SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

RINAT DRAY,

Plaintiff,

-against-

Index No.: 500510/2014

Hon. Laura Lee Jacobson

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

Defendants.

BRIEF OF NATIONAL ADVOCATES FOR PREGNANT WOMEN ET AL. AS AMICI CURIAE IN SUPPORT OF PLAINTIFF RINAT DRAY

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Table of Contents

Table of Authorities

Cases

Statutes

Other Authorities

Regulations

Foreign Law

Introduction and Interest of Amici

National Advocates for Pregnant Women (NAPW) is a nonprofit organization dedicated to advancing the rights, health, and dignity of pregnant and parenting women and their families. Amici NAPW, Choices in Childbirth, the International Cesarean Awareness Network, Improving Birth, and Henci Goer bring expertise that is essential to resolving the issues in this case. Amici seek to address misstatements of law with regard to pregnant women and their rights to medical decision-making, and the serious implications that acceptance of Defendants' arguments would have for gender equality and maternal, fetal, and child health.

Summary of Argument

Rinat Dray, a legally competent adult, was forced to have cesarean surgery without her consent. As a result of the forced surgery, her bladder was seriously damaged, and she brought this lawsuit. Unable to oppose Ms. Dray's summary judgment motion on factual grounds, as their own records indicate that Ms. Dray was competent and forced to have surgery over her objection, Defendants instead posit that major surgery over the refusal of a conscious and competent adult patient is legally and ethically justified if that patient is pregnant. Essentially, they claim that pregnant women are in a special class of persons who may be subjected to surgical invasions with no redress at law.

To support this position, Defendants minimize the risks of cesarean surgery,

suggest that doctors are infallible in their predictions of harm, and claim that this case presents "novel" issues for which there is no "precise decision or statutory authority." (Alexander Sikoscow Aff. in Opp'n ¶¶ 3-6.) They go so far as to make the remarkable argument that legislative action is required to establish that pregnant women have the same legal rights as other persons under New York law. (Sikoscow Aff. in Opp'n ¶¶5, 58 at 2, 19.)

Defendants' claims are premised on a legally incorrect notion that outside parties have the authority, in the name of fetal protection, to impose medical decisions on pregnant women and to deprive them of their fundamental rights, including potentially their right to life. This notion is rooted in discriminatory beliefs that it woman's role to sacrifice everything — her body, her safety, her autonomy — for the pregnancy she carries, and the concomitant view that if the baby is born healthy, the pregnant woman has suffered no real harm.

To accept such a view in law would enshrine gender inequality by creating a separate law of tort for pregnant women, and elides the very real harms of this violation. Forced surgery and other coercive obstetric interventions are increasingly recognized as a form of gender-based violence. Such violence not only harms the pregnant woman and diminishes her legal personhood, but undermines maternal, fetal, and child health. This Court should refuse Defendants' invitation to insulate them from legal redress for their actions.

Argument

I. Absent emergency, the law forbids physicians from performing unconsented surgery on any person. Pregnancy is no exception.

Defendants contend that the constitutionally-protected right to be free from unwanted bodily invasions disappears during pregnancy, calling it "naïve and foolish" to assert that pregnant women have the same rights as other patients. (Sikoscow Aff. in Opp'n ¶ 57 at 19.) But this is not the law.

A. The right to refuse surgery, regardless of whether the surgery is intended to benefit the fetus, is protected by state and federal law.

The rights at stake here are protected by common law and the U.S. Constitution. *See, e.g., Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 289 (U.S. 1990)(O'Connor, J., concurring)("[T]he liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment. . . ."). *See also Carey v. Population Services Int'l*, 431 U.S. 678, 684, 685 (1977).[1] A New York case articulates the most frequently cited legal tenet regarding the common law right to bodily integrity: "Every human being of adult years and sound mind has a right to determine what shall be done with [her] own body." *Schloendorff v. New York Hospital*, 211 N.Y.

[1] Pregnancy does not justify denying women fundamental rights. *See e.g., Ferguson v. City of Charleston*, 532 U.S. 67 (2001)(upholding, at all stages of pregnancy, a woman's Fourth Amendment protection against illegal searches and seizures, rejecting claims of fetal protection as a "special needs" exception).

125, 129 -30(194). *See also Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251(1891) ("No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.").

As these cases recognize, all competent adults are entitled "to make their own personal health care decisions without interference from the State." *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 226, 231 (N.Y. 1990). Recognizing this high regard for the right to bodily integrity and a patient's right to self-determination, New York has created safeguards to ensure that every patient is able to determine his or her own medical care. *See* N.Y. Pub. Health L. § 2803-c (3)(e) et seq.; N.Y. Pub. Health L. § 2504; N.Y. Pub. Health L. § 2805-d; 10 NYCRR 405.7 *et seq.* New York's Maternity Information Act further mandates that hospitals publicly disclose information about their birth-related practices, including cesarean surgery. N.Y. Pub. Health L. § 2803-j (2)(a-m). This law was passed to ensure that women have the information they need about healthcare facilities and to address overuse of cesarean surgery and other procedures.[2]

[2] *See* Laurel Tumarkin et al., *Giving Birth in the Dark: City Hospitals Still Failing to Provide Mandated Maternity Information*, Office of the New York City Public Advocate 7 (2006), http://publicadvocategotbaum.com/policy/documents/GivingBirthInTheDark12.06.pdf.

Moreover, New York courts have repeatedly rejected claims that women's rights may be diminished because they are pregnant. *See Wilner v. Prowda,* 158 Misc.2d 579, 583 (Sup. Ct. N.Y. County 1993) (rejecting a husband's motion to prevent his pregnant wife from leaving town and explaining that "women do not lose their constitutionally protected liberty . . . when they are pregnant"); *Matter of Sara Ashton McK. v. Samuel Bode M.,* 111 A.D.3d 474, 475 (App. Div. 1st Dep't 2013) (rejecting an interpretation of the Uniform Child Custody Jurisdiction and Enforcement Act that would deny New York jurisdiction of a child custody dispute because the mother left her home state while eight months pregnant, holding "[p]utative fathers have neither the right nor the ability to restrict a pregnant woman from her constitutionally-protected liberty.") To suggest, as Defendants urge, that pregnancy is an "emergency" that exculpates them from any liability for forced surgery flies in the face of these well-recognized rights.

B. **Pregnancy is not an emergency exception to informed consent.**

All people have the common law and statutory right to informed consent to medical treatment. *Fosmire*, 75 N.Y.2d at 226. New York law recognizes only a narrow exception to this requirement: when emergency medical treatment is necessary but a patient is "unconscious or otherwise unable to consent." *Id.* at 225. *See also* N.Y. Pub. Health L. § 2805-d (2).

Despite Defendants' claims that this exception authorized unconsented surgery on Ms. Dray, the emergency exception, by its terms, could not apply to a conscious, competent pregnant woman. *See, e.g., Fosmire* at 225. For Defendants' argument to make any sense, all that a doctor would need to override a patient's right to informed consent is to assert that a medical emergency exists – not for the pregnant woman herself but for the fetus. Under this reasoning, every pregnancy could be framed as an emergency.

But pregnancy does not grant doctors free reign to impinge on women's rights in the name of fetal health. As the Appellate Division has noted, New York laws "specifically provide that a patient has a right to determine [her] own medical treatment and that right is superior to the physician's duty to provide necessary care." *Randolph v. New York*, 117 A.D.2d 44, 49 (App. Div. 1st Dep't 1986) (limiting liability where a Jehovah's Witness died from blood loss related to childbirth after refusing a transfusion). While fundamental rights to bodily integrity and medical decision-making are not absolute, these rights may be overcome only through process of law and upon showing of a compelling state interest. *Fosmire,* 75 N.Y.2d at 226. Here, Defendants make the astounding claim that as long as a doctor believes there are "ominous signs of fetal distress" (Evans Aff. in Opp'n ¶ 24) and risk of "severe and permanent neurological damage" (*Id*. at 27), pregnant

women not only lose their rights to consent and bodily integrity, but also due process.

C. The existence of a fetus does not entitle doctors to override the medical decisions women make about their own bodies.

Defendants make several variations on the argument that the existence of the fetus entitles them to take action. No law, however, supports this position.

1. That another's life might be saved is not a basis for unconsented to surgery on anyone — including pregnant women.

Even assuming that Ms. Dray's physician's predictions about her pregnancy outcome were correct, they do not have the right to perform surgery on her for the benefit of the fetus without her consent. The law is crystal clear: the constitutional and common law rights to control one's own body may not be violated, even when it appears that such intervention would be the only way to save the life of another person. In *McFall v. Shimp,* 10 Pa.D. & C.3d 90 (Allegheny County Ct. 1978), a judge refused to order an unwilling man to donate bone marrow to his cousin, even though the intrusion would be minimal and the marrow was the only thing that could save his cousin's life. Calling the man's refusal morally reprehensible, the court nevertheless found that compelling unwanted medical procedures "causes revulsion to the judicial mind" and "would change every concept and principle upon which our society is founded." *Id*. at 92.

Thus, the law does not support forcing the pregnant woman to undergo surgery for the benefit of the fetus, when the law would not allow a doctor to force a parent to contribute a kidney or even bone marrow to the patient child, even if the child is facing death without the donation. As the District of Columbia Court of Appeals explained in *In re A.C.,* 573 A.2d 1235, 1244 (D.C. Ct. App. 1990), "[s]urely . . . a fetus cannot have rights in this respect superior to those of a person who has already been born."

2. Pregnant women retain the right to bodily integrity and medical decision-making.

Defendants selectively cite four non-precedential cases to argue that "[i]t is well-settled that this State's interest in protecting a viable fetus warrants forcing medical interventions to a pregnant mother despite her refusal to consent." (Sikoscow Aff. in Opp'n ¶ 68 at 16.) The law does not support such a claim.

a) The weight of authority is against forcing women to have cesarean surgery against their will.

The only New York case Defendants cite is *Matter of Jamaica Hospital*, 128 Misc.2d 1006 (Sup. Ct. Queens County 1985), a case both wrongly decided and inapplicable here. In that case, a trial court, on an emergency basis at a gravely ill pregnant woman's bedside, ordered a blood transfusion over the woman's religious objection. But this decision involved protecting the woman's own life and is improperly based on a *parens patriae* interest in an 18-week old fetus, *Id.* at 1008;

an interest that properly applies to children, not fetuses at any stage of development. The other cited cases are similarly inapposite. *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 201 A.2d 537 (N.J. 1964), a New Jersey trial court decision that also involved a claim of religious liberty for a transfusion that was necessary to preserve the life of the woman, was reached prior to the now well-established recognition of the right to privacy in medical decision-making.

Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Georgia 1981) and *Pemberton v. Tallahassee Mem. Reg. Med. Ctr*., 66 F.Supp.2d 1247 (Fla. Cir. Ct. 1999) are used by Defendants for the proposition that "other states have ordered a c-section to be performed over the mother's refusal in order to save the fetus' life." (Sikoscow Aff. in Opp'n ¶ 70 at 16.) While that is true, both of these cases demonstrate the fallibility of medical predictions, and neither comports with the kind of process that would be required to deprive a person of their medical decision-making rights. The *Jefferson* decision was reached without briefing or even representation of the pregnant woman at one of the two court proceedings. 274 S.E.2d at 458. In that case, the hospital sought a court order to force a woman to submit to cesarean surgery based on a physician's claim that there was a 99% chance that the fetus would die during a vaginal delivery, and a 50% chance that Ms. Jefferson would die. The trial court granted an emergency order based on these

predictions – which turned out to be wrong. Her health condition resolved and Ms. Jefferson had a safe vaginal delivery.[3]

Similarly, *Pemberton* (which, like *Jefferson*, is not controlling precedent in this court) involved a woman who lost a civil rights suit after being compelled to undergo cesarean surgery based upon an "unacceptable" risk of fetal death if she delivered vaginally. 66 F.Supp.2d at 1256. Notably, Ms. Pemberton did not challenge the notion that her fetus had rights that outweighed her own. *Id*. at 1252. Moreover, the court reached its decision in reliance on predictions of harm that are called into doubt by the fact that Ms. Pemberton subsequently safely delivered other children vaginally, despite now having had two previous cesarean deliveries.[4]

Far more authoritative decisions undermine Defendants' claims. In *In re A.C.,* a trial court granted an emergency order forcing a pregnant woman to have cesarean surgery over her objections. Neither she nor the baby survived. On appeal the *en banc* District of Columbia Court of Appeals vacated the court-ordered cesarean and held that pregnant women, even those carrying presumptively viable fetuses, have a right "under the common law and constitution to accept or refuse

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[3] Helene M. Cole, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2664 (1990); *see also* Robert N. Berg, *Georgia Supreme Court Orders Cesarean Section – Mother Nature Reverses on Appeal*, 70 J. Med. Ass'n Ga. 451 (1981).

[4] Marsden Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*, 124 (2008); Laura Pemberton, Address at NAPW's National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (Jan. 18-21, 2007), *available at* http://vimeo.com/4895023.

treatment." 573 A.2d at 1247. *See also, In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994) (refusing to grant a court order for cesarean surgery because "[a] woman's competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus"); *In re Fetus Brown*, 689 N.E.2d 397 (Ill. App. Ct. 1997) (overturning a court-ordered blood transfusion of a pregnant woman). In each of these cases, courts recognized that pregnant women have the same rights to consent to medical treatment as other people, rights that are not outweighed by physician claims of potential harms to the fetuses they carried.

b) *The judicially recognized state interests in children and "potential life" do not countenance forcing pregnant women to have unconsented surgery for the claimed benefit of a fetus*.

Defendants also seek support for their radical position in cases in which the state has exercised its *parens patriae* power, not to force a parent to undergo major surgery, but rather to order through legal process that a living child receive life-saving treatment over the objection of the parent. (Sikoscow Aff. in Opp'n ¶¶71-72 at 16-17.) But fetuses are not children. *Byrn v. New York City Health & Hospitals Corp.*, 31 N.Y.2d 194, 203 (1972) (holding "the Constitution does not confer or require legal personality for the unborn."); *see also Roe v. Wade*, 410 U.S. 113, 158 (U.S. 1973) ("[T]he word 'person,' as used in the Fourteenth Amendment, does not include the unborn.")

Defendants misconstrue abortion regulation jurisprudence and suggest that it allows private actors to impose their medical decision on women who seek to continue their pregnancies to term. Even in the abortion context, it is clear that at all points in pregnancy the woman's life is the strongest interest – both of the individual woman and of the state – and the woman's health remains paramount, even over the state's interest in prohibiting abortion to protect potential life. *Planned Parenthood v. Casey*, 505 U.S. 833, 879 (1992). Thus, while a state interest in potential life has been deemed compelling enough to permit states to prohibit some (although not all) post-viability abortions, that interest and its reach are specific to the abortion context: it does not give private actors, much less the state, the authority to deprive women of their fundamental rights simply because they are nearing the end of their pregnancies.[5]

Moreover, no state interest shields Defendants from the common law consequences of their private negligent conduct. Simply put, Defendants are not state actors. If they wanted to cloak themselves in the state interest they assert, then they were required to seek a court order to operate on Ms. Dray without her

[5] Whatever duty of care physicians owe to developing fetuses, that was "impliedly recognized in *Woods v Lancet,* 303 N.Y. 349 (1951)" it in no way permits violating a woman's rights. *Broadnax v. Gonzalez*, 2 N.Y.3d 148, 154 (2004) (recognizing that whatever the duty of care to the fetus, doctors "surely owe a duty of reasonable care to the expectant mother, who is, after all the patient").

consent. This Defendants did not do. Pregnancy is a risky thing[6]– to allow the state (or, in this case, private actors) to determine what risks the pregnant woman may or may not take will reduce every woman's status as equal citizens of this nation.

II. Ethical standards require physicians to abide by their patient's wishes, and recognize that doctors are fallible.

Far from being "debatable," the overwhelming consensus of bioethicists and medical groups is that it is ethically forbidden to infringe upon a pregnant woman's right to make decisions about the course of her medical care, even when her decisions may pose a risk to fetal health. Recognizing the trust that is required for an effective provider-patient relationship, the American Medical Association (AMA) and American College of Obstetricians and Gynecologists (ACOG) ethics guidelines forbid coercing or forcing patients to following physician orders.[7]

These guidelines recognize that forcing pregnant women to accede to medical intervention is unethical in part because it assumes a level of infallibility that does not exist. [8] Defendants imply that they are in fact infallible to the point where consent is not required; other forced surgery cases belie that assumption. For example, in *Jefferson*, the doctors' conviction that the surgery was needed turned

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[6] Amnesty International, *Deadly Delivery: The Maternal Health Crisis in the USA, One-Year Update* 3, 5-7 (2011).
[7] ACOG Committee on Ethics, Opinion No. 55, *Patient Choice: Maternal-Fetal Conflict* (Oct. 1987); ACOG Committee on Ethics, Opinion No. 321, *Maternal Decision Making, Ethics, and the Law* 8 (2005).
[8] ACOG Ethics Op. 55, *supra* note 7, at 7; *see also* Veronica E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 New Eng. J. Med. 1192, 1195 (1987) (in nearly one-third of court-ordered obstetrical interventions, the medical judgment proved incorrect).

out to be wrong.[9] *See also Baby Boy Doe*, 632 N.E.2d 326 (fetus was given "close to zero" chance of surviving vaginal birth; baby born healthy after court refused to grant order for cesarean); *In re Madyun*, 573 A.2d. 1259 (D.C. Sup. Ct. 1986) (risk of infection reason for forced surgery; no such infection found upon delivery).[10]

Other cases similarly expose the danger in Defendants' claims of their capacity to predict pregnancy outcomes accurately. In *In re Baby Kenner*, No. 79-JN83 (Colo. Juv. Ct. Denver County 1979), an emergency hearing was called because a pregnant woman refused cesarean surgery when her labor was not progressing and fetal monitoring apparently indicated that the fetus showing signs of distress.[11] On this basis, a court ordered that she undergo cesarean surgery. The allegedly dire condition of the fetus, however, was not in evidence upon birth.[12] Similarly, when a Manhattan hospital sought a court order to force a pregnant woman to undergo cesarean surgery, the outcome was very different from what doctors predicted. Her doctors believed that the fetus was in danger of brain damage if delivered vaginally. The judge who was called into the hospital for the hearing refused to grant the order, stating "I couldn't see subjecting her to possible death for someone

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[9] Cole, *supra* note 3, 2664.
[10] *See* Cynthia Gorney, *Whose Body is it, Anyway? The Legal Maelstrom That Rages When the Rights of the Mother and Fetus Collide*, Wash. Post, Dec. 13, 1988, at D1 (reporting that, after forced surgery, Ayesha Madyun "delivered a 6.5 pound baby boy who was born with excellent lungs and no sign of infection").
[11] Nancy K. Rhoden, *The Judge in the Delivery Room*, 74 CAL. L. REV. 1951 n.3 (1986); Watson A. Bowes & Brad Selegstad, *Fetal Rights Versus Maternal Rights: Medical and Legal Perspectives*, 58 Obstetrics & Gynecology 209 (1981).
[12] *Id.* at 211.

who's not even born yet. It's been held unreasonable to subject an accused criminal to surgery to find a bullet for evidence. If that's unreasonable, this certainly is."[13] Two hours later, the woman delivered a healthy baby vaginally.[14]

Even when the risk to a fetus is less in doubt, the intervention may be futile for the fetus and dangerous to the woman.[15] As the tragic case of Angela Carder demonstrates, medical providers and courts risk grave consequences when they interfere with women's medical choices based on fallible judgments of medical providers. *See A.C.*, 573 A.2d at 1240- 241. Because it is impossible for doctors to predict accurately what the outcome of any given pregnancy will be, and because they cannot guarantee that a pregnant woman will not be harmed by a given medical intervention, ethics require doctors to respect the pregnant woman's decision making. By not doing so, Defendants evoke outmoded views of women's roles, used to shield from legal redress other forms of violence against women.

III. The Defendants' proposed standard for evaluating this case minimizes the risks to women, entrench gender discrimination, and endorses a form of gender violence.

Defendants suggest a three-part test for evaluating this case: "(1) high reliability of the prognostic judgment that on balance Cesarean delivery is expected to

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[13] Ronni Sandroff, *Invasion of the Body Snatchers*, Vogue, Oct. 1988, at 330.
[14] *Id*., Janet Gallagher, *The Fetus and the Law – Whose Life is it Anyway,* MS., Sept. 1984, at 62; Tamar Lewin, *Courts Acting to Force Care on the Unborn,* N.Y. TIMES, Nov. 23, 1987, at A1.
[15] *See* Nancy K. Rhoden, *Cesareans and Samaritans,* 15 J. L. Med. & Health Care 112, 122 (1987). ("The court cannot know the exact risks it is planning to impose on the individual woman, because statistics don't tell us this").

prevent serious infant morbidity or mortality, (2) the lack of physical resistance from the patient that could significant[ly] increase risks of maternal and fetal harm, (3) insufficient time to consider a court order." (Dr. Chase Aff. ¶ 10). This proposal represents an extreme outlier ethics opinion and is dangerous to maternal, fetal, and child health. If accepted, it would validate long-rejected notions of gender inequity and encourage the violence of forced and threatened medical interventions on non-consenting women. It also ignores crucial medical facts about pregnancy, cesarean surgery, and the lives of pregnant women.

A. **Defendants' proposed standard minimizes the risks women bear.**

Pregnancy should provide grounds for particular regard for women's constitutional and common law rights. As the U.S. Supreme Court has observed,

> The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. . . . Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture.

Casey, 505 U.S. at 852. As the Court rightly observed, childbearing is potentially dangerous. More women die from complications of pregnancy and childbirth in the United States than in any other wealthy nation.[16] More still are "near misses":

[16] *See* C.I.A. World Factbook, *Country Comparison: Maternal Mortality Rate*, https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html (last visited May 7, 2012).

according to Amnesty International, 68,433 women nearly died in childbirth in the U.S. in 2004 and 2005.[17]

While both vaginal and cesarean delivery carry risk, evidence suggests that cesarean delivery is more dangerous to mothers than vaginal delivery.[18] Those risks include infection, hemorrhage, bladder and uterine lacerations, and death.[19] A comprehensive analysis of maternity care found that "maternal death, emergency hysterectomy, blood clots and stroke . . . poor birth experience, less early contact with babies, intense and prolonged postpartum pain, poor overall mental health and self-esteem, poor overall functioning" were more likely to occur with cesarean surgeries than vaginal birth.[20] Cesarean surgery also increases the risk of future infertility and deliveries marked by low birth weights, preterm births, and stillbirths.[21] High cesarean rate is correlated with maternal mortality: women have a 21% greater risk of dying of pregnancy-related causes in states with high

[17] Amnesty Int'l, *supra* note 6.
[18] F. Gary Cunningham et al., Williams Obstetrics 592 (22nd ed. 2005).
[19] *Id.*
[20] Carol Sakala & Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve* 44 (2008).
[21] *Id.* at 46.

cesarean rates.[22] The risks are compounded with each successive surgery; by the third surgery, the chance of a major surgical complication is 1 in 13.[23]

Thus, it is reasonable for a woman to withhold consent to cesarean surgery. 60-80% of women who attempt a vaginal birth after cesarean are successful.[24] Even among women are not optimal candidates for a trial of labor, "[r]espect for patient autonomy supports the concept that patients should be allowed to accept increased levels of risk."[25] In light of the serious risks associated with cesarean surgery, subjecting a woman to unwanted surgery not only undermines her rights, it could, as the *A.C.* case demonstrates, amount to a death sentence.

B. **Forced surgery undermines maternal fetal and child health.**

In addition to subjecting individual women to risks to their own health, imposing such surgery has broader public health consequences. Cesarean surgery can be a beneficial and life-saving procedure in certain circumstances. But "cesarean section has potential for great harm when overused."[26] The overuse of this surgery erodes public health; likewise, the betrayal of the physician-patient

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[22] G.K. Singh, U.S. Dep't of Health and Human Servs., Maternal and Child Health Bureau, *Maternal Mortality in the United States, 1935–2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist* (2010).
[23] Victoria Nisenblat et al, *Maternal Complications Associated with Multiple Cesarean Deliveries,* 108 Obstetrics & Gynecology 21, 25 (2006).
[24] ACOG *Practice Bulletin No. 115: Vaginal Birth After Previous Cesarean Delivery* 3 (Aug. 2010), *reaff'd* 2013.
[25] *Id*. at 8.
[26] Sakala & Corry, *supra* note 20, at 44.

relationship inherent in forced medical interventions, including cesarean, will undermine maternal, fetal, and child health.

1. Allowing unconsented surgeries would increases the likelihood of the overuse of cesarean surgery.

Unfortunately, cesarean surgery is often performed when unnecessary.[27] In fact, cesarean surgery rates in the United States have reached levels far beyond those recommended by national and international health organizations.[28] At 32.7% of births, the New York City cesarean rate is more than twice the proportion identified by the World Health Organization (WHO) as a threshold beyond which cesarean rates may do more harm than good.[29]

The high rate of cesarean surgery in New York suggests that cesarean surgeries are likely being performed in circumstances under which they may not be medically necessary or even advisable.[30] Experts argue that increased rates of cesarean surgery are the result of a belief that the procedure is "efficient and lucrative."[31] Others note that cesarean surgeries are "widely viewed as reducing

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[27] *Id.* at 41-48.
[28] *Id*. at 42; *see also* WHO, United Nations Children's Fund, United Nations Population Fund, *Monitoring Emergency Obstetric Care: A Handbook* 25 (2009). .
[29] Regina Zimmerman et al., *Summary of Vital Statistics, 2012: Pregnancy Outcomes* N.Y.C. Dep't of Health & Mental Hygiene (2013).
[30] Diana Bowser & Kathleen Hill, *Exploring Evidence for Disrespect and Abuse in Facility Based Childbirth: Report of a Landscape Analysis*, USAID TRAction Project, Harvard School of Public Health, at 10 (Sept. 2010) [hereinafter USAID Report]; Sakala & Corry, *supra* note 21, at 41.
[31] *Id.* at 44 (internal citations omitted).

risk for malpractice claims and suits" even if such practices are not in the interests of pregnant women.[32]

ACOG and the Society for Maternal-Fetal Medicine (SMFM) have issued a joint consensus statement on the importance of reducing the rate of primary cesarean delivery.[33] These groups recognize the health risks inherent in a major surgical intervention, but also the impact on subsequent pregnancies. Allowing unconsented surgeries in light of physician fallibility only increases the risk that women will be subjected to unnecessary surgery with major health risks, in direct contravention of strong public and medical association policies.

2. Forced surgery over a patient's objection undermines the patient-physician relationship, increasing risks to public health.

Beyond the harms to Ms. Dray, permitting forced surgery over pregnant women's consent undermines all pregnant women's trust in the medical profession. Overriding pregnant women's decision-making renders the hospital setting adversarial, counter to the fundamental purpose of the medical profession. Adversarial or coercive doctor-patient relationships risk harm to women and babies by "precipitat[ing] general distrust of physicians on the part of pregnant women."[34] Women who fear coercion may withhold information from their doctors or may

[32] *Id.*
[33] ACOG & SMFM, *Consensus No 1: Safe Prevention of the Primary Cesarean Delivery*, 123 Obstetrics & Gynecology, 693 (2014).
[34] Cole, *supra* note 3, at 2666.

avoid medical care altogether.[35] *See A.C.,* 573 A.2d at 1248 ("Rather than protecting the health of women and children, court-ordered caesareans erode the element of trust that permits a pregnant woman to communicate to her physician . . .") Denying tort recovery validates unchecked power to force surgery on pregnant women and is counterproductive, particularly because experts recognize "[e]ncouraging prenatal care and treatment in a supportive environment" is most likely to advance maternal and child health.[36]

C. Unconsented surgery on pregnant women is a form of discrimination and gender-based violence.

Forced surgery is a violent act. But forced cesarean surgery, that takes place in a setting where women hold less power than doctors, in a society where women's capacity for pregnancy has been historically used to sanction their exclusion from full citizenship, is not a simple battery. It is a form of gender-based violence, increasingly recognized around the world as *obstetric violence*. Shielding Defendants from liability would suggest that such violence is acceptable, and grant renewed vigor to long-rejected notions about women's proper roles in society.

1. The idea that pregnant women can be forced to submit to surgery is rooted in discriminatory views of women's roles.

Throughout history, the capacity to become pregnant has been used as a reason to discriminate against women in ways that diminish their role in society.

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[35] *Id.* at 2667.
[36] ACOG Ethics Opinion No. 321, *supra* note 7, at 8.

Defendants' arguments hark back to antiquated justifications for women's subordinate legal status. See e.g., *Int'l Union v. Johnson Controls*, 499 U.S. 187 (U.S. 1991)(corporate policy barred women capable of becoming pregnant from certain positions); *Muller v. Oregon*, 208 U.S. 412, 421 (U.S. 1908)(law limited work hours for women because "the physical well-being of woman becomes an object of public interest and care in order to preserve the strength and vigor of the race"); *Bradwell v. State*, 83 U.S. 130, 141 (U.S. 1873)(Bradley, J, concurring) (law denied access to the bar based on "duties, complications, and incapacities arising out of the married state"). Those who espouse the view that the status of pregnancy nullifies the need to respect the pregnant patient's decisions are in fact "proposing that, in the name of pregnancy, women should have fewer rights than do their male counterparts."[37]

2. Forced obstetrical interventions are a form of gender-based violence.

Increasingly, legal authorities and scholars recognize that "[f]orced medical treatment is a form of violence against women."[38] This violence is not just the assaultive act, but includes recourse to state authority, "even if the violence is obscured by her cowed compliance in the face of judicial power."[39] Understanding that domination and coercion occurs on a spectrum that includes unconsented

[37] Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. Rev. 451, 471 (2000).
[38] Sonya Charles, *Obstetricians and Violence Against Women*, Am. J. Bioethics 51, 53 (2011).
[39] Rhoden, *Cesareans and Samaritans, supra* note 15, at 122.

surgery and threats of legal force and abandonment of care, international and foreign authorities have developed a framework for identifying violence in maternity care that recognizes it as a form of gender-based violence.

Defendants' expert tacitly acknowledges the power differential between pregnant patient and doctor, explicitly anticipating that some women will physically resist the forced medical intervention. (Dr. Stephen Chase Aff. ¶ 10.) Disturbingly, Defendants suggest a pregnant woman's failure to resist the forced surgery should shield them from legal claims after the fact, echoing rape law before its reform, when a woman's failure to resist rape could be used as a defense. *See People v. Yanik*, 43 N.Y.2d 97, 99-100 (N.Y. 1977) (calling the "utmost resistance" jury charge for the "forcible compulsion" element in rape cases "widely discredited").

While physical resistance is irrelevant to the analysis, examples of resistance demonstrate the violation women suffer when forced to have unconsented surgery. For example, once an Illinois hospital's plans to perform cesarean surgery on a woman delivering triplets was revealed to her,

> [t]he woman became combative and was placed in full leathers, a term that refers to leather wrist and ankle cuffs that are attached to the four corners of a bed to prevent the patient from moving. Despite her restraints, the woman continued to scream for help and bit through her intravenous tubing in an attempt to get free.[40]

[40] Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong With Fetal Rights*, 10 HARV. WOMEN'S L.J. 9 (1987).

See also Fetus Brown, 689 N.E.2d at 400. (pregnant woman attempting to resist a blood transfusion was "yelled at and forcibly restrained, overpowered, and sedated.") As the D.C. Court of Appeals recognized, "such actions would surely give one pause in an civilized society . . ."*A.C.,* 573 A.2d at 1244.

Forced surgery is a profound violation. One pregnant woman subjected to forced surgery reported,"[t]he experience was 'a nightmare for me,' . . . 'I felt overpowered. I felt they were dominating me. I felt I was being raped.'"[41] Some women who have suffered this experience refer to the kind of unconsented to and degrading treatment at issue in this case with the controversial term "birth rape."[42] While some find this term jarring,[43] to many women who have experienced it, obstetric violence is substantively equivalent to a sexual assault.[44] Just as legal recognition of other forms of gender violence grew over time,[45]there is a growing understanding that unconsented cesarean, along with other forms of coercive treatment in childbirth, collectively constitute obstetric violence and radically depart from sound medical practice and the ethical standards.

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[41] Kenneth Jost, *Mother Versus Child; Law and Medicine*, Am. Bar Ass'n J., Apr. 1989, at 84.
[42] Amity Reed, *'It's not RAPE rape'*, The F Word, Contemporary UK Feminism (Sept.30, 2010), http://www.thefword.org.uk/features/2010/09/its_not_rape_ra.
[43] *See* Tracy Clark-Flory, *The Push to Recognize "Birth Rape,"* Salon.com, Sept 9, 2010 11:06AM EDT, http://www.salon.com/2010/09/09/birth_rape.
[44] Amity Reed, *Not a Happy Birthday*, The F Word, Contemporary UK Feminism, (March 7, 2008), http://www.thefword.org.uk/features/2008/03/not_a_happy_.
[45] *See generally* Reva B. Siegel, *"The Rule of Love": Wife Beating as Prerogative and Privacy*, 105 Yale L.J. 2117 (1996).

3. Amici urge the Court to look to the increasing recognition of "obstetric violence" in formulating the legal response to this case.

How women are treated when they seek reproductive health care is an area of concern for international authorities on maternal health. This year, the World Health Organization (WHO) issued a groundbreaking statement on the prevention and elimination of "disrespect and abuse"[46] during childbirth in health facilities.[47] Calling the phenomenon "an important public health and human rights issue," the WHO urged governments to recognize and redress abusive maternity care.[48]

Independent experts appointed by the United Nations Human Rights Council to monitor human rights have expressed concern that coercion in reproductive health care, including childbirth, may be human rights violations. In 2009, the Special Rapporteur on the right to health presented a report about the importance of informed consent to the General Assembly, noting "[p]regnant women are at times denied consent along an appropriate health-care continuum justified by the best interests of the unborn child.[49] The Special Rapporteur on torture echoed these concerns in a 2013 report on abusive practices in health care settings, observing

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[46] WHO and some international researchers use the term "disrespect and abuse" in maternity care. This terminology encompasses obstetric violence and is used interchangeably. USAID Report, supra note 16, at 9.
[47] WHO, *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth*, WHO/RHR/14.23 (2014)[hereinafter *WHO Statement*].
[48] *Id.* at 1.
[49] Anand Grover, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. A/64/272 (Aug.10, 2009).

that "international and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender."[50] By failing to address practices like coercion or failure to provide informed consent, states violate the rights to dignity, equality, and health.[51]

Bodies that monitor U.N. human rights treaties have urged nations "to eliminate discrimination against women in their access to health care services, throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the post-natal period."[52] To meet this requirement, jurisdictions in Central and South America have passed laws recognizing obstetric violence as a form of gender-based violence.[53] Jurisdictions vary in the precise definition, but obstetric violence is most often defined as form of domination and control carried

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[50] Juan E. Méndez, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc. A/HRC/22/53 (Feb, 1, 2013).
[51] *WHO Statement*, supra note 49, at 2.
[52] Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24, 20th Session (Article 12, women and health) ¶ 2.
[53] *See* Rogelio Pérez D'Gregorio, *Obstetric Violence: A New Legal Term Introduced in Venezuela*, Int. J. Gynecology & Obstetrics 111 (2010); Organic Law on Women's Right to a Life Free from Violence, http://www.fiscalia.gov.ve/leyes/10-LEYDERECHOMUJER.pdf; Law of Women's Access to a Life Free from Violence for the State of Guanajuato, art. 5 (Guanajuato, Mex.), Periódico Oficial del Gobierno del Estado de Guanajuato, year 97, vol. 148, no. 189, part 4, 2010, http://periodico.guanajuato.gob.mx/archivos/201011261836100.PO_189_4ta_Parte.pdf; Law for Women's Lives Without Violence for the State of Durango (Durango, Mex.) (2007), http://bit.ly/XErUmu; Law No. 235 for Women's Access to a Life Free from Violence for the State of Veracruz de Ignacio de la Llave (Veracruz, Mex.), Gaceta Oficial del Estado de Veracruz, núm. ext. 65, (2008) *available at* http://bit.ly/VKZW1A; Grupo de Información en Reproducción Elegida (GIRE)[Group for Information on Reproductive Choice], *Omisión e Indiferencia: Derechos Reproductivos* [Omission and Indifference: Reproductive Rights], 126 (2013).

out by people in a position of power over a woman during a time of vulnerability, with physical and psychological ramifications. For example, the Mexican state of Chiapas defines obstetric violence as

> Appropriation of the body and reproductive processes of women by health personnel, which is expressed in dehumanizing treatment, abuse of medicalization and pathologizing of natural processes, bringing loss of autonomy and ability to decide freely about their bodies and sexuality.[54]

The creation of mechanisms for redress of obstetric violence is ongoing,[55] but Venezuela and the Mexican state of Veracruz[56] impose civil and even criminal penalties for obstetric violence. While women's rights advocates question the efficacy of criminal penalties and civil fines,[57] there is widespread agreement that obstetric violence is a form of gender-based violence that must be eliminated.

Conclusion

What Defendants essentially seek is this Court's imprimatur on a separate law of tort for pregnant women, one that ignores the pregnant women's own risks and decision-making capacity, and is incompatible with existing law and with gender equality. Neither law nor ethics supports this untenable position, a view that underlies numerous troubling medical interventions throughout pregnancy that are

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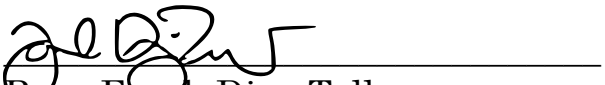
[54] Law of Access to a Life Free from Violence for Women in the State of Chiapas, Periódico Oficial del Estado de Chiapas, No. 152 (2009) http://www.sedem.chiapas.gob.mx/docs/leyes/Ley.pdf.
[55] *See* GIRE, *Omisión e Indiferencia, supra* note 55, at 144.
[56] Gaceta Legislativa del Congreso del estado de Veracruz (Veracruz, Mex.), año 2, núm. 94, at 7 (2008) http://www.legisver.gob.mx/gaceta/gacetaLXI/GACETA94.pdf
[57] GIRE, *Omisión e Indiferencia, supra* note 55, at 128.

recognized increasingly throughout the world as a form of gender violence.

The law of New York and the weight of legal authority are decidedly not in favor of forcing pregnant women to have surgery against their will. Not only does the Constitution protect pregnant women's rights to medical decision-making and bodily integrity, so too do the ethical obligations that govern physicians' interactions with their patients. The same standard of care that prevents physicians from imposing their decisions about what is best for their patients on the people that trust in them applies with equal force to pregnant women. *Amici* thus urge this Court to reject Defendants' arguments and grant Ms. Dray's motion for summary judgment.

Respectfully submitted,

National Advocates for Pregnant Women



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