

**IN THE COURT OF APPEALS OF TENNESSEE
MIDDLE SECTION AT NASHVILLE**

ALLYSON PHILLIPS, et al.,

Appellees / Plaintiffs,

v.

STATE OF TENNESSEE, et al.,

Appellants / Defendants.

M2026-00578-COA-R3-CV

Trial Court Case No.: 23-1196-I

**BRIEF OF *AMICI CURIAE* MEDICAL ASSOCIATIONS
IN SUPPORT OF APPELLEES AND CROSS-APPELLANTS**

Stella Yarbrough, BPR #033637
HERZFELD, SUETHOLZ, GASTEL,
LENISKI AND WALL, PLLC
1920 Adelia St., Ste. 300
Nashville, TN 37212
stella@hsglawgroup.com
(615) 800-6225

A. Yarnell Beatty, BPR #013712
TENNESSEE MEDICAL
ASSOCIATION
701 Bradford Avenue
Nashville, TN 37204
(615) 460-1644

*Attorneys for Amicus Curiae,
Tennessee Medical Association*

Molly Meegan*
Meaghan Davant*
AMERICAN COLLEGE OF
OBSTETRICIANS
AND GYNECOLOGISTS
409 12th Street, SW
Washington, D.C. 20024

Kaitlyn Golden*
Carrie Flaxman*
Robin F. Thurston*
DEMOCRACY FORWARD
FOUNDATION
P.O. Box 34553
Washington, DC 20043
(202) 448-9090

*Attorneys for Amici Curiae
Pro hac vice pending

TABLE OF CONTENTS

TABLE OF AUTHORITIES	iii
INTEREST OF THE <i>AMICI CURIAE</i>	1
INTRODUCTION AND SUMMARY OF ARGUMENT.....	4
ARGUMENT	7
I. Tennessee physicians must be able to offer abortion care that is within the standard of care for pregnant Tennesseans with high-risk or complicated pregnancies.....	7
II. Tennessee’s criminal abortion law employs an indiscernible, unworkable exception that deters physicians from providing standard of care abortions to pregnant Tennesseans with high-risk or complicated pregnancies.	13
A. Tennessee’s criminal abortion “medical necessity” exception is vague and confusing because it is impossible to know when a patient’s condition rises to the level of serious risk.	14
B. The “reasonable medical judgment” standard fails to protect physicians who act in good faith to preserve the life or health of a patient.....	18
III. Subjecting Tennessee physicians to liability under the state’s criminal abortion law is in tension with physicians’ professional ethical obligations to patients.	21
A. The statute interferes with the physician-patient relationship and a physician’s duty of loyalty to the patient.	21
B. The statute is incompatible with medical principles of beneficence and non-maleficence.	23

IV. The harm from the abortion law disproportionately falls on Tennessee’s most vulnerable populations and diminishes the pipeline of new ob-gyns coming to Tennessee.	24
A. Harm to Vulnerable Populations	24
B. Even before Tennessee’s confusing criminal abortion law was in place, Tennessee suffered a shortage of ob-gyns, and the law is exacerbating it.	27
C. The law discourages physicians and medical students who want to specialize in reproductive health from practicing in Tennessee and deprives Tennessee-based residency programs of the ability to offer the full scope of required training.....	28
D. Fear of prosecution has caused pharmacies to protect themselves rather than stock standard of care drugs used to safely induce medically indicated abortions.....	30
CONCLUSION	31
CERTIFICATE OF ELECTRONIC COMPLIANCE.....	33
CERTIFICATE OF REDACTION COMPLIANCE.....	34
CERTIFICATE OF SERVICE.....	35

TABLE OF AUTHORITIES

Cases

<i>June Med. Servs. LLC v. Russo</i> , 591 U.S. 299 (2020)	3
<i>Memphis Ctr. for Reprod. Health v. Slatery</i> , 14 F.4th 409 (6th Cir. 2021)	19
<i>Planned Parenthood S. Atl. v. State</i> , 882 S.E.2d 770 (S.C. 2023).	3
<i>State v. Hollon</i> , 671 S.W.3d 561 (Tenn. Crim. App. 2023)	20
<i>Stenberg v. Carhart</i> , 530 U.S. 914 (2000)	3
<i>Whole Woman’s Health v. Hellerstedt</i> , 579 U.S. 582 (2016)	3
<i>Whole Woman’s Health v. Paxton</i> , 978 F.3d 896 (5th Cir. 2020)	3
<i>Women’s Med. Pro. Corp. v. Voinovich</i> , 130 F.3d 187 (6th Cir. 1997).....	19-20

Statutes

Tenn. Code Ann. § 39-11-301(b), (c).....	20
Tenn. Code Ann. § 39-15-213	4
Tenn. Code Ann. § 39-15-213(a)(5)(B)	17
Tenn. Code Ann. § 39-15-213(c)(1)(A).....	14
Tenn. Code Ann. § 63-6-1102(14).....	19

Other Authorities

Accreditation Council for Graduate Med. Educ., <i>ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology</i> (Sep. 2025), https://perma.cc/4G7N-LJD7	29
ACOG, Code of Professional Ethics 2 (Dec. 2018), https://perma.cc/4UAH-S3MQ	22, 23
ACOG, Comm. Op. No. 390, <i>Ethical Decision Making in Obstetrics and Gynecology</i> (Dec. 2007, <i>reaff'd</i> 2019), https://perma.cc/3UGX-LBX7	23
ACOG, Comm. Op. No. 586, <i>Health Disparities in Rural Women</i> (Feb. 2014), https://perma.cc/D29D-M2NY	24
ACOG, Comm. Op. No. 786, <i>Perinatal Palliative Care</i> (Sep. 2019, <i>reaff'd</i> 2024), https://perma.cc/Z5JV-JS JL	11
ACOG, <i>Increased Risk of Maternal Morbidity Associated With Previa and Periviable Preterm Prelabor Rupture of Membranes</i> (June 2025), https://perma.cc/GC66-UHX9	16, 17
ACOG, <i>Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions</i> (Aug. 15, 2022), https://perma.cc/JX3S-Z6T8	18
Am. Med. Ass'n, Code of Medical Ethics Opinion 1.1.1, https://perma.cc/H4EJ-HE52	22, 23
Am. Med. Ass'n, Principles of Medical Ethics (rev. June 2001), https://perma.cc/F97P-3XA8	23
Anita Wadhvani, <i>TennCare's Maternal Death Rates are 3x Those of Private Insurance</i> , Tennessee Lookout (Jan. 21, 2025), https://perma.cc/64SL-84SM	25
Anna-Grace Lilly et al., <i>Our Hands are Tied: Abortion Bans and Hesitant Medicine</i> , 350 Soc. Sci. & Med. 116912 (2024), https://perma.cc/C36B-E8GK	13

Anuli Njoku et al., <i>Listen to the Whispers Before They Become Screams: Addressing Black Maternal Morbidity and Mortality in the United States</i> , 11 <i>Healthcare</i> 1 (Feb. 3, 2023), https://perma.cc/LXD6-KT97	26
Ashish Premkumar, <i>Society for Maternal-Fetal Medicine Special Statement: Considerations for Management of High-Risk Pregnancies When Abortion Care is Restricted</i> , 2 <i>Pregnancy e70376</i> (July 2026), https://perma.cc/T38G-AGUD	18
Ashley N. Battarbee et al., <i>Society for Maternal-Fetal Medicine, Consult Series #71: Management of Previa and Periviable Preterm Prelabor Rupture of Membranes</i> , 231 <i>Am. J. Obstet. Gynecol.</i> B2 (2024), https://perma.cc/NLH9-2WMA	16
Ashley Redinger & Hao Nguyen, <i>Incomplete Miscarriage</i> , StatPearls, NIH Library of Medicine (Feb. 12, 2024), https://perma.cc/ZZ9Z-H282	10
Callie Cox Bauer, et al., <i>Turning Rage Into Action: Abortion Care and Residency Training in the United States</i> , 15 <i>J. Grad. Med. Educ.</i> 291 (2023), https://perma.cc/56JH-K9KF	29
Carolyn A. Miller et al., <i>Patient Experiences With Miscarriage Management in the Emergency and Ambulatory Settings</i> , 134 <i>Obstetrics & Gynecology</i> 1285 (2019), https://perma.cc/H896-CT25	10
Ctrs. for Disease Control & Prevention, <i>Maternal Deaths and Mortality Rates: Each state, the District of Columbia, United States, 2018-2022</i> , https://perma.cc/V523-R7WC	8
Ctrs. for Medicare & Medicaid Servs., <i>Advancing Rural Maternal Health Equity</i> 1 (2022), https://perma.cc/77MS-JB9V	24
Juanita J. Chinn et al., <i>Health Equity Among Black Women in the United States</i> , 30 <i>J. Women's Health</i> 212 (2021), https://perma.cc/6JYE-4SKW	26
Katherine Rizzolo, <i>Implications of Antiabortion Laws on Patients with Kidney Disease in Pregnancy</i> , 18 <i>Clinical J. of the Am.</i>	

Society of Nephrology 276 (Jan. 2023), https://perma.cc/CV39-M2VC	11
Kendal Orgera & Atul Grover, <i>States With Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants</i> , AAMC (May 9, 2024), https://perma.cc/8W9V-ZLQB	30
Kendal Orgera et al., Ass’n Am. Med. Colls., <i>Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women’s Health Organization Decision</i> (Apr. 13, 2023), https://perma.cc/SM9G-G7EV	30
Lyndsey S. Benson et al., <i>Early Pregnancy Loss in the Emergency Department, 2006–2016</i> , 2 J. Am. Coll. Emergency Physicians Open e12549 (2021), https://perma.cc/7CCQ-M857	10
Madison Mellquist et al., <i>Medical Implications of Restricting Abortions on Women Diagnosed With Fetal Anomalies Following the Overturn of Roe v. Wade: A Scoping Review</i> , 16 Cureus e58894 (Apr. 2024), https://perma.cc/785S-EGJ5	12
<i>March of Dimes, Maternity Care in Tennessee</i> , https://perma.cc/JM4K-JCU8	25, 27
<i>March of Dimes, Nowhere to Go: Maternity Care Deserts Across the U.S.</i> , March of Dimes 5 (2026), https://perma.cc/GV4Y-AM8K	25
Melissa Suran, <i>Treating Cancer in Pregnant Patients After Roe v Wade Overturned</i> , 328 JAMA 1674 (Nov. 1, 2022), https://perma.cc/Z66L-XCBA	10
Robert Silver, et. al., Society for Maternal-Fetal Medicine Consult Series #64: Systemic lupus erythematosus in pregnancy, SMFM B41 (2023), https://perma.cc/SX6R-CHTL	11
Rula Atwani et. al, <i>Maternal Implications of Fetal Anomalies: a Population-Based Cross-Sectional Study</i> , 6 Am. J. Obstetrics & Gynecology MFM101440 (2024)	12

Tenn. Dep’t of Health, <i>Maternal Mortality in Tennessee Annual Report 2024</i> (Dec. 2024), https://perma.cc/HPA2-XDU8	11, 25, 26
Tenn. Dep’t of Health, <i>Severe Maternal Morbidity in Tennessee 2018-2022</i> (Apr. 2025), https://perma.cc/LPG5-TQMA	8
Tenn. Dep’t of Health, <i>Uninsured Adult Healthcare Safety Net Annual Report 2024</i> , https://perma.cc/6PDG-R7DF	27
U.S. Dep’t of Health and Human Servs., <i>Overview of the State – Tennessee – 2023</i> , https://perma.cc/2WEX-Q43Z	27

INTEREST OF THE *AMICI CURIAE*

Amici curiae are leading medical societies representing physicians and other clinicians who serve patients in Tennessee and across the nation. *Amici* are well suited to explain how Tennessee’s criminal abortion law interferes with the way physicians treat patients experiencing high-risk and complicated pregnancies, which will assist this Court in deciding the issues raised on appeal.

Amicus **Tennessee Medical Association (“TMA”)** was founded in 1830 and is Tennessee’s largest volunteer professional advocacy organization for physicians. TMA is comprised of approximately 10,000 members who are medical doctors, doctors of osteopathy, medical residents in Tennessee training programs, and medical students enrolled in Tennessee medical schools. These members include ob-gyns, family physicians and emergency physicians who provide care to pregnant women in Tennessee.

TMA enhances the effectiveness of physicians throughout the state and protects the health interests of patients by defining and promoting (1) high-quality, safe and effective medical care; (2) public policy to protect the sanctity of the physician-patient relationship and

improve access to and the affordability of quality medical services; (3) ethics and competence in medical education and practice; and (4) open communications between the medical profession and the public, to foster a better understanding of the capacities of medical practice. TMA has worked with its members to understand the implications of the criminal abortion law and the consequences on their practice, including hearing from its members on the impact of the law.

The **American College of Obstetricians and Gynecologists (ACOG)** is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. With more than 62,000 members, ACOG's members represent more than 90% of all board-certified obstetricians and gynecologists practicing in the United States. ACOG maintains and publishes the industry-recognized, highest standards of evidence-based clinical practice and continuing education of its members as they evolve, promotes patient education, and increases awareness of the changing issues facing women's healthcare. ACOG is committed to ensuring access to high-quality, safe, and equitable

obstetric and gynecologic care, including abortion care. ACOG's *amicus* briefs have been repeatedly recognized as authoritative sources.¹

The **Society for Maternal-Fetal Medicine (SMFM)** is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 6,500 members caring for high-risk pregnant people. SMFM provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing high-risk pregnancies. SMFM's *amicus* briefs also have been cited by many courts.

The **American Medical Women's Association (AMWA)** is the oldest multi-specialty organization dedicated to advancing women in medicine and improving women's health. Our membership is comprised

¹ See, e.g., *June Med. Servs. LLC v. Russo*, 591 U.S. 299, 340 (2020); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 613 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 916, 928, 932 (2000); *Whole Woman's Health v. Paxton*, 978 F.3d 896, 910 (5th Cir. 2020); *Planned Parenthood S. Atl. v. State*, 882 S.E.2d 770, 787-88 (S.C. 2023).

of physicians, residents, medical students, pre-medical students, health care professionals, and supporters. AMWA's mission is advancing women physicians and improving the health of women with a vision of a thriving healthy, equitable world. American Medical Women's Association co-founded the Reproductive Health Coalition, a wide-range of health professional associations and allied organizations who advocate with a unified voice to protect access to reproductive care. Through the coalition, AMWA advocates for full, comprehensive reproductive health care access, including the right to contraception.

Amici write in support of Appellees and Cross-Appellants to explain how Tennessee's criminal abortion law forces Tennessee physicians to choose between practicing ethical standard of care medicine for their pregnant patients and protecting themselves from criminal prosecution and loss of their licenses.

INTRODUCTION AND SUMMARY OF ARGUMENT

Tennessee's criminal abortion law, *see* Tenn. Code Ann. § 39-15-213, forces physicians to choose between practicing evidence-based medicine and protecting themselves from criminal prosecution and loss of their licenses. Pregnant women in Tennessee face substantial risks

of pregnancy complications: Tennessee has the highest maternal mortality rate in the country. For a significant number of women experiencing a high-risk or complicated pregnancy, termination of the pregnancy by the performance of an abortion is the standard of care. This case addresses the tragic circumstance of pregnant women facing serious, irreversible health consequences if they do not timely receive a standard of care abortion.

Tennessee law makes it a Class C felony with imprisonment and fine if a physician performs an unlawful abortion. An unlawful abortion also subjects a physician to discipline by the physician's licensing board, which can include revocation of the physician's medical license. Physicians who perform an abortion in Tennessee can rely only on a vague and circular "medical necessity" exception in the statute to protect them from this legal exposure, which allows care only when a patient faces death or a "serious risk of the substantial and irreversible impairment of a major bodily function."

This exception is confusing to Tennessee physicians, who worry that providing the recognized medical standard of care to a patient experiencing pregnancy complications might be construed as a crime or

put their professional licenses at risk. As a consequence, many physicians are being forced to delay pregnancy terminations until very dangerous conditions manifest. The consequences are devastating for Tennessee women, many of whom are facing long-term consequences based on that delay.

Physicians also risk violating their ethical obligations to patients. The law intrudes on the physician-patient relationship by preventing physicians from offering the full range of medical care to their patients. Acting to avoid prison, which can mean delaying care or waiting until the patient's condition worsens, rather than providing timely evidence-based care, conflicts with the physician's duty to place patients' welfare above the physician's own self-interest.

The consequences of the criminal abortion law potentially harm all Tennessee patients with high-risk and complicated pregnancies, but that harm disproportionately falls on Tennessee's most vulnerable populations. Even before the law, Tennessee was experiencing a significant shortage of ob-gyn care, especially in rural areas. Now that the law is in effect, ob-gyn residents must leave the state for portions of their residency training to receive abortion training. This discourages

ob-gyn residents and medical students from choosing to learn or practice medicine in Tennessee, and exacerbates an existing physician shortage. This is alarming because Tennessee's already high maternal mortality rate is higher for patients living in rural areas, patients of color, and patients with low incomes.

Amici support the Plaintiff physicians' right to be free from the risk of arbitrary prosecution and loss of their licenses based on an ambiguous law and to be able to deliver timely, essential life- and health-saving medical care to pregnant women across Tennessee who need it, like Plaintiff patients.

ARGUMENT

I. Tennessee physicians must be able to offer abortion care that is within the standard of care for pregnant Tennesseans with high-risk or complicated pregnancies.

It is essential to the life and health of pregnant women experiencing medical complications that their physicians be able to offer them standard of care medicine. Serious pregnancy complications are not theoretical or even rare events in Tennessee. Tennessee has the highest maternal mortality rate in the country, with roughly 42 deaths for every 100,000 live births. R.Vol.33 4806. Between 2018-2022, 166

Tennessee women died while pregnant or shortly thereafter from pregnancy-related causes.² During that same time period, 2,795 deliveries in Tennessee involved severe maternal morbidity, meaning patients experienced a health-impacting or life-threatening pregnancy complication.³ *Amicus* TMA's physician members regularly see patients experiencing pregnancy complications that pose imminent risk if not treated by pregnancy termination.

For patients with certain medical conditions or complications, the recognized standard of care is to offer or recommend abortion, with the patient and the physician ultimately making the determination based on the patient's unique circumstances.

While it is impossible to create a comprehensive list of conditions where abortion care may be the recommended or appropriate treatment, there are categories of patient risk for which the standard of care dictates that an abortion should be offered. Those include (i) medical conditions arising during pregnancy that pose a risk of

² Ctrs. for Disease Control & Prevention, *Maternal Deaths and Mortality Rates: Each state, the District of Columbia, United States, 2018-2022*, <https://perma.cc/V523-R7WC>.

³ Tenn. Dep't of Health, *Severe Maternal Morbidity in Tennessee 2018-2022* (Apr. 2025), <https://perma.cc/LPG5-TQMA>.

infection, bleeding, organ damage, or other health risk that makes continuing a pregnancy unsafe for the pregnant patient; (ii) medical conditions unrelated to pregnancy that can be exacerbated by pregnancy, cannot be effectively treated during pregnancy, or that require recurrent invasive intervention; and (iii) instances where there is a lethal fetal condition that makes the fetus unlikely to survive the pregnancy or sustain life after birth.

Some examples of conditions that can develop in a pregnancy for which abortion might be the standard of care treatment include preterm premature rupture of membranes (PPROM), preeclampsia, dilation of the cervix prior to viability of the pregnancy, and placental conditions such as placenta previa with bleeding, placenta accreta spectrum, or placental abruption. Patients experiencing these types of conditions can experience uterine infection, sepsis, hemorrhage, hysterectomy, pulmonary edema, liver failure, acute renal failure, heart failure, severe dehydration, prolonged hospitalization, hemolytic anemia, thrombocytopenia, and death. Miscarriage also carries similar risks, and is extremely common, occurring in approximately 10% of clinically

recognized pregnancies.⁴ Miscarriage care may be precluded under the law when embryonic or fetal cardiac activity is still observed, even if the pregnancy will not continue.⁵

Some conditions unrelated to pregnancy that may be exacerbated during pregnancy or cannot be treated during pregnancy include cancer, chronic renal disease, certain psychiatric conditions, Type 1 and 2 diabetes, heart disease, hypertension, sickle cell disease, and autoimmune disorders. Because such conditions may worsen during pregnancy, it is important that pregnant women have the option to terminate the pregnancy *before* their condition progresses in severity, as the disease progression may otherwise become irreversible.⁶

⁴ Carolyn A. Miller et al., *Patient Experiences With Miscarriage Management in the Emergency and Ambulatory Settings*, 134 *Obstetrics & Gynecology* 1285, 1285 (2019), <https://perma.cc/H896-CT25> (noting that “[p]atients with concerns about a potential miscarriage . . . present for care in [EDs] at a rate of approximately 500,000 each year in the United States”); Lyndsey S. Benson et al., *Early Pregnancy Loss in the Emergency Department, 2006–2016*, 2 *J. Am. Coll. Emergency Physicians Open* e12549, 8 (2021), <https://perma.cc/7CCQ-M857> (finding that “[early pregnancy loss]-related care accounts for > 900,000 [emergency department] visits in the United States each year”).

⁵ Ashley Redinger & Hao Nguyen, *Incomplete Miscarriage*, StatPearls, NIH Library of Medicine (Feb. 12, 2024), <https://perma.cc/ZZ9Z-H282>.

⁶ Melissa Suran, *Treating Cancer in Pregnant Patients After Roe v Wade Overturned*, 328 *JAMA* 1674 (Nov. 1, 2022), <https://perma.cc/Z66L-XCBA> (“Generally, the longer the time until cancer treatment, the

Finally, fatal (or lethal) fetal anomalies are fetal or pregnancy conditions where the pregnancy will not result in a child with sustained life – fatal in utero or shortly after birth.⁷ One example is anencephaly, a neurological disorder that involves a defect in the closure of the neural tube during fetal development, resulting in the absence of a major portion of the brain, skull, and scalp. Forcing patients to prolong their pregnancy increases the risks to the patient without increasing the

higher the risk of mortality.”); Katherine Rizzolo, *Implications of Antiabortion Laws on Patients with Kidney Disease in Pregnancy*, 18 Clinical J. of the Am. Society of Nephrology 276 (Jan. 2023), <https://perma.cc/CV39-M2VC> (“Pregnancy carries a substantial risk of worsening kidney disease: 20% of people with advanced [chronic kidney disease] (stages 4 or 5) who become pregnant experience a worsening of eGFR [estimated. glomerular filtration rate] or need to initiate KRT [kidney replacement therapy], which confers a greater mortality risk over time.”); Tenn. Dep’t of Health, *Maternal Mortality in Tennessee Annual Report 2024*, 10 (Dec. 2024), <https://perma.cc/HPA2-XDU8> (“One in four pregnancy-related deaths due to mental health conditions was found to be a confirmed or probable suicide by the MMRC.”); Robert Silver, et. al, *Society for Maternal-Fetal Medicine Consult Series #64: Systemic lupus erythematosus in pregnancy*, SMFM B41, B52 (2023), <https://perma.cc/SX6R-CHTL> (“We recommend that pregnancy be generally discouraged in patients with severe maternal risk, including patients with active nephritis; severe pulmonary, cardiac, renal, or neurologic disease; recent stroke; or pulmonary hypertension (GRADE 1C). Patients who become pregnant with these conditions, among others, may need abortion care because of life-threatening maternal risk.”).

⁷ ACOG, Comm. Op. No. 786, *Perinatal Palliative Care* (Sep. 2019, *reaff’d* 2024), <https://perma.cc/Z5JV-JS JL>.

fetus's prospects of survival. Fetal anomalies are associated with an increased risk of cesarean section, pregnancy-associated hypertension, and severe maternal morbidity (SMM).⁸ For example, “pregnant women with anencephalic fetuses are at greater risk of redundant cesarean deliveries, polyhydramnios [excessive amniotic fluid] and associated complications, and obstetrical hemorrhage for the birth of a nonviable fetus.”⁹ At the time of delivery, fatal fetal anomalies can cause complications that create risks for future pregnancies, including increased risk of cesarean section.

When these or other conditions arise during a pregnancy, it is imperative to the physicians in Tennessee to be able to timely offer to terminate the pregnancy.

⁸ Rula Atwani et al, *Maternal Implications of Fetal Anomalies: a Population-Based Cross-Sectional Study*, 6 Am. J. Obstetrics & Gynecology MFM101440 (2024).

⁹ Madison Mellquist et al., *Medical Implications of Restricting Abortions on Women Diagnosed With Fetal Anomalies Following the Overturn of Roe v. Wade: A Scoping Review*, 16 Cureus e58894, at 2 (Apr. 2024), <https://perma.cc/785S-EGJ5> (internal quotations omitted).

II. Tennessee’s criminal abortion law employs an indiscernible, unworkable exception that deters physicians from providing standard of care abortions to pregnant Tennesseans with high-risk or complicated pregnancies.

Every pregnancy is unique, and obstetrical complications are varied and nuanced. The criminal abortion statute does not provide clarity to or room for physicians to discern whether providing a timely abortion pursuant to the standard of care would be a crime. Indeed, many of TMA’s members report that they lack sufficient clarity and legal protections to lawfully terminate a pregnancy in Tennessee.¹⁰ Individual physicians are often forced to rely on hospital ethics committees or lawyers for legal support to decide on case-by-case bases or to refer the patient to another physician/facility even though that means delaying necessary care.

¹⁰ This is consistent with statements from other Tennessee physicians. One study that included qualitative interviews of Tennessee physicians included providers noting “There are going to be delays in care based on how confusing the law is. I think lives will be compromised” and “It’s so vague . . . how am I supposed to know how close to death’s door someone needs to be before I feel comfortable jeopardizing my freedom and my ability to raise and provide for my family?” Anna-Grace Lilly et al., *Our Hands are Tied: Abortion Bans and Hesitant Medicine*, 350 Soc. Sci. & Med. 116912, at 4 (2024), <https://perma.cc/C36B-E8GK>.

A. Tennessee’s criminal abortion “medical necessity” exception is vague and confusing because it is impossible to know when a patient’s condition rises to the level of serious risk.

The statutory language of the criminal abortion law does not reflect the nuances of medical practice. The statute provides that abortion is permitted when it is “necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function.” Tenn. Code Ann. § 39-15-213(c)(1)(A). But there is no clear line delineating when an abortion is necessary and when it is not. Nor is there a clear line where potential risk of adverse health consequences crosses into a “serious risk of substantial and irreversible impairment.” Instead, the law forces a physician to allow their patient’s condition to deteriorate before offering the medical standard of care.

Plaintiff Dr. Maune provided testimony about a pregnant patient that illustrates this point. The patient had a shortened cervix and cerclage¹¹ who presented at a routine check-up with her cervix no longer present around 17 weeks. APP.255-56, Decl. of Heather Maune in Opp’n

¹¹ A cervical cerclage is a procedure to keep the cervix closed during pregnancy.

to Defs.’ Mot. for Summ. J (“Maune Decl.”) ¶ 12.b (Feb. 17, 2026). After hospital admission and antibiotic therapy to prolong her pregnancy, the physician had to remove her cerclage, and patient’s water broke at 20 weeks. *Id.*

A pregnancy in which a cerclage has been removed and the membranes rupture at approximately 20 weeks gestation is a serious clinical situation. The pregnant woman faced a wide range of critical risks, from life-threatening maternal sepsis to infection of the uterus and amniotic sac (chorioamnionitis), placental abruption, umbilical cord prolapse or compression, and progressive labor. The more these conditions progress, the more serious the patient’s condition becomes. Rather than the standard practice of offering an abortion immediately, which could have eliminated the possibility of a serious infection or hemorrhage, Dr. Maune waited for the patient to develop an infection before Dr. Maune’s team felt they could offer an abortion under the law. *Id.*

The criminal abortion law forces many Tennessee physicians to wait until the patient’s condition develops overt and severe signs of deterioration. This is not the standard of care. Instead, physicians must

be able to rely on their medical judgment and not wait for serious pregnancy complications to get worse. Delaying care can and does worsen patient outcomes.¹² And for some conditions, the only way to prevent death or risk of loss of bodily function is to perform an abortion *before* the patient’s condition has progressed, by which time it may be too late.¹³ Patients with chronic conditions or illnesses do not necessarily follow a linear path of deteriorating health—a diabetic patient may be fine one day and in a coma the next.

Leading medical guidance discourages delaying care for this exact reason. The Society for Maternal-Fetal Medicine observes, for example, that previable and periviable PPRM involve a “substantial risk of maternal morbidity and mortality, with no guarantee of fetal benefit.” It recommends that all patients with previable or periviable PPRM be offered abortion care; expectant management (closely monitoring

¹² ACOG, *Increased Risk of Maternal Morbidity Associated With Previa and Periviable Preterm Prelabor Rupture of Membranes* (June 2025), <https://perma.cc/GC66-UHX9>.

¹³ Ashley N. Battarbee et al., *Society for Maternal-Fetal Medicine, Consult Series #71: Management of Previa and Periviable Preterm Prelabor Rupture of Membranes*, 231 Am. J. Obstet. Gynecol. B2, B7 (2024), <https://perma.cc/NLH9-2WMA> (noting that for PPROMS “once infection was identified, the median time to death was only 18 hours”).

without intervention) may also be offered when there are no contraindications.¹⁴ ACOG likewise recommends that patients experiencing PPROM be “counseled on the higher rates of morbidity associated with expectant management . . . to ensure they can make a fully informed decision regarding their care” and notes that “physicians and other health care professionals must be able to intervene and, in cases of previable and perivable preterm PROM, provide abortion care *before* the patient becomes critically ill.”¹⁵

The more recent amendment to the criminal abortion law fails to clarify when abortion is “necessary.” The amendment states that “serious risk of substantial and irreversible impairment of a major bodily function” “*may*” include various conditions, including PPROM, *see* Tenn. Code Ann. § 39-15-213(a)(5)(B) (emphasis added), but this still fails to solve the bind the law imposes on Tennessee physicians. First, it is impossible to create a single list of medical conditions that may necessitate an abortion, as “[t]he practice of medicine is complex and requires individualization,” “[n]o single patient’s condition progresses

¹⁴ *Id.* at B2-B15.

¹⁵ ACOG, *supra* note 12 (emphasis added).

at the same pace” and “[a] patient may experience a combination of medical conditions or symptoms that, together, become life-threatening.”¹⁶ Second, the amendment’s use of “may” implies that not every instance of preterm premature rupture of membranes, inevitable abortion, severe preeclampsia, or other conditions constitutes a “serious risk,” and leaves physicians vulnerable to prosecution or license revocation when providing an abortion in these circumstances.¹⁷

B. The “reasonable medical judgment” standard fails to protect physicians who act in good faith to preserve the life or health of a patient.

The law’s use of the “reasonable medical judgment” standard to determine the legality of medical care heightens physician uncertainty. It means that a physician could be subject to prosecution for providing

¹⁶ ACOG, *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions* (Aug. 15, 2022), <https://perma.cc/JX3S-Z6T8>; see also Ashish Premkumar, *Society for Maternal-Fetal Medicine Special Statement: Considerations for Management of High-Risk Pregnancies When Abortion Care is Restricted*, 2 *Pregnancy* e70376 (July 2026), <https://perma.cc/T38G-AGUD> (“It is difficult for national organizations and professional societies to create evidence-based approaches universally responsive to state-specific restrictions and the needs of individual patients, clinicians, and institutions.”).

¹⁷ This is particularly concerning, given Defendants’ own expert could not identify any circumstance where a patient with one of those conditions would not face such a “serious risk.” R.Vol.42 6944

an abortion even if the physician acts in good faith according to their best medical judgment. The law substitutes hindsight review for bedside clinical judgment because it permits prosecutors and the licensing boards to second-guess the physician's decision.

Under Tennessee law, “reasonable medical judgment’ means a judgment made by a reasonably prudent physician knowledgeable about the patient's case and the treatment possibilities with respect to the medical conditions involved.” Tenn. Code Ann. § 63-6-1102(14).

Under this standard, “[a] physician may act in good faith and yet still be held criminally and civilly liable if, after the fact, other physicians determine that the physician’s medical judgment was not reasonable. In other words, a physician need not act willfully or recklessly in determining whether a medical emergency or medical necessity exists in order to be held criminally or civilly liable; rather, ... , physicians face liability even if they act in good faith according to their own best medical judgment.”

Memphis Ctr. for Reprod. Health v. Slatery, 14 F.4th 409, 434 (6th Cir. 2021) (quoting *Women’s Med. Pro. Corp. v. Voinovich*, 130 F.3d 187, 204 (6th Cir. 1997)). As Dr. Maune observed, the standard “... does not consider whether my ‘direct purpose’ was to preserve the life or health of my patient.” APP.259, Maune Decl. ¶ 21.

That such a standard is problematic in a criminal statute is confirmed by Tennessee law defining the *mens rea* required for other criminal offenses. Tennessee generally requires proof of a culpable mental state as an element of criminal offenses. *See* Tenn. Code Ann. § 39-11-301(b), (c) (providing that “[a] culpable mental state is required” unless the offense “plainly dispenses with a mental element”); *State v. Hollon*, 671 S.W.3d 561, 565 (Tenn. Crim. App. 2023). (“In general, our legislature has chosen to define criminal offenses through the combination of two components: a voluntary act and a culpable mental state.”); *see Voinovich*, 130 F.3d at 206 (finding abortion law was unconstitutionally vague when law lacked scienter requirement and “a physician may be held criminally and civilly liable for adhering to his or her own best medical judgment.”).

While Tennessee criminal law ordinarily punishes only intentional, knowing, reckless, or criminally negligent conduct, here a physician can act honestly, ethically, and solely to save a patient by providing an abortion, and still face prosecution because another physician, prosecutor, or licensing official later disagrees about whether the physician's judgment was “reasonable.” The threat of criminal

penalties makes the case drastically different than other cases addressing the competency of the physician, such as malpractice actions. Placing a criminal statute in the middle of clinical decisions about complex and quickly-changing patient circumstances directly interferes with access to life- and health-saving care and places physicians on the defensive.

Because so many conditions may arise or worsen during pregnancy, it is important that pregnant women have the option to terminate the pregnancy before their condition progresses in severity, as the disease progression may become irreversible. Unfortunately, physicians' confusion over the law leads to hesitation, delays and even referring cases to another state, causing additional delays for the patients. This is unsafe, unworkable, and flies in the face of the evidence-based standards of medical care that Tennessee families deserve.

III. Subjecting Tennessee physicians to liability under the state's criminal abortion law is in tension with physicians' professional ethical obligations to patients.

A. The statute interferes with the physician-patient relationship and a physician's duty of loyalty to the patient.

The foundation of medical practice is the patient-physician relationship. ACOG's Code of Professional Ethics states that "the welfare of the patient must form the basis of all medical judgments" and that ob-gyns should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."¹⁸ The American Medical Association's ("AMA's") Code of Medical Ethics places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."¹⁹

Tennessee's criminal abortion law forces physicians to choose between avoiding prosecution and offering the standard-of-care treatment that best helps the patient. The uncertainty created by the law has hindered Tennessee physicians ability to deliver the standard of care and forced physicians to delay medically necessary abortion care until a patient's condition worsens. APP.255-56, Maune Decl. ¶ 12.b. By restricting physicians from exercising their medical judgment, the law undermines the patient-physician relationship.

¹⁸ ACOG, *Code of Professional Ethics* 2 (Dec. 2018), <https://perma.cc/4UAH-S3MQ>.

¹⁹ Am. Med. Ass'n, *Code of Medical Ethics Opinion* 1.1.1, <https://perma.cc/H4EJ-HE52>.

B. The statute is incompatible with medical principles of beneficence and non-maleficence.

Beneficence, the obligation to promote the well-being of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2500 years ago.²⁰ Both principles arise from the foundational ethical principle that the welfare of the patient forms the basis of all medical decision-making.²¹ If a physician reaches the conclusion that an abortion is within the standard of care, the principles of beneficence and non-maleficence require the physician to provide that course of treatment if the patient agrees after being informed of the risks. A physician, relying on experience and medical expertise, may understand that a patient has a poor prognosis and is likely to deteriorate absent care. Yet the state's criminal abortion law, and avoiding criminal liability, requires a physician to consider the potential criminal consequences to themselves for offering that care.

²⁰ Am. Med. Ass'n, *Principles of Medical Ethics* (rev. June 2001), <https://perma.cc/F97P-3XA8>; ACOG, Comm. Op. No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1, 3 (Dec. 2007, reaff'd 2019), <https://perma.cc/3UGX-LBX7>.

²¹ ACOG, Code of Prof. Ethics, *supra* note 18; Am. Med. Ass'n, *supra* note 19.

The law forces the doctor to choose between satisfying their ethical responsibilities or avoiding criminal liability, so that the welfare of the patient no longer forms the basis of medical decision-making. By pitting physicians' interests *against* interests of their patients, the law compromises medical ethics.

IV. The harm from the abortion law disproportionately falls on Tennessee's most vulnerable populations and diminishes the pipeline of new ob-gyns coming to Tennessee.

A. Harm to Vulnerable Populations

Abortion restrictions like the Tennessee law are particularly burdensome on the most vulnerable patients, including rural patients, low-income patients, and patients of color.

Rural “women experience poorer maternal health outcomes compared to their non-rural counterparts, including higher pregnancy-related mortality.”²² Pregnant rural patients are less likely to seek prenatal care, and the initiation of prenatal care in the first trimester is lower for rural pregnant patients than suburban patients.²³ Rural

²² Ctrs. for Medicare & Medicaid Servs., *Advancing Rural Maternal Health Equity* 1 (2022), <https://perma.cc/77MS-JB9V>.

²³ ACOG, Comm. Op. No. 586, *Health Disparities in Rural Women* 2 (Feb. 2014), <https://perma.cc/D29D-M2NY>.

patients may be forced to travel much further to access needed care. That is particularly true in Tennessee: nearly one-third of counties are maternity care deserts,²⁴ meaning there is no birthing hospital and no obstetric clinician.²⁵ Patients in rural areas in Tennessee travel an average of 2.1 times longer to access hospitals with labor and delivery services.²⁶ If a rural patient is forced to wait to obtain needed abortion care until their condition deteriorates, lengthy travel times to hospitals may result in catastrophic consequences.

Low-income patients in Tennessee already face dramatic health risks when pregnant. Nearly half the births in Tennessee in 2024 were covered by Tennessee's Medicaid program, TennCare.²⁷ Pregnant women with TennCare were three times more likely to die during or after pregnancy than pregnant women with private insurance in

²⁴ March of Dimes, *Maternity Care in Tennessee*, <https://perma.cc/JM4K-JCU8>.

²⁵ March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S.*, March of Dimes 5 (2026), <https://perma.cc/GV4Y-AM8K>.

²⁶ March of Dimes, *supra* note 24.

²⁷ R.Vol.33 4807 (reporting that Tennessee's Medicaid program, TennCare, covered 38,766 births in 2024, representing 46.7% of Tennessee live births).

Tennessee.²⁸ Low-income women must typically travel longer distances to access a maternal-fetal medicine subspecialist capable of managing a complicated pregnancy.

Black patients face a higher risk of death because of pregnancy than any other racial group.²⁹ In Tennessee, Black women are nearly two times more likely to die from pregnancy-related causes than non-Hispanic white women.³⁰ Pregnant women of color are also less likely to receive prenatal care, resulting in increased risk for complex health issues in pregnancy.³¹

Each of these groups of pregnant patients is more likely to experience complications when pregnant and thus more likely to need critical care obstructed by the Tennessee law.

²⁸ Anita Wadhwani, *TennCare’s Maternal Death Rates are 3x Those of Private Insurance*, Tennessee Lookout (Jan. 21, 2025), <https://perma.cc/64SL-84SM>; Tenn. Dep’t of Health, *supra* note 6.

²⁹ Anuli Njoku et al., *Listen to the Whispers Before They Become Screams: Addressing Black Maternal Morbidity and Mortality in the United States*, 11 Healthcare 1, 1 (Feb. 3, 2023), <https://perma.cc/LXD6-KT97>.

³⁰ Tenn. Dep’t of Health, *supra* note 6.

³¹ R.Vol.33 4806; *see also* Juanita J. Chinn et al., *Health Equity Among Black Women in the United States*, 30 J. Women’s Health 212, 215 (2021), <https://perma.cc/6JYE-4SKW> (explaining that “Black women are at a disadvantage regarding the protective factor of the early initiation of prenatal care”).

B. Even before Tennessee’s confusing criminal abortion law was in place, Tennessee suffered a shortage of ob-gyns, and the law is exacerbating it.

Tennessee’s criminal abortion law is worsening the statewide shortage of ob-gyns. Tennessee’s worst primary-care workforce shortage is in obstetrics.³² This shortage predated the effective date of the state’s criminal abortion law, and it has only worsened since. Before the law took effect, there were 730 actively licensed physicians practicing obstetrics and gynecology for an estimated population of 6.9 million.³³ Across the state’s 95 counties, ten counties (11%) had no obstetric providers, three had patient: obstetric provider ratios greater than 15,000:1, and 27 counties had ratios greater than 4000:1.³⁴ Since then, the distribution of ob-gyns has worsened. For example, in 2026, 33% of Tennessee counties have no obstetrics provider, while another 15% have a single clinician for the entire county.³⁵ *Amicus* TMA is aware of

³² Tenn. Dep’t of Health, *Uninsured Adult Healthcare Safety Net Annual Report 2024* at 30, <https://perma.cc/6PDG-R7DF>.

³³ U.S. Dep’t of Health and Human Servs., *Overview of the State – Tennessee – 2023*, <https://perma.cc/2WEX-Q43Z>.

³⁴ *Id.*

³⁵ March of Dimes, *supra* note 24.

physicians (or physicians-in-training) leaving the state due to their concerns about abortion laws.

Absent an influx of qualified physicians, this shortage is expected to worsen over time, leaving countless Tennessee women without access to ob-gyn care even if they never seek an abortion. The uncertainty created by Tennessee's criminal abortion law discourages physicians from practicing in the state. Given this alarming shortage and need for more ob-gyns in Tennessee, doctors and patients deserve clear laws that do not create potential liability for providing evidence-based medical treatment within the standard of care.

C. The law discourages physicians and medical students who want to specialize in reproductive health from practicing in Tennessee and deprives Tennessee-based residency programs of the ability to offer the full scope of required training.

Tennessee's criminal abortion law is deterring ob-gyn residents from choosing Tennessee institutions for their training, which will further limit the pipeline of physicians needed to provide everyday care in Tennessee. The Accreditation Council for Graduate Medical Education has long required, and continues to require, training in abortion care as a core competency that must be taught in residency

programs.³⁶ This training is necessary to ensure that ob-gyns have the skills to properly manage miscarriages (*i.e.* spontaneous abortion) and other pregnancy complications.³⁷

Unfortunately, for those residents who train in Tennessee, their residency programs must now send them to other regions of the country to obtain the required training because the law prevents the full scope of ob-gyn training from being provided in the state. Where a physician completes residency training is one of the most important determinants of where physicians choose to practice.³⁸ With the inability to receive the level of training and experience necessary to provide quality reproductive care to patients in Tennessee, ob-gyn residents are much less likely to choose to train and practice here.

According to a recent nationwide study, 75% of those surveyed felt state abortion laws affected where they would apply for residency, with roughly 60% of medical students reporting they would not apply to

³⁶ Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sep. 2025), <https://perma.cc/4G7N-LJD7>.

³⁷ Callie Cox Bauer, et al., *Turning Rage Into Action: Abortion Care and Residency Training in the United States*, 15 J. Grad. Med. Educ. 291 (2023), <https://perma.cc/56JH-K9KF>.

³⁸ *Id.*

states with restrictive laws.³⁹ Tennessee's statistics are consistent with this trend. Fewer ob-gyn residents are applying for residencies in Tennessee, a 20.9% decrease in the 2023-2024 cycle.⁴⁰

Tennessee's law discourages medical professionals and trainees from practicing and training in Tennessee to the detriment of all Tennesseans in need of ob-gyn care. And those physicians who do choose to remain in Tennessee after their training may have less experience offering the full scope of needed medical care to their patients. Abortion aside, these trends will harm the Tennessee medical community and all Tennessee women.

D. Fear of prosecution has caused pharmacies to protect themselves rather than stock standard of care drugs used to safely induce medically indicated abortions.

The two-drug protocol for medication abortion (mifepristone, followed by misoprostol) is also the standard of care for patients who are experiencing a miscarriage. Before Tennessee's criminal abortion

³⁹ Kendal Orgera et al., Ass'n Am. Med. Colls., *Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health Organization Decision* (Apr. 13, 2023), <https://perma.cc/SM9G-G7EV>.

⁴⁰ Kendal Orgera & Atul Grover, *States With Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants*, AAMC (May 9, 2024), <https://perma.cc/8W9V-ZLQB>

ban went into effect, a physician could easily prescribe misoprostol to patients who could pick the pills up at their pharmacies. After the law went into effect, many pharmacies no longer stock misoprostol and those that do are reluctant to dispense the drug to patients, even when the prescription is specifically coded by the treating physician as being for miscarriage management. APP.247, Decl. of Laura Andreson in Opp'n to Defs.' Mot. for Summ. J ¶ 13 (Feb. 17, 2026); APP.281, Decl. of Nicole Schlechter in Opp'n to Defs.' Mot. for Summ. J ¶ 17.

CONCLUSION

Access to abortion is essential for Tennessee women experiencing high-risk or life and health-threatening pregnancy complications and other medical conditions. Tennessee physicians should never be forced to decide between following the standard of care to treat their patients or avoiding criminal prosecution. The Court should affirm the decision below.

Dated: October 7, 2026

Respectfully submitted,

A. Yarnell Beatty, BPR #013712
General Counsel
Tennessee Medical Association
701 Bradford Avenue

/s/ Stella Yarbrough
Stella Yarbrough, BPR #033637
HERZFELD, SUETHOLZ, GASTEL
LENISKI AND WALL, PLLC
1920 Adelia St., Ste. 300

Nashville, TN 37204
(615) 460-1644

Nashville, TN 37212
stella@hsglawgroup.com
(615) 800-6225

Kaitlyn Golden*
Carrie Flaxman*
Robin F. Thurston*
DEMOCRACY FORWARD FOUNDATION
P.O. BOX 34553
Washington, DC 20043
(202) 448-9090

Molly Meegan*
Meaghan Davant*
AMERICAN COLLEGE OF
OBSTETRICIANS
AND GYNECOLOGISTS
409 12th Street, SW
Washington, D.C. 20024

**Pro hac vice pending*

CERTIFICATE OF ELECTRONIC COMPLIANCE

Pursuant to Tennessee Supreme Court Rule 46, § 3.02, the relevant sections of this brief contain 5,886 words, as calculated by Microsoft Word, and it was prepared using 14-point Century Schoolbook font pursuant to § 3.02 (a)(3).

Dated: October 7, 2026

s/ Stella Yarbrough

Stella Yarbrough

CERTIFICATE OF REDACTION COMPLIANCE

I hereby certify that this filing in Phillips v. State of Tennessee, No. M2026-0578-COA-R3-CV, complies with the omission and redaction requirements of Tennessee Rule of Appellate Procedure 20B.

Dated: October 7, 2026

s/ Stella Yarbrough

Stella Yarbrough

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing was served upon the following on October 7, 2026, via the Court's e-filing system and electronic mail.

s/ Stella Yarbrough

Stella Yarbrough