New York Supreme Court
Appellate Division – Second Department

Docket Nos.:
2015-12064
2015-12068

RINAT DRAY,

Plaintiff-Appellant-Respondent,

– against –

STATEN ISLAND UNIVERSITY HOSPITAL and JAMES J. DUCEY,

Defendants-Respondents-Appellants,

– and –

LEONID GORELIK and METROPOLITAN OB-GYN ASSOCIATES, PC,

Defendants-Respondents.

BRIEF OF NATIONAL ADVOCATES FOR PREGNANT WOMEN, *ET AL.*, AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFF-APPELLANT-RESPONDENT

NATIONAL ADVOCATES FOR
PREGNANT WOMEN
Amicus Curiae
875 Avenue of the Americas, Suite 1807
New York, New York 10001
(212) 255-9252

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Amici Statement of Interest

Amici are New York, national, and international health and bioethics experts and health and civil rights advocacy organizations.[1] They bring expertise to this matter essential to the resolution of this appeal. Although this case appears in the form of an individual tort suit, it raises matters of public concern and has the potential to affect anyone who is or may become pregnant in New York. Amici support the plaintiff's arguments and wish to assist this Court by providing insight into legal and bioethical standards that apply to patients' decision-making in pregnancy and birth, the implications for maternal, fetal, and child health, and the impact on gender equality.

Introduction and Decision Below

According to the undisputed facts in the pleadings below, Rinat Dray was subjected to cesarean surgery despite her conscious and competent refusal. The surgery was carried out according to a policy for "Managing Maternal Refusals" developed by defendant Staten Island University Hospital (SIUH).[2] This policy creates a protocol by which physicians may force pregnant patients to undergo medical interventions when disagreements arise about the course of medical care. Consistent with the policy, the Defendants overrode Ms. Dray's wishes to have a

[1] Amici are described individually in the Addendum.

[2] Staten Island University Hospital Administrative Policies and Procedures Manual, Managing Maternal Refusals of Treatment Beneficial for the Fetus, Manual Code: ADM III A 14.0 (Effective Date May 2008) ("SIUH Policy") (A-308 in Joint Appendix).

vaginal delivery after previous cesarean, and did not consult the SIUH bioethics department or summon a patient care advocate to assist Ms. Dray before subjecting her to the unwanted surgery.

Defendants seek to justify these actions by claiming that pregnant patients have fewer rights to medical decision-making than others and that pregnancy may be treated as an emergency obviating the need for consent or due process. They also assert that private medical providers have a duty to override the medical decisions of a conscious, competent pregnant patient to protect an asserted but indefinite state interest in the fetus[3], and that this duty obviates the need for legal process that would ordinarily be due anyone being deprived of well-established common law, statutory and constitutional rights.

In the two orders on appeal,[4] the trial court denied nearly all of the plaintiff's claims. The Court concluded that the plaintiff's expert "failed to show, as a matter of law, that plaintiff was not placing the fetus at risk by declining to proceed with the C-section" The Court also held that a pregnant woman does not have "an absolute right to reject medical care necessary to protect her viable fetus," (A-18) noting that "New York Appellate Courts have not specifically held that medical providers can never override a pregnant woman's refusal to proceed with a C-

[3] Defendants describe this interest and their asserted obligations to and actions on behalf of the fetus as everything from: "sav[ing] the life of a full-term viable fetus" (Hospital Br. 1, 27); to protecting it from "harm" (3) to safeguarding its "well-being" (67-68).
[4] May 12, 2015 (A-6); Oct. 29, 2015 (A-24).

section." and 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.'" (A-16) (citations omitted).

The trial court further opined "while it would have been preferable for defendants to have obtained a court order before proceeding with the C-section, their failure to do so, particularly in light of their assertion of the risk to the fetus and the lack of time, is not, in and of itself, grounds for holding the defendants liable." (A-18).

Summary of Argument

The trial court's ruling is inconsistent with New York statutory and common law, the U.S. Constitution and human rights. It also flouts the tenets of medical ethics. It is a decision that, if permitted to stand, threatens maternal, fetal, and child health, and validates the institutional violence in the birth setting known as obstetric violence. It is an error this Court must correct – not merely to vindicate Ms. Dray, but to protect all other present and future pregnant New Yorkers from a second-class status.

I. Because pregnant women are entitled to the same legal protections as all other patients, the trial court's decision should be overturned.

The right of every adult person of sound mind to choose what will happen to his or her body is a bedrock of our concept of liberty. This cherished right is not suspended due to pregnancy at any point in the gestation or birth process. Most importantly, even though no right is absolute, it is impermissible for private actors to deny this right without legal authority.

A. Pregnant patients' right to forego unwanted surgery is protected by New York and U.S. Constitutional law.

The U.S. Supreme Court has acknowledged that "[n]o 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." *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891). And where the law seeks to interfere with that right, the liberty guaranteed by the Fourteenth Amendment to the Constitution provides protection. *See, e.g., Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 289 (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. . . .").

New York Courts recognize that the common law right of every adult of sound mind to "to determine what shall be done with [one's] own body,"

Schloendorff v Socy. of New York Hosp., 211 N.Y. 125, 129 (1914), is coextensive with the patient's liberty interest protected by the due process clause of our State Constitution. *Rivers v. Katz*, 67 N.Y.2d 485, 493, 495 N.E.2d 337, 341 (1986). This right is "paramount to what might otherwise be the doctor's obligation to provide needed medical care." *Matter of Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71 (1981). As the Court of Appeals explains, "In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment[.]" *Rivers*, 67 N.Y.2d at 493.

There is no exception for pregnant women. While this right may (rarely) be overcome by a state interest deemed to be "superior," *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 226 (1990), the trial court's conclusion that the state has an "interest in the well being of a viable fetus"[5] that is "sufficient to override a mother's objection to medical treatment" (A-17) is without support.

1. There is no recognized state interest sufficient to override a pregnant woman's objection to medical treatment.

The trial court reached its conclusion by reference to New York's pre-*Roe v. Wade* abortion law and to a series of outlying and inapposite cases. While New

[5] The state interest and legal question are vague in the order. (A-16)(expert's opinions raise issues of "whether the fetus was truly at risk"); (A-16) (plaintiff failed to show that she "was not placing the fetus at risk"); (A-16-17) (state "interest in the protection of a viable fetus"); (A-17) ("state interest in the well being of a viable fetus"); (A-17) ("interest in protecting unborn baby is paramount").

York abortion law limits a woman's right to abortion it does not create the basis for more broadly denying pregnant women their common law, statutory, or constitutional rights to autonomy, bodily integrity and medical decision making. As a recent opinion from New York State's Attorney General clarifies,[6] even in the context of abortion, the pregnant woman's life and health are paramount at all stages of pregnancy. *See Roe v. Wade,* 410 U.S. 113, 164-65 (1973)*; Planned Parenthood v. Casey*, 505 U.S. 833, 879 (1992).

While focusing on a single state interest identified in the abortion context, the court below ignored a wide body of New York law demonstrating respect for and protection of the rights and health of pregnant women at all stages of pregnancy. For example, New York is one of only two states in the country that has a Maternity Information Act mandating 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.[7] And while numerous states have advance directive laws that specifically exclude some or all pregnant women from deciding what will happen to them if they become unable to communicate their medical

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[6] 2016 N.Y. Op. Att'y Gen. No. F1 (Sept. 7, 2016).

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

wishes, New York's law applies to all people, including pregnant women, equally.[8]

Finally, upholding the trial court's opinion here and its reliance on what it terms a "state-interest in the *well being* of a viable fetus" would make pregnant women subject, with virtually no recourse, to an unlimited number of medical treatments and interventions any time a health care provider believed the fetus would otherwise be "at risk" or "truly at risk." (A-6).

2. None of the cases cited by the trial court provide authority for overriding a pregnant woman's objection to medical treatment.

In reaching its decision, the trial court relies on a series of cases, many of which are not from New York, which were decided on an emergency basis and had factual outcomes that overwhelmingly contradicted claims of risk to the fetus. These cases include *Jefferson v. Griffin Spalding County Hosp. Auth.,* 274 S.E.2d 457 (Ga. 1981) (on an ex parte basis upholding orders for forced cesarean surgery and for taking the *fetus* into custody to protect it from imminent death where the pregnant woman eventually gave birth vaginally to a healthy baby[9]); *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson,* 201 A.2d 537, 538 (N.J. 1964) (a pre-*Roe* case decided on an emergency appeal of a trial court decision); and *Pemberton v. Tallahassee Mem. Reg. Med. Ctr.*, 66 F.Supp.2d 1247, 1252, 1256

[8] N.Y. Comp. Codes R. & Regs. tit. 10, § 400.21 (2016).

[9] *See* Berg, *Georgia Supreme Court Orders Cesarean Section – Mother Nature Reverses on Appeal*, 70 J. Med. Ass'n Ga. 451 (1981).

(Fla. Cir. Ct. 1999) (denying civil rights claims by a woman who had been compelled to undergo cesarean surgery where no challenge was made to the argument that her fetus had rights outweighing her own and where predictions of harm from a vaginal delivery after previous cesarean surgery were called into doubt by subsequent, successful vaginal deliveries).[10] The trial court also cites *Burton v. State*, 49 So.3d 263 (Fla. Dist. Ct. App. 2010) (reversing a lower court order detaining a pregnant woman in a hospital and forcing her to have cesarean surgery as incorrectly decided under "ultimate welfare of the child" principle), a case that in fact supports the plaintiff's position.

The only cases from within the Second Department cited below are *Matter of Jamaica Hospital*, 128 Misc.2d 1006, 1007-08 (Sup. Ct. Queens County 1985), and a single line of dicta from this Court's review of *Fosmire v. Nicoleau,* 144 A.D.2d 8, 15 (1989)("the State's interest, as *parens patriae,* in protecting the health and welfare of the [fetus] is deemed to be paramount") that was *not* endorsed on appeal. This dicta itself cites *Jamaica Hospital*, a case simply wrongly decided at the time.

In *Jamaica Hospital*, a hearing was convened at the bedside of a gravely ill 18-weeks-pregnant Jehovah's Witness who refused a blood transfusion. The trial

[10] Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First* 124 (2008).

court acknowledged "that the fetus in this case is not yet viable, and that the state's interest in protecting its life would be less than 'compelling' in the context of the abortion cases," but then invented "a highly significant [state] interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds." 128 Misc.2d at 1008. The court found that "the fetus can be regarded as a human being, to whom the court stands in *parens patriae*, and whom the court has an obligation to protect." *Id.* The assertion that the state is the ultimate parent of all fetuses in utero finds no support in New York law.

The *Fosmire* dictum itself wrongly relies on *Crouse Irving Mem'l Hosp., Inc. v. Paddock*, 127 Misc.2d 101 (Sup. Ct. Onondaga County 1985). In that case, the trial court asserted its status as *parens patriae* in authorizing a blood transfusion for a pregnant woman and her child *after* delivery, but made no mention of expanding that doctrine to fetuses. *Id.* at 102-03. The court's authorization of the transfusion was under a separate doctrine, even clarifying that "Mrs. Paddock's freedom to direct the course of her own treatment shall be interdicted only in the post-operative period." *Id.* at 104.

The two other New York cases cited by the trial court in support of its ruling are also inapposite. (A-17). In *Matter of Stefanel Tyesha C.*, 157 A.D.2d 322, 329 (2d Dept. 1990), the child welfare agency was not seeking and did not obtain an order overriding a pregnant woman's medical treatment decisions, nor a finding of

neglect with respect to fetuses.[11] In *In re Guardianship of Baby K.*, 188 Misc. 2d 228, 229 (Surr. Ct, Broome Co. 2001) a court took protective steps for the benefit of a fetus as a result of the pregnant woman's application, not over her objection. As that court acknowledged, the pregnant woman "filed her written consent" to appoint her parents as guardians for the purpose of health insurance.[12]

These cases, including those that authorize treatment of children over parental objection, are not relevant to this Court's determination of whether there is a basis for denying pregnant women the closely-guarded right to refuse bodily invasion.

3. Appellate case law from other states supports Ms. Dray's position.

Appellate cases from other states that were decided with the benefit of briefing and presentation of evidence have all held that a pregnant patient retains the right to refuse unwanted medical care, a fundamental right that courts can rarely override.

[11] This neglect finding concerned a child already born and relied on medical claims from a single law review article and statements in popular media without reference to, or apparently consideration of, evidence-based peer reviewed studies. 157 A.D.2d at 330-31. This case was effectively overruled by the Court of Appeals in *Nassau Cty. Dep't of Soc. Servs. on Behalf of Dante M. v. Denise J.*, 87 N.Y.2d 73, 79 (1995).

[12] Defendants assert that one may "deduce" from *In Re Baby K* and the trial court opinion in *In re Gloria C. v William C.*, 124 Misc.2d 313, 323 (Fam Ct, Richmond County 1984) (pregnant victim of domestic violence sought an order of protection for herself, her children, and her fetus) a legislative intent "to provide protection to a fetus in the third trimester of gestation regardless of its lack of personhood" (Gorelik Br. 12). These courts, however, only extended protections to which a child would be entitled at birth to the prenatal period when "the mother's constitutional privacy right is not involved." *Gloria C.,* 124 Misc.2d at 323.

In *In re A.C.,* 573 A.2d 1235 (1990), a trial court granted an emergency order forcing a pregnant woman to have cesarean surgery over her objections. Neither she nor the baby survived. In a posthumous appeal, with benefit of full briefing and amicus participation, the *en banc* D.C. Court of Appeals vacated the order, holding that pregnant women, even those carrying presumptively viable fetuses, have the right "under the common law and constitution to accept or refuse treatment." 573 A.2d 1235, 1238 (D.C. 1990). Referencing *McFall v. Shimp,* 10 Pa.D. & C.3d 90 (Allegheny County Ct. 1978), a case in which a court refused to order one cousin to donate bone marrow to another, the D.C. appellate court explained that if A.C. could not have been compelled to donate blood to save her child after delivery; "[s]urely . . . a fetus cannot have rights in this respect superior to those of a person who has already been born." *In re A.C.,* 573 A.2d at 1244.

The *A.C.* court held that "in virtually all cases the question of what is to be done is to be decided by the patient — the pregnant woman — on behalf of herself and the fetus." *In re A.C.* 573 A.2d at 1237. In doing so, the court admonished that "some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against that person's will." *Id.* at 1252. The decision makes clear that neither fetal viability nor the commonplace nature of cesarean surgery constituted such an extraordinary or compelling reason.

That court also noted that efforts to obtain court orders against laboring women necessarily occur under time constraints or other circumstances that make it "difficult or impossible" to seek counsel or any other hallmark of fair process that a person would be entitled to in even a minor legal dispute. *Id.* at 1248-49. Such rampant procedural shortcomings "undermine the authority of the decisions themselves," *id.,* and, consistent with prevailing medical and bioethics opinions (*see infra*) suggest that hearings for court-ordered cesareans are so procedurally precarious that they should not even be sought.

The Appellate Court of Illinois in *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994), after full briefing, similarly concluded that a pregnant woman's decision-making may not be overridden. In this case, a woman, days shy of full term pregnancy, refused a cesarean even though the prognosis for the fetus was "close to zero" for a vaginal delivery. *Id.* at 328. That court refused to issue an order for the surgery, holding that "a woman's right to refuse invasive medical treatment [. . .] is not diminished during pregnancy." *Id.* at 332. The woman had a successful vaginal birth.[13] This court also recognized a woman's right to refuse even relatively non-invasive procedures such as blood transfusions in *In re Fetus Brown*, 689 N.E.2d 397 (Ill. App. Ct. 1997).

[13] As a result of the ruling, the pregnant woman was not forced to have the surgery and she delivered vaginally on December 29, 1993. According to a Northwestern spokesman Daniel Parker, the "infant is 'apparently perfectly healthy.'" AP, *Baby appears healthy without Caesarean*, Sarasota Herald Trib., Dec. 31, 1993 at 3A.

In each of these cases – all consistent with New York law and well-established medical and bioethics standards, courts recognized that pregnant women have the same rights to consent to medical treatment as others, a right that cannot be outweighed even by serious concern for a fetus, whether that concern is asserted by private actors or raised in an *ex parte* or emergency court hearing.

II. The hospital's decision to operate without consent was ethically impermissible.

The SIUH policy allows individual doctors to decide when they may override a pregnant patient's decision-making.[14] The consensus among bioethicists, however, is that it is not ethically permissible to disregard a competent patient's refusal of treatment. Even when the patient's wishes are not known, standards for surrogate decision-making are well established in the medical community. Labor and delivery, and its potential complications, are the routine of obstetrics, not the exceedingly rare emergency in which unconsented surgery could be ethically acceptable.

The American Medical Association (AMA) and American College of Obstetricians and Gynecologists' (ACOG) ethics guidelines forbid coercing or forcing care upon pregnant patients.[15] In addition, these professional groups clearly state the expectations for ethical professional behavior when patient and doctor disagree and fetal well-being is at risk. None condone unconsented surgery.

A. Standards of medical ethics unequivocally support a patient's right to refuse surgical intervention, without exception for pregnant women.

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[14] Defendants assert that "it is the doctors who must determine when a procedure a medically necessary." (Hospital Br. 28.) But legal permissibility and medical necessity are not equivalent; the consent of the patient or a legally sufficient substitute determines permissibility.

[15] ACOG Comm. on Ethics, Opinion No. 664, *Refusal of Medically Recommended Treatment During Pregnancy* 3 (June 2016) (hereinafter ACOG Op. 664); ACOG Comm. on Ethics, Opinion No. 55, *Patient Choice: Maternal-Fetal Conflict* (Oct. 1987)(hereinafter ACOG Op. 55); ACOG Comm. on Ethics, Opinion No. 321, *Maternal Decision Making, Ethics, and the Law* 8 (2005)(hereinafter ACOG Op. 321); AMA Code of Medical Ethics (2016), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page.

Honoring patient consent, and its necessary corollary of informed refusal, is a vital ethical requirement of modern medical practice, as the major medical professional organizations' guidance demonstrate. Consent and refusal are based on the principles of respect for persons and patient autonomy. In medical ethics, patient autonomy refers to the right to make choices, hold views, and take actions based on personal beliefs. "Consent" in the ethical sense must honor the patient's ability to weigh risks, benefits, and alternatives of recommended treatment against her personal values and beliefs, and to choose, even against her own interest, not to accept a doctor's recommendation. The right to consent is meaningless without the right to refuse.[16] A hospital policy that allows a clinician to ignore a patient's right to accept or refuse treatment recommendations violates informed consent.

Pregnancy does not alter the right of a patient to refuse. Longstanding consensus exists among professional medical organizations, including ACOG, the AMA, and the American Academy of Pediatrics (AAP) that the right to self-determination and to bodily integrity is maintained during pregnancy, and that interventions intended to benefit a fetus must not occur without the informed consent of the pregnant woman. For example, ACOG's Ethics Committee states

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[16] *See, e.g.,* Beauchamp & Childress, *Principles of Biomedical Ethics* 106 (3d ed. 1989) ("Being free to act is sometimes as important for autonomous action as being competent and being informed."). *See generally* Rhoden, *Cesareans and Samaritans,* 15 J. L. Med. & Health Care 118 (1987); Annas, *Women as Fetal Containers,* Hastings Center Rep., Dec. 1986, at 13; Murray, *The Worth of a Child* (1996); Minkoff & Marshall, *Fetal Risks, Relative Risks, and Relatives' Risks*, Am. J. Bioethics, Feb. 2016, at 3.

that where the pregnant woman and her doctor are unable to agree on a plan, "the primacy of the obstetrician-gynecologist's duties [are] to the pregnant woman."[17] Consent is incompatible with coercion or pressure, and even involves the ability to "select a course other than what may be recommended."[18]

The complexities of obstetrics require a high degree of ethical consideration and communication that the hospital and its physicians here should have been prepared to address because "the obstetrician-gynecologist's actions should be guided by the ethical principle that adult patients who are capable decision makers have the right to refuse recommended medical treatment."[19]

The AMA's Code of Medical Ethics[20] unequivocally states that the patient's right to self-decision is one that "physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent." There is no exception during pregnancy. In a joint ACOG/AAP opinion on maternal decision-making, the norm is clear that "any fetal intervention has implications for the pregnant woman's health and necessarily her bodily integrity, and, therefore, cannot be performed without her explicit informed

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[17] ACOG Op. 664 at 3.
[18] ACOG Comm. on Ethics, Opinion No. 439, *Informed Consent* 3 (Aug. 2009) *reaff'd* 2015 (hereinafter ACOG Op. 439).
[19] *Id.* at 2.
[20] AMA, Code of Medical Ethics, Opinion No. 8.08, *Informed Consent* (2006).

consent."[21] Defendants' failure to obtain consent, coupled with a policy that purports not to need it, is a serious deviation from standard medical response to disagreements about care.

B. Informed consent is necessary before medical treatment.

Patients and doctors may occasionally disagree about a recommended course of care after a patient has been counseled to understand the risks and benefits of a treatment recommendation. Some outlier theories hold that a doctor has an independent ethical duty to a fetus in cases where the pregnant patient and her doctor disagree about the clinical course of care. But ACOG states that "questions of how to care for the fetus cannot be viewed as a simple ration of maternal and fetal risks but should account for the need to respect fundamental values, such as the pregnant woman's autonomy and control over her body."[22] A patient may evaluate the risks differently than her doctor, in the context of her relationships with her family and community.[23]

As the ACOG's Ethics Committee explains, "Informed consent includes freedom from external coercion, manipulation, or infringement of bodily integrity. It is freedom from being acted on by others when they have not taken account of

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[21] ACOG, Comm. on Ethics, AAP, Comm. on Bioethics, Joint Comm. Opinion No. 501, *Maternal-Fetal Intervention and Maternal Care Centers* (Aug. 2011) *reaff'd* 2014.
[22] ACOG Op. 664 at 4.
[23] *Id.* at 3.

and respected the individual's own preference and choice."[24] By operating on Ms. Dray without her consent, the physicians acted in bad faith and outside of the scope of the trust she gave them as her health care providers. The SIUH policy bypassing these ethical requirements unmistakably departs from the standard of ethical care in the bioethics community.

The Defendants misstate and misunderstand the purpose of bioethicists and patient advocates whom SIUH did not utilize, suggesting that their role is to persuade an unwilling patient to undergo surgery. (Hospital Br. 28). Rather, a clinical ethics consultation would have explained the ethically appropriate course of action to be taken when patient and doctor disagree on a clinical recommendation. Ethics consultations are intended to "support informed, deliberative decision making on the part of patients, families, physicians, and the health care team," and to ensure that all viewpoints and options are considered, not to make decisions or achieve a particular outcome.[25]

C. Every person has a right to decide which risks to undertake.

Much of the SIUH policy is predicated on the assessment of potential risks to the pregnant patient and the fetus, and a misguided attempt to substitute a physician's assessment of risk for the patient's. But nobody is closer to the risks

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[24] ACOG Op. 439 at 5.

[25] AMA, Code of Medical Ethics, Opinion 10.7.1; ACOG Comm. on Ethics, Opinion 390 *Ethical Decision Making in Obstetrics and Gynecology* (Dec. 2007) *reaff'd* 2013.

associated with birthing than the patient herself. More women die from complications of pregnancy and childbirth in the United States than in any other wealthy nation.[26] While both vaginal and cesarean delivery carry risk, evidence suggests that cesarean delivery is more dangerous to mothers than vaginal delivery.[27] Risks including "maternal death, emergency hysterectomy, blood clots and stroke" are more likely to occur with cesarean surgeries than vaginal birth.[28] The risks are compounded with each successive surgery.[29]

Thus, it is reasonable for a woman to want to avoid repeated cesarean surgery. Even among women who 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."[30] In light of the serious risks associated with cesarean surgery, subjecting a woman to unwanted surgery not only undermines her rights, it could amount to a death sentence. *See, In re A.C., supra.*

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[26] *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 Oct 14, 2016).
[27] Cunningham et al., Williams Obstetrics 592 (22nd ed. 2005).
[28] Sakala & Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve* 44 (2008).
[29] Nisenblat et al, *Maternal Complications Associated with Multiple Cesarean Deliveries,* 108 Obstetrics & Gynecology 21, 25 (2006).
[30] ACOG, *Practice Bulletin No. 115: Vaginal Birth After Previous Cesarean Delivery* 8 (Aug. 2010), reaff'd 2013.

D. Medical judgment is fallible.

Ethical 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.[31] This is why, "In the obstetric setting, [] a competent pregnant woman is the appropriate decision maker for the fetus that she is carrying."[32] Unexpected outcomes in other forced surgery cases bear this out. *See* cases discussed *supra* at 7-8, 3; *In re Madyun*, 573 A.2d 1259 (D.C. Sup. Ct. 1986) (risk of infection as reason for forced surgery; no infection found upon delivery[33]); *In re Baby Kenner*, No. 79-JN83 (Colo. Juv. Ct. Denver County 1979)(emergency order for cesarean granted on the basis of apparent fetal distress and arrested labor; no distress apparent at birth).[34] Worse, predictions that the risk to the mother is low and the benefit to the fetus is high may turn out to be incorrect,[35] as with the forced cesarean that contributed to the death of a pregnant woman and failed to ensure a healthy birth. *See In re A.C.*, 573 A.2d at 1240- 241.

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[31] ACOG Op. 55, *supra*, at 7; *see also* 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).

[32] ACOG Op. 390 at 4.

[33] *See* 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").

[34] Rhoden, *The Judge in the Delivery Room*, 74 CAL. L. REV. 1951, 1951 n.3 (1986).

[35] *See* Rhoden, *Cesareans and Samaritans, supra*, at 122. ("The court cannot know the exact risks it is planning to impose on the individual woman, because statistics don't tell us this").

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 given medical intervention will not harm a pregnant woman, both law and medical ethics require doctors to respect the pregnant woman's decision-making.

III. The legal standard laid out by the trial court threatens women's human rights.

The trial court opinion endorses an interpretation of the law under which pregnant women lose their fundamental rights and private entities may assert the power of the state in the name of fetal protection to subject unwilling women to surgery with impunity. The decision elevates medical recommendation and gives it the force of law for pregnant women alone. New York law does not support such a claim; for any court to do so would violate human rights principles.

Human rights principles affirm and protect human dignity. They are codified in international conventions, many of which are legally binding commitments made by the U.S.[36] Others are not yet legally binding;[37] nevertheless, by signing them, the United States is "obliged to refrain from acts which would defeat [their] object and purpose."[38] But even when specific human rights do not create a legal cause of action, the underlying principles are a lodestar to domestic courts in the interpretation of law.

The case before this Court implicates women's human rights. Specifically, this Court should consider this decision's effect on women's rights to bodily

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[36] International Covenant on Civil and Political Rights, Dec. 16, 1966; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984; International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966.

[37] *E.g.*, Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979; International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966.

[38] Vienna Convention on the Law of Treaties, U.N. Doc. A/CONF. 39/26.

autonomy, freedom from gender-based discrimination and violence, freedom from torture or other cruel, inhuman, or degrading treatment, and to the highest attainable standard of health. That private actors violated Ms. Dray's human rights speaks to the need for decisive action by this Court to ensure redress and prevent the same thing from happening in the future. To do otherwise threatens women's health, perpetuates discriminatory notions of women's inferiority, and encourages institutionalized gender-based violence.

A. Forced surgery threatens women's health.

Cesarean surgery can be a beneficial and life-saving procedure, but "has potential for great harm when overused."[39] All cesareans pose significant risks to individual women, and unnecessary surgery threatens public health. Likewise, the betrayal of the physician-patient relationship inherent in forced medical interventions endangers maternal, fetal, and child health by corroding trust in the health system.

Unfortunately, cesarean surgery is often performed when unnecessary.[40] Reporting on a recent visit to the U.S., the experts of the UN Working Group on Discrimination Against Women (WGDAW) urged state agencies to "carefully address [the U.S.'s high rate of cesarean surgeries] and take measures to prevent

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[39] Sakala & Corry, *supra*, at 44. *See* ACOG & Soc'y Maternal Fetal Med, *Consensus No 1: Safe Prevention of the Primary Cesarean Delivery*, 123 Obstetrics & Gynecology 693 (2014).
[40] *Id.* at 41-48.

the performance of [cesarean] sections for non-medical reasons."[41] At 32.8% 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.[42] This rate suggests that many cesareans may not be medically necessary or even advisable.[43]

Allowing unconsented surgeries only increases the chance that women will be subjected to unnecessary surgery with major health risks. Permitting forced surgery over pregnant women's consent undermines all pregnant women's right to the highest attainable standard of health by rendering the hospital setting adversarial. Adversarial doctor-patient relationships risk harm to women and babies by "precipitat[ing] general distrust of physicians on the part of pregnant women,"[44] thus acting as a barrier to care.[45] *See A.C.,* 573 A.2d at 1248. Instead,

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[41] Raday *et al.*, Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice, on its Mission to the U.S., U.N. Doc. A/HRC/32/44/Add.2 (June 7, 2016) para 73.
[42] Li *et al.*, N.Y.C. Dep't of Health & Mental Hygiene, *Summary of Vital Statistics, 2014: Pregnancy Outcomes* 74 tbl. P04 (2016); WHO, U.N. Children's Fund, *Monitoring Emergency Obstetric Care: A Handbook* 25 (2009).
[43] Bowser & Hill, *Exploring Evidence for Disrespect and Abuse in Facility Based Childbirth: Report of a Landscape Analysis*, USAID TRAction Project at 10 (Sept. 2010) [USAID Report]; Sakala & Corry, *supra* note 21, at 41.
[44] *See* AMA Bd. of Trs. Report, Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, 264 JAMA 2663, 2670 (1990).
[45] *Id.* at 2670; ACOG Op. 664 at 4-5.

"[e]ncouraging prenatal care and treatment in a supportive environment" is most likely to advance maternal and child health.[46]

B. Permitting unconsented surgery violates women's right to freedom from gender-based discrimination and violence.

Forced surgery is a violent act. But forced cesarean surgery, where women patients hold less power than doctors and capacity for pregnancy has been historically used to sanction women's subordination,[47] is also a form of gender-based violence, increasingly recognized globally as "obstetric violence." Those who suggest that pregnancy nullifies patient autonomy are in fact "proposing that [. . .] women should have fewer rights than do their male counterparts."[48] This position is irreconcilable with the right to gender equality.

1. Forced cesarean surgery is a form of gender-based violence.

Increasingly, legal authorities and scholars recognize that "[f]orced medical treatment is a form of violence against women."[49] This is so "even if the violence is obscured by her cowed compliance in the face of judicial power."[50] To remedy

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[46] ACOG Op. 321, *supra*, at 8.
[47] *See, e.g., Muller v. Oregon*, 208 U.S. 412, 421 (1908) (upholding gender based work restrictions because "healthy mothers are essential to vigorous offspring"); *Bradwell v. Illinois*, 83 U.S. 130, 141 (1873) (Bradley concurring) (upholding law denying women Illinois bar admission, noting "[t]he natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life....")
[48] Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. Rev. 451, 452–53 (2000).
[49] Charles, *Obstetricians and Violence Against Women*, Am. J. Bioethics 51, 53 (2011).
[50] Rhoden, *Cesareans and Samaritans, supra*, at 122.

this, foreign authorities have developed a framework for identifying violence in maternity care that recognizes it as a form of gender-based violence.

Defendants in this case explicitly anticipate that some women will physically resist the forced medical intervention, (Hospital Br. 13) and suggest that a failure to resist physically should shield the hospital from liability. This argument echoes archaic rape law, when failure to resist rape was a defense. *See People v. Yanik*, 43 N.Y.2d 97, 99-100 (1977) (calling the "utmost resistance" jury charge for the "forcible compulsion" element in rape cases "widely discredited").

Case examples demonstrate the violence of forced surgery. For example, once an Illinois hospital's plans to perform cesarean surgery on a woman delivering triplets was revealed to her, she "became combative," was shackled to the bed, screamed for help and bit through the intravenous line.[51] *See also Fetus Brown,* 689 N.E.2d at 400. (pregnant woman was "yelled at and forcibly restrained, overpowered, and sedated.") As one court recognized, "such actions would surely give one pause in an civilized society . . ." *In re A.C.,* 573 A.2d at 1244.[52]

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

[52] See also Kenneth Jost, *Mother Versus Child; Law and Medicine*, A.B.A. J., Apr. 1989, at 84. (Ayesha Madyun reported "I felt overpowered. I felt they were dominating me. I felt I was being raped" when describing the court ordered cesarean performed over her objections).

Just as legal recognition of other forms of gender violence grew over time,[53] there is a growing understanding that unconsented and coercive treatment in childbirth collectively constitute "obstetric violence."

2. Obstetric violence is increasingly recognized as a human rights violation.

Treatment of women seeking reproductive health care is an area of concern for international authorities on maternal health. In 2014, the World Health Organization (WHO) issued a groundbreaking statement on the prevention and elimination of disrespect and abuse during childbirth in health facilities.[54] The WHO urged governments to recognize and redress abusive maternity care.[55]

Experts appointed by the U.N. Human Rights Council have also expressed concern that coercion in reproductive health care violates women's human rights. The WGDAW issued a 2015 report on discrimination against women in the area of health and safety, observing that pregnant women face "disproportionate risk of being subjected to humiliating and degrading treatment in health-care facilities" [56] It called upon states to "regulate birthing facilities to ensure respect for women's

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[53] *See generally* Siegel, *"The Rule of Love": Wife Beating as Prerogative and Privacy*, 105 Yale L.J. 2117 (1996).
[54] WHO, *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth*, WHO/RHR/14.23 (2014)[hereinafter *WHO Statement*].
[55] *Id.* at 1.
[56] Zielinska et al., *Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice*, U.N. Doc. A/HRC/32/44 para. 17 (April 8, 2016).

autonomy and privacy and human dignity,"[57] and to ensure that "penalties are incurred" for obstetric violence."[58]

In 2009, the U.N. Special Rapporteur on the right to health issued a report about the importance of informed consent, noting "[p]regnant women are at times denied consent along an appropriate health-care continuum justified by the best interests of the unborn child.[59] The Special Rapporteur on torture echoed these concerns in a 2013 report on abusive practices in health care settings, observing 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."[60] Failure to address practices like coercion or failure to provide informed consent, violates the rights to dignity, equality, and health.[61]

Bodies that monitor U.N. human rights treaties have urged nations "to eliminate discrimination against women in their access to health care services," especially in the perinatal period.[62] To meet this requirement, jurisdictions in Latin America have passed laws recognizing obstetric violence as a form of gender-based

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[57] *Id.* at para 106(g).
[58] *Id.* at para 106(h).
[59] 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).
[60] 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).
[61] *WHO Statement*, supra note 49, at 2.
[62] Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24, 20th Session (Art. 12) ¶ 2.

violence.[63] Obstetric violence is most often defined as form of domination and control carried out by people in a position of power over a woman during a time of vulnerability, with physical and psychological ramifications.[64] The development of mechanisms of redress of obstetric violence (including fines and other penalties) is ongoing,[65] and reflect growing accord that the state has an obligation to prevent and redress obstetric violence.[66] For this Court to reject the Defendants' justifications for the obstetric violence they inflicted on Ms. Dray is an important step toward the fulfillment of that obligation.

Conclusion

Amici respectfully urge this court to grant Plaintiff's request for relief.

Dated: New York, NY
October 21, 2016

By: Nancy Rosenbloom
Farah Diaz-Tello
Lynn M. Paltrow
National Advocates for Pregnant Women
Counsel for *Amici Curiae*
875 Ave. of the Americas #1807
New York, NY 10001
(212) 255-9252

[63] *See* Pérez D'Gregorio, *Obstetric Violence: A New Legal Term Introduced in Venezuela*, Int. J. Gynecology & Obstetrics 111 (2010).
[64] Grupo de Información en Reproducción Elegida (GIRE), *Omisión e Indiferencia: Derechos Reproductivos* [Omission and Indifference: Reproductive Rights], 126 (2013).
[65] *Id.* at 144.
[66] *Id.* at 128.

Certificate of Compliance
Pursuant to 22 NYCRR 670.10.3(f)

The foregoing brief was prepared on a computer. A proportionally spaced typeface was used, as follows:

Name of typeface: Times New Roman

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ADDENDUM

Addendum: Statements of Interest of Amici

Amicus Curiae **National Advocates for Pregnant Women** is a legal advocacy organization dedicated to protecting the rights, health, and dignity of pregnant and parenting women. Through litigation, organizing, and public education, NAPW works to ensure that nobody loses their rights at any point in pregnancy or the birth process. NAPW submits this brief out of concern that the actions and policies that have come to light in this case deprive women of their humanity and create a second-class status for anyone who is or may become pregnant.

Amicus Curiae **The National Women's Health Network (NWHN)** was founded in Washington, DC, in 1975 to improve the health of all women by developing and promoting a critical analysis of women's health issues. NWHN works to defend women's sexual and reproductive health and autonomy against threats that seek to undermine access to the full range of safe and effective reproductive health technologies, services, and information.

Amicus Curiae The **National Organization for Women New York State** works to promote reproductive rights, secure women's economic empowerment, and end discrimination and violence against women. NOW New York gives women a powerful voice. As the largest NOW chapter in the country, we play a key role in shaping both the local and national debate on the issues that impact women. NOW New York advocates for reproductive justice, including for the rights of pregnant women.

Amicus Curiae **Planned Parenthood of New York City**. As a leading provider of sexual and reproductive health services and education, Planned Parenthood of New York City supports this amicus brief on behalf of Rinat Dray to affirm the rights of all individuals, including those who are pregnant, to decide what happens to their bodies and refuse unwanted medical treatment.

Amicus Curiae **The Center for Reproductive Rights (the "Center")** is a global advocacy organization that uses the law to advance reproductive freedom as a fundamental right that all governments are legally obligated to respect, protect, and fulfill. It has a vital interest in ensuring that the rights of pregnant women, among others, are recognized and protected by the courts. Since its founding in 1992, the Center has been actively involved in nearly all major litigation in the U.S. concerning reproductive rights, in both state and federal courts. Notably, the Center's attorneys served as lead counsel for the plaintiffs in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), in which the U.S. Supreme Court

reaffirmed the constitutional right to access legal abortion, and *Ferguson v. City of Charleston*, 532 U.S. 67 (2001), which held that a state hospital's policy of drug-testing pregnant patients without consent and reporting positive test results to the police violated the Fourth Amendment.

Amicus Curiae **Choices in Childbirth** is a New York-based consumer advocacy group dedicated to educating all health care consumers about their options and rights in making decisions regarding maternity care.

Amicus Curiae **New York County Lawyers Association Committee on Women in the Law** is part of a not-for-profit membership organization of over 8,000 members committed to applying their knowledge and experience in the field of law to the promotion of the public good and ensuring access to justice for all. Founded in 1908, the New York County Lawyers Association was the first major bar association in the country to admit members without regard to race, ethnicity, religion or gender. Since its inception, the Committee on Women in the Law has been involved in important public policy issues, representing its members who strongly believe that women's domestic civil rights issues are of the utmost importance. The Committee on Women in the Law join amicus curiae because the outcome of this case has the potential for broad impact on patient autonomy and medical decision-making statewide.[67]

Amicus Curiae **ACCESS Women's Health Justice** removes barriers to sexual and reproductive health care and builds the power of Californians to demand health, justice and dignity. Its programs include: a bilingual Healthline that connects women and girls throughout California to information, referrals and advocacy on sexual and reproductive health issues, upstream and downstream policy advocacy within the reproductive justice movement and policy debates, and engaging with communities to build support for women seeking reproductive health care, including abortion.

Amicus Curiae **Birthrights** is the UK's only organisation dedicated to improving women's experiences of pregnancy and childbirth by promoting respect for human rights. Birthrights is a charitable organisation with a board of expert lawyers, doctors, midwives and maternity service users. Birthrights provides advice, training, research and campaigning around lawful maternity care in the UK.

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[67] The endorsement of the Committee on Women in the Law does not necessarily represent the views of the New York County Lawyers Association Board of Directors.

Amicus Curiae **The Center on Reproductive Rights and Justice at Berkeley School of Law (CRRJ)** seeks to realize reproductive rights and advance reproductive justice by furthering scholarship, bolstering law and policy advocacy efforts, and influencing legal and social science discourse through innovative research, teaching, and convenings. In essence, CRRJ propels policy solutions by connecting people and ideas across the academic-advocate divide. CRRJ believes all people deserve the social, economic, political, and legal conditions, capital, and control necessary to make genuine choices about reproduction – decisions that must be respected, supported, and treated with dignity.

Amicus Curiae **Civil Liberties & Public Policy Program** is a national program that was founded in 1981 at Hampshire College to provide education and training on reproductive and sexual health, rights and justice issues.

Amicus Curiae **The Desiree Alliance** is a social justice organization that is led by current and former sex workers in coalition with health professionals, harm reductionists, social scientists, educators, and their supporting networks focused on building leadership, capacity-building, political advocacy, policy-making, organizing and constructive activism among sex workers so that they can work for sex workers' human, labor and civil rights. Ultimately, The Desiree Alliance works to eradicate barriers that prevent best practices for those impacted by criminalization. The Desiree Alliance believes in the right to make one's own reproductive choices and any choice regarding one's own care, safety, and well-being.

Amicus Curiae **The Human Rights and Gender Justice Clinic at the City University of New York Law School** engages in litigation and advocacy, locally and globally to promote women's human rights and gender justice. In conjunction with advocates for women's and LGBTQ rights, human rights lawyers, and grass-roots organizations, the Clinic advocates on behalf of individual clients and groups to promote the human rights of women, LGBTQ individuals and youth. In the United States, the Clinic represents victims of human rights abuses with international and domestic claims in U.S. courts and files amicus curiae briefs in cases with significant and otherwise overlooked international dimensions.

Amicus Curiae **In Our Own Voice: National Black Women's Reproductive Justice Agenda** is a national organization focused on ensuring full access to reproductive healthcare services without political interference. They define Reproductive Justice as the human right to control one's own body, sexuality, gender, work, and reproduction. That right can only be achieved when all women

and girls have the complete economic, social, and political power and resources to make healthy decisions about their bodies, their families, and their communities in all areas of their lives. At the core of Reproductive Justice is the belief that all women have 1) the right to have children, 2) the right to not have children, and 3) the right to nurture the children they have in a safe and healthy environment. In Our Own Voice: National Black Women's Reproductive Justice Agenda focuses on abortion rights and access, contraceptive equity, and comprehensive sex education as their key policy issues. As a Reproductive Justice organization, In Our Own Voice: National Black Women's Reproductive Justice Agenda approaches these issues from a human rights perspective, incorporating the intersections of race, gender, class, sexual orientation and gender identity with the situational impacts of economics, politics and culture that make up the lived experiences of Black women in America.

Amicus Curiae **Jacobs Institute for Women's Health (JIWH)** is an organization that works to improve health care for women across their lifespan and in all populations. The mission of JIWH is to identify and study issues involving the interaction of medical, health and social systems, facilitate informed dialogue and foster awareness among consumers and providers, and promote problem resolution, interdisciplinary coordination and information dissemination.

Amicus Curiae **Legal Advocates for Birth Options & Rights (LABOR)** is organized to provide research and advocacy that brings together law, policy and bioethics in the service of birthing families. LABOR joins this brief to urge the court to uphold the rights of all pregnant persons to refuse unwanted medical care.

Amicus Curiae **Legal Voice** is a non-profit public interest organization that works in the Pacific Northwest to advance the legal rights of women through public impact litigation, legislation, and legal rights education. Since its founding in 1978 (as the Northwest Women's Law Center), Legal Voice has been dedicated to protecting and expanding women's legal rights. Toward that end, Legal Voice has advocated for legislation protecting pregnant persons' rights, including their rights to make decisions about their pregnancies, to be protected from workplace discrimination, and to be free from shackling if they are incarcerated and pregnant or in labor. In addition, Legal Voice has participated as counsel and as amicus curiae in the Pacific Northwest and across the country in numerous cases involving the rights of pregnant and birthing women. Legal Voice opposes, and has successfully challenged, prosecutions of women for their pregnancy outcomes and works to end punitive measures that undermine the humanity and legal rights of all pregnant women.

Amicus Curiae **The National Asian Pacific American Women's Forum (NAPAWF)** is the only national, multi-issue Asian and Pacific Islander (AAPI) women's organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for AAPI women and girls. AAPI women and girls are already vulnerable to medical coercion due to factors such as limited English proficiency and inconsistent access to healthcare. The Defendants' assertion that outside parties should be allowed to impose medical decisions upon pregnant people implies that pregnancy is a form of incompetence, and would further bar AAPI women and girls from receiving healthcare.

Amicus Curiae **National Perinatal Association ("NPA")** promotes the health and well being of mothers and infants enriching families, communities and our world. NPA is a multi-disciplinary organization comprised of doctors, nurses, midwives, social workers, administrators, parents, and those interested in collaborating to improve perinatal health.

Amicus Curiae the **New York University School of Law Reproductive Justice Clinic** trains students in the legal knowledge and skill required to secure fundamental liberty, justice and equality for people across their reproductive lives, with a particular focus on pregnancy and birth. The Clinic seeks to advance the goal of reproductive justice, a broad concept that opposes the use of reproduction—and, in particular, of pregnancy and parenting status—as a tool of oppression.

Amicus Curiae **Physicians for Reproductive Health ("Physicians")** is a doctor-led nonprofit that seeks to assure meaningful access to comprehensive reproductive health services, including contraception and abortion, as part of mainstream medical care. Physicians exists to ensure that all people have the knowledge, access to quality services and freedom of choice to make their own reproductive health decisions.

Amicus Curiae **SisterReach** is a grassroots Reproductive Justice organization focused on empowering and mobilizing women and girls in the community around their reproductive and sexual health to make informed decisions about themselves, therefore to become advocates for themselves. SisterReach does their work by a three-pronged strategy of reproductive and sexual health education, policy and advocacy on the behalf of women and girls of color, poor and rural women and their families. SisterReach considers punitive measures taken against pregnant mothers a Human Rights violation not only for the mother, but her family as well.

SisterReach considers a violation of these rights an act of violence from both the medical community and the government and are committed to ensuring that low income families, in particular, are not further marginalized by punitive measures which have proven to be detrimental to the health and well-being of families.

Amicus Curiae **Surge: Mobilizing Communities for Reproductive Justice** is a statewide non-profit organization in Washington State that advocates for the advancement of racial and reproductive justice in the Pacific Northwest through community engagement, education, and policy advocacy by mobilizing communities. Surge's cornerstone belief is that everyone must have meaningful access to health care, including reproductive health care, and to truthful, accurately-translated, culturally proficient information about sexuality and reproductive health. Surge believes in bodily autonomy for all reproductive health decisions and rejects discriminatory, forced, non-consensual and/or violent treatment of pregnant people.

Amicus curiae **White Ribbon Alliance (WRA)** is a global alliance of maternal health advocates who work in Africa, Asia and Europe to advocate for safe birth for every woman, everywhere. WRA catalyzes and convenes advocates who campaign to uphold the right of all women to be safe and healthy before, during and after childbirth. Its focus is on holding governments accountable and campaigning for them to deliver on their commitments. WRA mobilizes citizens to demand decent and respectful health care for all pregnant women. WRA recognizes that there are complex hierarchies that determine how care is provided to women and there are gender dynamics that impact how women and midwives are treated. WRA advocates for respectful maternity care, grounded in internationally recognized human rights.

Individual Experts
*Institutional affiliations designated with * are provided for identification purposes only.*

Amicus Curiae **Lynn Borgatta, MD, MPH,** is a board certified obstetrician-gynecologist with a special interest in ethical interests. She is currently a board member of an independent institutional review board (also known as an IRB or research review board), and a member of the Ethics Committee of the American Congress of Obstetricians and Gynecologists. During her tenure as a Professor of Obstetrics and Gynecology, she was the chair of the Boston University Medical Campus IRB.

Amicus Curiae **Arthur L. Caplan, PhD,*** is the Drs. William F. and Virginia Connolly Mitty Professor and founding head of the Division of Bioethics at New York University Langone Medical Center in New York City. Prior to coming to NYU, he was the Sidney Dr. Caplan Professor of Bioethics at the University of Pennsylvania Perelman School of Medicine in Philadelphia where he created the Center for Bioethics and the Department of Medical Ethics. He also taught at the University of Pittsburgh, Columbia University, and the University of Minnesota, where he founded the Center for Biomedical Ethics. Dr. Caplan received his Ph.D. from Columbia University. He is the author or editor of thirty-five books and over 700 papers in peer reviewed journals on topics in medical ethics. He served on a number of national and international committees including as the Chair, National Cancer Institute Biobanking Ethics Working Group; the Chair of the Advisory Committee to the United Nations on Human Cloning; the Chair of the Advisory Committee to the Department of Health and Human Services on Blood Safety and Availability; a member of the Presidential Advisory Committee on Gulf War Illnesses; the special advisory committee to the International Olympic Committee on genetics and gene therapy; the special advisory panel to the National Institutes of Mental Health on human experimentation on vulnerable subjects, the WellcomeTrust advisory panel on research in humanitarian crises, and the Co-Director of the Joint Council of Europe/United Nations Study on Trafficking in Organs and Body Parts.

Amicus Curiae **R. Alta Charo*** is the Warren P. Knowles Professor of Law and Bioethics at the University of Wisconsin with appointments to both the Law School and the School of Medicine & Public Health's Department of Medical History and Bioethics. Her areas of scholarship include reproductive rights, women's rights, maternal-child health, and health policy.

Amicus Curiae **Professor Soo Downe, BA (Hons), RM, MSc, PhD, OBE,*** is an expert in maternity care research. She is a consultant for the World Health Organisation (specifically on their antepartum, intrapartum, and cesarean section guidelines) and has been a contributor to two recent Lancet Series (stillbirth and midwifery). She is a member of a number of national (UK) and international boards and committees in the area of maternity care design and delivery. She directs an EU network of around 120 scientists from 32 countries, undertaking basic and applied research in this area.

Amicus Curiae **Anna Forbes** is a widely published independent consultant with 39 years of experience working in women's health and rights, specializing in reproductive and sexual health and HIV prevention.

Amicus Curiae **Henci Goer** is an award-winning medical writer, internationally known speaker, and acknowledged expert on evidence-based maternity care. A former doula and Lamaze educator, she is the author of The Thinking Woman's Guide to a Better Birth and Obstetric Myths Versus Research Realities, a highly-acclaimed resource for childbirth professionals. Her expertise lies in reading, evaluating, and synthesizing medical literature in order to determine what constitutes safe, effective, and satisfying maternity care.

Amicus Curiae **Hytham M. Imseis, MD,*** is a Maternal-Fetal Medicine Specialist practicing in both North and South Carolina. In addition to his medical practice, he provides medical education to Obstetrician/Gynecologists across the United States and has won numerous teaching awards. He currently serves on the Women's Executive Board of Novant Health Presbyterian Medical Center in Charlotte, NC, and also serves on the Grant Committee of the Novant Health Foundation Physicians Impact Fund. In addition, he is the Co-Chair of the Novant Health Ethics Committee. Dr. Imseis has published research articles in the *American Journal of Obstetrics and Gynecology* and in *Obstetrics and Gynecology* and currently reviews manuscripts for publication in both the *American Journal of Obstetrics and Gynecology* and *Ultrasound in Obstetrics and Gynecology* and the *British Journal of Obstetrics and Gynaecology.* Dr. Imseis serves on the Board of Directors of National Advocates for Pregnant Women.

Amicus Curiae **Cecilia Jevitt, CNM, PhD, FACNM,*** believes individual hospitals may not make policy that contradicts state and federal law. Women in labor have decisional capacity and have the right to refuse surgery. The fetus is not a separate life more valuable than that of the mother. Cesarean sections have immediate and future health risks that women must be able to refuse. A pregnancy does not give obstetricians, hospitals or governments the right to violate a woman's right to bodily integrity. She has been a practicing midwife for 35 years and is an associate professor of midwifery at Yale University. The hospital action upon Mrs. Dray was unconscionable and must not become a precedent.

Amicus Curiae **Sigridur Sia Jonsdottir** is a Clinical Nurse Specialist, alumni from Adelphi University, a Clinical Nurse Midwife educated in Iceland, and a doctoral student in perinatal health at Linnaeus University in Sweden. Through her education and being a CNM for over 30 years, as well as having lived and worked as a CNS in NY and NJ totally for 8 years, she also is knowledgeable in women´s rights in the Scandinavian countries. She is joining this brief as an expert in

pregnancy and delivery and to support the human rights of women to make their own decisions about their lives and bodies.

Amicus Curiae **Andrea Kalfoglou, PhD,*** is an expert in reproductive ethics.

Amicus Curiae **Mary Faith Marshall, PhD, FCCM,*** is the Emily Davie and Joseph S. Kornfeld Professor and Director of the Program in Biomedical Ethics, and Professor of Public Health Sciences at the University of Virginia School of Medicine. Dr. Marshall is an elected fellow in the American College of Critical Care Medicine and is a former Fellow of the Kennedy Institute of Ethics at Georgetown University. She is past-president of the American Association of Bioethics and Humanities and past-president of the American Association for Bioethics. Dr. Marshall was the chairperson of the National Human Research Protections Advisory Committee, DHHS, has been an on-site reviewer for the Office for Human Research Protections, and has served on several special emphasis panels regarding clinical trials and research ethics at the National Institutes of Health. She has testified before Congress on the subject of perinatal substance abuse. She sits on the Ethics Committees of the American College of Obstetricians and Gynecologists and the American College of Critical Care Medicine.

Amicus Curiae **Christine H. Morton, PhD,*** is a research sociologist with expertise in maternal health and women's childbirth experiences. Her research on maternal morbidity and mortality has been published in leading obstetric, midwifery and nursing journals. She sits on the Editorial Board for Birth, an Elsevier academic journal, and on the Board of Directors of Lamaze International. She has served on the Advisory Board for Childbirth Connection's Listening to Mothers surveys and is currently analyzing data from the most recent survey of women who gave birth in 2012.

Amicus Curiae **Lawrence J. Nelson, PhD, JD,*** is the lead author of: (1) a 1988 article in the Journal of the American Medical Association arguing that it is contrary to professional medical ethics for physicians and other health care providers to seek court orders forcing competent pregnant women to undergo any treatment for the sake of their unborn; and (2) a 1986 article in the Hastings Law Journal arguing that no legal support exists for court ordered treatment of pregnant women. He is the sole author of: (1) a 2009 article in the Lewis & Clark Law Review that expands on Roe's holding that prenatal humans are not constitutional persons and explains how it is unconstitutional for any State interest in the unborn to justify depriving competent persons of their basic rights, such as the right to

bodily integrity and to refuse medical treatment; and (2) a 2016 article in the University of Denver Criminal Law Review that argues only legislatures have the constitutional authority to grant any legal status or protection to prenatal humans and that legislatures lack the constitutional authority to enact statutes that deprive persons, such as pregnant women, of their basic rights.

Amicus Curiae **Miriam Zoila Pérez** is a writer and reproductive justice activist. She writes about the intersections of race, health and gender for Colorlines and other national publications. She is a trained doula and for ten years has written about maternal health activism at Radical Doula, the blog and resource she founded.

Amicus Curiae **Barbara Katz Rothman, PhD,*** is a Professor of Sociology, Public Health, Disability Studies and Women's Studies at the City University of New York. Her newest book is *A Bun in the Oven: How the Food and Birth Movements Resist Industrialization*. Her prior books include *In Labor*; *The Tentative Pregnancy*; *Recreating Motherhood*; *The Book of Life*; *Weaving a Family: Untangling Race and Adoption*, and *Laboring On*. She is Past President of Sociologists for Women in Society; the Society for the Study of Social Problems, and the Eastern Sociological Society. She is a proud recipient of an award for "Midwifing the Movement" from the Midwives Alliance of North America.

Amicus Curiae **Lisa R. Rubin, Ph.D.** is an Associate Professor of Psychology, former chair of the American Psychological Association's Division 35 (Society for the Psychology Women) committee on reproductive issues, expert on women's mental health concerns (including reproductive trauma), and researcher who has studied women's experiences of VBAC.

Amicus Curiae **Lois Shepherd, JD,*** is the Wallenborn Professor of Biomedical Ethics, Professor of Law, and Professor of Public Health Sciences at University of Virginia. She is an expert in biomedical ethics and law, including reproductive rights, areas in which she has taught and written for 23 years.

Amicus Curiae **Kayte Spector-Bagdady, JD, MBioethics,*** is a Postdoctoral Research Fellow at the Center for Bioethics & Social Sciences in Medicine at the University of Michigan, where she focuses on issues of disparate impacts of laws and vulnerable populations.

Amicus Curiae **Rebecca Spence, JD, MPH,** is the founder of Legal Advocates for Birth Options & Rights. She has published award winning scholarship and presented widely on legal issues in childbirth, particularly court-ordered and other interference with patient decision making. She holds an MPH in public health ethics from the University of Virginia and practices as a bioethics attorney. She joins this brief out of concern that Ms. Dray was subjected to surgery without her consent, a practice that is inconsistent with the ethical practice of medicine.

Amicus Curiae **Katie Watson,*** is a bioethicist who is an Associate Professor of Medical Education & Obstetrics and Gynecology at the Feinberg School of Medicine, a member of the Board of Directors of the American Society for Bioethics o& Humanities, and a member of the ethics of Northwestern Memorial Hospital.

Amicus Curiae **Dr. Sara Wickham, PhD, RM, MA, BA(Hons), PGCE(A),** is a registered midwife, midwifery lecturer, researcher and author who provides educational and consultancy services to organizations around the world, specializing in evidence-based midwifery, the protection of physiological birth and women's rights in childbirth.