NEW YORK SUPREME COURT APPELLATE DIVISION
SECOND DEPARTMENT

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RINAT DRAY,

Plaintiff-Appellant,

-against-

STATEN ISLAND UNIVERSITY HOSPITAL and JAMES J. DUCEY

Defendants-Respondents

-and-

LEONID GORELIK, and METROPOLITAN OB-GYN ASSOCIATES, P.C.,

Defendants-Respondents.

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Docket No.: 2019-12617

NOTICE OF MOTION

Oral Argument Not Requested

NOTICE OF MOTION OF BIRTH RIGHTS BAR ASSOCIATION AND THE BIRTH PLACE LAB TO FILE AN *AMICUS CURIAE* BRIEF

PLEASE TAKE NOTICE that, upon the annexed Affirmation of Elizabeth Kukura, dated November 2, 2020, together with the Exhibit annexed thereto, the undersigned will move this Court, located at 45 Monroe Place, Brooklyn, New York, 11201 on the 16th day of November 2020 at 9:30 a.m. of that day or as soon as counsel can be heard, for an order granting Birth Rights Bar Association and The Birth Place Lab leave to file an *amicus curiae* brief. A copy of the proposed brief is annexed hereto as Exhibit A.

Pursuant to CPLR 2214(b), answering affidavits, if any, are required to be served upon the undersigned at least 7 days before the return date of this motion.

Respectfully submitted,

Birth Rights Bar Association and The Birth Place Lab

Dated: New York, NY
November 2, 2020

Elizabeth Kukura

By: Elizabeth Kukura
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NEW YORK SUPREME COURT APPELLATE DIVISION
SECOND DEPARTMENT

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RINAT DRAY, Docket No.: 2019-12617

Plaintiff-Appellant,

-against- **AFFIRMATION OF** ELIZABETH KUKURA

STATEN ISLAND UNIVERSITY HOSPITAL and JAMES J. DUCEY

Defendants-Respondents

-and-

LEONID GORELIK, and METROPOLITAN OB-GYN ASSOCIATES, P.C.,

Defendants-Respondents.

----------X

Elizabeth Kukura, an attorney duly admitted to practice before the courts of the State of New York, hereby affirms under penalty of perjury as follows:

1. I make this affirmation on behalf of Birth Rights Bar Association and The Birth Place Lab in their application to file a brief *amicus curiae* in this case. I am authorized by the proposed *amici* to bring this motion and to submit the proposed brief attached to this motion as Exhibit A.
2. Plaintiff-Appellant Rinat Dray moved this court to reverse the lower court's dismissal of her amended complaint. Ms. Dray sought to add important consumer protection and discrimination claims to her initial complaint based on information that only came to light after her initial filing. The lower court's improper dismissal of the Second Amended Complaint prevents the

court from considering Plaintiff's contentions that health care providers deceiving pregnant women in order to obtain and keep them as patients violates New York laws of fair dealing and discriminates on the basis of pregnancy. These claims should be aired.

3. Birth Rights Bar Association is an organization dedicated to protecting and advancing the human rights of people seeking reproductive health care services, with particular expertise in the area of pregnancy and childbirth. The Birth Place Lab in the Faculty of Medicine at the University of British Columbia facilitates community-based participatory research around equitable access to high quality maternity care. Together, amici seek to assist the Court with understanding the problem of mistreatment and violence by health care providers during childbirth.

WHEREFORE, Birth Rights Bar Association and The Birth Place Lab respectfully request that this Court grant their motion to file an *amicus curiae* brief.

Respectfully submitted,

Birth Rights Bar Association and The Birth Place Lab

Elizabeth Kukura

Dated: November 2, 2020
New York, NY

By: Elizabeth Kukura

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EXHIBIT A

To be Submitted by:
ELIZABETH KUKURA

New York Supreme Court
Appellate Division – Second Department

Appellate Case No.: 2019-12617

RINAT DRAY,

Plaintiff-Appellant,

– against –

STATEN ISLAND UNIVERSITY HOSPITAL, LEONID GORELIK, METROPOLITAN OB-GYN ASSOCIATES, P.C. and JAMES J. DUCEY,

Defendants-Respondents.

BRIEF FOR *AMICUS CURIAE* BIRTH RIGHTS BAR ASSOCIATION and THE BIRTH PLACE LAB

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STATEMENT OF INTEREST

Amicus curiae Birth Rights Bar Association (BRBA) is dedicated to protecting and advancing the human rights of people seeking reproductive health care services, with particular expertise in the area of pregnancy and childbirth. BRBA conducts research, provides continuing legal education, and participates in legal advocacy to prevent and address the violation of rights in childbirth. As part of its research efforts, BRBA maintains data regarding birth-related rights violations, identifying trends in the global movement to promote respectful maternity care and the integration of human rights in healthcare settings.

Amicus curiae The Birth Place Lab (BPL), located in the Faculty of Medicine at the University of British Columbia, facilitates community-based participatory research and knowledge translation around equitable access to high-quality maternity care. BPL supports multi-national, multi-disciplinary teams of researchers on projects relating to health services, experience of care, provider attitudes, interprofessional collaboration, and access to physiologic birth. Together, BRBA and BPL are uniquely well-positioned to assist the Court in understanding the extent to which people experience mistreatment during childbirth and the legal context in which those people lack recourse.

SUMMARY OF ARGUMENT

Rinat Dray's unconsented cesarean constituted unlawful mistreatment by her doctors. Mistreatment during childbirth is a global phenomenon, with pregnant people all too frequently experiencing abuse, coercion, and other forms of disrespect by their healthcare providers during childbirth. As the United Nations has recognized, mistreatment during childbirth violates human rights and is associated with negative health outcomes for mothers and infants. In the U.S., existing law enables and perpetuates such mistreatment by applying a narrow conception of autonomy to reproductive healthcare decision-making, elevating the legal status of the fetus, allowing blunt use of the criminal law to regulate pregnancy, and restricting how and where people give birth.

Collectively, these dynamics have established conditions that allow some healthcare providers to assert their will upon their patients, inflicting physical and emotional harm on individuals who are doing the vulnerable and life-affirming work of giving birth. But when birthing people who have experienced mistreatment seek recourse, they often find that the legal system refuses to acknowledge their experiences or hold health care providers accountable. They experience access-to-justice gaps in the form of unwilling lawyers who refuse to represent them, encounter courts that fail to appreciate the seriousness of "invisible" harms that leave profound emotional and psychological scars, and have

their autonomy infringed when courts engage in flawed reasoning that improperly applies abortion doctrine to the childbirth context. Law not only enables mistreatment during childbirth but also fails to hold healthcare providers accountable for the harms they perpetrate. Against this backdrop, it is clear that Rinat Dray's experience did not occur in a vacuum but rather reflects the failure of the medical and legal systems to care sufficiently for—and about—birthing people.

ARGUMENT

When courts are asked to decide the claims of people mistreated by their healthcare providers during childbirth, they are often unfamiliar with the realities of obstetric violence and the social and cultural context in which such harms occur. The abuse, coercion, and disrespect that some pregnant people face during childbirth are enabled and perpetuated by legal norms that increasingly restrict reproductive health care, recognize (in some contexts) the fetus as a legal entity independent from the person carrying it, restrict where and how people give birth, and leverage criminal law to punish pregnant people perceived to deviate from societal expectations of a "good mother." As Ms. Dray can attest, and the research confirms, many barriers prevent people from speaking out about experiences of obstetric violence, but when they turn to the law for recourse, they often find it impossible to have their claims heard, their harms recognized, or their rights in

childbirth upheld. This Court can interrupt this trend by reversing the court below and allowing the claims in Ms. Dray's amended complaint to be heard.

I. MISTREATMENT AND VIOLENCE ARE UNDENIABLE PROBLEMS IN MATERNITY CARE

A. Mistreatment and Violence in Childbirth is a Global Phenomenon That Violates International Human Rights Law

1. The United Nations has recognized mistreatment during childbirth as a global problem

The World Health Organization (WHO), the United Nations (UN) agency responsible for international public health, has long urged governments to promote obstetric services that respect the emotional, psychological, and social aspects of birth.[1] In 2014, the WHO condemned the pervasive disrespectful and abusive treatment that sometimes occurs during facility-based childbirth, including physical and verbal abuse, coercive or non-consensual medical procedures, the absence of informed consent, refusal to give pain treatment, and medical neglect.[2] It characterized such treatment as threatening women's rights to life, health, and bodily integrity, as well as the right to be free from discrimination.[3] In particular, the WHO noted that disrespectful and abusive treatment violates the trust between healthcare providers and their patients and "can also be a powerful disincentive for

[1] *See, e.g.*, WHO, *Appropriate Technology for Birth*, 326 Lancet 403 (1985).
[2] WHO, *Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth* (2015), https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1.
[3] *Id*. at 1.

women to seek and use maternal health care services."[4] Subsequently, in 2015, UN human rights experts identified obstetric violence as a form of violence against women, calling on Member States to take action.[5]

In 2019, the UN Special Rapporteur on Violence Against Women submitted a report to the General Assembly on mistreatment and violence against women during childbirth ("UN Report").[6] The UN Report identified multiple root causes contributing to mistreatment during childbirth, including: (1) the lack of informed consent; (2) medicalization of childbirth; (3) asymmetrical power dynamics in patient-provider relationships; (4) pervasive gender stereotypes regarding women's societal roles; (5) the rise in feto-centrism that positions fetal interests against maternal interests and justifies overriding the rights of pregnant people; and (6) health care systems that lack accountability for provider-inflicted harm.[7] Importantly, the UN Report analyzed obstetric violence as a form of systemic gender-based violence and affirmed that it spans all geographic regions.[8]

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[4] *Id*.
[5] Joint Statement by UN Human Rights Experts, et al. (Sept. 24, 2015), https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16490.
[6] *Report of the Special Rapporteur on Violence Against Women on a Human-Rights Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence*, UN General Assembly A/74/137 (July 11, 2019).
[7] *Id*.
[8] *Id*. at 6, 7.

2. *Research confirms that mistreatment and violence during childbirth are prevalent and widespread*

Historically, obstetric violence has been an under-appreciated problem in both medicine and law, but recent research confirms that mistreatment during childbirth is a systemic and pervasive issue requiring urgent attention. An unprecedented systematic review of research on mistreatment during childbirth, conducted by WHO researchers in 2015, reported widespread disrespect and human rights violations experienced by women giving birth globally ("Bohren Review").[9] The Bohren Review identified 65 qualitative and quantitative studies on childbirth experiences in 34 different countries, encompassing all geographical and income-level settings.[10] In identifying evidence of pervasive mistreatment, the researchers created a typology for assessing findings, which includes the following categories: (1) physical abuse, (2) sexual abuse, (3) verbal abuse, (4) stigma and discrimination, (5) failure to meet professional standards of care, (6) poor rapport between women and providers, including ineffective communication, lack of supportive care, and loss of autonomy, and (7) health system conditions and

[9] Meghan A. Bohren, et al., *The Mistreatment of Women During Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review*, PLOS Medicine (2015), https://doi.org/10.1371/journal.pmed.1001847.
[10] *Id.*

constraints.[11] Ultimately, the Bohren Review's findings "illustrate how women's experiences of childbirth worldwide are marred by mistreatment."[12]

Recent evidence shows that the emergence of COVID-19 in early 2020 has exacerbated the mistreatment of pregnant people, which suggests that the conditions leading to Ms. Dray's forced surgery in 2011 are still present today and may be worsening. Efforts to contain the virus' spread have led healthcare providers to depart from evidence-based practices and to justify disrespectful care by invoking the pandemic. The international organization Human Rights in Childbirth (HRiC) has documented rights violations in maternity care during the pandemic.[13] These violations include denial of the right to a companion during labor and birth, forced interventions, compelled inductions and cesarean surgeries without medical indication, separation from infants and interruption of breastfeeding, lack of access to care due to maternity site closures or understaffed facilities, and unsafe exposure to COVID-19 due to lack of personal protective equipment or overcrowded maternity wards.[14] In monitoring such violations, HRiC has noted that marginalized populations have been disproportionately

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[11] *Id*.
[12] *Id*.
[13] Human Rights in Childbirth, *Human Rights Violations in Pregnancy, Birth and Postpartum During the Covid-19 Pandemic* (May 2020), http://humanrightsinchildbirth.org/wp-content/uploads/2020/05/Human-Rights-in-Childbirth-Pregnancy-Birth-and-Postpartum-During-COVID19-Report-May-2020.pdf ("HRiC Report"). *See also* Michelle Sadler, et al., *COVID-19 as a Risk Factor for Obstetric Violence*, Sexual and Reproductive Health Matters 28:1 (2020).
[14] HRiC Report at 8-19.

affected by changes associated with COVID-19.[15] HRiC also identified the possibility that COVID-19 is invoked in some settings to obscure and excuse mistreatment by providers, reflecting the broader concern that COVID-19 emergency measures are making ongoing rights violations invisible.

3. Obstetrics Violence Violates International Human Rights Law

Mistreatment and violence during childbirth violate international human rights law and may, in certain instances, constitute torture. For example, in February 2020, the UN body that oversees compliance with the Convention on the Elimination of All Forms of Violence Against Women ("CEDAW Committee") condemned Spain for failing to protect a woman from obstetric violence. *S.M.F. v. Spain*, Decision, CEDAW/C/75/D/138/2018 (Feb. 28, 2020). In *S.M.F.*, the pregnant complainant sought care at a public hospital, where she was subjected to multiple interventions without consent, including a medically unnecessary induction, medically unnecessary vaginal examinations, and unconsented administration of oxytocin. *Id.* at 2. In addition, she was—contrary to the WHO's recommendation—prevented from moving around during labor, was forced to deliver in the lithotomy position, and received both an instrumental extraction and episiotomy without informed consent. *Id.* at 4.

[15] *Id*. at 9, 18.

In ruling against Spain, the CEDAW Committee addressed the physical and psychological harm resulting from mistreatment during childbirth and emphasized the significance of informed consent in reproductive health care. The CEDAW Committee called on Spain to provide reparations for the damage that S.M.F. sustained, including physical and psychological trauma; to combat medical mistreatment through public policy; and to ensure access to effective legal procedures in obstetric violence cases. *Id.* In doing so, the CEDAW Committee highlighted how harmful gender stereotypes interfered with S.M.F.'s ability to seek redress, noting that in deciding her case, the Spanish judiciary employed gendered stereotypes about the expected behavior of women as "submissive," "obedient," and lacking decisional capacity. *Id*.

Significantly for Ms. Dray, human rights authorities have stated that forced obstetrical procedures, including cesarean sections, may amount to torture. Noting that overuse of cesarean surgery is linked to the medicalization of birth and cesareans may be encouraged for reasons other than medical necessity, the UN Special Rapporteur concluded, "When practiced without a woman's consent, caesarian [sic] sections may amount to gender-based violence against women and even torture."[16]

[16] UN Report at 10.

B. Research Shows Birthing People Experience Mistreatment and Violence in U.S. Healthcare System

1. A growing body of research documents mistreatment in U.S. obstetric care

Recent research confirms that mistreatment during childbirth is all too common and often takes the form of pressure to accept unwanted care or the outright imposition of treatment upon an unconsenting patient. The 2019 Giving Voice to Mothers study, which surveyed over 2,100 participants across all fifty states, reported that over 17% experienced one or more forms of mistreatment during childbirth.[17] Among women who delivered in a hospital, 28% experienced mistreatment.[18] Five percent of all respondents reported their provider threatened to withhold treatment or forced them to accept unwanted treatment.[19] Of those patients who had a difference of opinion about the right care for themselves or their baby, 79% reported mistreatment.[20] Women of color were more likely to experience mistreatment, with 23% of Black women and 33% of Native women

[17] Saraswathi Vedam, et al., *The Giving Voices to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 Reprod. Health, no. 77, 7 (2019) ("GVtM Study").
[18] *Id*. at 8, 12. Because women who planned community-based births were overrepresented in the sample relative to the less than 2% of women who have out-of-hospital births in the U.S., the GVtM Study authors consider the rate for women who gave birth in the hospital to be a better estimate of the true mistreatment rate. *Id*. at 12.
[19] *Id.* at 7.
[20] *Id*. at 9.

reporting one or more forms of mistreatment, compared to 14% of White women.[21]

These national trends hold true on Staten Island, where Rinat Dray gave birth. In March 2020, the non-profit legal organization National Advocates for Pregnant Women conducted a focus group with new mothers on Staten Island, many of whom reported forms of mistreatment during childbirth. Common themes included: (1) assertion of medical authority to shame or coerce patients; (2) restrictions on patient access to information; (3) bias in provider treatment; (4) disregard of patient concerns or reports of pain; and (5) humiliating or degrading comments. Participants signed releases granting the Birth Rights Bar Association permission to use their experiences to inform this brief.[22]

2. Covid-19 pandemic has increased rights violations in hospital-based birth in U.S.

Similar to the global findings discussed in Section I.A.2, *supra*, BRBA has documented an increase in rights violations in the U.S. during the COVID-19 pandemic.[23] Such violations include restrictions on the presence of support persons during childbirth, separation of newborns, prohibitions on virtual doula

[21] *Id.* at 8.
[22] Records related to the focus group are on file with National Advocates for Pregnant Women.
[23] Birth Rights Bar Association, "Challenges Facing Pregnant and Birthing People During Covid-19" (Apr. 9, 2020), https://birthrightsbar.org/resources/Documents/Birth%20in%20a%20Pandemic%20-%20Identifying%20Issues.pdf.

support justified by pre-pandemic hospital restrictions on videotaping or streaming, pressure to accept interventions without proper information, lack of access to needed interventions, and lack of continuity of care.[24] In addition, BRBA has identified systemic factors that contribute to or exacerbate rights violations during childbirth, including the legal and de facto exclusion of midwives from mainstream maternity care in many jurisdictions; restrictive public and private health insurance policies that limit access to care; and various forms of bias that pervade the health care system.[25]

II. EXISTING LAW ENABLES AND PERPETUATES MISTREATMENT DURING CHILDBIRTH

Mistreatment of birthing people by their healthcare providers does not happen in a vacuum but rather is the product of various historical and cultural forces, including gendered stereotypes about childbearing, medicalization of childbirth, bias and discrimination in the medical profession, and contested norms about autonomy in healthcare decision-making. The practice of obstetrics as risk-based medicine—in which minimizing perceived liability takes precedence over providing patient-centered, evidence-based care—undermines informed consent, thereby exposing pregnant people to mistreatment. Structural problems like fragmentation of the healthcare system lead to mistreatment by limiting access and

[24] *Id*. at 2.
[25] *Id*. at 2-5.

creating perverse financial incentives for providers. Significantly, certain laws enable and perpetuate mistreatment during childbirth by reshaping legal norms regarding reproductive health care, restricting access to out-of-hospital birth settings and providers, and enshrining skepticism and distrust of pregnant people's decision-making. The lower court's reasoning is a clear example of enshrining distrust of pregnant people's decision-making; this Court should interrupt this dynamic and prevent future harm by reconsidering Ms. Dray's claims.

A. Increasing Legal Restrictions on Reproductive Health Care Have Laid Groundwork for Violations of Autonomy During Childbirth

In recent decades, state and federal lawmaking bodies have enacted increasingly restrictive reproductive health policies. Many have imposed stricter regulations on induced abortion, imposing burdensome costs and administrative requirements without increasing patient safety.[26] Such regulations include mandatory waiting periods and state-mandated counseling, both of which purport to help people make better decisions for their pregnancies but in fact delay needed care and disseminate medically inaccurate information.[27] States have also imposed requirements for medically unnecessary ultrasounds on people seeking abortions.[28]

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[26] Guttmacher Institute, *Targeted Regulation of Abortion Providers* (as of Oct. 1, 2020), http://bit.ly/2w3O0nL.
[27] Jason M. Lindo & Mayra Pineda-Torres, *New Evidence on the Effects of Mandatory Waiting Periods for Abortion,* National Bureau of Economic Research Working Paper 26228 (2019); Guttmacher Institute, *Mandatory Counseling for Abortion* (2020), bit.ly/32Em0Z0.
[28] Guttmacher Institute, *Requirements for Ultrasound* (as of Oct. 1, 2020), https://bit.ly/32CX18s.

The most recent efforts to restrict abortion are extreme, prohibiting abortion after six weeks or after fetal pole cardiac activity is perceptible.[29] Attempts to interfere with pregnant individuals' healthcare decisions suggest that pregnant people as a class are less capable of weighing the gravity of pregnancy and arriving at appropriate choices for their personal circumstances, and that their bodies may be violated to discourage or punish certain pregnancy decisions. So far, New York has not instituted such extreme restrictions, but the reasoning of the lower court reflects similar philosophical underpinnings.

B. Ideological Pursuit of Legal Personhood for Fetuses Clouds Clearly-Established Autonomy Rights of Pregnant People, Inviting Patient Mistreatment in Name of Fetal Protection

An important driver in the mistreatment of pregnant patients has been an increased focus on the fetus as a juridical entity separate from the pregnant person. In *Roe v. Wade*, 410 U.S. 113, 158 (1973), the Supreme Court stated that the Constitution's protections attach at birth. Abortion opponents seeking to re-criminalize abortion have attempted to create legal recognition for fetuses *in utero* by passing laws that impose penalties for harm to a fetus.[30] This framing of a fetus as a separate legal entity has been part of a longstanding campaign by abortion

[29] Guttmacher Institute, *Radical Attempts to Ban Abortion Dominate State Policy Trends in the First Quarter of 2019* (April 2019), http://bit.ly/2JpNecl.
[30] Glen A. Halva-Neubauer & Sara L. Zeigler, *Promoting Fetal Personhood: The Rhetorical and Legislative Strategies of the Pro-Life Movement after Planned Parenthood v. Casey,* 22 Feminist Formations 101 (2010).

opponents to "encourage the public perception of the fetus as a baby, rather than something that will become a baby."[31]

Historically, state penal codes adhered to the common law "born alive" rule, which limited criminal liability for harm to fetuses. A person could be charged with homicide for causing a woman to lose a pregnancy only if an infant was born and lived for some amount of time before dying. If the fetus died *in utero*, the injury was a crime, but not homicide. In the late 1970s, lawmakers began to increase punishment for harm to fetuses, either by creating new crimes with fetal victims, redefining "persons" or "victims" to include fetuses, or both.[32] Although these laws are typically justified as protecting pregnant women and thus garner widespread support, in practice, they make pregnant people vulnerable to mistreatment during childbirth, and even subject them to criminal prosecution.

In virtually every state where the law punishes harm to fetuses, arguments that a fetus constitutes an independent legal entity over which the state has jurisdiction have been used to justify reporting pregnant people to law enforcement, subjecting them to criminal investigations, and even imprisoning them on the basis of acts or omissions believed to have caused or even *risked* harm

[31] *Id*. at 103.
[32] Nat'l Conference of State Legislatures, *Fetal Homicide State Laws* (May 1, 2018) http://bit.ly/2qToXCL.

to a fetus.[33] In fact, prosecutors have permitted such arrests even while the law explicitly prohibits charging the pregnant person with an offense against their own fetus.[34]

Those who frame fetuses as distinct legal entities, and investigate and charge pregnant people for suspected crimes against their fetuses, are suggesting that the legal status of a fetus is roughly equal to that of the pregnant person, and that fetuses might need protection from the pregnant person by third-party actors. This, in turn, creates the conditions in which medical personnel may conceive of a birthing person and their fetus as separate patients with competing interests and mistreat the birthing person in the name of protecting the fetal patient.

C. Criminalization of Pregnancy Outcomes Cruelly Subjects Pregnant People to Sanctions for Abortion, Pregnancy Loss, and Substance Use Disorders

Pregnant people who give birth are not alone in experiencing mistreatment due to laws and legal arguments that cast fetuses as victims. People who end their own pregnancies using abortion pills or other means, or who have stillbirths or miscarriages that they cannot explain to the satisfaction of medical personnel, are treated with suspicion and even reported to law enforcement for prosecution.

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[33] Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Politics, Pol'y & L. 299 (2013) ("Forced Interventions").

[34] *See, e.g.*, Andrea Grimes, *Pregnant Texans are Being Charged with Crimes that Don't Exist*, Rewire (Oct. 16, 2014), http://bit.ly/2px7wmX; Tenn. Code Ann. § 39-13-107(c).

States wield a hodgepodge of laws to criminalize persons who end their pregnancy or assist another in doing so.[35]

For example, when Purvi Patel sought emergency help for severe bleeding at a Catholic hospital in Indiana, the obstetrician treating her—a member of an anti-abortion professional society—called the police.[36] Patel was interrogated without an attorney at 3 a.m. in her hospital bed as she recovered from surgery and was charged with feticide for allegedly taking abortion pills she obtained over the internet to end her pregnancy.[37] Patel was convicted and sentenced to 20 years in prison.[38] Ultimately, the Court of Appeals of Indiana ruled that neither Indiana's feticide law nor its criminal abortion laws were intended to punish women for self-inducing abortions; the law was subsequently amended in 2018 to preclude similar prosecutions.[39]

Patel's arrest is just one of many arrests for abortion or suspected abortion: even though abortion is legal in the U.S. and the vast majority of states do not authorize criminal punishment for self-managed abortion, at least 21 people have

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[35] *See* SIA Legal Team, *Roe's Unfinished Promise: Decriminalizing Abortion Once and For All* (2017) ("Unfinished Promise"), http://bit.ly/2Vjp62g.
[36] *See* If/When/How: Lawyering for Reproductive Justice, Birth Rights Bar Association et al., *Report to the U.N. Special Rapporteur on Violence Against Women: Mistreatment and Violence Against Women During Reproductive Health Care With a Focus on Childbirth in the United States of America* 11 (2019) ("BRBA Report"), https://birthrightsbar.org/resources/Documents/190517%20IWH%20BRBA%20NAPW%20HRGJ%20Submission.pdf.
[37] *Id.*
[38] *Id.*
[39] *Id.*

been arrested for ending a pregnancy or helping someone else do so.[40] The criminalization of people who have abortions and pregnancy losses creates an atmosphere of fear and mistrust, deterring people from seeking necessary care and creating the conditions for mistreatment during birth. The criminalization of pregnancy outcomes may also dissuade pregnant people from seeking prenatal care, which is crucial for healthy birth outcomes. In this way, the fear of criminal prosecution may increase the risk of maternal mortality or morbidity, with a disproportionate impact on women of color.[41] The criminal legal system has no place in reproductive health care.

People who use criminalized drugs are particularly vulnerable to mistreatment when giving birth. Pregnant people who self-disclose drug use or test positive may be subjected to degrading or stigmatizing comments, find their pain disregarded or labeled as "drug-seeking behavior," or have their confidentiality breached when reported to law enforcement. Such repercussions occur despite the fact that ingestion of criminalized drugs is not criminal behavior in most states, and despite constitutional jurisprudence that forbids penalizing people for suffering a substance use disorder. *See Robinson v. California*, 370 U.S. 660 (1962).

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[40] *See Unfinished Promise* at 20.

[41] Black women are three to four times more likely than White women to die of pregnancy-related causes. Black Mamas Matter Alliance, et al., *Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care* 9 (2018), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf.

Most U.S. courts faced with such prosecutions have agreed that absent explicit statutory authorization, laws protecting fetuses may not be used to punish the people who carry them. *See, e.g.*, *Arms v. State,* 471 S.W.3d 637 (Ark. 2015); *State v. Louk*, 786 S.E.2d 219 (W.Va. 2016); *People v. Jorgensen*, 41 N.E.3d 778 (N.Y. 2015); *State v. Stegall*, 828 N.W.2d 526 (N.D. 2013); *Cochran v. Commonwealth*, 315 S.W.3d 325 (Ky. 2010). However, these fundamental principles do not always prevent unlawful arrests and prosecutions, particularly given the general antipathy toward women perceived—often incorrectly—as having caused harm to a fetus.[42]

Medical and public health experts uniformly reject punitive responses to substance use during pregnancy because such a response deters people from seeking prenatal care.[43] When healthcare providers look upon their birthing patients with suspicion, and are drawn to take punitive or coercive action in light of such suspicion, they miss crucial opportunities to understand more about their patients' health status, circumstances, and goals of treatment. In fact, that

[42] One study identified 413 arrests or forced medical interventions involving pregnant women between 1973-2005—noting that this is a likely undercount due to limitations on data collection. *Forced Interventions* at 299-300. More recent investigations have uncovered nearly 500 arrests in Alabama from 2006-2015, and more than 100 arrests in Tennessee from 2014-2016. Wendy Bach, *Prosecuting Poverty, Criminalizing Care*, 60 Wm. & Mary L. Rev. 809, 848 & n.23 (2019).

[43] *See, e.g.*, ACOG, *Committee Opinion 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (2011), http://bit.ly/2JLJ4Mf.

suspicion can inflict long-lasting harm on birthing people and their families, as it has for Ms. Dray.

D. Legal Exclusion of Midwives Exposes Pregnant People to Mistreatment by Limiting Alternatives to Hospital Birth

Although midwives are highly-skilled experts in uncomplicated birth, and access to midwifery is associated with better perinatal health outcomes,[44] various legal restrictions limit access to midwifery care in the U.S. Such restrictions contribute to mistreatment by foreclosing a safe alternative to hospital-based care for pregnant people who seek to avoid unnecessary medical intervention during delivery, who have previously been mistreated by a healthcare provider, or who otherwise feel unsafe giving birth in a hospital.

The manner in which midwives are marginalized within, or excluded from, mainstream maternity care depends on the category of midwife. Nurse-midwives train as nurses with supplemental midwifery education, earn the Certified Nurse-Midwife (CNM) credential, mostly practice in hospitals (and some freestanding birth centers), and are licensed in every state, although with varying scopes of practice. Professional (or direct-entry) midwives train only as midwives, can earn the Certified Professional Midwife (CPM) credential, practice in community

[44] *See* Saraswathi Vedam, et al., *Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes*, Plos One (2018) ("Mapping Integration").

settings such as homes and birth centers, and are legally authorized to practice in 36 states, with considerable variety in scope and autonomy of practice.[45]

In addition to exclusion from licensing in 14 states, including New York, CPMs also face overly restrictive regulation in many jurisdictions where they are licensed. Although midwives' training equips them for autonomous practice during the childbearing cycle, some states require CPMs, CNMs, or both to enter into signed supervisory agreements with physicians—without accounting for the medical profession's historically hostile attitude towards midwives or the prohibition on such agreements contained in many physician liability insurance policies.[46] In addition, some states effectively limit midwife practice by making midwives dependent on physicians to obtain access to medications necessary for the safe practice of midwifery.[47]

Popular non-evidence-based restrictions on midwifery scope of practice include prohibitions against CPMs caring for pregnant people with a previous cesarean, carrying a fetus in breech presentation, or carrying multiples.[48] These are the exact limitations that further narrowed Ms. Dray's options and left her

[45] The Big Push for Midwives, https://www.pushformidwives.org/cpms_legal_status_by_state.
[46] *See, e.g.*, California Legislative Analyst's Office, *Analysis of California's Physician-Supervision Requirement for Certified Nurse Midwives* (March 11, 2020), https://lao.ca.gov/Publications/Report/4197.
[47] *Mapping Integration* at 5-6.
[48] Rebecca Fotsch, *Regulating Certified Professional Midwives in State Legislatures*, 8 J. Nursing Reg. 47, 47-48 (2017).

vulnerable to the harm her doctors and the hospital ultimately caused. Access to midwifery care is also impeded by the refusal of ten states to license birth centers,[49] which in turn precludes Medicaid reimbursement for birth center facility fees.[50] Exclusion of CPMs from participation in Medicaid further limits access to midwives. In 2017, only 13 states included CPMs as Medicaid providers, even though half of all births nationwide are financed by Medicaid.[51] Together, restrictions on midwifery practice translate to reduced choice for pregnant people, limiting them to one model of care (medical), one type of provider (obstetrician), and one place of birth (hospital).

When access to midwifery is curtailed, pregnant people lose one of the few alternatives to hospital-based providers. For those who have previously experienced mistreatment in hospitals, this absence of options means returning to the site of their trauma. The lack of alternatives also harms marginalized populations who face not only mistreatment but also statistically poorer outcomes as a result of individual or institutional bias. Restrictions on pregnant people's ability to choose their birth attendants contribute to a culture in which healthcare

[49] American Association of Birth Centers, *Birth Centers Regulations*, https://www.birthcenters.org/page/bc_regulations.
[50] Patient Protection and Affordable Care Act, § 2301, 42 U.S.C. § 1396d(l)(3)(A).
[51] National Association of Certified Professional Midwives, *CPMs: Midwifery Landscape and Future Directions* (October 2017), https://www.nacpm.org/wp-content/uploads/2017/10/4E-Reimbursement-and-Employment.pdf.

providers and other non-state actors feel entitled to intervene in pregnant people's medical decision-making, a precursor to mistreatment during childbirth.

E. Criminal Punishment of Pregnant People for Community-Birth Increases Stigma and Exposes Them to Mistreatment by Hospital-Based Providers

The criminal punishment of people who give birth outside the hospital reflects the high degree of surveillance and regulation certain pregnant people experience. As discussed in the context of the criminalization of pregnancy in Sections II.B & II.C, *supra*, people who give birth outside the hospital, particularly in the case of a fetus that does not survive, face intense scrutiny for the use of criminalized drugs and/or abortifacients, with added suspicion and penalties for giving birth without medical oversight.

When unattended birth comes to the attention of hospital personnel, lines between medical providers and law enforcement may become blurred. When Purvi Patel presented at the emergency room with vaginal bleeding and admitted to having given birth recently, an emergency room doctor called the police, and "drove to the Super Target and started searching the Dumpsters," where the police joined him.[52] Such conduct violates the Supreme Court's requirements for the relationship between medical professionals and law enforcement. *See Ferguson v.*

[52] *Granger Woman Accused of Dumping Baby in Trash Bonds Out*, WSBT 22, July 18, 2013, https://wsbt.com/archive/granger-woman-accused-of-dumping-baby-in-trash-bonds-out-court-document-shows-drug-taken-to-abort-child.

Charleston, 532 U.S. 67 (2001). More recently, Latice Fisher was charged with second-degree murder after giving birth at home, unattended, to a 35-week stillborn fetus. The prosecutor noted that Fisher told a nurse a month earlier that she was pregnant but "failed to make any follow-up appointments for an ultrasound or other prenatal care."[53] This suggests that pregnant people can be penalized not only for engaging in actions that may harm their fetuses, but also for *not* engaging in actions that benefit them, such as obtaining prenatal care.

Many pregnant people birthing at home or in a birth center who transfer to the hospital for medical care experience rough or punitive treatment because they had planned to deliver outside a hospital. If they transfer with a midwife, the pregnant person's body becomes "a symbolic battleground" in the struggle over who controls where and how people give birth.[54] When *no* community care provider is present and the birth is unplanned, the patient bears the brunt of the stigma of community birth and greater censure for an assumed failure to exercise due care.

Policing of the pregnant person's body in this manner is obstetric violence. Treating birthing people as if medical observation is necessary to keep them from

[53] Ryan Phillips, *Infant Death Case Heading Back to Grand Jury*, Starkville Daily News, May 9, 2019, https://www.starkvilledailynews.com/infant-death-case-heading-back-to-grand-jury/article_cf99bcb0-71cc-11e9-963a-eb5dc5052c92.html.
[54] Melissa Cheyney, et al., *Homebirth Transfers in the United States: Narratives of Risk, Fear, and Mutual Accommodation*, 24 Qualitative Health Research 443 (2014).

harming their fetuses or neonates likewise constitutes mistreatment. Assumptions of such patients' malfeasance may result in physical violence and coercion by health care providers, sometimes contracted out by medical personnel to law enforcement.

F. Institutional Restrictions on Vaginal Birth After Cesarean (VBAC) Constitute Mistreatment by Forcing Pregnant People to Undergo Unnecessary and Unwanted Cesarean Surgeries

Through institutional policy, hospitals routinely prohibit healthcare providers from attending vaginal deliveries where the birthing person has had a prior cesarean surgery (known as "vaginal birth after cesarean" or "VBAC").[55] By doing so, these facilities essentially—and sometimes expressly—prohibit pregnant people from giving birth without agreeing in advance to a cesarean. Evidence demonstrates that VBAC is a safe and reasonable choice for many pregnant people, and that repeat cesarean surgery carries substantial risk.[56] Furthermore, when hospitals take VBAC off the table, they appropriate birthing people's power to make decisions based on weighing risks and benefits, combined with personal values and circumstances. By stripping birthing people's decision-making

[55] Cristen Pascucci, *VBAC Bans: The Insanity of Mandatory Surgery* (Apr. 14, 2014), https://improvingbirth.org/2014/04/bans/.
[56] ACOG, *Practice Bulletin No. 184: Vaginal Birth After Cesarean Delivery*, 130 Obstetrics & Gynecology e217 (November 2017). *See also* Jen Kamel, *Eleven Things to Love about ACOG's 2017 VBAC Guidelines* (Oct. 25, 2017), http://bit.ly/2WPThLh.

authority in this way, they violate birthing people's autonomy and right to informed consent.

III. CURRENT LEGAL FRAMEWORKS FAIL TO PROVIDE RECOURSE FOR RIGHTS VIOLATIONS IN CHILDBIRTH

When pregnant people seek to hold healthcare providers accountable for mistreatment during childbirth, they often find that the law does not recognize their harms and they are unable to secure the legal recourse that would be available to other victims of healthcare provider misconduct. Law fails such putative plaintiffs in three critical ways that are relevant to Dray's case: (1) lack of access to justice created by the difficulty of finding counsel, leading to lengthy delays and expired claims; (2) failure to recognize the invisible harms most commonly associated with mistreatment during childbirth, including emotional suffering, psychological trauma, and disruption of future fertility; and (3) the improper and logically unsound reliance on abortion jurisprudence to resolve disputes, creating a false conflict between the pregnant person and their fetus that is used to justify infringement of the pregnant person's rights.

A. Lack of Access to Legal Representation Causes Prejudicial Delays and Precludes Accountability

Pregnant people who have suffered mistreatment during birth often encounter significant hurdles to filing a lawsuit. Because most people in this situation depend on lawyers who are willing to provide representation on a

contingency-fee basis, they must convince prospective counsel that their claims are strong. For the reasons discussed in Part III.B, *infra*, lawyers often incorrectly conclude that prospective clients' claims are not compelling, and thus refuse to represent women claiming provider mistreatment.[57] Even women with strong cases report the inability to secure counsel as an impediment to seeking recourse; for example, a California woman whose forced, unconsented episiotomy was captured on her birth video, providing strong evidence of physician misconduct, sought counsel unsuccessfully for a year-and-a-half before filing a lawsuit pro se with crowdsourced funds.[58] Because the law privileges claims for injuries to fetuses or babies over those to women,[59] lawyers are especially reluctant to take cases where maternal injuries are not accompanied by an injury to the baby, which are generally viewed as lucrative medical malpractice claims.

The difficulty of securing counsel in obstetric violence cases often results in a delay in filing the initial complaint and the expiration of certain claims under the relevant statute of limitations. Not only does this prejudice the plaintiff, it may also lead the court to draw skeptical inferences about the strength of a claim based

[57] *See, e.g.*, Cristen Pascucci, *Caught on Video: Improving Birth Breaks the Silence on Abuse of Women in Maternity Care* (Aug. 28, 2014), https://improvingbirth.org/2014/08/vid/.
[58] *See* "California Woman Charges Doctor with Assault & Battery for Forced Episiotomy," Improving Birth Press Release (June 4, 2015), https://improvingbirth.org/2015/06/preview-woman-charges-ob-with-assault-battery-for-forced-episiotomy/.
[59] *See* Jamie Abrams, *Distorted and Diminished Tort Claims for Women*, 34 Cardozo L. Rev. 1955, 1980 (2013) ("Distorted and Diminished").

on the delay and omission of expired claims. Ultimately, the access to justice gap for pregnant people who experience mistreatment and violence reflects a catch-22 situation: lawyers are reluctant to take on such cases because they misperceive the harms suffered and strength of the legal claim, leading to delays, expired causes of action, and weaker cases. As a result, courts have few opportunities to rule on such cases and there is limited precedent for future plaintiffs to rely on, leading lawyers to misjudge the potential for recovery and refuse to take on future cases. Lack of access to legal representation means pregnant people who experience mistreatment are unable to hold providers accountable for the harms they perpetrate.

B. Societal Stereotypes of the "Self-Sacrificing Mother" Make it Difficult for Plaintiffs to Prove the Seriousness of Invisible Harms

Pregnant people who experience mistreatment during childbirth often struggle to have their injuries taken seriously within the legal system. After giving birth, women encounter the widespread attitude that having a healthy baby is the only result that matters; when a birth is more complicated than expected or the woman struggles with the physical toll of delivery, she is often told—by doctors, nurses, family members, and friends—to "stop complaining and be grateful she has a healthy baby," as if processing a difficult birth or managing postpartum pain

makes her selfish.[60] Indeed, society expects that a "good mother" is a "self-sacrificing mother" who sacrifices her own body, health, and emotional well-being in favor of her child.[61] These stereotypes cause women's birth-related pain and suffering to be downplayed; as a result, women who have experienced provider-inflicted harm struggle to get legal audiences to understand how provider-inflicted harm differs from the normal physical and emotional strain of childbirth.

Pregnant people seeking recourse for childbirth-related mistreatment face the additional challenge that their injuries are often invisible regarding emotional, psychological, or future fertility harms—setting them apart from typical medical malpractice cases where courts are asked to evaluate physician conduct and harm to patients. For example, research suggests that many women experience lasting psychological harm from traumatic birth experiences, with experts concluding that up to 9% of new mothers satisfy the clinical criteria for PTSD.[62] However, postpartum emotional and psychological suffering is often dismissed as "baby blues," rather than the clinical expression of an illness that can be traced to

[60] Christen Pascucci, *Improving Birth/ Consumers Welcome Recognition by Medical Community of Disrespect and Abuse in Childbirth*, Improving Birth (Aug. 26, 2015), https://www.kindredmedia.org/2015/08/improving-birthconsumers-welcome-recognition-by-medical-community-of-disrespect-and-abuse-in-childbirth/.
[61] *See Distorted and Diminished* at 1960 (analyzing the "subordination of maternal harms").
[62] *See* Cheryl Tatano Beck et al., *Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey*, 38 Birth: Issues in Perinatal Care 216, 217 (2011); Cheryl Tatano Beck, *Post-Traumatic Stress Disorder Due to Childbirth: the Aftermath*, 53 Nursing Res. 216, 216 (2004).

provider mistreatment. In addition, mistreatment in the form of forced interventions—particularly forced cesareans—can negatively impact future fertility. Research confirms that the risk of complications increases with each subsequent cesarean: unwanted and unconsented cesareans increase the likelihood of placenta accreta, placenta previa, adhesions or incision-related complications in future pregnancies—with the associated risks of premature birth, hemorrhage, bladder or bowel injury, need for blood transfusion, or hysterectomy.[63] Nevertheless, it is virtually impossible for women to secure recourse for harms to future fertility caused by provider mistreatment because courts struggle with the speculative nature of harm that emerges over a longer period of time.[64] In this way, the legal system fails to provide accountability for mistreatment during childbirth by excluding a wide array of invisible present and future harms from patients' claims against their health care providers.

C. Courts Rely Improperly on Abortion Jurisprudence to Decide Obstetric Violence Claims, Resulting in Flawed Analysis of Pregnant People's Rights

Courts fail pregnant people who experience provider mistreatment by looking in the wrong place for guidance on autonomy and decision-making rights in childbirth. Instead of applying the rights to informed consent, freedom from

[63] *See, e.g.*, Robyn Kennare et al., *Risks of Adverse Outcomes in the Next Birth After a First Cesarean Delivery*, 109 Obstetrics & Gynecology 270, 274–76 (2007).
[64] Courts are usually unwilling to consider impact to subsequent fertility as a compensable harm in tort cases. *See, e.g.*, *Albala v. City of New York*, 429 N.E.2d 786 (1981).

battery, and bodily integrity, along with other relevant statutory protections, courts improperly invoke the line of cases flowing from *Roe v. Wade* that establish a woman's right to terminate a pregnancy and delineate when the state may intervene to protect its interest in potential life.

Though abortion and obstetric violence cases both involve fetuses, the analogy between the two situations is flawed. In the former circumstance the pregnant person wants to end the pregnancy, while in the latter situation, the pregnant person wants to deliver the baby and ensure a safe and healthy birth. By assuming a *Roe*-like state interest in intervening to compel a cesarean or other intervention during childbirth, the court inaccurately pits mother against child—when in fact, both mother and child share an interest in a safe and healthy birth. *See, e.g.*, *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc*., 66 F. Supp. 2d 1247, 1251-52 (N.D. Fla. 1999).

By superimposing a *Roe*-like conflict between pregnant person and fetus on an obstetric violence plaintiff, the court transforms a physician-patient conflict into a maternal-fetal conflict.[65] This reflects a fundamental misunderstanding of why some women choose to delay or forego recommended treatment: they are attempting to achieve the best possible outcome. Presuming a maternal-fetal

[65] *See* Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 Nw. U. L. Rev. 451 (2000).

conflict enables the court to justify intervention or excuse a physician's disregard for informed consent and other rules that normally constrain provider conduct, as has been demonstrated in this case. In this way, courts improperly import reasoning from doctrine that is inapposite to the claims and context surrounding childbirth mistreatment cases.

IV. CONCLUSION

Mistreatment and violence in childbirth are all too common in childbirth. Forced treatment like Rinat Dray's unnecessary and unwanted cesarean are made possible by social forces that devalue women's reproductive decision-making while normalizing third-party regulation of and intervention upon pregnant bodies. Courts must take this problem seriously. By allowing Ms. Dray's valid claims to proceed, this Court can create the conditions that would enable healthcare providers to be held accountable for the harms they inflict on birthing people through mistreatment.

Dated: New York, NY
November 2, 2020

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NOTICE OF APPEAL AND ORDER APPEALED FROM

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

----------X

RINAT DRAY,

Plaintiff(s),

-against-

NOTICE OF APPEAL

STATEN ISLAND UNIVERSITY HOSPITAL, LEONID GORELIK, METROPOLITAN OB-GYN ASSOCIATES, PC. and JAMES J. DUCEY

Defendant(s). Index No. 500510/14

----------x

PLEASE TAKE NOTICE that the plaintiff hereby appeals to the Supreme Court Appellate Division in and for the Second Judicial Department from an Order made in this action dated October 1, 2019 by the Hon. Genine D. Edwards, Justice of the Supreme Court and entered in the office of the County Clerk on or about October 4, 2019.

Plaintiff hereby appeals from every part of the order from which she is aggrieved.

Dated: Brooklyn, NY
October 30, 2019

Yours, etc.,

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

----------X

RINAT DRAY,

Plaintiff(s),

-against-

NOTICE OF APPEAL

STATEN ISLAND UNIVERSITY HOSPITAL, LEONID GORELIK, METROPOLITAN OB-GYN ASSOCIATES, PC. and JAMES J. DUCEY

Defendant(s).

Index No. 500510/14

----------x

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At an IAS Term, Part 80 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 1st day of October 2019.

PRESENT:

HON. GENINE D. EDWARDS,
Justice.

----------X

RINAT DRAY,

Plaintiff,

- against -

Index No. 500510/14

STATEN ISLAND UNIVERSITY HOSPITAL, LEONID GORELIK, METROPOLITAN OB-GYN ASSOCIATES, P.C., AND JAMES J. DUCEY,

Defendants.

----------X

The following e-filed papers read herein:	NYSCEF Docket No.:
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	264-265, 273-274
Opposing Affidavits (Affirmations)	306
Reply Affidavits (Affirmations)	334, 335

Upon the foregoing papers, defendants Staten Island University Hospital (SIU Hospital) and James J. Ducey, M.D. (Dr. Ducey), move for an order: (1) pursuant to CPLR 3211 (a) (1) and 3211 (a) (7), dismissing with prejudice Rinat Dray's (plaintiff) causes of action sounding in breach of contract, fraud, false advertising and gender discrimination (the sixth through twelfth causes of action); or, in the alternative, (2) pursuant to CPLR 2221 granting leave to reargue SIU Hospital and Dr. Ducey's prior cross-motion to dismiss these

MS 18, 19

claims which was denied in this Court's order dated January 7, 2019, and, upon reargument, granting dismissal of the above noted causes of action. Defendants Leonid Gorelik, M.D. (Dr. Gorelik), and Metropolitan Ob-Gyn Associates, P.C., (Metropolitan), similarly move for an order, pursuant to CPLR 3211 (a) (7), dismissing the sixth through the twelfth causes of action.

FACTUAL AND PROCEDURAL BACKGROUND

On July 26, 2011, Dr. Gorelik delivered plaintiff's third child by way of a cesarean section at SIU Hospital over her express objection and despite her desire to give birth by way of a spontaneous vaginal delivery. In order to proceed with a vaginal delivery despite the two preceding cesarian sections, plaintiff chose non-party Dr. Dori, an Obstetrician-Gynecologist (Ob-Gyn) employed by or associated with Metropolitan, who told plaintiff that he was willing to let plaintiff try to proceed by way of a vaginal delivery.

At around 8:00 a.m., on July 26, 2011, plaintiff, who was experiencing contractions, proceeded to SIU Hospital, but found that Dr. Dori was not available. Dr. Gorelik, another Ob-Gyn associated with Metropolitan, was present and examined plaintiff. While Dr. Gorelik initially told plaintiff that she should proceed by way of a cesarean section, he later agreed to let plaintiff try to proceed by way of a vaginal delivery. By early afternoon, however, Dr. Gorelik told plaintiff that it wasn't good for the baby and that plaintiff should proceed by way of a cesarean section. Thereafter, Dr. Gorelik consulted with Dr. Ducey, SIU Hospital's director of obstetrics, who likewise agreed that plaintiff should undergo a cesarean

section, and he attempted to convince plaintiff to undergo such procedure. Plaintiff refused to grant her consent, and Dr. Ducey, after consulting with Arthur Fried (Fried), senior vice president and general counsel of SIU Hospital, determined that it would take too long to obtain a court order allowing the procedure over plaintiff's objections, and, with the concurrence of Fried, Dr. Gorelik made the decision to proceed with a cesarean section despite plaintiff's objections. A cesarean section was performed by Dr. Ducey and Dr. Gorelik. Plaintiff's son was healthy upon delivery. Plaintiff, however, suffered a cut to her bladder, the repair of which required additional surgery immediately following the completion of the C-section. SIU Hospital discharged plaintiff on July 31, 2011.

Plaintiff commenced the instant action on January 22, 2014 by filing a summons and complaint. In an amended verified complaint, plaintiff alleged causes of action for negligence, medical malpractice, lack of informed consent, violations of Public Health Law § 2803-c (3) (e) and 10 NYCRR 405.7, and punitive damages based on allegations that defendants, among other things, performed the cesarean section against plaintiff's will, caused or allowed the injury to plaintiff's bladder during the cesarean section and failed to properly repair the laceration to her bladder, and failed to properly evaluate plaintiff and the fetal monitoring strips in choosing to proceed with a cesarean section rather than allowing a vaginal delivery. Defendants, in separate motions, moved to dismiss, as untimely, plaintiff's causes of action to the extent that they were based on the performance of the cesarean section over the objection of plaintiff, and to dismiss the fourth cause of action

based on violations of Public Health Law § 2803-c (3) (e) and 10 NYCRR 405.7, for failing to state a cause of action. As is relevant here, in an order dated October 29, 2015, the Court (Jacobson, J.) granted the portions of defendants' motions that were based on statute of limitations grounds, but, in an order dated May 12, 2015, the Court (Jacobson, J.) denied the portions of the motions seeking dismissal of the fourth cause action based on violations of Public Health Law § 2803-c (3) (e) and 10 NYCRR 405.7.

On appeal of these orders, the Appellate Division, Second Department, affirmed the dismissal of the action to the extent that it was based on the performance of the cesarean section over plaintiff's objection, emphasizing that the essence of that claim is an intentional tort for which a one-year statute of limitations applies, and that plaintiff "could not avoid the running of the limitations period by attempting to couch the claim as one sounding in negligence, medical malpractice, or lack of informed consent." *Dray v. Staten Is. Univ. Hosp.*, 160 A.D.3d 614, 75 N.Y.S.3d 59 (2d Dept. 2018); *Dray v. Staten Is. Univ. Hosp.*, 160 A.D.3d 620, 74 N.Y.S.3d 69 (2d Dept. 2018). The Second Department, however, found that the Court erred in denying the portion of the motion to dismiss the fourth cause of action. In doing so, the Second Department held that it was clear from the statutory scheme that Public Health Law § 2803-c applies to nursing homes and similar facilities and does not apply to hospitals. The Second Department also held that, while 10 NYCRR 405.7, which requires patients be afforded certain rights, applies to hospitals and may be cited in support of a medical malpractice cause of action, it does not give rise to an independent private right

of action. *See Dray*, 160 A.D.3d 614, 75 N.Y.S.3d 59; *Dray*, 160 A.D.3d 620, 74 N.Y.S.3d 69.

As a result of these determinations, plaintiff's claims against defendants were effectively limited to a negligence action relating to the failure to follow hospital rules relating to summoning a patient advocate group and a bioethics panel, medical malpractice relating to whether it was necessary to perform the cesarean section instead of the vaginal delivery,[1] and medical malpractice relating to the injury to her bladder. Plaintiff thereafter moved to amend the complaint to add causes of action for: (1) breach of contract; (2) fraud; (3) violations of consumer protection statutes (General Business Law §§ 349 and 350); (4) violations of equal rights in public accommodations (Civil Rights Law § 40); and violations of the New York State and City Human Rights Laws (Executive Law art 15; Administrative Code of the City of NY § 8–101, et seq.). These causes of action are all primarily based on documents plaintiff appended to the then proposed amended complaint, which are made a part thereof under CPLR 3014, and which include SIU Hospital's internal administrative policies relating to "Managing Maternal Refusals of Treatment Beneficial for the Fetus" (Maternal Refusal Policy), documents SIU Hospital gave plaintiff upon her admission, and plaintiff's own affidavit dated September 11, 2014.

The documents SIU Hospital provided to plaintiff included the patient bill of rights,

[1] In other words, the medical malpractice in this respect does not relate to any issue of consent, but rather relates to whether the decision to proceed with the cesarean section was a departure from accepted medical practice.

a form all New York hospitals are required to provide to patients upon admission (10 NYCRR 405.7 [a] [1], [c]), which, as relevant here, informed plaintiff that as a patient, "you have the right, consistent with law, to," among other things, "[r]efuse treatment and be told what effect this may have on your health," and the form plaintiff signed in which she consented to the performance of the vaginal delivery. Of note, in addition to specifically mentioning the vaginal delivery, the consent form contains a provision stating, as relevant here, that "I understand that during the course of the operation(s) or procedure(s) unforeseen conditions may arise which necessitate procedure(s) different from those contemplated" and one stating "I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation(s), or procedure(s) or treatment(s)." SIU Hospital also provided plaintiff with a consent form for the cesarean section that plaintiff refused to sign.

In addition to these documents provided to plaintiff, SIU Hospital's internal Maternal Refusal Policy provided for the overriding of a pregnant patient's refusal to undergo treatment recommended for the fetus by the attending physician when: (a) the fetus faced serious risk; (b) the risks to the mother were relatively small; © there was no viable alternative to the treatment, the treatment would prevent or substantially reduce the risk to the fetus, and the benefits of the treatment to the fetus significantly outweighed the risk to the mother; and (d) the fetus was viable based on having a gestational age of over 23 weeks and having no lethal untreatable anomalies. This policy also required, among other things,

that the attending physician consult with SIU Hospital's director of maternal fetal medicine, that the ultimate decision was to be made in consultation with a representative of the SIU Hospital's office of legal affairs, and that a court order be obtained if time permitted.

After receipt of plaintiff's motion to amend, SIU Hospital and Dr. Ducey cross-moved, pursuant to CPLR 3211 (a) (1) and 3211 (a) (7), to dismiss the proposed causes of action and Metropolitan and Dr. Gorelik cross-moved for an order denying the proposed amendments and for costs and counsel fees for the motion. This Court, in an order dated January 7, 2019, granted plaintiff's motion to amend, and denied defendants' cross motions. In doing so, the Court found that defendants failed to meet their burden of demonstrating the insufficiency of plaintiff's proposed claims. Following the Court's order, plaintiff filed the second amended complaint on January 23, 2019.

It is in this context that defendants' instant motions must be considered. As this Court finds that the sufficiency of plaintiff's proposed amendments and whether they are barred by documentary proof warrants reargument. *See Castillo v. Motor Veh. Acc. Indem. Corp.*, 161 A.D.3d 937, 78 N.Y.S.3d 162 (2d Dept. 2018); *Ahmed v. Pannone*, 116 A.D.3d 802, 984 N.Y.S.2d 104 (2d Dept. 2014); CPLR 2221 (d) (2).

While a motion for leave to amend the complaint should be freely given, such a motion should be denied where the proposed claim is palpably insufficient, such as where the proposed claim would not withstand a motion to dismiss under CPLR 3211 (a) (7). *See Lucido v. Mancuso*, 49 A.D.3d 220, 851 N.Y.S.2d 238 (2d Dept. 2008); *Norman v. Ferrara*,

107 A.D.2d 739, 484 N.Y.S.2d 600 (2d Dept. 1985); *See also Perrotti v. Becker, Glynn, Melemed & Muffly LLP*, 82 A.D.3d 495, 918 N.Y.S.2d 423 (1st Dept. 2011). In considering a motion to dismiss a complaint pursuant to CPLR 3211 (a) (7), "the court must accept the facts as alleged in the complaint as true, accord plaintiffs the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory" *Mawere v. Landau*, 130 A.D.3d 986, 15 N.Y.S.3d 120 (2d Dept. 2015) (internal quotation marks omitted); *see Nonnon v. City of New York*, 9 N.Y.3d 825, 842 N.Y.S.2d 756 (2007).

BREACH OF CONTRACT

"A breach of contract claim in relation to the rendition of medical services by a hospital [or physician] will withstand a test of legal sufficiency only when based upon an express promise to affect a cure or to accomplish some definite result." *Catapano v. Winthrop Univ. Hosp.*, 19 A.D.3d 355, 796 N.Y.S.2d 158 (2d Dept. 2005); *see Detringo v. South Is. Family Med., LLC*, 158 A.D.3d 609, 71 N.Y.S.3d 525 (2d Dept. 2018); *Nicoleau v. Brookhaven Mem. Hosp. Ctr.*, 201 A.D.2d 544, 607 N.Y.S.2d 703 (2d Dept. 1994). Here, contrary to plaintiff's assertions, a definite agreement not to perform a cesarean section cannot be found by a reading of the patient bill of rights form, the consent forms and other documents provided to plaintiff upon her admission. Notably, the consent form that plaintiff did sign expressly states that other procedures for which consent is not expressly given might be necessary and states that the consent form itself is not a promise or a guarantee of a

particular result. Further, plaintiff's refusal to sign the consent form for the cesarean section does not create an agreement by defendants accepting her refusal. Finally, the "provisions of the 'Patient Bill of Rights' do not constitute the requisite 'express promise' or special agreement with the patient so as to furnish the basis for a breach of contract claim." *Catapano*, 19 A.D.3d 355, 796 N.Y.S.2d 158; *see Detringo*, 158 A.D.3d 609, 71 N.Y.S.3d 525.

FRAUD

"The elements of a cause of action for fraud require a material misrepresentation of a fact, knowledge of its falsity, an intent to induce reliance, justifiable reliance by the plaintiff and damages." *Euryclea Partners, LP v. Seward & Kissel, LLP*, 12 N.Y. 553, 883 N.Y.S.2d 144 (2009). Here, plaintiff's fraud claim is premised on the above noted consent forms and the patient bill of rights, which plaintiff asserts constitute a representation that plaintiff would be entitled to proceed with a vaginal delivery and could refuse the cesarean section. Plaintiff further asserts that this representation was knowingly false in view of the Maternal Refusal Policy, the provisions of which allow for the overriding of maternal refusal of consent under certain circumstances. Accepting this view of the documents, however, plaintiff's fraud claim is insufficient to state such a claim, as any fraudulent inducement was not collateral to the purported contract. *See Joka Indus., Inc. v. Doosan Infacore Am. Corp.*, 153 A.D.3d 506, 59 N.Y.S.2d 506 (2d Dept. 2017); *Stangel v. Chen*, 74 A.D.3d 1050, 903 N.Y.S.2d 110 (2d Dept. 2010).

Moreover, as discussed with respect to plaintiff's contract claims, the consent forms do not constitute a promise that plaintiff would not have to undergo a cesarean section or that her refusal would not be overridden. Similarly, the patient bill of rights, the provisions of which every hospital is mandated to provide to patients under 10 NYCRR 405.7 (a) (1), ©, does not constitute a promise by SIU Hospital or the defendant doctors. Also, by expressly stating that a patient's right to refuse treatment is definitive to the extent that the right is "consistent with law," the patient bill of rights suggests that the right to refuse treatment may not be an absolute right. *See Gaidon v. Guardian Life Ins. Co. of Am.*, 94 N.Y.2d 330, 704 N.Y.S.2d 177 (1977). Plaintiff has thus failed to plead that there was any misrepresentation. In any event, plaintiff, in her own affidavit that was submitted in support of the motion to amend and which can be considered as a basis for dismissal, *see Held v. Kaufman*, 91 N.Y.2d 425, 671 N.Y.S.2d 429 (1998); *Norman*, 107 A.D.3d 739, 484 N.Y.S.2d 600, asserts that Dr. Gorelik was resistant to her proceeding by way of a vaginal delivery from the time he first saw her in the hospital, an assertion that demonstrates that defendants were not misleading plaintiff, or at least that plaintiff could not justifiably rely on the patient bill of rights in this respect. *See Shalam v. KPMG, LLP*, 89 A.D.3d 155, 931 N.Y.S.2d 592 (1st Dept. 2011).

GENERAL BUSINESS LAW §§ 349 & 350

The protections against deceptive business practices and false advertising provided by General Business Law §§ 349 and 350 may apply to the provision of medical services. *See Karlin v. IVF Am.*, 93 N.Y.2d 282, 690 N.Y.S.2d 495 (1999). These General Business

Law sections, however, are not implicated by plaintiff's allegations here, which, to the extent that they are based on the consent forms, relate only to her personal treatment and care and cannot be deemed to be consumer oriented. *See Greene v. Rachlin*, 154 A.D.3d 814, 63 N.Y.S.3d 78 (2d Dept. 2017); *Kaufman v. Medical Liab. Mut. Ins. Co.*, 92 A.D.3d 1057, 938 N.Y.S.2d 367 (3d Dept. 2012). Without an ability to rely on these consent forms, plaintiff's deceptive business practices claims rest solely on the provisions of the patient bill of rights. 10 NYCRR 405.7 (a) (1) and ©. As 10 NYCRR 405.7 does not give rise to an independent private right of action, *See Dray*, 160 A.D.3d 614, 75 N.Y.S.3d 59, plaintiff may not circumvent this legislative intent by bootstrapping a claim based on a violation of 10 NYCRR 405.7 onto a General Business Law §§ 349 or 350 claim. *See Schlesenger v. Valspar Corp.*, 21 N.Y.3d 166, 969 N.Y.S.2d 416 (2013); *Nick's Garage, Inc. v. Progressive Cas. Ins. Co.*, 875 F.3d 107 (2d Cir. 2017).

In any event, the regulatory mandated dissemination of the patient bill of rights simply cannot be compared to the multi-media dissemination of information that the Court of Appeals found in *Karlin* to constitute deceptive consumer oriented conduct in violation of General Business Law §§ 349 and 350. *Karlin*, 93 N.Y.2d 282, 690 N.Y.S.2d 495. And, as noted with respect to the discussion of the fraud claims, by expressly stating that a patient's right to refuse treatment is conditioned upon that right being "consistent with law," the patient bill of rights suggests that the right to refuse treatment is not an absolute right. As such, the representations of the patient bill of rights in conjunction with SIU Hospital's

internal Maternal Refusal Policy did not mislead plaintiff or other patients in any material way. *See Gomez-Jimenez v New York Law Sch.*, 103 A.D.3d 13, 956 N.Y.S.2d 54 (1st Dept. 2012); *Andre Strishak & Assoc. v. Hewlett Packard Co.*, 300 A.D.3d 608, 752 N.Y.S.2d 400 (2d Dept. 2002); *Abdale v. North Shore-Long Is. Jewish Health Sys., Inc.*, 49 Misc. 3d 1027, 19 N.Y.S.3d 850 (Sup Ct, Queens County 2015).

CIVIL RIGHTS AND HUMAN RIGHTS LAWS

Plaintiff cannot state a cause of action based on Civil Rights Law § 40, which applies to discrimination in public accommodations, because that statute pertains only to discrimination against "any person on account of race, creed, color or national origin" and does not extend to gender discrimination or discrimination based on a plaintiff's pregnancy. *See DeCrow v. Hotel Syracuse Corp.*, 59 Misc. 2d 383, 298 N.Y.S.2d 859 (Sup Ct, Onondaga County 1969); *Seidenberg v. McSorleys' Old Aile House, Inc.*, 317 F. Supp. 593 (SDNY 1970).

On the other hand, the State and City Human Rights Laws bar discriminatory practices in places of public accommodations because of sex or gender and extend to distinctions based solely on a woman's pregnant condition. *See Elaine W. v Joint Diseases N.Gen. Hosp.*, 81 N.Y.2d 211, 597 N.Y.S.2d 617 (1993); *see also Chauca v. Abraham*, 30 N.Y.3d 325, 67 N.Y.S.2d 85 (2017); Executive Law § 296 (2) (a); Administrative Code of the City of NY § 8–107 (4). In the proposed pleading, plaintiff's causes of action based on the City and State Human Rights Laws are based solely on a claim that SIU Hospital's Maternal

Refusal Policy facially violates these provisions. The determination of whether the Maternal Refusal policy is one that makes distinctions based solely on a woman's pregnant condition turns on a patient's rights in refusing treatment.

Under the long held public policy of this state, a hospital cannot override the right of a competent adult patient to determine the course of his or her medical care and to refuse treatment even when the treatment may be necessary to preserve the patient's life. *See Matter of Fosmire v. Nicoleau*, 75 N.Y.2d 218, 551 N.Y.S.2d 876 (1990); *Matter of Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266 (1981). The Court of Appeals, however, noted that when an "individual's conduct threatens injury to others, the State's interest is manifest and the State can generally be expected to intervene." *See Matter Fosmire*, 75 N.Y.2d 218, 551 N.Y.S.2d 876. While a fetus is not a legally recognized person until there is a live birth, Penal Law § 125.05 (1); *Byrn v. New York City Health & Hosps. Corp.*, 31 N.Y.2d 194, 335 N.Y.S.2d 390 (1972), the State recognizes an interest in the protection of viable fetal life after the first 24 weeks of the pregnancy, *see Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705 (1973) (state has compelling interest in protecting fetal life at the point of viability),[2] by holding a mother liable for neglect for drug use during a pregnancy, *Matter of Stefanal Tyesah C.*, 157

[2] In this respect, the Court notes that, until January 22, 2019, the Penal Law criminalized abortions and self abortions that took place after 24 weeks of gestation where the life of the mother was not at risk. *See* former Penal Law §§ 125.05 (3), 125.40, 125.45, 125.50, 125.55 and 125.60, repealed by L. 2019, ch. 1, § 5-10. Although these amendments decriminalized abortion, they specifically allow an abortion to be performed only if the fetus is not viable, if the mother's health is at risk, or if it is within 24 weeks of the commencement of the pregnancy. *See* Public Health Law § 2500-bb; L. 2019, ch. 1, § 2.

A.D.2d 322, 556 N.Y.S.2d 280 (1st Dept. 1990), and by allowing an infant born alive to sue for injuries suffered in utero. *See Woods v. Lancet*, 303 N.Y. 349, 102 N.E.2d 691 (1951); *Ward v. Safejou*, 145 A.D.2d 836, 43 N.Y.S.3d 447 (2d Dept. 2016).

New York trial courts have found that this interest in the well being of a viable fetus is sufficient to override a mother's objection to medical treatment, at least where the intervention itself presented no serious risk to the mother's well being. *See Matter of Jamaica Hosp.*, 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup Ct, Queens County 1985); *Matter of Crouse-Irving Mem. Hosp. v. Paddock*, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (Sup Ct, Onondaga County 1985), and the Appellate Division, Second Department, has also so found, albeit in dicta. *Matter of Fosmire v. Nicoleau*, 144 A.D.2d 8, 536 N.Y.S.2d 492 (2d Dept. 1989), *affd.* 75 N.Y.2d 218, 551 N.Y.S.2d 876 (1990).

In view of this legal background, and regardless of whether it is ultimately determined that a mother may refuse consent to medical procedures regardless of the risk the procedure may present to the fetus, SIU Hospital's Maternal Refusal Policy clearly presents an attempt to comply with the law relating to the refusal to consent to procedures where the rights of a viable fetus are at stake. As such, while the Maternal Refusal Policy only affects pregnant woman, the policy's interference in a pregnant woman's refusal decision only applies under circumstances such that the distinctions it makes are not solely based on a woman's pregnant condition, but rather, take into account concern for the fetus, and thus, the policy does not constitute discrimination based solely on sex or gender under the City and State Human

Rights Laws.

CONCLUSION

In conclusion, this Court grants reargument, vacates it's January 7, 2019 decision and order to the extent that the Court found that plaintiff's proposed causes of action sufficient to state causes of action, and denies plaintiff's motion to amend her complaint.

This constitutes the decision and order of the court.

ENTER,

J. S. C.

HON. GENINE D. EDWARDS

2019 OCT -4 AM 8:21

Supreme Court of the State of New York
Appellate Division: Second Judicial Department

Informational Statement (Pursuant to 22 NYCRR 1250.3 [a]) - Civil

Case Title: Set forth the title of the case as it appears on the summons, notice of petition or order to show cause by which the matter was or is to be commenced, or as amended.

Rinat Dray,

Plaintiff

- against -

Staten Island University Hospital, Leonid Gorelik, Metropolitan OB-Gyn Associates PC and James J. Ducey,
Defendants

For Court of Original Instance

Date Notice of Appeal Filed

For Appellate Division

Case Type

- ☒ Civil Action
- ☐ CPLR article 75 Arbitration
- ☐ Action Commenced under CPLR 214-g
- ☐ CPLR article 78 Proceeding
- ☐ Special Proceeding Other
- ☐ Habeas Corpus Proceeding

Filing Type

- ☒ Appeal
- ☐ Original Proceedings
  - ☐ CPLR Article 78
  - ☐ Eminent Domain
  - ☐ Labor Law 220 or 220-b
  - ☐ Public Officers Law § 36
  - ☐ Real Property Tax Law § 1278
- ☐ Transferred Proceeding
  - ☐ CPLR Article 78
  - ☐ Executive Law § 298
- ☐ CPLR 5704 Review

Nature of Suit: Check up to three of the following categories which best reflect the nature of the case.

☐ Administrative Review	☐ Business Relationships	☐ Commercial	☐ Contracts
☐ Declaratory Judgment	☐ Domestic Relations	☐ Election Law	☐ Estate Matters
☐ Family Court	☐ Mortgage Foreclosure	☐ Miscellaneous	☐ Prisoner Discipline & Parole
☐ Real Property (other than foreclosure)	☐ Statutory	☐ Taxation	☒ Torts

Appeal

Paper Appealed From (Check one only):	If an appeal has been taken from more than one order or judgment by the filing of this notice of appeal, please indicate the below information for each such order or judgment appealed from on a separate sheet of paper.

☐ Amended Decree	☐ Determination	■ Order	☐ Resettled Order
☐ Amended Judgement	☐ Finding	☐ Order & Judgment	☐ Ruling
☐ Amended Order	☐ Interlocutory Decree	☐ Partial Decree	☐ Other (specify):
☐ Decision	☐ Interlocutory Judgment	☐ Resettled Decree	
☐ Decree	☐ Judgment	☐ Resettled Judgment	

Court: Supreme Court	County: Kings
Dated: 10/30/2019	Entered: October 4,2019
Judge (name in full): Genine D. Edwards	Index No.:500510/2014
Stage: ■ Interlocutory ☐ Final ☐ Post-Final	Trial: ☐ Yes ☐ No If Yes: ☐ Jury ☐ Non-Jury

Prior Unperfected Appeal and Related Case Information

Are any appeals arising in the same action or proceeding currently pending in the court? ☐ Yes ■ No
If Yes, please set forth the Appellate Division Case Number assigned to each such appeal.

Where appropriate, indicate whether there is any related action or proceeding now in any court of this or any other jurisdiction, and if so, the status of the case:

Original Proceeding

Commenced by: ☐ Order to Show Cause ☐ Notice of Petition ☐ Writ of Habeas Corpus	Date Filed:

Statute authorizing commencement of proceeding in the Appellate Division:

Proceeding Transferred Pursuant to CPLR 7804(g)

Court: Choose Court	County: Choose County
Judge (name in full):	Order of Transfer Date:

CPLR 5704 Review of Ex Parte Order:

Court: Choose Court	County: Choose County
Judge (name in full):	Dated:

Description of Appeal, Proceeding or Application and Statement of Issues

Description: If an appeal, briefly describe the paper appealed from. If the appeal is from an order, specify the relief requested and whether the motion was granted or denied. If an original proceeding commenced in this court or transferred pursuant to CPLR 7804(g), briefly describe the object of proceeding. If an application under CPLR 5704, briefly describe the nature of the ex parte order to be reviewed.

In this personal injury action plaintiff moved to amend her complaint to add addititional causes of action. The court granted the motion. Defendants moved to reargue, and upon reargument, the court vacated its previous order and denied the motion to amend the complaint. This is an appeal from the second order.

Informational Statement - Civil

Issues: Specify the issues proposed to be raised on the appeal, proceeding, or application for CPLR 5704 review, the grounds for reversal, or modification to be advanced and the specific relief sought on appeal.

Plaintiff contends the lower court impermissibly decided issues of fact, and held the plaintiff's complaint to a higher standard of proof than is necessary on a motion to amend the complaint. Plaintiff appeals from each and every part of the order from which she is aggrieved.

Party Information

Instructions: Fill in the name of each party to the action or proceeding, one name per line. If this form is to be filed for an appeal, indicate the status of the party in the court of original instance and his, her, or its status in this court, if any. If this form is to be filed for a proceeding commenced in this court, fill in only the party's name and his, her, or its status in this court.

No.	Party Name	Original Status	Appellate Division Status
1	Rinat Dray	Plaintiff	Appellant
2	Staten Island University Hospital	Defendant	Respondent
3	Leonid Gorelik	Defendant	Respondent
4	Metropolitan OB-Gyn Associates PC	Defendant	Respondent
5	James J. Ducey	Defendant	Respondent
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Attorney Information

Instructions: Fill in the names of the attorneys or firms for the respective parties. If this form is to be filed with the notice of petition or order to show cause by which a special proceeding is to be commenced in the Appellate Division, only the name of the attorney for the petitioner need be provided. In the event that a litigant represents herself or himself, the box marked "Pro Se" must be checked and the appropriate information for that litigant must be supplied in the spaces provided.

Attorney/Firm Name: Michael M. Bast, PC			
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E-mail Address:michael@michaelbastlaw.com			
Attorney Type: ☒ Retained ☐ Assigned ☐ Government ☐ Pro Se ☐ Pro Hac Vice			
Party or Parties Represented (set forth party number(s) from table above):1			
Attorney/Firm Name: Gerspach Sikoscow LLP			
Address:40 Fulton Street			
City:New York	State:NY	Zip:10038	Telephone No:212-422-0700
E-mail Address:sikoscow@gerspachlaw.com			
Attorney Type: ☒ Retained ☐ Assigned ☐ Government ☐ Pro Se ☐ Pro Hac Vice			
Party or Parties Represented (set forth party number(s) from table above):2 and 5			
Attorney/Firm Name: Belair & Evans LLP			
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E-mail Address:escheffiein@belairevans.com			
Attorney Type: ☒ Retained ☐ Assigned ☐ Government ☐ Pro Se ☐ Pro Hac Vice			
Party or Parties Represented (set forth party number(s) from table above): 3 and 4			
Attorney/Firm Name:			
Address:			
City:	State:	Zip:	Telephone No:
E-mail Address:			
Attorney Type: ☐ Retained ☐ Assigned ☐ Government ☐ Pro Se ☐ Pro Hac Vice			
Party or Parties Represented (set forth party number(s) from table above):			
Attorney/Firm Name:			
Address:			
City:	State:	Zip:	Telephone No:
E-mail Address:			
Attorney Type: ☐ Retained ☐ Assigned ☐ Government ☐ Pro Se ☐ Pro Hac Vice			
Party or Parties Represented (set forth party number(s) from table above):			
Attorney/Firm Name:			
Address:			
City:	State:	Zip:	Telephone No:
E-mail Address:			
Attorney Type: ☐ Retained ☐ Assigned ☐ Government ☐ Pro Se ☐ Pro Hac Vice			
Party or Parties Represented (set forth party number(s) from table above):			

AFFIDAVIT OF SERVICE BY E-FILE and MAIL

State of New York }
}ss:
County of Kings }

Frances B. Bast, being duly sworn, deposes and says: I am over the age of 18 years, reside at Brooklyn, NY and am not a party to this action; that on October 31, 2019 deponent served within **Notice of Appeal** upon:

Gerspach & Sikoscow LLP
Attorneys for Staten Island University Hospital and James J. Ducey
40 Fulton Street
New York, NY 10038
(212) 422-0700

Belair & Evans LLP
Attorneys for Leonid Gorelik and
Metropolitan OB-GYN Associates, PC
90 Broad Street 14th floor
New York, NY 10004
(212) 344-3900

The address designed by said attorney(s) for that purpose by depositing a true copy of same enclosed in E-File and a post-paid, properly addressed wrapper, in a post office/official depository under the exclusive care and custody of the E-Filing and the United States Postal Service with the State of New York.

Frances B Bast
Frances B. Bast

Sworn to before me this
October 31, 2019

Notary Public

MICHAEL M. BAST
NOTARY PUBLIC, STATE OF NEW YORK
No. 02BA4780186
Qualified in Kings County
Commission Expires 5.31.23

Index #: 500510/14

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

RINAT DRAY

Plaintiff,

-against-

STATEN ISLAND UNIVERSITY HOSPITAL, LEONID GORELIK, METROPOLITAN OB-GYN ASSOCIATES, PC. and JAMES J. DUCEY,

Defendants

NOTICE OF APPEAL

MICHAEL M. BAST, P.C.
Attorney at Law
26 Court Street – Suite 1811
Brooklyn, New York 11242
(718) 852-2902

By: _____
Michael M. Bast, P.C.

Service of a copy of the within
is hereby admitted.

Dated: Brooklyn, New York

STATE OF NEW YORK)

COUNTY OF NEW YORK)

Filed
☒ Court Portal

Loree Chow, being duly sworn, deposes and says that deponent is not a party to the action, is over 18 years of age, and resides at the address 7 West 36th Street, 10th floor, New York, New York 10018, that on the 2nd day of November, 2020, deponent personally served via email the

Motion for Leave to File Amicus Brief

upon the attorneys who represent the indicated parties in this action, and at the email addresses below stated, which are those that have been designated by said attorneys for that purpose.

Names of attorneys served, together within the names of the clients represented and the attorney's designated email addresses.

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Appellate Counsel to:

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Attorneys for Defendants-Respondents
Staten Island University Hospital
and James J. Ducey
sikoscow@gerspachlaw.com

Sworn to before me this
2nd day of November, 2020.
E-Notarization Authorized by
N.Y.S Executive Order 202.7

SONJIA R. RICHARDS
Notary Public, State of New York
No. 03-4998375
Qualified in Bronx County
Commission Expires June 29, 2022

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