NO. M2026-00578-COA-R3-CV

IN THE COURT OF APPEALS OF TENNESSEE
MIDDLE SECTION AT NASHVILLE

ALLYSON PHILLIPS et al.,
Plaintiffs/Appellees and Cross-Appellants,
v.
STATE OF TENNESSEE et al.,
Defendants/Appellants And Cross-Appellees.

On Appeal from the Chancery Court Of Davidson County
Case No. 23-1196-I – Three-Judge Panel (Chancellor Moskal, Chancellor Culbreath, Judge Donaghy)

BRIEF OF INDIVIDUAL TENNESSEE MEDICAL PROFESSIONALS AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS/APPELLEES

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae are 51 medical professionals who currently practice or have practiced medicine in the State of Tennessee ("*amici*").[2] *Amici* practice, or have practiced, in a variety of medical specialties—including obstetrics and gynecology—across both metropolitan and rural areas of the state. *Amici* believe it is important that the Court have a clear understanding of the harmful effects that Tennessee's abortion ban, Tenn. Code Ann. § 39-15-213, has and will continue to have on medical professionals and patients in Tennessee. Indeed, *amici* can attest that Tennessee's abortion ban, which supplants the medical standard of care with a vague statutory standard, has deprived patients of necessary stabilizing treatment and tied the hands of their health care providers.

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[1] All parties consented to the filing of this amicus brief. No party's counsel in this case authored this brief in whole or in part. No party or party's counsel contributed any money intended to fund preparing or submitting this brief. No person, other than *amici*, their members, or their counsel, contributed money that was intended to fund preparing or submitting this brief.

[2] A full list of *amici's* names is included in the Appendix A to this brief.

SUMMARY OF ARGUMENT

Tennessee's criminal abortion ban, Tenn. Code Ann. § 39-15-213 (the "Ban"), has left providers unable to determine, in the moment a patient needs care, whether providing that care will cost them their liberty or their license.

More specifically, the Ban, which was enacted in 2019 and became effective thirty days after *Dobbs v. Jackson Women's Health Organization*, originally provided no exceptions whatsoever—not even for abortions necessary to preserve the life or health of the pregnant patient.[3] Instead, it required a provider to prove as an affirmative defense to prosecution that such abortion was necessary or face potential criminal felony liability.[4] When the Ban took effect, only two other states—Idaho and North Dakota—banned abortion without any exception for life-saving care, and enforcement of those states' bans was enjoined as to certain life-saving abortion care for that reason.

The result was exactly what one would expect: providers across Tennessee were left confused and afraid to act. With no true exception on the books—only the prospect of having to justify their conduct after being charged with a felony—providers reasonably feared that providing textbook, life-saving obstetric care could end their careers and their liberty. That fear was not confined to a handful of practitioners. On October 10, 2022, Tennessee medical professionals published an open letter to the Tennessee General Assembly (the "2022 Letter"), warning

[3] 2019 Tenn. Pub. Acts, ch. 351, § 2.
[4] *Id.* at § 2(c)(2)-(3).

that the Ban's lack of any exception "forces health care providers to balance appropriate medical care with the risk of criminal prosecution."[5] The 2022 Letter, which amassed over 1,000 signatures, called on the legislature to "reconsider" the Ban that made "ending any pregnancy a felony offense, even when the pregnancy cannot survive to viability and threatens the life of the mother."[6] Tennessee's own providers, in other words, were sounding the alarm before a single one of the women whose stories animate this litigation ever set foot in an emergency room.

On April 28, 2023, the Tennessee General Assembly first amended the Ban to remove the affirmative defense provision. In its place, the amendment carved out the first iteration of the medical necessity exception (the "Medical Necessity Exception").[7] But the amended Ban did little to clarify when, where, and how a provider in Tennessee may perform a medically necessary abortion without being subject to criminal liability. And the same is true with the Tennessee General Assembly's April 2025 amendment to the Ban (the "2025 Amendment"). The 2025 Amendment was passed to conform with the Chancery Court's temporary injunction order in this suit and defined conditions that potentially qualify under the Medical Necessity Exception.[8] Notably, the 2025

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[5] Anita Wadhwani, *In Open Letter, 700 Tennessee Healthcare Providers Call on Legislature to 'Reconsider' Abortion Ban*, Tennessee Lookout (Oct. 10, 2022), https://tennesseelookout.com/2022/10/10/in-open-letter-700-tennessee-healthcare-providers-call-on-legislature-to-reconsider-abortion-ban/.

[6] *Id.*

[7] Tenn. Code Ann. § 39-15-213(c)(1) (2023).

[8] Plaintiffs/Appellees' App. at 329-330.

Amendment included five medical conditions that *may* qualify as a "[s]erious risk of substantial and irreversible impairment of a major bodily function." As explained below, this does little in practice to clarify whether a physician may be subject to criminal liability for performing an abortion.

The consequences of the Ban, even with these two narrow amendments, are that Tennessee medical providers remain in precisely the same position that provoked the 2022 Letter to the Tennessee legislature—which is that medical providers are forced to weigh their patients' medical needs against the risk of criminal prosecution—based on statutory language that no medical or legal authority has defined with any precision.

And as Dr. B, a board-certified OB-GYN and a faculty member of an OB-GYN medical residency program remarked "[n]o one wants to be the test case." Instead, experienced providers are forced to delay or deny necessary abortion care, that they believe, in their medical judgment, falls within the standard of care—not because the law plainly forecloses that care, but because it does not plainly allow it. "If a case had been brought and we can see that doctor was protected by using the language in the [patient's] chart or two-person sign off maybe [we] would be more comfortable moving forward." That chilling effect falls hardest on exactly the patients this litigation describes: women who receive devastating fetal diagnoses, who develop dangerous complications such as preeclampsia or infection, and who are told by their own physicians that the law leaves no room to provide the standard of care until the patient's

condition has grown considerably worse—or until she can find the time, money, and support to travel out of state.

The record thus tells a consistent story, from the Ban's original enactment through both of its subsequent amendments—a law that affords medical providers no genuine safe harbor cannot be squared with the standard of care physicians are trained to provide and patients are entitled to receive. This brief provides first-hand accounts, collected from numerous interviews and written quotes from medical practitioners across Tennessee, as to why the Ban remains constitutionally infirm even as amended, and why the harms that Tennessee's own medical providers warned of in 2022 continue to play out in Tennessee hospitals and private clinics today.

ARGUMENT

I. THE BAN REMAINS VAGUE AND UNWORKABLE IN PRACTICE

The Chancery Court was correct in denying summary judgment on Plaintiffs/Appellees' vagueness claims where it found "significant disputes among Tennessee medical professionals about when, where, and how abortion care is permissible under the Medical Necessity Exception and the uncertainty of its application."[9] Because providers across the state are unclear on when and where they can act within the bounds of the Medical Necessity Exception, there have been and will continue to be lasting and severe impacts on maternal health outcomes across the state.

[9] Plaintiffs/Appellees' App. at 362.

A. *After the 2025 Amendment, Providers Are Still Unsure of When They Can Provide Medically Essential Abortion Care.*

Even with the 2025 Amendment, the Ban is unworkable because providers across the state are unclear on when they may face criminal penalties for providing necessary care. Defendants/Appellants point to the fact that the 2025 Amendment added "examples of conditions" that "may" satisfy §39-15-213(c)(1).[10] Notably, for all of these conditions, abortion is the standard of care.[11] But Defendants/Appellants—many of whom have never practiced medicine nor have performed life-saving medical procedures—offer a sterile interpretation of the workability of the Ban that is contradicted by the experiences of medical providers across the state. Indeed, the 2025 Amendment merely sets forth conditions that "*may*" qualify for the exception. Medical providers are still forced to question whether their patient—even when diagnosed with a condition listed in the 2025 Amendment—is the type of case that would qualify under the Medical Necessity Exception. And numerous medical providers in the state have expressed that there is definitely still a delay in care and confusion about care. Dr. C, a board-certified OB-GYN, also noted that "no one knows how much risk is considered substantial risk…[i]t is not clearly defined and people are uncomfortable deciding

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[10] Defendants/Appellants' Br. at 56-57.

[11] The 2025 Amendment now carves out a possible exception for: (1) previable preterm premature rupture of membranes, (2) inevitable abortion, (3) severe preeclampsia, (4) mirror syndrome associated with fetal hydrops, and (5) an infection that can result in uterine rupture or loss of fertility. Tenn. Code Ann. § 39-15-213(a)(6).

how much risk meets the exception in the 2025 amendment. [It is a] [v]ery grey situation."

1. "I am unable to make the decisions I need to make in the moment."

In hospitals across Tennessee, the Ban has complicated the procedures that medical providers must go through in order to determine when abortion care is appropriate. Many hospitals have established ethics committees or other review bodies that are designed to provide legal support to physicians and hospitals to insulate them from liability. After a physician has determined that abortion care is the appropriate and necessary treatment, these committees must be consulted before care can be provided. And these providers have experienced how this ethical and legal review of their medical decisions can delay care in cases where the health of the pregnant person is rapidly deteriorating in real time—including in cases where patients have been diagnosed with the conditions outlined in the 2025 Amendment to the Medical Necessity Exception. Cases seen by Dr. A, a board-certified obstetrician and gynecologist ("OB-GYN") and a faculty member of an OB-GYN medical residency program, illustrate these challenges.

Dr. A's hospital system has an ethics committee to assist physicians in assessing the legality of providing abortion care. In practice, this means that once Dr. A has determined that abortion care is the necessary treatment, she must then consult with the ethics committee before giving care. In her experience, this has complicated and delayed her ability to perform medically necessary procedures.

Dr. A describes a recent situation where a patient was suffering from mirror syndrome, a condition that "may" be covered under the current version of the Medical Necessity Exception. Mirror syndrome is an extremely rare and serious condition that causes both the fetus and the mother to experience severe fluid buildup, and in Dr. A's experience, can cause heart failure in both the pregnant person and the fetus.[12] Symptoms for the pregnant person can include high blood pressure, pulmonary edema (*i.e.*, shortness of breath caused by fluid buildup in the lungs), eclampsia, and placental abruption.[13] For the fetus, symptoms include hydrops fetalis, severe swelling, heart failure, and intrauterine fetal demise.[14] Mirror syndrome is a serious pregnancy complication that can jeopardize both maternal and fetal health.[15]

Prior to the patient's arrival at the hospital, Dr. A's patient previously had genetic testing that demonstrated evidence for partial molar pregnancy—a pregnancy not compatible with life.[16] In Dr. A's experience, "the standard of care is spelled out very clear" that this should be treated immediately with a dilation and curettage ("D&C") or a dilation and evacuation ("D&E") procedure.

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[12] *Mirror Syndrome*, Boston Childs. Hosp., https://www.childrenshospital.org/conditions-treatments/mirror-syndrome (last visited Sept. 22, 2026).
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Molar Pregnancy*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/molar-pregnancy/symptoms-causes/syc-20375175 (last visited Sept. 23, 2026).

Dr. A's patient was experiencing heart failure and was receiving multiple medications to treat acute severe hypertension. She was also put on oxygen because there was fluid buildup in her lungs. In Dr. A's professional judgment, the patient was "clearly not stable." However, the fetus still had a heartbeat and after consulting her hospital's ethics committee, it was determined because of the legality concerns that the hospital would not provide the abortion care that Dr. A had determined was medically necessary.

Instead, the patient was ordered to be immediately transferred to a different hospital. Despite the fact that the transfer was to be expedited due to the severity of the patient's declining health, the transfer did not happen until almost five hours after the fact. In Dr. A's experience, this was detrimental to the health of the mother, and Dr. A felt unable to "make the decisions I needed to make in the moment."

2. "You have no idea what's going on in the room."

In another recent instance from this past year, Dr. A described a patient who came in to the hospital at 22 weeks pregnant and laboring. The patient was suffering from cervical insufficiency—another condition that "may" be covered under the current Medical Necessity Exception. Cervical insufficiency is the inability of the cervix to retain the fetus.[17] Progressive cervical dilation at early gestational ages can result in serious complications, such as preterm premature rupture of

[17] Monika Thakur, et al., *Cervical Insufficiency*, StatPearls (Oct. 6, 2024), https://www.ncbi.nlm.nih.gov/books/NBK525954/.

membranes ("PPROM"), mid-trimester pregnancy loss, or spontaneous preterm birth.[18] As Dr. A described, the patient's cervix was unable to stay closed, causing her to go into early labor.

Dr. A's patient was attempting to deliver the baby; however, she began to hemorrhage. In a short time span, the patient had lost around 1.5 liters of blood and her condition was deteriorating rapidly. As Dr. A described, "you can bleed out very quickly" in this situation because the patient's placenta was still in place. It became clear to Dr. A that the patient required a D&E procedure in order to provide stabilizing care. Dr. A's priority was then to counsel the patient as to her condition and explain the life-threatening circumstance.

However, Dr. A's ability to provide adequate care to her patient was both delayed and undermined by the Ban and the fact that she still needed to consult with her hospital's ethics committee in order to provide life-saving abortion care—something she did not have time to do in the emergency situation. She also experienced criticism from multiple hospital employees, stating that "we don't do" those procedures at the hospital and with some even accusing her of performing a criminal abortion.

Ultimately, by the time the patient was brought to the operating room, the fetus had died. Dr. A felt that her ability to adequately provide care to her patient and counsel her as to the options available in an emergency situation was undermined by individuals "who have no idea what's going on in the room." She expressed that she has to "show up the

[18] *Id.*

best [she] can for [her] patient" but was faced with competing procedural hurdles that undermined her ability to provide life-saving care.

B. *The 2025 Amendment Does Not Cover All Medically Necessary Situations for an Abortion.*

As Dr. D, a board-certified OB-GYN and professor of medicine in Tennessee, explained, "it would be impossible to create an exhaustive list" of conditions that may require abortion care to save the life of a patient. As a result of the Ban, providers in Tennessee have seen many cases where patients are being refused abortion care even where it is appropriate or necessary. And medical providers are being forced to wait until their patients are extremely ill or suffering from other complications to provide care.

1. "There is this idea that we can just snatch people back from the jaws of death."

Dr. C describes the disconnect between when the Ban permits medical providers to act and how these providers actually give care in emergency situations: "There is this idea that we can just snatch people back from the jaws of death. But when we are being forced to wait for an acute illness or worsening of a chronic illness, that is just not how medical care works. Patients end up with chronic kidney disease, loss of fertility, they can die, the list goes on."

A case seen by Dr. C illustrates this challenge. Dr. C was referred a patient who was suffering from placenta accreta spectrum ("PAS")—a condition not explicitly covered under the Medical Necessity Exception. PAS "occurs when the placenta implants into scar tissue instead of

healthy tissue in your uterine lining. [PAS] is most common in people who have had a [cesarean section ("[C]-section")]."[19] PAS distorts the uterus and surrounding anatomy and effectively transforms the pelvis into an extremely high-flow vascular state.[20] It is "one of the most dangerous conditions in pregnancy and is increasing in frequency."[21] The guidance for a PAS diagnosis made in the previable period includes "counseling [the patient] about the possibility of pregnancy termination for maternal indications given the significant risks of maternal morbidity and mortality."[22]

But despite the severity of the condition, Dr. C describes how medical providers in Tennessee are still afraid to offer abortion care even where their patients are diagnosed with extreme conditions such as PAS.

By the time the patient was referred to Dr. C, she was 24 weeks, had already been diagnosed with PAS, and had been seen by four different providers in three states. The patient explained to Dr. C that she had been requesting abortion care since the first trimester. The patient's OB-GYN told her that an abortion "was not medically

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[19] *Placenta Accreta*, Univ. of Utah, https://healthcare.utah.edu/womens-health/pregnancy-birth/placenta-accreta (last visited Oct. 2, 2026).
[20] Brett D. Einerson, et al., *Placenta Accreta Spectrum*, 142 Obstetrics & Gynecology 1 (Jul. 1, 2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10491415/pdf/nihms-1894145.pdf.
[21] *Id.*
[22] *Placenta Accreta Spectrum*, American College of Obstetrics & Gynecologists (ACOG), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2018/12/placenta-accreta-spectrum (last visited Oct. 5, 2026).

necessary," even after diagnosis with potential PAS despite the medically recognized increased morbidity and mortality risk associated with PAS. Instead, the patient was told she would be referred to the PAS team around 32 weeks for delivery planning. Dr. C stated her "understanding was that the provider felt that because it is a condition that can be treated and result in a live birth that abortion care [was] not medically necessary." This opinion, which flatly contradicts clinical guidance from ACOG, is shared by other providers throughout the state of Tennessee.

Left with no other option, the patient sought out abortion care in another state through online resources. But because of the concern about PAS, she was considered too high risk for abortion care in a clinic setting. Her doctor contacted Dr. C, but the patient was too far along in the pregnancy to have abortion care at Dr. C's hospital. They made a plan together that the patient would travel to the referring provider for abortion care by injection, then travel to Dr. C for a surgery to evacuate and repair her uterus in hopes of maintaining her fertility, which was the patient's preference. Had she been promptly treated when she was first diagnosed with PAS at 16 weeks, Dr. C could have treated her with a far less invasive D&E procedure following abortion care by injection instead of a major abdominal surgery with high risk of loss of fertility.

But that is not even the extent of the problem here. As Dr. C describes, PAS complications are life-threatening, and there were "so many ways this could have ended poorly" because the patient was denied care by multiple providers, forced to travel across state lines by both ground and air, and significantly delayed receiving care while at high risk of "bleeding to death at any time." Dr. C's patient was also located

in a rural area, and proper PAS treatment requires a delivery care center specialized in PAS to decrease the risk of major complications or death. Dr. C's patient was "at risk of having an emergency at any time" and very likely could have bled to death if she delivered outside of a center with a large blood bank and specialized services. Yet even though the risk of death with a PAS diagnosis is 20 to 30 times higher than with a normal pregnancy, providers remain so unclear about when they may act under the Ban.

2. "As soon as we make a list, a situation not covered would arise and that physician would not be able to proceed with care."

There is an inexhaustible list of conditions that are not expressly covered under the Medical Necessity Exception where abortion care may be the appropriate and necessary treatment, but medical professionals are afraid to give care. Dr. D explained, "we are seeing more situations where there's overlap between fetal issues and maternal issues." Under the Ban, fetal issues do not qualify for the Medical Necessity Exception unless they pose a substantial risk of impairment to a major bodily function or death, but "who determines when the fetal issue would increase the risk beyond acceptable or traditional pregnancy risk for the mother?" An example of such a condition could include fetal skeletal abnormalities that would require a classical cesarean. According to Dr. D, implications of such conditions include blood loss, loss of the ability to labor, and future problems with pregnancy including having other pre-term c-sections. But under the current Ban, medical providers are

unclear as to whether this type of condition would permit them to perform life or system saving abortion care—protecting the patient's future fertility—and they are wary to provide such care in these situations.

Dr. C echoed the confusion medical providers are experiencing. Dr. C recalled seeing two patients, who were seen at a tertiary care center, with similar post-trauma vascular injuries being offered different care. The first patient was counseled and offered abortion care, while the other patient, who came in within the same month, was not offered abortion care because she was not deemed high risk enough to qualify.

Dr. E, an Internal Medicine Physician, explained other life-threatening scenarios that are not expressly covered under the Medical Necessity Exception.

> I work as an oncologist and tragically, pregnant women do get cancer. Oftentimes, we are able to wait until the second trimester and start some form of treatment, but depending on the cancer and the stage, this is not always an option. In situations where cancer treatment is delayed to protect the fetus, the pregnant patient is put at high risk for cancer progression. I agree that fetuses are important—I have children of my own and made every effort to protect them while they were in my womb. But as a doctor, I also must protect the life of the woman already born and here in my office. Unfortunately, I feel this abortion ban makes an already incredibly difficult and emotional decision even harder for these women and their doctors.

The Medical Necessity Exception as amended simply does not provide any clarity on when abortion care may be permitted in these types of scenarios.

3. They were "uncomfortable even calling it a cesarean scar ectopic pregnancy so that we couldn't use the diagnosis as justification for a termination procedure that they didn't want me to do."

Medical providers are so unclear as to when a procedure will be exempted under the Medical Necessity Exception that they are avoiding diagnosing patients with conditions that may qualify altogether.

Dr. B has seen this situation firsthand with a patient who was suffering from a cesarean scar ectopic pregnancy ("CSEP"). A CSEP is a rare form of an ectopic pregnancy, where "an embryo attaches to the scar tissue left from a previous C-section instead of attaching to the wall of the uterus, where a healthy pregnancy can grow. The scar tissue is not as strong as the uterine wall and can tear and may result in hemorrhage."[23] This condition will often become PAS if untreated. While the Ban arguably would exempt the termination of an "ectopic or molar pregnancy" from the definition of abortion,[24] which arguably would exempt providers from criminal liability for providing life-saving care in this instance, Dr. B describes, in practice, medical providers in the state are still extremely fearful of providing termination care in such situations. This means doctors may even fear diagnosing patients with

[23] Patricia Santiago-Munoz, *Cesarean Scar Ectopic Pregnancy: Facts and Treatment Options*, Univ. of Tex. Sw. Med. Ctr. (Aug. 23, 2022), https://utswmed.org/medblog/cesarean-scar-ectopic-pregnancy/.
[24] Tenn. Code Ann. § 39-15-213(a)(1).

these conditions so as to avoid the possibility of having to provide abortion care.

The patient in this case came to Dr. B's emergency room at nine to ten weeks pregnant. It was her desire to be pregnant, but she had been passed along by three separate providers who knew something was wrong with the pregnancy but were fearful of diagnosing the patient because the fetus had a heartbeat. By the time the patient was seen by Dr. B—around five weeks after she was first seen by a provider—she had still received no diagnosis or care and was experiencing vaginal bleeding, pain, and was emotionally distraught.

Dr. B knew that this was a CSEP and that the necessary and appropriate treatment for the condition would be to terminate the pregnancy to avoid potentially fatal complications. But medical providers at her hospital were fearful of providing abortion care. And Dr. B was required to consult her hospital's ethics panel to determine whether she could provide the necessary and appropriate termination care and was told she could not. As Dr. B recounts, this was a procedure that her hospital would have previously treated with an abortion but, since the Ban, this "impacted how our hospital handled this case." The Radiology Department at her hospital was "uncomfortable even calling it ectopic so that we couldn't use the diagnosis as justification for a termination procedure that they didn't want me to do." Instead, the patient was ultimately forced to seek care in a different state that did not have the same restrictions as Tennessee.

Had she been timely diagnosed, Dr. B believes she may have been eligible for medication for her condition, but because she was passed

along by so many providers she ended up with a surgical procedure that "puts her at risk in the future because she has now had multiple surgeries in the same spot and may have future complications." As Dr. B describes, "this is a hot potato issue." In Dr. B's experience, "because people are afraid, the pregnant woman gets passed along and doesn't get the diagnosis she needs until it is too late." And, importantly, Dr. B describes—even in an instance of a CSEP that may cause life-threatening hemorrhaging and technically is exempted from criminal liability under the Ban—"there is a lack of clarity on whether this was an acceptable diagnosis for an abortion."

Proper and timely diagnosis is an essential component to providing adequate care to patients. The Ban is critically undermining medical providers' ability to provide care in the state where they are fearful of even diagnosing patients with certain conditions because they fear being charged with criminal liability under the Ban.

* * *

The 2025 Amendment provides no additional clarity on the Ban for providers across the state to know when they are permitted to provide abortion care. Trying to make situations that are very complex into a black-and-white list of qualifying conditions is simply not possible—and adding a shortlist of potentially qualifying conditions does not make it any more workable. Medical providers across the state remain unclear on when and how the Ban permits them to act when the health of their patients is at risk.

II. THE BAN CREATES A MORAL HAZARD FOR MEDICAL PROVIDERS AND PREVENTS THEM FROM PROVIDING AN APPROPRIATE STANDARD OF CARE TO PATIENTS

A. *The Ban Undermines the Patient-Provider Relationship and Prevents Providers from Providing Essential Care to their Patients.*

The medical profession has long subscribed to a body of ethical standards developed primarily for the benefit of the patient, under which medical professionals must recognize their responsibility to patients first and foremost. The American Medical Association's *Code of Medical Ethics* requires providers "to act for the good of patients" and "to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."[25] "The welfare of the patient must form the basis of all medical judgments" and OB-GYNs should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[26]

Since the Ban took effect, medical providers have experienced significant changes in their ability to practice medicine and provide an adequate standard of care for their patients. Indeed, the Ban violates the

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[25] Am. Med. Ass'n (AMA), *AMA Code of Medical Ethics,* Opinion 1.1.1 Patient-Physician Relationships, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2026-07/1.1.1_1.pdf (last visited Oct. 2, 2026).

[26] Am. Coll. of Obstetricians & Gynecologists (ACOG), *Code of Professional Ethics* 2 (Dec. 2018), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf.

long-established principles of medical ethics and intrudes on the foundation of the patient-physician relationship. Dr. D remarked that pregnancy and abortion care are complex, "it's not black and white; there's so many shades of grey." She continued that the Ban "creates moral distress among providers" and that "providers are scared of the laws. Things are not getting better, they're getting worse."

The Ban creates a no-win situation for medical providers. As Dr. A explained, "doctors are afraid [for their] livelihood. Many are the breadwinners of their home. . . I've dedicated my whole life to the study and taking care of women, and the idea of doing something to jeopardize that is scary. Sometimes you just hold your breath and do the next right thing. You think twice and explain yourself more." The Ban creates an ethical dilemma for medical professionals: choosing between the providers' interests and those of their patients. As Dr. F, a board-certified OB-GYN, explained, "our first duty is [to] care [for] the patient not the fetus. We struggle with determining when to intervene as determined by laws enacted by people with no healthcare knowledge. For this reason, women are suffering and dying unnecessarily."

Not only does the Ban challenge and violate physicians' ethical oaths, it also has shifted the discourse and diagnoses surrounding pregnancy. Dr. B stated that "we are actually seeing changes in diagnoses or the terms used in a patient's chart to avoid recommending abortion care." Physicians are so terrified to provide oftentimes life-saving abortion care because of the criminal liability they may face. Dr. B continued stating that, "I just want to take care of my patients. As a medical professional I want to be able to take care of the person in front

of me . . . If there are legal words in the [patient's] chart that I can put in and be protected I would. My legal team is unwilling to do that because no one wants to be the test case." In addition to legal consequences, abortion care has become stigmatized to a point where physicians do not want to develop a reputation as someone who is trained to perform or does in fact perform abortions. Dr. C explained that the Ban has "magnified the stigma around abortion care," and that "some people don't want to become known as a person who performs D&E procedures because of the stigma around them."

Further, physicians have to counsel their patients differently under the Ban, often delaying care or referring them to different states for care—all of which negatively impacts the patient-provider relationship and causes distrust and anxiety among patients. Dr. C recalled a recent case that exemplifies this new reality. Dr. C's patient, who had previously had four prior c-sections, was pregnant and the fetus had recently been diagnosed with a severe fetal brain anomaly. She had a previous pregnancy affected by the same condition, and the child had died shortly after birth. The patient would have needed another c-section for this fetus that potentially would not survive, and did not want to take that risk. The patient had already traveled almost two hours to seek abortion care with Dr. C, but Dr. C was forced to refer her out of state, further delaying care. She explained that "the patient was angry with me and saw me as the gatekeeper [of abortion care], but no one else in my practice thought this was within [Tennessee's] laws enough that we could get approval. We don't offer abortion care in our facility for patients based on the risk with a high number of cesarean deliveries." Traveling

out of state was a burden for this patient and her family because she had other children to care for and would have had to miss work.

B. *The Ban Threatens Patient Autonomy.*

Providers are worried about the harms of limiting patient choice because they are ethically obligated to respect patient autonomy by "acknowledg[ing] an individual's right to hold views, to make choices, and to take actions based on [their] own personal values and beliefs."[27] Longstanding medical ethics guidelines require fostering patient autonomy as part of the standard of care.[28] Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[29] Denying patients the option for an abortion and/or forcing them to travel for abortion care defies these basic principles of patient autonomy. Tennesseans should have the right to make personal health care decisions with the assistance of their doctors and healthcare team—without the intrusion of the government. The Ban hands

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[27] *Ethical Decision Making in Obstetrics and Gynecology*, ACOG Committee Opinion No. 390, 110 Obstetrics & Gynecology 1479, 1481 (Dec. 2007, *reaffirmed* 2016).

[28] *See generally* Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics (9th ed. 2026).

[29] ACOG *Code of Professional Ethics*, *supra* note 26, at 1 ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental"); *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, ACOG Committee Opinion No. 819, (Feb. 2021); AMA *Code of Medical Ethics, supra* note 25, at Opinion 2.1.1 Informed Consent, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2024-12/2.1.1_0.pdf.

government officials the power to determine what healthcare options are available to patients, establishing a dangerous precedent that intrudes on the sacred physician-patient relationship (discussed above) and a patient's autonomy. Dr. A remarked that "patients are more fearful to seek care." It is Dr. A's role as a faculty member for an OB-GYN program in Tennessee to "make sure resident [physicians]" inform patients that they "can travel to other places for abortion care and information." Dr. B noted patients' lack of choice and how many will travel as far as Florida from Tennessee for abortion care, "rushing to meet an arbitrary deadline set forth in state laws. Some patients can't travel, so they seek telehealth abortion care," which is not always the mechanism that a patient wants to use for care.

III. THE BAN NEGATIVELY IMPACTS THE FUTURE OF MEDICAL PROFESSIONALS IN TENNESSEE

A. *The Ban Has Resulted in Current Medical Providers Leaving Tennessee.*

The moral hazards and distress discussed above are not merely an ethical abstraction—it is emptying Tennessee of the very providers equipped to deliver this care, and it is compromising the state's ability to recruit and train the next generation of reproductive healthcare professionals. Retention is as urgent a crisis as recruitment. Current medical professionals are fleeing the state for fear of criminal liability and the legal repercussions that come with misinterpreting the language of the law and performing an abortion procedure that does not equate to a medical necessity under the Ban. Together, these effects severely

compromise Tennessee's local healthcare infrastructure now, and its capacity to serve patients in the future.

Tennessee is already seeing sharp drops in retention of qualified and trained medical providers. "As these ban[s] are implemented, medical providers are increasingly choosing to leave these states to protect themselves from criminal lawsuits and the possibility of medical licensure termination."[30] Dr. D agreed with this sentiment, noting that "[p]hysicians already have stressful lives, adding moral distress is causing people to leave the state or the profession." The institutional risk-aversion discussed above, where legal teams and hospitals refuse to protect the doctors who rely on their sound medical judgment to offer medically necessary abortion care, is itself driving providers to leave rather than continue practicing under that uncertainty.

Legal concerns are not the only factor driving medical professionals out of the state. Providers are also leaving for personal reasons, including their own lack of autonomy in reproductive care. Dr. C explained that colleagues at reproductive ages or stages in their lives—or with partners who were—ultimately left Tennessee because they did not feel comfortable accessing maternal care for themselves or their family. The consequences of this exodus are already visible: "[o]ver half

[30] Anne-Grace Lilly et al., *Our Hands Are Tied: Abortion Bans and Hesitant Medicine*, 350 Soc. Sci. & Med. 116912, at 5 (2024), https://www.sciencedirect.com/science/article/pii/S0277953624003563.

of rural hospitals in Tennessee do not offer obstetric services,"[31] and "forty-six percent of counties [in Tennessee] are without OB-GYNs[.]"[32]

B. *The Ban Discourages Medical Students Seeking Careers in Reproductive Health from Practicing in Tennessee and Deprives Tennessee-Based Residency Programs of the Ability to Offer Full Scope of Required Training.*

The Ban is also crippling the state's medical education system. Medical students must factor abortion restrictions into where they apply and train, since Tennessee hospitals typically cannot offer comprehensive reproductive training in-house, forcing interested students into competitive out-of-state rotations that can add logistical and financial hurdles. For example, as Dr. A explained, if a student's home institution's insurance coverage is restricted for out-of-state reproductive healthcare training and a student's host institution's insurance requires independent external coverage, the student may be required to obtain their own ad hoc short-term insurance (*e.g.*, short-term medical malpractice or workers' compensation insurance).

1. Influence on medical residency selection.

Medical residents interested in obstetrics and gynecology are likely being dissuaded from pursuing their education in Tennessee given the

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[31] Courtney Joslin, Lindsay Heck & Stacey McKenna, *Navigating Women's Health: Tennessee*, R St. Inst. (June 9, 2025), https://www.rstreet.org/commentary/navigating-womens-health-tennessee/.

[32] *Id.*

Ban. Dr. A put it: "[w]e do not attract people who have a strong life-long goal of advocating for complex family planning. We will never recruit that person." Dr. B agreed: "my applicant pool is kind of self-selecting, people that want to do abortions aren't coming to Tennessee."

A study by the Association of American Medical Colleges found a drop in the overall number of residency applications among states with similar abortion bans and restrictions, with even higher drops in applications for obstetric residencies.[33] These decreases were much larger in abortion restricted states compared to states without such laws in place.[34] Specifically, "Tennessee saw a 12.7% decline in overall residency applications during the 2023-2024 school year, despite overall residency applications increasing before the trigger ban went into effect by 2.8% during the 2021-2022 school year, 2.3% during the 2020-2021 school year, and 4.3% during the 2019-2020 school year."[35] The 2023-2024 school year also recorded an astounding 21% drop in obstetric residency applications within Tennessee.[36] While the study recognized that states with more restrictive abortion laws may be "less populous" and "have fewer residency programs" to begin with, the decreases were

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[33] Tori Gessner, *Fewer Medical Students Applying to Tennessee Residency Programs Since Abortion Ban, Study Finds*, WKRN (Dec. 17, 2024), https://www.wkrn.com/news/tennessee-news/fewer-medical-students-applying-to-tn-residency-programs-since-abortion-ban-study-finds/.

[34] *See id.*

[35] *See id.*

[36] Kendal Orgera & Atul Grover, *States with Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants*, Assoc. Am. Med. Colls. (AAMC) (May 9, 2024), https://www.aamc.org/about-us/mission-areas/clinical-care/post-dobbs-2024.

consistent on an applicant to program basis as well.[37] Bottom line—for residents looking for on-site, comprehensive abortion training that they are then also able to apply during their careers, Tennessee is not a viable option.

2. Fragmentation of standard medical education.

Beyond its immediate constraints on healthcare delivery, the Ban introduces structural challenges that threaten the sustainability of medical education within Tennessee. As Dr. D explained, "the biggest issue is not being able to train the next generation, so that when someone needs this care they can get it safely." Dr. B put it starkly: there is now "[a]n entire generation of OB-GYN residents in our state who do not know what an outpatient abortion is or how to do it. Even if the Ban were to lift today we are battling against years and we would not have providers ready to provide care." Since the Ban criminalizes abortion, the state's OB-GYN residency programs cannot provide abortion training in-state. It stands to reason that the next generation of doctors in Tennessee will have a fundamental misunderstanding of what reproductive medicine truly entails. Dr. D shared the long-standing, damaging impact of this educational void in real-world practice:

> There is a term HALO - high acuity, low occurrence. Essentially, you want doctors to be able to save lives, even when they see things rarely. If a trainee has never performed an abortion from 16-22 weeks, they will not be able to act quickly if a patient comes in septic or hemorrhaging. It may be rare, but it is life threatening, and all OB-GYNs should be

[37] *See id.*

> able to provide this healthcare. In the future in ban states, most [OB-GYNs] will not.

Despite the Ban, the Accreditation Council for Graduate Medical Education still requires OB-GYN residency programs to provide access to abortion training.[38] While many OB-GYN residency programs try to get around this requirement through the management and treatment of spontaneous pregnancy losses through D&Cs, it still results in many residents having to "travel out of state to meet clinical requirements, incurring substantial financial and logistical burdens."[39] Dr. A elaborated on these burdens in the context of state-funded medical programs, remarking on Tennessee's lack of financial support for students traveling out of state for training,[40] premised on the dubious justification that its mission is to teach residents how to practice in Tennessee. She added that if the resident's home institution, nor any hosting institution, does not agree to provide insurance coverage while they seek out-of-state training, residents are then also tasked with securing short-term liability coverage in the form of temporary medical malpractice or workers' compensation. To combat the lack of funding and support for out-of-state training programs within Tennessee, Dr. B mentioned fellowships being

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[38] Brooke Gully et al., *The Impact of Restrictive Abortion Laws on Medical Residency Applications and Healthcare Access: Implications for Maternal Health Equity*, 2026 J. Pregnancy 1 (2026), https://pmc.ncbi.nlm.nih.gov/articles/PMC13315824/pdf/JP-2026-6613889.pdf.

[39] *See id*. at 2.

[40] The lack of access and support isn't just for abortion care, but can, and does, include out of state maternal medicine training and specialties such as gynecologic oncology.

created by out-of-state institutions, or through independent organizations, for abortion and advanced family planning education. Although these fellowships provide surgical, medical, and advocacy training, Dr. B stressed that it should not be necessary for residents to have to go through them to receive this education. It would be much more effective if offered directly through a resident's medical program.

It is not surprising then that researchers predict that "the current status of reproductive health in Tennessee [will] deter[] providers from practicing medicine in the state" and instead persuade them "to pursue a career in states in which they can use the full scope of their education."[41]

The loss of training extends beyond surgical skill to counseling itself. Dr. C explained that residents used to rotate through Planned Parenthood clinics, where "everyone was trained on how to provide that counseling, and saw that aspect" of patient care. "Those clinics no longer provide abortion care, so [they are] not available to rotate through. Nothing replaced that." Some state funded institutions do not fund away rotations, and without sending residents out of state for the same experience, they are left "learning to counsel patients about how to find care elsewhere, if they discuss it at all." This results in what Dr. C called a "normalization of not discussing abortion care" that leaves residents unprepared to counsel patients on options they themselves are being taught to avoid.

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[41] Lilly, *supra* note 30, at 6.

CONCLUSION

For the foregoing reasons, *amici* respectfully request this Court to affirm the Chancery Court's denial of summary judgment of Plaintiffs/Appellees' vagueness claims.

Dated: October 7, 2026

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with Tennessee Supreme Court Rule 46 §3.02 because it is typed in fourteen-point Century Schoolbook font and, according to the word-count feature of Microsoft Word, contains 7,472 words, exclusive of those parts of the brief exempted by § 3.02(a)(1).

Dated: October 7, 2026 */s/ John Spragens*

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CERTIFICATE OF REDACTION COMPLIANCE

I hereby certify that this filing in *Phillips v. State of Tennessee*, No. M2026-00578-COA-R3-CV, complies with the omission and redaction requirements of Tennessee Rule of Appellate Procedure 20B.

Dated: October 7, 2026 */s/ John Spragens*

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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:

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