorney has the
19 hospital using donated breast milk from other women. This is not consistent with
20 what is in the best health interest of the children.

21 15. Preterm infants are at great risk for physiological and
22 neurodevelopmental impairments due to prematurity and are also likely to be
23 exposed to high levels of painful stimuli as they are cared for in the neonatal
24 intensive care unit (NICU) (Cruz et al, 2015; Vinall et al, 2014). The American
25 Academy of Pediatrics acknowledges that maternal skin to skin care and
26 breastfeeding are associated with “significantly lower pain responses” compared to
27 other nonpharmacological interventions (AAP Committee on Fetus and Newborn,
28 and Section on Anesthesia and Pain Medicine, 2016). Infants cuddled and nursed

1 by mother have lower mortality, decreased risk of neonatal sepsis, hypothermia,
2 and increased exclusive breastfeeding, lower mean respiratory rates and pain
3 measures, and higher oxygen saturation (Boundy et al, 2016; Gao et al, 2015).
4 Premature infants are at higher risk of pain and stress in the neonatal period and
5 benefit most from maternal comfort and feeding (Morelius et al, 2015;).

6 16. Because of the medical realities set forth in this section, gestational
7 surrogacy creates unique risks of harm to the children.

8 **II. The developing fetus depends upon the mother and is shaped by**
9 **prenatal experiences in ways that profoundly influence his or her life**
10 **after birth. The relationship between mother and child that begins**
11 **before birth is unique and important.**

12 17. For all children, whether conceived through natural conception or
13 through in vitro fertilization, fetal development is dependent on a human mother in
14 order to grow, develop and begin the process of unique and independent individual.
15 Fetal brain development begins about 16 days after conception as a neural tube. The
16 neural tube gives rise to billions of neurons that form during the first few months of
17 intrauterine life. Coordinated movement begins in the embryo eight weeks after
18 conception. By mid-gestation (20 weeks) in the womb, the fetus has most of the
19 100 billion neurons that will be used in their adulthood, and the brain has developed
20 basic pathways and systems for breathing, vision, hearing, pain, smell, taste,
21 responding and learning (Stiles et al, 2010). Critical periods during embryonic brain
22 development also form the basis for adult social behavior (Belinson et al, 2016).

23 18. Fetal growth and development is partially guided by genetic blueprints
24 but entirely dependent on maternal factors including nutrition, health status,
25 exercise, rest, and stress (Barua et al, 2015; Marques et al, 2015). The mother's diet
26 must be sufficient in calories, protein, minerals and vitamins to provide the
27 substrate necessary for formation of an infant's immune system and neurologic
28 development (Marques et al, 2013). Deficiencies in certain minerals, such as iodine,

1 or vitamins, such as the B vitamins, are associated with serious developmental
2 problems like cretinism, or neural tube defects (Salisbury, 2003; IOM, 2003). Even
3 before the infant can respond to taste, noise, pain or movement, the child's well-
4 being and development demands maternal health and intake for growth. The
5 presence of the embryo also affects the mother both hormonally and metabolically,
6 often changing sleep patterns, food preferences, and levels of energy or fatigue. The
7 mother-child interdependency during gestation is formative for the child and
8 profoundly influential for the mother.

9 19. Fetal brain development is sensitive to maternal contentment and
10 hormones of bonding such as oxytocin. Women with higher first trimester plasma
11 levels of oxytocin (known as the "hormone of love and bonding") have improved
12 bonding, caring behaviors and child responsiveness after delivery of the child
13 (Feldman et al, 2007). Higher oxytocin levels are associated with increased
14 behaviors that support strong relationships, care giving and infant safety (Gordon et
15 al, 2010). Infants and mothers benefit from the continuous production of these
16 maternal hormones both before and after birth. Mothers with lower levels of
17 oxytocin during the pregnancy have fewer behaviors related to maternal bonding,
18 for example affection touch, gaze, and vocalizations. These in turn are related to
19 lower levels of infant contentment and bonding (Feldman et al, 2007; Galbally et al,
20 2011).

21 20. Fetal brain development is also sensitive to maternal stress and the
22 hormones of stress such as cortisol. Research done in animal models demonstrates
23 that the offspring of stressed pregnant animals have more difficulty responding to
24 isolation and novel situations (Rault et al, 2013). When the unborn child is exposed
25 to higher levels of cortisol, a stress hormone from the mother, during pregnancy,
26 infant learning is impaired after birth (Bergman, 2010). Children whose mothers
27 experience significant health or emotional challenges during pregnancy may
28 demonstrate impaired adaptive behaviors after birth. The hormones released during

1 stressful, traumatic events during pregnancy can disrupt neural circuit function,
2 resulting in permanent changes in the brain, such as loss of neurons, changes in the
3 glial structures, and alteration of neurogenesis (production of new brain cells)
4 (Belinson, 2016). The intrauterine mother-fetal relationship is critical to brain
5 development and brain structure, as well as future cognitive, emotional, and social
6 function.

7 21. Pregnancy plays a vital role in the bonding process between mother
8 and child, and is foundational to the healthy development of the child. It forms the
9 basis of a lifelong loving relationship between a mother and the child. The plan to
10 deprive the child of the benefits that pregnancy affords him or her in the child's
11 future relationships and development is detrimental to the child.

12 **III. The maternal-child relationship in the earliest days and weeks of life lays**
13 **the framework for child development and should be maintained**
14 **whenever possible.**

15 22. Pediatricians have watched the early reflexes and responses of both
16 preterm and mature newborns and wondered about the interconnection of nature
17 and nurture. Now the trajectories of brain development are studied using advanced
18 imaging techniques as well as behavioral and anatomical measures. Early
19 developmental research points to sensitive periods for development of patterns of
20 emotional control, hearing, and vision beginning well before birth (Roskams,
21 2014). Critical developments occur in infancy and early childhood around the areas
22 of peer-social skills, language and habitual ways of responding (Roskams, 2014).
23 Sophisticated neuro-imaging has revealed that genetic patterns and environment
24 influence development. The brain modifies how it uses its genetic code in response
25 to life experiences. Consequently, the shared maternal-fetal relationship is a
26 determinant of actual brain growth and health and has long-lasting effects.

27 23. Infants base their sensory responses on maternal sounds (e.g. heart,
28 voice), maternal actions (activities, patterns of movement, and sleep), smell and

1 tastes (food and spices preferred). During the second and third trimester of
2 pregnancy, sensory regions of the cerebral cortex begin to function. Hearing, touch,
3 vision, taste and smell develop (Clark-Gambelunghe, 2015). The infant can hear his
4 mother's voice, sleep to her heartbeat, recognize the muffled sounds in the
5 environment, and demonstrate habituation to loud sounds or sudden actions in order
6 to diminish fetal startle responses. Infant hearing is affected by excessive
7 occupational noise their mothers are exposed to while they are pregnant (Selander
8 et al, 2015). Infants have been shown to respond to familiar odors (such as their
9 own amniotic fluid). By the time they are delivered, newborn patterns and
10 responses are attuned to the mother's sounds, actions and routines.

11 24. Consequently, infants experience their mother as their baseline for
12 growth, environment and sensations which establish patterns for the child's
13 behavioral, learning and emotional responses. Due to the intricacies of shared and
14 dependent existence of the mother and child during pregnancy, infants enter the
15 outside world with their mother as their primary and most important relationship.
16 Research on mammals demonstrates that neural mechanisms promote maternal-
17 infant bonding, and this provides the basic neural foundation for other social
18 relationships (Numan et al, 2016). **In other words, development and**
19 **continuation of the maternal-infant bond that begins before birth is critical to**
20 **the formation of the neural pathways that an individual uses to establish**
21 **relationships throughout life.**

22 25. As a result of their prenatal experiences, infants are most easily
23 comforted by sensations, sounds and smells associated with their home in their
24 mother's womb. Healthy infants cry soon after delivery in response to the abrupt
25 and uncomfortable transition of birth. However, most infants soothe quickly when
26 placed on their mother's chest. The familiarity of the voice and heartbeat and the
27 smell of their mother provides reassurance while facilitating bonding. Skin-to-skin
28 contact immediately after delivery provides the baby with a positive, supportive

1 entry into the world and has positive effects on the mother-infant relationship in
2 subsequent years, which lays the basis for future relationships (Bystrova et al,
3 2009). The American Academy of Pediatrics and the American College of
4 Obstetrics and Gynecology support the “golden hour,” which encourages
5 uninterrupted contact between a mother and infant for one to two hours after
6 delivery. The benefits of this contact have short-term benefits for the infant
7 including stabilization of heart and respiratory rates, reduced infant crying and
8 irritability, maintenance of infant blood sugar levels (which can drop to dangerous
9 levels with stress), improved temperature regulation and earlier initiation of
10 breastfeeding and breast milk production (Brady et al, 2016). Over the past two to
11 three decades, health professionals have implemented almost universal “rooming-
12 in” procedures to maximize maternal/infant bonding, improve opportunities for the
13 infant to be soothed and comforted, and increase frequency of breastfeeding and
14 holding. I am advised that when Melissa Cook gave birth on February 22nd, all
15 three of the babies cried. That is a healthy response. However, I understand that the
16 children were immediately taken away from the mother and the children are not
17 permitted to see their mother or be held or nurtured by her. This is clearly
18 detrimental to the development of the babies based on the aforementioned research.
19 This harmful practice is employed in virtually every surrogacy situation, much to
20 the detriment of the children.

21 26. Both newborns and mothers benefit from the increased release of
22 oxytocin during labor, birth, post-delivery comforting, and breast-feeding. Oxytocin
23 has important and long-lasting effects on the mother and baby during pregnancy,
24 labor, delivery, breastfeeding, and early parenting (Buckley SJ, 2015). Oxytocin
25 augments uterine contractions which reduced the loss of blood from the placental
26 attachment site, and initiates restoration of muscle tone in the mother’s abdomen.
27 Oxytocin also stimulates breast milk production to provide the most nutritionally
28 beneficial food for the newborn. Oxytocin triggers neurochemical changes that are

1 associated with positive attachment and bonding for both the mother and child. The
2 calm, alert period of a newborn after delivery, as well as the experience of positive
3 maternal engagement, may both be strengthened by oxytocin. Deregulation of the
4 oxytocin system has been implicated in the pathophysiology of neuropsychiatric
5 problems such as autism, schizophrenia, mood and anxiety disorders (Romano et al,
6 2016). Healthy, consistent maternal physical and emotional connections may reduce
7 the possibility of long-term, debilitating neuropsychiatric disorders. Consequently,
8 the early disruption of the mother-child relationship due to surrogacy places the
9 child at increased risk of neuropsychiatric disorders.

10 27. In early infancy, babies have limited capacity to fight off infections
11 based on their own immune system. During pregnancy the mother shares her own
12 antibodies and immune capacity with the infant in her womb. At delivery a healthy
13 newborn is carrying a broad array of immune responses to viral and bacterial
14 infections in his/her mother's environment. If the newborn is placed in an
15 environment dissimilar to the mother, the efficacy of the prenatally acquired
16 antibodies may not be as protective. These protective antibodies allow infants to
17 avoid many early disease threats, including potentially life-threatening infections,
18 while their body begins to establish immune-competency, the ability to make their
19 own antibodies and fight off infection (Oddy, 2001; Hanson, 1998). The breastfed
20 infant has the additional benefit of receiving supplemental immunity through breast
21 milk for the first few months of life, further reducing the disease load from
22 diarrhea, ear infections, and other problems caused by infectious agents (Jackson,
23 Nazar, 2006). That is why Baby A, Baby B and Baby C, in this case, would benefit
24 from using Melissa Cook's breast milk. Using another woman's donated milk is not
25 as beneficial for the children.

26 28. Newborn brains have plasticity, which means they are very
27 impressionable and molded by their environment and experiences. As noted by the
28 National Center for Infants, Toddlers and Families, "this plasticity has both a

1 positive and a negative side. On the positive side, it means that young children's
2 brains are more open to learning and enriching influences. On the negative side, it
3 also means that young children's brains are more vulnerable to developmental
4 problems should their environment prove especially impoverished or un-nurturing"
5 (Zero to Three, 2009). Consequently, our society should positively support
6 maternal and child interaction and bonding in a continuous manner, before birth,
7 through the birth experience and early infancy, and into childhood. The ideal
8 environment for emotional, social and cognitive development includes a stable,
9 caring continuation of the maternal/child interaction. The stability of that
10 relationship minimizes stress due to new environments, sensations, and discomfort,
11 while enabling efficient learning, behaviors and adaptation.

12 29. Breastfeeding is another component of continued maternal/child
13 interaction. Breast milk not only provides basic nutrition in the form of water,
14 proteins, carbohydrates, vitamins and minerals, it is also an avenue for providing
15 protection from infections and allergies (Montjaux-Regis, 2011; AAP, 2012;
16 Schanler et al, 2005; Rogier et al, 2014). A mother's milk also introduces the infant
17 to flavors, spices, and proteins that will be a part of the child's diet as weaning
18 occurs. Mothers also benefit from breastfeeding through strengthening of the uterus
19 and abdominal musculature, and loss of "baby fat" associated with pregnancy.
20 Because of all of these benefits, the American Academy of Pediatrics recommends
21 exclusive breastfeeding for the first six months of life, followed by continued
22 breastfeeding as additional foods are introduced to the baby for a year or longer
23 after birth (AAP, 2012). The continuation of the mother-child relationship in the
24 first days, weeks, and months of life are critical to the health and well-being of the
25 child. Planning to terminate that relationship through surrogacy is a plan to do
26 potential harm to the children.

27 **IV. The Relationship between Mother and Child Established During**
28 **Pregnancy Forms the Basis for Life Long Relationships.**

1 30. Newborns are not a blank slate of neurological and biological material
2 or just the products of their genetics. Considering the unique interactive and
3 interdependent experience of pregnancy, labor and delivery, infants have been
4 deeply imprinted by their intrauterine environment, their mother's voice and
5 patterns, as well as the emotional and health status of the mother. That environment
6 has provided the foundation for immediate and long-term development.

7 31. The past two decades have produced extensive research on the role of
8 stress in health. It is commonly recognized that infants, both before and after birth,
9 experience stress. Positive stress allows infants to develop coping mechanisms with
10 the support of a nurturing parent who will strengthen the infant's ability to adapt
11 and learn. Toxic stress occurs when an infant is exposed to an adverse situation or
12 experience while deprived of nurturing support. Stressful experiences in the early
13 postnatal period, including separation from the mother through adoptive placement
14 or neonatal hospitalization, have been shown to increase the risk of long term stress
15 and trauma reactions in the child as they grow. These early traumatic reactions
16 change the child's developing neuroendocrine responses to stress (Shonkoff et al,
17 2012). Positive and sustained interactions with the mother can mediate these
18 negative and stressful experiences since the infant and young child is familiar with
19 his or her mother and easily comforted by her.

20 32. The relationship between mother and child before birth affects the
21 infant once he or she is born. Attachment and bonding are correlated with
22 personality characteristics and capacity to cope with stress. Longitudinal studies
23 have shown that the mother's attachment to her unborn child is correlated with her
24 infant's mood (White and Wilson, 1999). A one-year old child's response to stress
25 is closely linked to secure or insecure attachments that begin during pregnancy
26 (Fonagy et al, 1991).

27 33. Placing the mother under the stress derived from demands over a
28 period of time to abort one of the children, when the mother clearly does not want

1 to do so, has a predictable harmful effect on the development of the child. Thus, the
2 practice of transferring multiple embryos only to demand a “selective reduction” is
3 potentially harmful to all of the children involved.

4 34. As discussed earlier, the relationship between mother and child begins
5 before birth and continues after delivery and, ideally, throughout the child’s life.
6 The development of the child’s identity is fundamentally shaped by the dyadic
7 relationship between mother and child, and then by the father and other family
8 members as the infant develops in the context of relationships. Loss of the mother
9 is devastating for the developing child. Psychiatrist John Bowlby cared for and
10 studied children in England during WWII, when thousands of infants and children
11 were removed from homes in London to reside in safe houses away from their
12 families. His observations and longitudinal tracking of these children demonstrated
13 the adverse outcomes many of these children experienced. He observed that a child
14 removed from a familiar environment often has diminished capacity to bond
15 securely. His work on attachment has been foundational to improving
16 compassionate care for infants and understanding attachment disorders (Bowlby,
17 1969; Follan, 2010). Infants depend on a consistent, compassionate care to establish
18 a sense of trust, and to recognize security and safety.

19 35. Secure maternal-child attachments in infancy are associated with
20 multiple shared experiences and exposures that are foundational to future growth,
21 health and learning. The familiar maternal environment of nurturing touch and
22 sounds through parental contact and comforting is associated with optimal brain
23 development and growth after birth. In animal models, increased levels of grooming
24 during the first week of life not only predicted better learning patterns in
25 development, it also predicted improved behavioral patterns in the adulthood of the
26 offspring (Shonkoff et al, 2012). Securely attached infants and toddlers approach
27 new environments with greater confidence. Mary Ainsworth, who worked with
28 John Bowlby and also conducted early research on attachment, described what

1 pediatricians and teachers often witness: children who enjoy climbing, tasting,
2 touching, exploring and laughing in new environments are those children who are
3 most confident that their mother was always there for them (Ainsworth and Bell,
4 1970).

5 36. The disruption of the maternal-infant relationship creates stress and
6 emotional responses that can result in the decreased ability to bond with others,
7 including a serious condition known as reactive attachment disorder (RAD).
8 Although RAD was first described in the WWII children and orphans, significant
9 mental health and socialization problems have been recognized in other children
10 with poor neonatal bonding. Reactive attachment disorder is a disorder
11 characterized by lack of attachment to any specific caregiver at an early age, and it
12 results in the inability of the child to form normal, loving relationships with others
13 (Zeahah, 2015; Smyke, 2015; Folan et al, 2014). A central criterion for RAD in the
14 ICD-10 is “an implicit lack of identifiable, preferred attachment figure” (DSM-IV
15 TR). RAD appears to be most severe in infants and children who are separated early
16 in life from their mothers. Removal of a child from the security and stability of a
17 mother can cause irreparable harm to the child’s capacity to form bonds and
18 maintain emotional and social relationships. Many children affected by RAD
19 struggle to establish and maintain relationships throughout life. Treatments of
20 reactive attachment disorder are inconsistent in quality and outcome (Hardy, 2007;
21 Allen, 2011). Children with severe attachment issues and complex trauma histories
22 frequently have difficulties with family and parental relationships, and these
23 psychiatric issues are often devastating to families, with expensive therapies with
24 limited effectiveness (Smyke, 2015; National Child Traumatic Stress Network,
25 2016; Folan et al, 2014).

26 37. Early childhood trauma and attachment issues are associated with long
27 term, severe adverse outcomes including increased risk of mental health issues
28 (depression, anxiety, panic reactions, and hallucinations), somatic disturbances

1 (sleep disturbance, obesity, and somatic symptoms), substance use and abuse
2 (smoking, alcoholism, and illicit drug use), sexual risk behaviors (early sexual risk
3 behaviors such as early intercourse, promiscuity, and sexually transmitted
4 infections), memory disturbances, high perceived stress, difficulty controlling
5 anger, and intimate partner violence (Anda et al, 2006; Felitti et al, 1998; Brown et
6 al, 2007; Dube et al, 2006). As the number of early adverse childhood events
7 increase, the adverse outcomes also increase dramatically (Anda et al, 2006;
8 Campbell et al, 2016; Dube et al, 2009). These adverse outcomes directly affect the
9 morbidity and mortality of the children with adverse childhood events, leading to
10 increased interactions with the mental health and criminal justice system over the
11 lifetime of the adult and increased negative health and social outcomes (Zero to Six
12 Collaborative Group, 2010; Campbell et al, 2016; Felitti et al, 1998).

13 38. Behavioral patterns of infancy and childhood are significantly
14 associated with the quality and continuity of the maternal-infant bond. Epigenetics,
15 a rapidly expanding area of research and study, investigates the molecular biology
16 that changes the way that genes are expressed in individuals (Wolffe, 1999;
17 Jablonka, 2002). Throughout life experiences, emotional responses, social
18 relationships and physical health can be changed by the security of continuous
19 relationships (Gunnar et al, 1996). Greater maternal attachment improves the
20 capacity of infants to tolerate vaccine injections and calm themselves following
21 vaccine administration (Walsh et al, 2008). The quality and security of the
22 maternal-infant bond during and after delivery are associated with stress responses
23 later in life. In both animal and human research, offspring that experience secure
24 bonding are more easily comforted and have less exaggerated stress responses both
25 in infancy and in later life (Sullivan et al, 2011).

26 39. Children with stable, strong relationships to their mother are better
27 equipped to manage learning tasks (O'Connor et al, 2012; Landry et al, 2006; Reid
28 et al, 2007). Pediatricians often observe children whose verbal or social skills are

1 advanced. The vast majority of these precocious children present with comfortable,
2 encouraging mothers. The term “experience expectant” is used to describe the
3 important role of experiences in the early postnatal period. These early interactions
4 help to pattern the brain for learning: stressful and strange “impoverished”
5 experiences reduce the capacity for future development; positive and secure
6 “enriched” environments increase future development (Greenough et al, 1987;
7 Joseph, 1999). Postnatal experiences set the stage for the emergence of normal
8 patterns of neocortical organization. Mothers are the strongest link to secure
9 postnatal experience. Optimal brain maturation and organization relies significantly
10 on the continuation of positive maternal care and interaction (Welch et al, 2015;
11 Greenough et al, 1987; Molet et al, 2016).

12 40. Children living with married, biological parents demonstrate fewer
13 developmental and behavioral problems than children living with single parents or
14 in other family structure arrangements (Laukkanen et al, 2016; Mitchell et al, 2015;
15 Kacenebogen et al, 2015). The National Health Information Survey that included
16 findings from over 240,000 families and over 600,000 individuals demonstrated
17 that children from nuclear families were less likely to experience developmental
18 delays, severe emotional and behavioral problems, and attention deficit disorders
19 (Blackwell, 2010). These children also experienced fewer problems with accessing
20 health care services appropriately (Blackwell, 2010). Surrogacy ensures that the
21 children born of the arrangement will never get to know both parents.

22 41. The National Longitudinal Study of Adolescent Health (Add Health)
23 studied over 90,000 teens into adulthood. Hundreds of studies drawn from the data
24 set demonstrate that individuals organize their beliefs about themselves and their
25 behavioral choices based on their connections. As stated on the Add Health
26 website, “Social relationships protect against poor health.” Adolescents with strong
27 connections to both parents are less likely to become involved with drugs, tobacco,
28 alcohol, teen pregnancy and violent behaviors and more likely to complete school

1 and form successful social relationships (Resnick et al, 1997; Neumark-Sztainer et
2 al, 1997; Resnick et al, 2004). Specifically, strong maternal connections are
3 protective for both males and females for refusing drug and alcohol risks, delaying
4 sexual involvement, and improving resiliency. (Resnick et al, 1997). A plan to
5 deprive a child of his mother, a plan made before conception in surrogacy
6 arrangements, is a plan to place children at significant increased risk of negative
7 health behaviors and adverse outcomes.

8 42. The CDC sponsored Adverse Childhood Experiences Study (ACE)
9 demonstrates the strong association of poor adult health outcomes with childhood
10 situations, including single-parent homes, disrupted relationships between parents,
11 and exposure to violence and substance abuse (Felitti et al, 1998; Anda et al, 2006).
12 Kaiser Permanente with the CDC surveyed and tracked 17,000 individuals for over
13 a decade to determine whether experiences in childhood could be linked to health
14 problems in the future. Clear connections have been demonstrated between the
15 difficult childhood experiences and later outcomes such as school failure,
16 alcoholism, depression, obesity, relationship problems (multiple sexual partners,
17 sexually transmitted infections and out-of-wedlock child-bearing), and increased
18 suicidality) (Schilling et al, 2007; Schonkoff, 2012; Anda et al, 2006).

19 43. Long-term cardio-vascular, metabolic and infectious consequences are
20 associated with both the early adverse experiences and the later unhealthy behaviors
21 (Hakulinen et al, 2016; Su et al, 2015; Campbell et al, 2016). Consequently, serious
22 relationship disruptions and family instability are associated with early death in
23 some individuals (Felitti et al, 1998; Campbell et al, 2016). The intentional
24 disruption of the natural maternal-infant bond created during pregnancy, and the
25 long-term removal of siblings from each other and their only known parent, are
26 consistent with the descriptions of an adverse childhood experience. Research now
27 clearly demonstrates that irreparable long-term health consequences are more likely
28 to occur (Schilling et al, 2007; Campbell et al, 2016; Anda et al, 2006; Su et al,

1 2015). In contrast to the adverse experience of a fractured family, stable bonds with
2 parents to play a powerful role in protecting and improving personal health,
3 behavioral patterns and long-term mental and physical health outcomes.

4 44. C.M. has been quoted as stating in writing that he intends to surrender
5 at least one of the children for adoption. Adoption introduces additional
6 neurodevelopmental risks secondary to the separation of the child from his or her
7 mother (Nickman et al, 2005; Grotevant et al, 2014). Adoption has been a social
8 practice for much longer than donor-assisted conception and surrogacy. Adoption
9 occurs due to some disruption or difficulty in sustaining the biological relationship
10 between the parent and child. This disruption of their earliest relationships and
11 environment is an early trauma for the infant or child, even if the child is later
12 provided with nurturing and love from their adoptive family. (Grotevant et al, 2014)
13 As adopted children grow up into adolescence and young adulthood, they
14 experience different stages of identity development and often wonder about their
15 biological parents and relatives and the experiences of their biological mother
16 before, during, and after labor and delivery (Smit, 2002). As more adopted children
17 have grown up and discussed their thoughts about their birth parents, it has become
18 more common for adoptees to seek their birth parents in order to understand more
19 about themselves. Adoption practices have become more open, meaning that there
20 are more types of possible contact between the adoptive family, child, and birth
21 family (Grotevant et al, 2008). Adoptees who have increased contact with their
22 birth parents are able to answer important questions about their own history and
23 identity as well as being able to answer medical questions about genetic risks and
24 prenatal and delivery experiences (Child Welfare Information Gateway, 2013).

25 45. The secure adoptive or foster placement of an infant or child is
26 dependent on documentation of the sufficiency of the receiving family. Interviews
27 of prospective parents, neighbors and extended family members, documentation of
28 financial stability, lack of a criminal history, and a home study are components used

1 to assure that the child or children will have the safety and security needed for care
2 (Child Welfare Information Gateway, 2013). Pediatricians, teachers and community
3 members recognize that if a child faces the loss of his birth mother, the receiving
4 home must be capable of extending extraordinary care to compensate for the loss of
5 maternal security and connectivity. Consequently, a child whose maternal bond is
6 broken should be placed in a home prepared for the challenges of a traumatized
7 child and equipped with excellent parenting skills (Nickman et al, 2005; Grotevant
8 et al, 2014; Smyke AT, 2015). If C.M. has compromised parenting skills, he is not
9 an appropriate parent for the children. I understand that the California Gestational
10 Surrogacy Statute does not provide for rigorous scrutiny of the parenting skills of
11 the “intended parent.” This deficiency places the children at special risk that their
12 development and general well-being will be compromised.

13 46. Although surrogacy using assistive reproductive technology is a
14 relatively recent practice, there have been some studies of children and families
15 created through surrogacy. One longitudinal study found that surrogate and egg
16 donation families showed less positive mother-child interaction at age 7 than
17 children conceived naturally (Golombock et al, 2011). The researchers reported that
18 difficulties may have been under-reported by the child’s mother due to wishing to
19 portray the child positively. The same study found that the children conceived
20 through surrogacy had higher levels of adjustment difficulties than children
21 conceived through gamete donation. The researchers concluded that the “absence of
22 a gestational connection to the mother may be more problematic for children than
23 the absence of a genetic link” (Golombok et al, 2013). A small study of children
24 whose families maintained a relationship with their surrogate mother found that the
25 children felt positively about their surrogate mother and birth (Jadva et al, 2012).

26 47. Adopted children, adolescents, and adults are able to answer important
27 questions about themselves through ongoing relationships with their birth family.
28 This has important considerations for children and young adults conceived through

1 donor assisted reproductive technologies (Sabatello, 2015). As these children have
2 grown up, there have been more studies that indicate that they would like to have a
3 relationship or knowledge about their biological origins, earliest caregivers, and
4 biological siblings (Crawshaw, 2002; Beeson et al, 2011; Jadva et al, 2010). A
5 representative sample of adults conceived using a sperm donor found that they
6 often described anxieties regarding identity and “circumstances of my conception”
7 (Marquardt et al, 2010). These young adults frequently expressed concern or loss
8 about unknown family members, missing siblings, or medical issues of their
9 biologic relatives (Marquadt et al, 2010; Jadva et al, 2010). These questions are
10 more easily answered in the context of an ongoing relationship with a birth mother.
11 Many researchers and ethicists have concluded that disclosing conception by donor
12 gametes to the children should not be optional (Feast, 2003; McGee et al, 2001).

13 48. Infants from a multiple pregnancy have known the companionship of
14 their siblings since before their birth. A study looked at the safety and benefits of
15 allowing twins to “co-bed” after delivery and determined that “co-bedding
16 promotes self-regulation and sleep and decreases crying with apparent increased
17 risk” (Hayward et al, 2015). Children from high-order pregnancies benefit from
18 maintaining their sibling relationship, even in the newborn nursery. Children and
19 young adults who were adopted or conceived through assistive reproductive
20 technologies often wonder about their siblings and families of origin (Jadva et al,
21 2010; Jadva et al, 2009; Crawshaw, 2002).

22 49. Maternal roles are not limited to care of an infant, child or teen. The
23 influence of a mother continues into adulthood. First-time parents often depend on
24 both their recollection of maternal involvement and the active presence of a caring
25 grandmother to model and support infant care. Adult offspring often trust the
26 experience and encouragement of their own mother rather than the “official”
27 directives of educators or health professionals. The healthy, secure attachment of a
28 mother and child extends to the following generations of grandchildren and great-

1 grandchildren. The continuity of relationships between children and their families
2 has effects on the child, adult, and their future dependents. The ripple effects of
3 disruption of maternal-infant bonding affect not only the health and well-being of
4 the child but the adult they become, their children, and ultimately all of society. It is
5 critically important to protect and promote these relationships.

6 50. For all of these reasons, surrogacy arrangements fail to address the
7 basic health, development and psychosocial needs of an infant and are therefore
8 intrinsically detrimental to the well-being of children. To institute a plan, made
9 before the children are conceived, to separate a child from the mother who carried
10 and nurtured her through pregnancy and delivery, is a plan to subject the child to
11 unnecessary and grave risks. It is also my opinion, within reasonable medical
12 certainty, that the woman who acts as a gestational carrier is placed at significant
13 risk for psychological harm, including depression, anxiety, low self-esteem and
14 trauma due to the separation from the children she bore.

15 51. Further, in this particular case, the children's interests are not
16 addressed by adhering blindly to the mandates of the statute. The statute, if
17 enforced, violates the children's material needs to maintain their relationship with
18 the mother who carried them. The fact that the statute fails to address basic child
19 and family development and ignores the best interests of the children, results in
20 likely harm for the three children in this case. Baby A, Baby B, and Baby C
21 confronted with great potential losses including loss of their only known parent,
22 loss of their full sibling relationships, and potential loss of hope for a stable, safe
23 parental home. Custody of the infants should be based on what is best for these

24 ///

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28

1 new individuals, upon the preponderance of research regarding maternal and child
2 bonding, and on the relative ability of Melissa Cook and C.M. to properly raise the
3 children. The children's relationship their mother, Melissa Cook, should not be
4 terminated, especially in order for them to be given to a stranger through an
5 adoption. In addition, their relationship with Melissa Cook certainly should not be
6 terminated if C.M. is not capable of providing a nurturing, safe, stable home to
7 raise the children or is unwilling to do so.
8
9

10 Pursuant to 28 U.S.C.1746, I certify under penalty of perjury that the
11 foregoing is true and correct.
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14 
15 ALMA L. GOLDEN, M.D., F.A.A.P.

16 Dated:

17 *March 8, 2016*
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EXHIBIT A
C.V. of Alma L. Golden, M.D., F.A.A.P.

CURRICULUM VITAE

NAME: Alma L. Crumm Golden, M.D., F.A.A.P.

DATE: February 25, 2016

PRESENT POSITION AND ADDRESS:

10/2006 to Present: Pediatrician, Baylor Scott and White Hospital, Temple, Texas
Vice Chair for Community Initiatives, McLane Children's Hospital
Associate Professor of Pediatrics

Current responsibilities:

- Development and strategic planning for pediatric services
- Faculty representative to the Curriculum Committee for Texas A&M Health Science Center
- Director of the Institute for Spiritual Care and Wellness addressing relationship and spiritual well-being impacts on health
- Lecturer and small group facilitator for Medical, Nursing and Chaplaincy Students on topics of Medical Ethics, Adolescent Health, Public Health Strategies, Health Policy
- Editor for "Child Health Matters", Pediatric and Family Health newspaper column
- Member and Liaison to Baylor University School of Education Dean's Advisory Council
- Review and recommendations regarding potential pediatric care sites and selection of pediatricians
- Pastoral Advisory Council member for Chaplaincy services in Baylor Scott and White
- Facilitating consultant (coordinating with Baylor First Lady Alice Starr) for establishment of the Baylor Center for Developmental Disabilities in collaboration with McLane Children's Hospital
- Liaison to regional schools, universities, municipalities and agencies regarding child health services
- Policy, development, and implementation for collaborations regarding Specialty and General Pediatrics, indigent care
- Training responsibilities with resident physicians on issues of Adolescent Health, Patient Education, Clinical Intervention Methods
- Member of Pediatric Operations Committee
- Consultant on domestic and international public health issues

Previous responsibilities: 9/2006-1/2009

- Director of Pediatrics, Scott and White Round Rock
- General pediatrics, neonatal care, urgent care and coordinator for pediatric services
- Founding chair of pediatric quality committee, Round Rock
- Liaison between Scott and White Temple and Round Rock Hospital and Williamson County health initiatives

PROFESSIONAL AND TEACHING EXPERIENCE:

6/2002- 6/2006 Presidential Appointee (2002)
Deputy Assistant Secretary for Population Affairs
Office of Population Affairs

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United States Department of Health and Human Services, Office of the Secretary
1101 Wootton Parkway, Suite 700
Rockville, Maryland 20852

In that position, directed the Office of Population Affairs in the United States Department of Health and Human Services. The Office of Population Affairs administers services delivered through Title X (Family Planning) and Title XX (Adolescent Family Life). Served as senior executive administrator

- For the Nation's Title X Family Planning program through \$289,000,000-worth of grants to 89 state and non-profit entities to 4600 clinics serving over 5,000,000 clients yearly.
- For the Title XX Adolescent Family Life program funding \$30,000,000 worth of grants to both abstinence education and care for pregnant and parenting teens through 104 community agencies.
- For the Embryo Adoption Awareness program providing \$2,000,000 in grants to promote the donation of frozen embryos to couples desiring pregnancy and parenting.
- For the National Abstinence Media Campaign utilizing \$10,000,000 in contracts to develop and distribute messages through websites and media to equip parents to communicate with their children about sexual abstinence and avoidance of health risk behaviors.
- For the development and completion of the Nation's first Abstinence Education Evaluation Conference, utilizing a "call for papers" and peer review. First conference November 2005, next conference planned for March 2007.
- For research and evaluation programs on Family Planning, including Service Delivery Improvement grants, HIV Prevention and Males services research.
- For research and evaluation of the Adolescent Family Life programs developing and implementing the nation's first OMB approved core survey instruments for abstinence education and care of pregnant and parenting teens.
- For the immediate Office of Population Affairs supervising three divisions, thirty regionally deployed employees, and thirty central staff.

Served as policy adviser

- To the White House, Domestic Policy Council on matters of Family Planning, Abstinence Education, HIV Prevention, Teen Pregnancy, Embryo Adoption, Statutory Rape and Parent Involvement.
- To the Secretary of Health on matters of Reproductive Health and Family Planning, legislative initiative on Title X and Title XX, and policy development and implementation.
- To the Assistant Secretary of Health on matters of Title X, Title XX, Embryo Adoption, Evaluation and Research, and Abstinence Media program development and management.
- To the Department of State on matters of international HIV Prevention with a focus on abstinence education, family planning and prevention of maternal to child transmission.
- To the Department of Justice on matters of sexual assault, exploitation, rape and coercion of young teens by older individuals.

Alma L. Crumm Golden, M.D.
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- To the Department of Defense and the National Institutes of Health on matters of adolescent research (National Longitudinal Study on Adolescent Health) relevant to military populations.

1999-2002 Editor-In-Chief, Adolescent and Family Health, professional journal of Institute for Youth Development
Responsibilities include:

- First editor of new multidisciplinary journal regarding adolescent risk behaviors and interventions.
- Development of journal policy, author guidelines, and editorial review systems
- Coordination of Editorial Board meetings and action
- Initial review and distribution for peer-review of original research articles

1997-2002 Medical Director and Founder
SAGE Advice Council
Responsibilities include:

- Conceptualization and development of health education training programs for health professionals
- Grant proposal development and submission
- Development of didactic and small group activities, videos, and lectures
- Review and development of written materials and resources
- Presentations regarding adolescent risk behaviors to practicing physicians, resident physicians, nurses and social workers
- Data collection and analysis of outcomes of training
- Review of research and evaluation regarding SAGE Advice

1996-2000 Associate Medical Director
UTMB HealthCare Systems
700 University Boulevard
Galveston, Texas 77550
Responsibilities include:

- Development of Medicaid managed care program and network for UTMB and associated counties
- Development of Children's Health Insurance Program (CHIP) for UTMB and associated counties
- Quality Improvement for children's programs
- Utilization Management for children's programs
- Provider network development and integration

1991-1999 Clinical Assistant Professor of Pediatrics

Alma L. Crumm Golden, M.D.
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Director of Pediatric Services
Regional Maternal Child Health Program
Department of Obstetrics and Gynecology
University of Texas Medical Branch

Responsibilities included

- Strategic development of pediatric care in underserved communities for indigent patients and their families
- Development, supervision and staffing of clinical laboratory services for pediatric patients, including assessment and implementation of CLIA-waived services
- Administrative management of pediatric services in 16 Maternal and Child Health Clinic sites
- Supervision of 8 pediatricians serving clinics

1988-1991

Outpatient Pediatrician
Pediatric Associates-Alvin office
Texas City, TX

1987-1988

Clinical Instructor with Division of School Health/Community Pediatrics
University of Texas Medical Branch
Galveston, Texas

Grants Received

Title V SPRANS Planning grant 7/2001 to 6/2002 for \$99,872

Title V Abstinence Education Grant: awarded 1/1/99 by the Texas Department of Health for \$217,000.

Continuation of above grant for period of 2/2000 to 8/2001 for \$517,000.

Continuation of above grant for period of 8/2001 to 9/2002 for \$458,000.

EDUCATION:

5/1971

Cum Laude Graduate
Bachelor of Arts Degree with majors in Chemistry, Biology and Secondary Education Certification
Houston Baptist College
Houston, Texas

11/1975

M. D. Degree
University of Texas Medical Branch
Galveston, Texas

1/1/76-12/31/76

Post-doctoral training, PL-1
Department of Pediatrics
University of Texas Medical Branch

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1/6/86-1/31/87 Galveston, Texas
Post-doctoral training, PL-2
Department of Pediatrics
University of Texas Medical Branch
Galveston, Texas

2/1/87-2/28/88 Post-doctoral training, PL-3
Department of Pediatrics
University of Texas Medical Branch
Galveston, Texas

COMMITTEE AND TASK FORCE RESPONSIBILITIES:

A. National Focus

2012-2013 CDC independent reviewer for internal and grantee publications and materials regarding HIV, Adolescent Health and School Health Policies

2012-Present Participant on CDC Expert Panel on Youth HIV/STI/Sexual Health Review

2012 Consultant to Annie Casey Foundation panel on Adolescents in Foster Care

2012-Present Baylor University School of Education, Dean's Advisory Committee

2010-Present Coordinating liaison for BS&W to the Baylor Center for Developmental Disabilities

2007-2011 Chair of Expert Panel for CDC-funded review of adolescent risk avoidance programs resulting in publication of the SMARTool through Center for Relationship Education, Denver, Colorado

2008 Institute Of Medicine: reviewer for IOM study on Title X Family Planning

2005-2006 NIH Expert Roundtable for the Add Health Study: Wave IV

2005-2006 Interagency Council for US Department of Justice, Juvenile Justice (OJJDP): consultant from HHS

2003-2006 President's Emergency Plan for AIDS Relief: Expert Task Force for Prevention of Maternal to Child Transmission and Pediatric Care

2002-2006 HHS Workgroup on Prevention of the Sexual Exploitation of Young Teens

2001-2003 Consultant on Adolescent Health to the American Academy of Pediatrics "Bright Futures" Project

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- 2001-2002 Department of Health and Human Services Maternal and Child Health (MCH) Research Grants Committee
- 1999-2002 Editor in Chief for Editorial Board of *Adolescent and Family Health*
- 1998-2002 Medical Institute Advisory Board
- 1997-2002 American Academy of Pediatrics, Task Force on the Family, Coordinator for AAP Policy Issues related to Task Force Findings
- 1995-2001 Work Group on Unintended Pregnancy—convened by National Association of County and City Health Officials
*Served on planning committees and assisted in developing and editing Work Group statement.
- 1993-2002 American Academy of Pediatrics
Community Access To Child Health (CATCH) program participant
*Featured in 1995 CATCH brochure and promotional video
- B. International
 - 2005 China Adolescent Health Conference, Beijing Medical University, featured speaker for three sessions on developing and implementing effective public health strategies with a focus on risk avoidance and family involvement
 - 2003-2004 Reviewer and editor of various international documents and proposals on maternal and child health, the ABC model, family planning and adolescent health associated with US Department of Health and Human Services, the US State Department, and US A.I.D.
 - 2002-2005 Reviewer for multiple sets of PEPFAR grant applications for HIV prevention through CDC and USAID: Primary focus Prevention of Maternal to Child Transmission and Youth Prevention Strategies
 - 2002, 2011 Senior physician, Honduras clinical outreach mission with medical students
- C. Texas
 - 2013-Present Deans' Advisory Council, Baylor University School of Education, Waco, Texas
 - 2010-Present Temple ISD School Health Advisory Committee, Temple, Texas
 - 2009-2012 Board of Directors, Lone Star Circle of Health FQHC, Central Texas
 - 1999-2002 Appointed by Governor George Bush to the newly created School Health Advisory Committee for the State of Texas, administered under the Texas Department of Health.
 - 1999-2002 District Chairperson for Texas Pediatric Society Executive Committee
 - 1996-2002 Legislative Committee Member, Texas Pediatric Society
 - 1999-2001 Acting Past President, CHARIOT (Children's Hospitals and Related Institutions of Texas)

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1999-2002 CHIP Task Force Chair, CHARIOT (Children's Hospitals and Related Institutions of Texas)
1997-2002 CHIP Coalition member and participant
1992-1999 Texas Department of Health Interagency Task Force on School Health
1997 Texas Department of Health, Health Care Financing, Medicaid Managed Care Medical Directors
1993-1994 Texas Education Agency Task Force on Health and Sexuality Curriculum Review

A. University of Texas Medical Branch, Galveston

1998-2000 Pediatrics CME Planning Committee
1997-1999 Chair, Graduate Medical Education Managed Care Training For Residents Committee
1995-1996 Continuing Process Improvement Committee for Pregnancy, Delivery and Neonatal Care

D. Other

1998-2000 President, UTMB Pediatric Alumni Association
1997-2000 Advisory Committee for Special Needs Children, Harris County Regional Area
1995-1999 Texas Community Access To Child Health (T-CATCH) Chair
1979-1995 Volunteer physician: Indigent care clinic
Brazoria County Health District
1993-2001 Texas Pediatric Society
Committee on Community Pediatrics—consultant
Executive Leadership Council
1992-1996 Teacher - Parenting workshop: "Parenting Within Reason" with R. A. Scott
Texas, New Mexico, Georgia, Florida, Tennessee
1986-1994 Teacher - Bible Study for Young Single Adults
Heights Baptist Church
Alvin, Texas
1982-1985 Trustee: Elected Board Member
Sweeny Independent School District
Sweeny, Texas
1979-2002 Consultant and inservice provider to school systems
Brazoria and Galveston Counties and Region IV Education Service Center

TEACHING RESPONSIBILITIES:

- A. Texas A&M Health Science Center, Temple
- MSI and MSII Ethics and Becoming A Physician 2010-2014

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- “Public Health and Policy for Physicians” Elective for Medical Students 2011-2014
 - Adolescent Interventions and Interviewing “Talking to Teens about Tough Topics” MSIII 2008-2014
 - Other courses and discussion groups as requested 2010-2014
- B. University of Texas Medical Branch 1991-2002
- Development and implementation of course on managed care and cost containment for faculty, residents and medical students at UTMB
 - Review, coordination, production and implementation of health education material for school and clinic systems
 - Preceptor and lecturer to pediatric, obstetrics and gynecology, and family medicine residents re: community health services, well child and preventive health management, breastfeeding, patient education methods.
 - Provide pediatric training to nurses, physician assistants, nurse practitioners, and midwives.

BOARD CERTIFICATION:

American Board of Pediatrics, February 1990
Latest re-certification, 2007

LICENSURE INFORMATION:

Texas State Board of Medical Examiners

PRESENTATIONS:

“SMARTool Implementation: Applying what works in risk-avoidance programming”
Multiple (>10) presentations in the US in a variety of conference settings 2010-2012

“The ABC Model: Effective Strategies for Public Health” presented at multiple (>8) Family Planning, HIV and Health and Human Services conferences 2003-2005

“Public Health Strategies for Adolescents: Risk Avoidance and Support Systems” presented in international meetings, federal and state conferences (>10) 2002-2006

“Effective Abstinence Education: Applying Science to Abstinence Programs” presented to abstinence educators at both state and federal conferences (>5) 2002-2006

“Parental Involvement and Adolescent Health” presented at multiple abstinence and adolescent conferences at state, local, and federal levels (>10) 2002-2007

“SAGE Advice” Presentations (over 100 presentations in Texas in 2001-2002). The 3-6 hour presentations trained over 3000 health and education professionals in effective, efficient teen interview and intervention techniques.

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“Talking to Teens about Tough Topics: Effective Communication in Individual Encounters”
multiple presentations (>30) for HHS, universities and other agencies 2002-2013

PUBLISHED:

Editor for weekly “Child Health Matters” Temple Daily Telegram: Authors many articles
and edits submissions for publication 2010- Present

Alma Golden, Stan Weed, Doug Kirby, The Center for Relationship Education (2010).
Systematic Method for Assessing Risk-Avoidance Tool (SMARTool). Denver, Colorado

Founding Editor, opinion-writer and reviewer for Adolescent and Family Health, 1999-2002.

Amr Abouleish, MD, MBA, Alma Golden, MD, Alice Anne O’Donnell, MD, Patricia S.
Beach, MD, Kirk Calhoun, MD, Thomas A. Blackwell, MD, Patricia Gallaway, RN, Lenore
Teske, RN, Suzanne m. Wilson, RN, Ester M. Koleng, Alvin LeBlanc, MD. “Problem-based
learning in a manged care seminar for all new residents at an academic medical center”.
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M.E. Cerebral neuroblastoma with elevated nerve growth factor. Bull Cancer (Paris).
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McCormick, D.P., Davis, A.L. Injuries in Sailboard Enthusiasts. Brit. J. Sports Med.
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Nichols, M. M., MD, Walker, D.H., MD, Frates, R.C., MD, and Davis, A., MD. Three-
Month-Old Infant With Diarrhea, Fever, and Rash. The Journal of Pediatrics (St. Louis).
114(1):154-160; January 1989.

Golden, A.L. Win-Win-Win! A School Health Program that Pleases Everyone. Texas Study
of Secondary Education (Austin, TX). III(II):18-20; Spring 1994.