NEW YORK SUPREME COURT APPELLATE DIVISION
SECOND DEPARTMENT

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RINAT DRAY,
Plaintiff-Appellant

Docket Nos.: 2019-12617

-against-

NOTICE OF MOTION
Oral Argument Not Requested

STATEN ISLAND UNIVERSITY HOSPITAL and JAMES J. DUCEY
Defendants-Respondents

-and-

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

----------X

NOTICE OF MOTION OF VBAC FACTS AND EVIDENCE BASED BIRTH TO FILE AN *AMICUS CURIAE* BRIEF

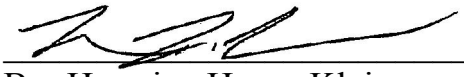
PLEASE TAKE NOTICE that, upon the annexed Affirmation of Hermine Hayes Klein, dated October 30, 2020, together with the Exhibit annexed thereto, the undersigned will move this Court, located at 45 Monroe Place, Brooklyn, New York, 11201 on the 16th day of November 2020 at 9:30 a.m. of that day or as soon as counsel can be heard, for an order granting VBAC Facts and Evidence Based Birth 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,

Hayes Klein Law

Dated: New York, NY
October 30, 2020



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NEW YORK SUPREME COURT APPELLATE DIVISION
SECOND DEPARTMENT

----------X

RINAT DRAY, Docket No.: 2019-12617

Plaintiff-Appellant

-against- **AFFIRMATION OF** HERMINE HAYES KLEIN

STATEN ISLAND UNIVERSITY HOSPITAL and JAMES J. DUCEY

Defendants-Respondents

-and-

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

Defendants-Respondents

----------X

Hermine Hayes Klein, 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 VBAC Facts and Evidence Based Birth 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 has moved this court to reverse the lower court's Order of October, 4 2019, arguing that the court improperly dismissed her motion to amend her complaint. Ms. Dray sought to add claims for breach of contract, fraud, deceptive acts, false advertising, denial of equal protection under New York civil rights law, and violations of the

New York human rights law and New York City human rights law to her complaint.

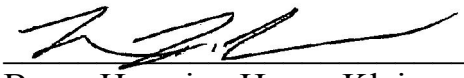
3. *Amici* VBAC Facts and Evidence Based Birth are both companies with unparalleled expertise in the issues before the court with regard to the risks and benefits of cesarean surgery and vaginal birth after cesarean surgery. VBAC Facts was founded in 2007 as a consumer-led organization, to help pregnant consumers to navigate the medical evidence relevant to making informed decisions between repeat cesarean section and vaginal birth after cesarean. VBAC Facts was founded in 2007 and has become a trusted consumer resource for the best and most accurate information about the medical facts at issue in this brief. Evidence Based Birth is an online childbirth resource founded in 2012 by a nurse with a PhD, with the mission of raising the quality of childbirth care globally, by putting accurate, evidence-based research into the hands of families and communities, so they can make informed medical choices throughout pregnancy and childbirth. *Amici* are able to bring to light relevant authority and information regarding the medical issues and decisions discussed throughout this brief, that were not considered by the Court below and which have not been raised by the parties.

4. *Amici* seek to assist the Court by supplementing the legal arguments raised by Ms. Dray with medical scholarship, and sources that put into context the nature of the parties' arguments with regard to VBAC in general and the facts of this case specifically. *Amici*'s collective expertise and experience in this area make them uniquely qualified to furnish the Court with this information.

WHEREFORE, VBAC Facts and Evidence Based Birth respectfully request that this Court grant their motion to file an *amicus curiae* brief.

Respectfully submitted,

Hayes Klein Law



Dated: New York, NY
October 30, 2020

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EXHIBIT A

To be Submitted by:
HERMINE HAYES KLEIN

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 *AMICI CURIAE* VBAC FACTS LLC and EVIDENCE BASED BIRTH

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Kings County Clerk's Index No. 500510/14

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AMICUS CURIAE STATEMENT OF INTEREST

VBAC Facts LLC is a Limited Liability Company based in California whose mission is to increase VBAC access through education, legislation, and amplifying the consumer voice. VBAC Facts provides unbiased information regarding evidence and options associated with repeat cesarean surgery and VBAC. This case has the power to significantly impact the right of New York citizens to make informed medical decisions in childbirth. Amicus VBAC Facts supports the plaintiff's arguments, and seeks to assist this Court by contributing the medical evidence on VBAC and repeat cesarean, as well as highlighting the contrast between national guidelines and U.S. obstetric practice.

Evidence Based Birth is an online childbirth resource that offers the latest, proven, evidence-based care practices to practitioners and parents. Evidence Based Birth seeks to raise the quality of childbirth care globally by putting accurate, evidence-based research into the hands of families and communities, so they can make informed choices. As a recognized expert on the weighing of risk related to childbirth, Evidence Based Birth offers critical insight for the court to consider.

SUMMARY OF THE ARGUMENT

Rinat Dray was fully conscious, decisionally capable, and informed about the risks that childbirth entails, when she was forced by Dr. Gorelick to have a cesarean surgery against her will. As an Orthodox Jewish woman who hoped for a large family, Dray carefully researched in preparation for her third birth. She read reports on her medical options from the American College of Obstetricians and Gynecology (ACOG), discussed her individual risk profile with multiple providers, and carefully selected a hospital and obstetrician who promised to respect her choice to attempt a vaginal birth after cesarean (VBAC). She made the informed decision that VBAC was right for her because it would give her the best chances at preserving her future fertility, would give her baby the healthiest start after birth, and would maintain her own physical, mental and spiritual wellbeing.

Even though the great weight of medical and legal authority were on her side—the potential risks of VBAC were very low, and she had a legal right to informed decisionmaking under New York and U.S. Constitutional law – Dray was forced under a surgical knife by the doctors she had trusted with the birth of her third child. The gender-based violence she experienced extended far beyond that surgery: Not only was she subjected to forced abdominal surgery and a bladder laceration that caused her to experience long-term urinary incontinence, but she has since become a victim of medical and judicial gaslighting as well. The lower

court, like her doctors, ignored her reasons for choosing vaginal over surgical delivery, and distorted the facts of her case so as to paint a terrifying picture of the risks involved with vaginal birth, depicting Dray's choice as unreasonable. In doing so, an egregious forced surgery was misrepresented as an emergency measure that was "reasonable to save the life of the fetus." No perceived emergency legally justifies forced surgery on a conscious patient. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (1914). However, even if one adopts the lower court's view that such circumstances exist, Rinat Dray's labor was not one. The court's conclusion that a cesarean section was necessary to save the life of the fetus, a key conclusion undergirding its decision to grant the defense motion to dismiss her amended complaint, was an error, and must be reversed.

ARGUMENT

I. The Lower Court Erred in Concluding That a Cesarean Section Was Necessary to Save the Life of the Fetus.

A. The Lower Court Made Factual Errors When It Accepted the Defense's Statement of Facts as True.

The defense enumerated a long list of medical risk factors that it deemed sufficient to establish that the "potential life of the fetus" was in danger, and the actions of the doctors were justified. These factors included: Dray's diagnosis of gestational diabetes in another pregnancy years earlier, her two previous cesareans, her gestational term, the claim that her labor "failed to progress" fast enough, the presence of meconium in the amniotic fluid, and moments of potential fetal heart deceleration detected by the electronic monitor. *See* Def.'s Br. at 4-6, 10, 13-14, 50. Not only are some of these assertions patently false with regard to Dray's medical record, but a different doctor could have made different recommendations on the risks associated with each of them. Dray has already submitted sufficient evidence to show that the medical facts that the defense identified as risks are contestable. *See* Lyerly Aff., 7-8. This section will address each issue, and explain why the risks associated with them are contestable matters of fact that could not form the basis of a dismissal pursuant to C.P.L.R. 3211 (a)(1) or C.P.L.R. 3211(a)(7).

1. The Defense Distorts the Actual Risks Present.

By framing recommendations in terms of relative risk rather than absolute risk, and ignoring the countervailing risks associated with surgical delivery, Metropolitan OB/GYN and SIUH gravely distort the risks present at the time of Dray's birth. Absolute (or actual) risk is the rate at which a particular outcome is known to occur in a given population. For instance, a 1% chance of uterine rupture during a VBAC is an absolute risk.[1] Relative risk describes how risky one choice is as compared to another. For example, the fact that a repeat cesarean section carries four times the rate of maternal death compared to a vaginal birth is a relative risk.[2] Rinat Dray understood and weighed the absolute and relative risks reasonably, despite the distorted risk story presented by her providers.

While a given choice in childbirth may lead to a significantly higher *relative* risk for the birthing person or fetus—even say three or four times the risk of a bad outcome—the *absolute* risk of harm typically remains low. For example, the rate of maternal death in a VBAC is 0.0019%.[3] The relative risk of death by cesarean

[1] Am. Coll. of Obstetricians and Gynecologists' Comm. on Practice Bulls., *Vaginal Birth After Cesarean Surgery Practice Bulletin*, *ACOG Practice Bulletin 205*, 33 OBSTETS. & GYNECOL. e110, e111 (2019), http://medi-guide.meditool.cn/ymtpdf/952D113A-E18B-95C6-4450-BCBD6EF9154C.pdf [hereinafter ACOG, *Vaginal Birth After Cesarean*] (reporting a risk of uterine rupture of 0.71% after one previous cesarean, and rates from 0.7% to 1.8% risk of uterine rupture after two cesareans from large studies).
[2] *See* ACOG, *Vaginal Birth After Cesarean, supra* note 1, at e111.
[3] *Id.*

is over four times higher, though still low in absolute terms.[4] Even though the relative risk is high, the absolute risk of dying during a cesarean birth—at 0.0096%--remains low.[5] The same is true when considering risks to the fetus from most clinical decisions during birth. The *relative* risk of the vaginal birth for the fetus may be high, but the *absolute* risk of perinatal mortality is low in either case.

There is no such thing as "risk-free" childbirth. The risk of death to mother or baby is always present in any mode of delivery, and the medical decisions that women face during pregnancy and childbirth involve balancing and trading off the risks that are present on both sides of each choice. The representation of risk by the defense, which emphasizes some risks while ignoring others, and focuses solely on relative risk, obscures the fact that the absolute risk levels present were low, and consistent normal levels of risk for childbirth. For example, the risk of uterine rupture in VBAC is similar to the rates of risk presented by emergency complications in childbirth present in any delivery, such as fetal distress from deprivation of oxygen, placental abruption (where the placenta separates from the uterine wall before birth), or a prolapsed umbilical cord (where the cord comes out before the fetus).

[4] *Id.*
[5] *Id.*

By focusing only on the relative risk of uterine rupture to the fetus—and ignoring all countervailing risks to Dray, her future fetuses, and this fetus—the defense misrepresents the risk tradeoffs on both sides of Dray's choice, and the low absolute levels of risk present at all times. This misrepresentation is not merely a clinical assessment on the part of the defendants; it is a proclamation of their values, in which the risks to Dray, her physical health, her postpartum mental health, and her future pregnancies were valued as irrelevant. Dr. Gorelick, Metropolitan and SIUH manipulated the concept of risk in childbirth in an attempt to coerce Rinat Dray into compliance with their preferred treatment plan. In this litigation, they have continued to distort and mispresent the actual risks present to the court as they seek legal sanction for their values, and attempt to establish an obstetric standard of care in which the right to refuse surgery does not apply.Prior Cesarean Sections Did Not Put This Fetus at Undue Risk.

Defendants focus on uterine rupture, and the risk of consequent fetal death, as rendering Dray's insistence on VBAC unreasonable and unsafe. *See* Def.'s Br. at 4-6, 10, 13-14, 50. They fail to disclose that 1) the chance of uterine rupture with a low-transverse or bikini cut incision like Dray's is anywhere from 0.7%—1.8%,[6] and 2) when a uterus ruptures, fetal death only occurs 1.6%—3% of that

[6] *See id,* at e113.

0.7% - 1.8% of TOLACs that resulted in uterine rupture.[7] In total, fetal demise from any cause occurs in 1.3 per 1,000 or 0.13% of VBAC attempts.[8] To put that in perspective, perinatal death occurs in 6 per 1,000 U.S. births, or 0.6% of pregnancies. Dray and her baby would have faced greater risks of health complications by having a tooth pulled or a hip replacement, than by VBAC.[9] The risk of uterine rupture was so low that even if the court had deemed it a matter of fact, forced surgery could not be called a life-saving measure.

In fact, Dray had almost none of the medical risk factors that are associated with increased risk for a VBAC. Medical authorities agree that pregnant people should have the supported choice for either mode of delivery.[10] Most people who attempt a trial of labor after cesarean (TOLAC) succeed with giving birth vaginally, achieving the health benefits of a vaginal birth for mother and baby, and

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[7] *See* Rebecca Dekker, *The Evidence on VBAC*, EVIDENCE BASED BIRTH (Jan. 28, 2020), https://evidencebasedbirth.com/ebb-113-the-evidence-on-vbac/; *See also* Loic Sentilhes et al., *FIGO Consensus Guidelines on Placenta Accreta Spectrum Disorders: Conservative management*, 140 INT. J GYNECOL. OBSTET., 291, 291 (2018); Yifru Berhan & Urgie Tadesse, *A Literature Review of Placenta Accreta Spectrum Disorder: The Place of Expectant Management in Ethiopian Setup*, 30 ETHIOP. J HEALTH SCI. 277, 282 (2020).

[8] *Id.*

[9] *See* Mayo Clinic Staff, *Dry Socket: Symptoms and Causes*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/dry-socket/symptoms-causes/syc-20354376; Periodontal Ass'n of Memphis, *How to Reduce the Chance of Dry Socket*, (Dec 31, 2010), https://www.periomem.com/blog/how-to-reduce-the-chance-of-dry-sockets/; Nat'l Health Serv., *Hip Replacement: Risks*, NHS.UK, (Dec. 23, 2019), https://www.nhs.uk/conditions/hip-replacement/risks/.

[10] ACOG, *Vaginal Birth After Cesarean, supra* note 1, at e112.

avoiding the risks of repeat cesarean deliveries.[11] According to the most recent ACOG practice bulletin, "given the overall data, it is reasonable to consider women with two previous low-transverse cesarean deliveries to be candidates for TOLAC."[12] Rinat Dray was no exception.

The risk level associated with VBAC, as opposed to Repeat Cesarean Surgery, is determined based on a series of factors, all of which Dray reviewed with her regular OB in making the decision to attempt a VBAC. As Dray's OB had acknowledged in supporting her plan, Dray had no contraindications for a trial of labor. *See* Lyerly Aff., 7-8. Her decision to refuse a cesarean birth was both reasonable and grounded in all available scientific evidence. Unfortunately, to Dray's regular OB was not on call the day that she went into labor, and the on-call OB simply believed that women like Dray should not be supported in a vaginal birth.

2. A Prior Diagnosis of Gestational Diabetes in a Different Pregnancy Did Not Put This Fetus at Risk.

The defense misled the court by falsely asserting that Dray had gestational diabetes ("GD"). *See* Def.'s Br. at 13. Although she had experienced GD in her first pregnancy, Dray tested negative for it in this third pregnancy, and her glucose

[11] *See* Am. Pregnancy Ass'n, *Vaginal Birth After Cesarean: VBAC,* AM. PREGNANCY ASS'N (Apr. 25, 2012), https://americanpregnancy.org/labor-and-birth/vaginal-birth-after-cesarean-669#:~:text=Statistically%2C%20the%20highest%20rate%20of,can%20successfully%20give%20birth%20vaginally.

[12] *See* ACOG, *Vaginal Birth After Cesarean, supra* note 1, at e112.

levels stayed within normal margins. *See* Ex. B. Zhabin Fact Stmt. at 2. The first pregnancy's diagnosis of GD created increased risk for *developing* GD in this pregnancy, a risk that Dray understood and managed successfully, so that she never did develop GD in this pregnancy. The defense inaccurately conflated the risk of *developing* GD, posed by the prior pregnancy, to falsely assert that Dray actually had GD at the time she was forced into surgery. The court should therefore disregard the defense's claim that Rinat Dray's prior history of gestational diabetes created risks that justified forced cesarean surgery.

3. Dray's Gestational Date of Delivery Did Not Contraindicate VBAC.

The length of Dray's pregnancy was normal. Although pregnancies calculate a "due date" of 40 weeks gestation, less than a quarter of labors begin in the 40th week of pregnancy, and a pregnancy is within a normal "full term" from 38 weeks to 42 weeks of pregnancy, with about half of babies born after 40 weeks.[13] The defense does not explain why Dray's gestational date of 41 weeks and 3 days is asserted as a risk factor of medical significance. *See* Def.'s Br. at 1, 10, 13. According to the most recent ACOG practice bulletin. "although one study has shown an increased risk of uterine rupture beyond 40 weeks of gestation, other studies, including the largest study evaluating this factor, have not found this

[13] *See* Rebecca Dekker & Anna Bertone, *The Evidence on Due Dates*, EVIDENCE BASED BIRTH (Nov. 24, 2019), https://evidencebasedbirth.com/evidence-on-due-dates/.

association."[14] Because the evidence is inconclusive that Dray's gestational date posed any increased risk to her fetus, the court should reject the assertion that it was a risk factor that justified forced cesarean surgery.

4. Dray's Labor Was Not "Failing to Progress."

The defense's claim that Dray's labor was "failing to progress" is false. Dray was still in early labor when her doctors began to apply timing standards that only apply later in the labor process.[15] Defendants argue that Dray's labor did not progress normally during the eight hours that she was at SIUH before surgery, but this is a gross misrepresentation. *See* Def.'s Br. at 1, 10, 15. By any evidence-based measure of labor progress, Dray's labor was progressing in a timely and healthy manner.

Cervical effacement, or thinning of the cervix, is one indicator of a labor's progress, along with cervical dilation and station of the baby. The rate of effacement does not, itself, present any risks to the fetus. Dray was 90% effaced at the time of the surgery, which the defense cites as a risk factor warranting an emergency cesarean. *See* Def.'s Br. at 1, 13, 15. This is a gross misrepresentation. The fact that Dray was 90% effaced at that stage actually indicates that her labor

[14] ACOG, *Vaginal Birth After Cesarean*, *supra,* note 1, at e112
[15] Am. Coll. of Obstetricians and Gynecologists and the Soc'y for Maternal-Fetal Med., *Safe Prevention of the Primary Cesarean Delivery*, 123 AM. J. OBSTET. GYNECOL. 179, 181 (2014), https://www.ajog.org/article/S0002-9378(14)00055-6/pdf [hereinafter ACOG, *Safe Prevention*.].

was progressing normally, and that her cervix was going through the normal process of preparing for vaginal birth.

Medical authorities agree that the "latent" stage of labor lasts until a pregnant person has reached 6 cm dilation, and that there is no universally applicable timeline for progress during this stage.[16] Because Dray was forced into surgery before her cervix had an opportunity to dilate to 6cm, Dray's doctors had no basis for their assessment that she was failing to progress. Dray met the evidence-based standards for labor progress in latent labor, because she was dilating more than one centimeter every four hours. The record also refutes defendants' claims that the station of the baby failed to progress. The baby's station, which measures the descent of the fetal head in the birth canal, went from -2 to +1 during Dray's hours at the hospital. *See* Ex. B. Zhabin Fact Stmt. This change indicates that Dray's baby descended three centimeters, normal progress for a vaginal birth. The defense's assertion that Dray's labor was failing to progress is unfounded and false.

In sum, the defense's claim that Dray's labor was not progressing is entirely unsupported by the documentary evidence. Dr. Gorelick used this mischaracterization to mislead, coerce and manipulate Dray during labor, and

[16] *Id.*

repeats it to this court to paint a false picture of risk, and to excuse forced surgery on pregnant New York citizens.

5. The Presence of Meconium Staining Did Not Mean the Fetus Was In Distress.

The presence of meconium—a collection of the fetus' digestive secretions—can, but does not necessarily, indicate that the fetus is experiencing stress during delivery. A fetus' bowels may release before birth for several reasons. Usually, it simply indicates that baby's digestive system has begun working: 15-20% of all term babies and 30-40% of babies born after 41 weeks, will have passed meconium in-utero.[17] Sometimes, meconium indicates normal cord compression during labor, without fetal distress. [18] Occasionally, meconium can indicate fetal distress resulting in hypoxia; however, the exact relationship between hypoxia and meconium is unknown. [19] Most babies who are born with health complications do not have meconium staining, and most babies born with meconium staining are healthy.[20] Meconium, by itself, cannot be relied on as an indication of fetal distress.

[17] *See id.*
[18] *Id.*
[19] *Id.*
[20] *See* Rachel Reed, *The Curse of Meconium Stained Liquor*, MIDWIFE THINKING, Jan. 14, 2015, https://midwifethinking.com/2015/01/14/the-curse-of-meconium-stained-liquor/.

6. The Fetal Heart Monitor's Indication of Fetal Heart Decelerations Was Not Reliable Evidence That the Fetus Was In Distress.

Electronic fetal monitoring (EFM) refers to the use of ultrasound to continuously track the baby's heart rate during labor.[21] EFM is used in 85% of births in the United States. However, expert Thomas Sartwelle writes that "EFM's scientific basis is not only weak, it is almost nonexistent," and that the machines are used by hospitals primarily to reduce the nursing costs associated with intermittent fetal heart monitoring.[22] Fetal heart decelerations occur routinely in labor and are usually no cause for concern. EFM is notoriously unreliable for ascertaining the wellbeing of the fetus, with a false positive rate of more than 99%--meaning that in 99% of "non-reassuring" EFM readings, the baby is fine.[23] Randomized trials have found that EFM has been a major driver of the 33% national c-section rate, without making any improvements in fetal outcomes like cerebral palsy, Apgar scores, cord blood gases, admission to the neonatal intensive care unit, low-oxygen brain damage, or perinatal death.[24]

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[21] Zarko Alfirevic et al., *Continuous Cardiotocography (CTG) as a Form of Electronic Fetal Monitoring (EFM) for Fetal Assessment During Labour,* 2 COCHRANE DATABASE SYST. REV, Feb. 3, 2017, at 1 (2017).
[22] *See* Thomas P. Sartwelle, *Electronic Fetal Monitoring: A Bridge Too Far*. 33 J. LEG. MED.., 313-379 (2012).
[23] *See* Thomas P. Sartwelle, *Defending a Neurologic Birth Injury: Asphyxia Neonatorum Redux,* 30 J. LEG MED. 181, at 213 (2009).
[24] *See* Rebecca Dekker & Anna Bertone, *The Evidence On: Fetal Monitoring*, EVIDENCE BASED BIRTH (May 21, 2018), https://evidencebasedbirth.com/fetal-monitoring/.

The fallibility of EFM is why best medical practice is to take additional steps to determine fetal distress. These include scalp stimulation to determine fetal responsiveness, administration of oxygen to the birthing person, or changing maternal position.[25] None of these steps were taken. Dray's baby was born with APGAR scores of 9/10 and 9/10, reflecting that the baby was not in distress at delivery, despite the doctors' coercive claims to the contrary. The condition of Dray's baby at birth demonstrates that EFM did not provide reliable evidence of fetal distress, and that the Defendants' claim that the condition of Dray's baby justified their abuse of Dray is false.

All of the risk factors identified by the defense are therefore contestable. By painting an exaggerated, inaccurate, and terrifying picture of Dray's labor, the defense successfully duped the court into believing that an emergency cesarean section was required to save the life of the fetus, when it was not. The dismissal must be reversed.

B. The Lower Court Erred When It Failed to Consider the Countervailing Risks of a Cesarean Section to This Fetus, to Rinat Dray's Future Fetuses, and to Dray Herself.

Reviewing facts in a light most favorable to Rinat Dray required, at a minimum, that the judge *consider* the reasons why she chose VBAC. Dray's reasoning is disturbingly absent from the court's discussion of what happened. To

[25] *See* ACOG, *Safe Prevention, supra* note 15, at 187.

disregard Dray's risk assessment is to selectively review facts in favor of the defendants, and to ignore the bedrock, constitutionally-grounded, legal and bioethical principle of informed consent and refusal. The lower court's analysis preemptively frames the plaintiff as irrational and ignorant of the biological process that she was going through on the day she gave birth to her third child. In fact, Dray had carefully reviewed—and weighed—the respective risks of VBAC compared to a cesarean, and she had the intellectual capacity to do so even without having gone to medical school. She understood that there were significant countervailing risks that a cesarean section created for this fetus, her future fetuses, and herself, that ultimately made VBAC the right choice for *her* and her family. Dray had a civil and human right to assess these risks for herself, and to have her ultimate decision be treated with respect by her doctors and by this court.[26]

1. The Lower Court Failed to Consider the Risks That a Cesarean Section Created for Rinat Dray.

Cesarean surgery created significant risks for Dray's health. Cesarean birth carries almost a five-fold higher risk of maternal death during the delivery than vaginal birth does.[27] The overuse of cesarean delivery by US obstetricians is associated with the fact that the US has the most expensive obstetric care in the

[26] See *Schloendorff*, *supra* p. 9, *Cruzan v. Dir., Mo. Dep't. of Health*, 497 U.S. 261, 271 (1990); *Konovalova v. Russia*, No. 37873/04, §1, European Court of Human Rights 2014.
[27] *See* ACOG, *Vaginal Birth After Cesarean, supra* note 1, at e11.

world, but is the only industrialized nation with rising maternal mortality.[28] In addition to a significantly increased risk of death, other increased health risks to Dray from a cesarean delivery included increased risk of cardiac arrest, hysterectomy, hemorrhage, blood clots, major infection, longer hospital stays, and hospital readmission.[29] These risks would be magnified in subsequent pregnancies, with each repeat cesarean increasing potentially life-threatening maternal complications.[30] Reading the evidence, let alone in the light most favorable to the plaintiff, reveals that the lower court's conclusion that a forced cesarean posed "no serious risk" to the health of the mother is in clear error.

Placenta accreta, in which the placenta grows into the uterine wall, often through scars in the uterus, is a much more difficult complication to treat than uterine rupture.[31] While fetal death will only occur in 1.3/1000 uterine ruptures, maternal death—which orphans a family—occurs in 60-70/1000 cases of placenta

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[28] Nina Martin, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World,* NPR (May 12, 2017) https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world.

[29] *See* Shiliang Liu et al., *Maternal Mortality and Severe Morbidity Associated with Low-risk Planned Cesarean Delivery Versus Planned Vaginal Delivery at Term*, 176 CAN. MED. ASS'N J., 455, 457 (2007); *See also* Henci Goer et al., *Vaginal or Cesarean Birth: What Is at Stake for Women and Babies*?, CHILDBIRTH CONNECTION (2012) https://www.nationalpartnership.org/our-work/resources/health-care/maternity/vaginal-or-cesarean-birth-what-is-at-stake.pdf.

[30] *See* Robert Silver, *Maternal Morbidity Associated with Multiple Repeat Cesarean Deliveries*, 16 OBSTET. GYNECOL. 1126, 1126 (2006); *See also* Darios Getahun et al., *Previous Cesarean Delivery and Risks of Placenta Previa and Placental Abruption*, 16 OBSTET. GYNECOL. 771, 771-778, (2006).

[31] *Id.*

accreta, usually from hemorrhage.[32] When Dr. Gorelick and Staten Island University Hospital ("SIUH") forced Dray to have surgery, they nearly quadrupled her risk of placenta accreta in subsequent pregnancies, from a 0.57% risk to a 2.13% risk after this third cesarean.[33] These are devastating consequences for someone like Rinat Dray, who planned on having several more children. Dray knew through experience that finding a doctor willing to try VBAC decreases with each surgical delivery. If it was difficult to find a provider willing to support her after two cesarean sections, it could be near-impossible after three or four. Dray preferred to take on the 0.7% to 1.8% risk of uterine rupture with her third pregnancy, rather than exponentially increase her risk of infertility or death in her next pregnancy.[34] Having a large family was fundamental to her personal, religious, and cultural identity. It is unethical and immoral to allow an individual doctor, or a hospital, or this court, to deem those priorities unreasonable or invalid.

Cesarean delivery also carried a risk of surgical injury for Dray—a risk that came to pass. Dray's doctors lacerated her bladder during the surgery, causing her to experience significant pain and long-term urinary incontinence. *See* Ex. B. Zhabin Fact Stmt. at 2. The lower court dismissed these consequences as "posing no serious risk to the mother's well-being." *See* Ct. Order, *supra*, at 14. In any

[32] *See* Dekker, *The Evidence on VBAC*, *supra* note 7.
[33] *See* Robert Silver et al., *supra* note 30..
[34] *See* ACOG, *Vaginal Birth After Cesarean*, *supra* note 1, at e113.

light that treats Dray as a human being who matters, an outcome that left her having to urinate into a bag, negotiate two catheters, and tend an infected abdominal incision, while attempting to care for a newborn infant and two small children, cannot be called an "insignificant" or of no serious risk to her well-being.

Many who have had cesareans report chronic long-term pain anywhere from three months to two years postpartum. Four different studies reported that 8.9% to 33% of those who have cesareans report long term chronic pain in comparison to 2 to 5.5% of those who have vaginal births.[35] Rinat Dray had personally experienced two previous cesareans. To disregard her (accurate) prediction that another would endanger her physical health violates the standard of review and the established law of informed consent and refusal.

2. The Lower Court Failed to Consider the Risks of a Cesarean Section to Dray's Fetus.

By focusing on the risks that vaginal birth created for Dray's fetus, the defense frames her decision as selfish and uninformed, and strategically ignores the risks that cesarean surgery created for that fetus. Dray knew the cesarean presented serious short- and long- term risks to her fetus. In the short-term,

[35] *See e.g.* Lone Nikolajsen et al, *Chronic Pain Following Cesarean Section*, ANAESTHESIOLOGICA SCANDINAVICA, 111, 112 (2004); Eugene Delcercq et al., *Mothers' Reports of Postpartum Pain Associated with Vaginal and Cesarean Deliveries: Results of a National Survey*, 35 BIRTH 16, 17 (2008); Maarten Loos et al., *The Pfannenstiel Incision as a Source of Chronic Pain*, 111 OBSTET. GYNECOL. 839, 839 (2008); Robert Silver, *Delivery After Previous Cesarean: Long-Term Maternal Outcomes*, 34 SEMIN. PERINATOL. 258, 259 (2010).

cesarean birth is associated with a higher risk of respiratory distress immediately following the birth, which often requires admitting the baby into the nursery or neonatal intensive care unit.[36] Even without respiratory distress, cesareans routinely result in significant early separation of the fetus from the mother, and critical harm to breastfeeding, bonding, and skin-to-skin contact.[37]

Breastfeeding is associated with numerous infant health benefits, such as fewer childhood illnesses, lower blood pressure and cholesterol levels, lower prevalence of obesity, and improved intelligence as adults.[38] Skin-to-skin contact has been proven to promote more effective breastfeeding initiation, greater likelihood of a stable heart rate, and a beneficial increase in blood sugar.[39] Because cesarean sections jeopardize the infant's access to breastfeeding and skin-

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[36] *See* Amy Hobbs et al., *The Impact of Caesarean Section on Breastfeeding Initiation, Duration and Difficulties in the First Four Months Postpartum*, 16 BIOMED. CENT. PREGNANCY CHILDBIRTH, 90, 92 (2016).

[37] *See id; See also* Roshni R. Patel et al., *Effect of Operative Delivery in the Second Stage of Labor on Breastfeeding Success*, 30 BIRTH 255, 255 (2003); Susan Watt et al., *The Effect of Delivery Method on Breastfeeding Initiation from the Ontario Mother and Infant Study (TOMIS) III*. 41 J OBSTET. GYNECOL. NEONATAL NURSING 728, 737 (2012); NJ MacMullen & LA Dulski, *Factors Related to Sucking Ability in Healthy Newborns*, 29 J OBSTETRIC GYNECOL. NEONATAL NURSING 390, 396 (2000).

[38] *See* Bernardo Horta et al., *Evidence on the Long-Term Effects of Breastfeeding: Systematic Reviews and Meta-Analyses*, WORLD HEALTH ORGANIZATION (2007); Cesar Victora et al., *Association Between Breastfeeding and Intelligence, Educational Attainment, and Income at 30 Years of Age: A Prospective Birth Cohort Study from Brazil,* 3 LANCET GLOB. HEALTH e199, e200 (2015); Amy Hobbs et al., *supra* note 36, at 92.

[39] *See* Rebecca Dekker & Anna Bertone, *The Evidence for Skin-to-Skin Care After a Cesarean*, EVIDENCE BASED BIRTH (Oct. 27, 2017), https://evidencebasedbirth.com/the-evidence-for-skin-to-skin-care-after-a-cesarean/#:~:text=After%20a%20Cesarean%2C%20the%20rates,after%20an%20uncomplicated%20Cesarean%20birth.

to-skin, they place the baby at risk for the chronic diseases mentioned above. In fact, research indicates that caesarean deliveries increase the relative risk of Type 1 diabetes by nineteen percent.[40] Similar increases were found in meta-analyses of asthma and obesity.[41] It was reasonable for Dray to prefer to reduce her child's risk of contracting diabetes by 19%, rather than reduce her risk of catastrophic uterine rupture by 0.7%.[42]

This cesarean section put Dray's baby at higher risk for multiple chronic diseases including Type 1 diabetes, obesity, and asthma.[43] In addition to these health risks, cesarean delivery carried a risk of death or serious complication for Dray's baby. There was no risk-free birth option for Dray's fetus, and Dray considered the full constellation of risks in making her decision. It is also important to note that any health risks to Dray herself also threatened her offspring. Any serious complication experienced by a birthing woman, either physical or

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[40] *See* Jan Blustein & Jianmeng Liu, *Time to Consider the Risks of Caesarean Delivery for Long Term Child Health,* 350 BMJ h2410, h2411 (2015), https://doi.org/10.1136/bmj.h2410.
[41] *See id.*
[42] Dray had a 0.02% risk of uterine rupture with a cesarean section and between a 0.7% and 1.8% risk of uterine rupture with TOLAC. *See* ACOG, *Vaginal Birth After Cesarean*, *supra* note 3=1, e11- e113.
[43] *See e.g.,* Blustein & Liu, *supra* note 40; G Loebel et al., *Maternal and Neonatal Morbidity After Elective Repeat Cesarean Delivery Versus a Trial of Labor After Previous Cesarean Delivery in a Community Teaching Hospital*, 15 J. MATERN. FETAL NEONATAL MED 243, 243 (2004); C.R. Cardwell et al., *Caesarean Section is Associated with an Increased Risk of Childhood-Onset Type 1 Diabetes Mellitus: a Meta-Analysis of Observational Studies*, 51 DIABETOLOGIA 726, at 735 (2008); S. Thavagnanam et al*., A Meta-Analysis of the Association Between Caesarean Section and Childhood Asthma*, 38 CLIN EXP ALLERGY 629, 633 (2008); H-t Li et al., *The Impact of Cesarean Section on Offspring Overweight and Obesity: A Systematic Review and Meta-Analysis*, 37 INT. J OBES. 893, 893 (2013).

emotional, necessarily impacts the newborn and children who will rely on her after the birth.

3. The Lower Court Failed to Consider the Risks That a Cesarean Section Created for Future Fetuses.

A third cesarean section put the future pregnancies that Rinat Dray intended to have at significantly higher risk than VBAC would have. According to ACOG, each subsequent cesarean increased her risk of hysterectomy (having her uterus removed), which would render her completely infertile.[44]

Because she planned to carry several more pregnancies, Dray weighed the risk of having four, five, or six cesareans. Repeat cesarean birth increases fetal risk in a future pregnancies, including miscarriage, prematurity, oxygen deprivation, and stillbirth.[45] The more cesarean sections a person has, the higher their risks of placenta previa (where the placenta is over the cervix) and placenta accreta become.[46] These risks increase only marginally after the first and second cesarean, but surge significantly after a third.[47] Rinat Dray was not comfortable with the risk of losing her ability to safely carry and deliver future babies. She

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[44] *See* ACOG, *Vaginal Birth After Cesarean, supra* note 1, at e111.
[45] *See* Am. Coll. of Obstetricians and Gynecologists, the Soc'y for Maternal-Fetal Med., *Management of Stillbirth*, ACOG OBSTETRIC CARE CONSENSUS 10, (Mar. 2020), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2020/03/management-of-stillbirth.
[46] *See* Mayo Clinic Staff, *Placenta Accreta*, MAYO CLINIC (Jun. 9, 2020), https://www.mayoclinic.org/diseases-conditions/placenta-accreta/symptoms-causes/syc-20376431.
[47] *See* Dekker, *The Evidence on VBAC*, *supra* note 7.

knew the cesarean would have long-term consequences for her and her family's well-being. She did everything she could to protect them from these risks, and has been treated by her doctors *and by the court* as irrational and uninformed for her evidence-based and rational perseverance. This is unacceptable, and must be reversed if the court is to be held accountable for its failure to consider the facts in a light most favorable to Rinat Dray.

II. Medical Uncertainty Means Patients Must Decide.

A. Science Is Uncertain About Most Risks in Childbirth.

The scientific uncertainty on which obstetric clinical recommendations are based underscores three relevant legal points in Dray's case: 1) that the facts must be weighed in Dray's favor on a motion to dismiss; 2) that defendant's claims of certain risk to the fetus are not grounded in scientific data; and 3) that Dray's decisions were reasonable, based on all of the available information.

There is a lack of clear scientific data on childbirth. As a result, providers make recommendations based on a combination of limited available evidence, personal experience, and common practice, rather than hard science. The recommendations given by Dr. Gorelick and SIUH to Rinat Dray are no exception. The dearth of medical certainty on risks, benefits, or the likelihood of various outcomes means that "the birthing process yields many decision-making points on

which professionals, patients—and even the state—may reasonably disagree."[48] When attempting to apply the limited data available, physicians regularly err in determining fetal risk. A review of court-ordered cesarean sections by physician experts found that the "prediction of harm to the fetus" made by medical providers who petitioned for court orders "was inaccurate" in over a third of cases.[49] Court orders forcing the patients to undergo cesarean sections were granted by the court in all of these cases, often within hours of being requested and with little scrutiny.[50] Such a rate of error undermines the notion that physician calculations of risk should allow forced intervention whenever a physician perceives it to be "in the fetal interest."

Most obstetric practice guidelines are based on little to no scientific evidence. In obstetrics, adherence to ACOG practice guidelines is considered the "benchmark for quality" in the United States.[51] But a review of obstetric guidelines issued by ACOG found that only 25.5% of its obstetric practice guidelines were based on "good and consistent" scientific evidence, while 74.5%

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[48] Jamie Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1959 (2013).
[49] Veronika E.B. Kolder, Janet Gallagher, & Michael T. Parsons, Special Article, *Court-Ordered Obstetrical Interventions*, 316 NEW ENGLAND J. OF MED., 1192, 1195 (1987).
[50] *Id.*
[51] J.D. Wright et al., *Scientific Evidence Underlying the American College of Obstetricians and Gynecologists' Practice Bulletins*, 118 OBSTET. GYNECOL. 505, 505 (2011).

of the guidelines were based on either "limited or inconsistent evidence" or "primarily on expert consensus or opinion."[52]

Due to the lack of strong evidence, clinical practices vary widely between individual medical providers and facilities.[53] Critically, patients have little control over which provider they see in labor, creating a significant element of chance as to the recommendations they receive. In Dray's case, had her own doctor been on call, or had she encountered an on-call provider who, in line with practice guidelines, supported VBAC, her birth would have gone very differently. The degree of provider variation in care, and strong element of chance for patients regarding which provider they will receive in labor, counsels against legal enforcement of provider recommendations over patient refusal. A birthing woman's only shield against the systemic dysfunction reflected in variations of provider preference and cesarean delivery rates is her right of informed consent and refusal, and she relies on the courts to enforce that right.

B. Risk Must Be Weighed According to Patient Values.

Childbirth carries risks, including loss of the baby or maternal death, regardless of the method of delivery. When a serious complication or death occurs

[52] *Id.* at 508. The classification of the quality of evidence used is performed by ACOG in its clinical bulletins. *Id.* at 506.
[53] *See* ACOG, *Safe Prevention of*, *supra* note 15 at 180; K.B. Kozhimannil et al., *Cesarean Delivery Rates Vary 10-Fold Among US Hospitals; Reducing Variation May Address Quality, Cost Issues*, 32 HEALTH AFF. 527–535 (2013).

during childbirth, that person must live with the outcome. The doctor does not share the same stake in the long-term outcome of the birth; lacks full information about the myriad social, cultural, and economic factors at play for the patient; and carries the doctor's own interests and subjective values into the birth.[54]

Physicians are not neutral.[55] Doctors have their own interests that influence and bias their perception of the "safest" course of treatment for the fetus.[56] Obstetricians face significant liability risks for poor neonatal outcomes, while they almost never face liability for harm to the birthing person, or for harm to the baby further down the line.[57] Therefore, doctors are incentivized to avoid any harm to the fetus, even if doing so comes at a steep cost to the mother. A meta-analysis of physician decisionmaking in labor that included 7,785 obstetricians found that "[c]linicians' fear of litigation was the most common factor influencing the

[54] *See, e.g.*, Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice Between Vaginal Delivery and Cesarean Section*, 71 THE MILBANK QUARTERLY 365 (1993) (finding that pregnant women with private, fee-for-service insurance have higher C-section rates than those who are covered by staff-model HMOs, uninsured, or publicly insured); Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. ECON. 99 (1996) (analyzing the correlation between a fall in fertility over the 1970-1982 period and the rise of cesarean delivery as an offset to lost profit).
[55] Raghad Al-Mufti et al., *Obstetricians' Personal Choice and Mode of Delivery*, 347 LANCET 544 (Feb. 24, 1996).
[56] Nathanael Johnson, *For Profit Hospitals Performing More C-Sections,* CALIFORNIA WATCH (Sept. 11, 2010), http://californiawatch.org/health-and-welfare/profit-hospitalsperforming-more-c-sections-4069 ("women are at least 17 percent more likely to have a cesarean section at a for-profit hospital than at one that operates as a non-profit");
[57] Abrams, *supra* note 48, at 1958.

decision to perform a CS."[58] Doctors routinely make care decisions based on the threat of liability rather than an assessment of actual risk, because potential liability puts their own neck on the line.[59]

Liability incentives in obstetrics currently do not incentivize good care. Under the current regime, providers believe they can protect themselves from liability if they impose interventions, including cesarean surgery. A liability rule that inclines doctors toward cesarean delivery might make sense if cesarean surgery carried no risks or costs, and vaginal birth were risky and dangerous. But, as reflected throughout this brief, that is not what the evidence shows. Courts must recognize that women are giving birth in environments where doctors claim that "liability" compels them to push for surgical deliveries that profit and convenience the provider, but impose risks on mother and baby, up to and including the risk of death.

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[58] Panda S, Begley C, Daly D., *Clinicians' Views of Factors Influencing Decision-Making for Caesarean Section: A Systematic Review and Metasynthesis of Qualitative, Quantitative and Mixed Methods Studies*. 13 PLoS ONE (2018), https://doi.org/10.1371/journal.pone.0200941.

[59] David Dranove & Yasutora Watanabe, *"Influence and Deterrence: How Obstetricians Respond to Litigation against Themselves and their Colleagues*, 12 AM. L. & ECON. REV. 69 (2010) (finding a short-lived increase in cesareans following the initiation of a lawsuit against obstetrician or colleagues); Lisa Dubay et al., *The Impact of Malpractice Fears on Cesarean Section Rates*, 18 J. Health Econ. 491 (Aug. 1999) (finding that physicians practice defensive medicine in obstetrics, resulting increased cesarean sections).

A holding that permits a provider to override the decisions of the birthing person marks a dangerous departure from existing legal and ethical standards. It may be tempting to create an "exceptional circumstance" provision that would only apply when the fetus's life was "truly in danger" and the birthing person still refused care. But the realities of childbirth make determining the level of fetal risk in a given situation with certainty impossible. Without state enforcement of informed consent in childbirth, birthing women are placed wholly at the mercy of whichever physician is on call, who can override maternal consent whenever they choose. Today, we urge this court to acknowledge that pregnant people are full citizens who retain the right of medical decision-making and bodily autonomy, and reverse the lower court's holding.

SUMMARY AND CONCLUSION

The lower court erred in dismissing the 2d Amended Complaint. By accepting the defense's exaggerated, and often false, representation of Ms. Dray's medical decisions, it shirked its procedural obligations to 1) abstain from findings of facts at the dismissal stage, and 2) view facts in favor of Ms. Dray. The conclusion that a cesarean section was necessary to save the life of the fetus was therefore both a procedural and factual error, and must be reversed.

To affirm the lower court would give doctors carte blanche to perform nonconsensual surgeries at will, making a court order un-necessary to override a decisionally capable adult's consent. Discovery and a trial are needed. The order below should be reversed, and the complaint reinstated.

Dated: Portland, Oregon, USA
November 2, 2020

Respectfully submitted,

VBAC Facts and Evidence Based Birth

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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

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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			
Address:26 Court Street Suite 1811			
City:Brooklyn	State:NY	Zip:11242	Telephone No:718-852-2902
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			
Address: 90 Broad Street 14th floor			
City:New York	State:NY	Zip:10004	Telephone No: 212-344-3900
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.

MICHAEL M. BAST, P.C.
Attorney for Plaintiff-Appellant
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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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