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IN THE CHANCERY COURT OF TENNESSEE
FOR THE TWENTIETH JUDICIAL DISTRICT

NICOLE BLACKMON; ALLYSON PHILLIPS; KAITLYN DULONG; HEATHER MAUNE, M.D., on behalf of herself and her patients; and LAURA ANDRESON, D.O., on behalf of herself and her patients,	)
Plaintiffs,	)
v.	)
STATE OF TENNESSEE; JONATHAN SKRMETTI, in his official capacity as Attorney General of Tennessee; TENNESSEE BOARD OF MEDICAL EXAMINERS; and MELANIE BLAKE, M.D., in her official capacity as President of the Tennessee Board of Medical Examiners,	)
Defendants.	)

PLAINTIFFS' COMPLAINT FOR DECLARATORY JUDGMENT AND PERMANENT INJUNCTION

Tennessee's near-total abortion ban threatens the lives and health of pregnant people throughout the state. Plaintiffs Nicole Blackmon, Allyson ("Allie") Phillips, Kaitlyn ("Katy") Dulong and countless others have been denied necessary and potentially life-saving medical care because doctors, like Plaintiffs Heather Maune, M.D. and Laura Andreson, D.O., fear the penalties imposed by that ban. Plaintiffs file this Complaint because Tennessee's abortion ban imperils the lives and health of pregnant people and the sole exception to that ban, codified at Tenn. Code Ann. § 39-15-213 (the "Medical Condition Exception"), threatens doctors with arbitrary enforcement.

In support of their complaint, Plaintiffs allege as follows:

INTRODUCTION

1. Abortion bans threaten the lives and harm the health of pregnant people. On August 25, 2022, approximately two months after the U.S. Supreme Court overturned *Roe v. Wade*,

Tennessee's near-total abortion ban took effect. Since then, pregnant people in Tennessee have suffered needless physical and emotional pain and harm, including loss of their fertility. These pregnant people are not imagined. They are not ideological talking points. They are real people, many with children who depend upon them. Three of them are Plaintiffs in this action.

2. In early July 2022, Nicole Blackmon realized that she was pregnant. Although she suffered serious ongoing health issues, Nicole stopped taking medication needed to treat the symptoms of her various medical conditions to avoid harming her pregnancy. Even though she took this precaution, 15 weeks into her pregnancy she learned that her baby had a lethal fetal diagnosis. Without resources to leave Tennessee to obtain an abortion, Nicole was forced to continue her pregnancy despite the grave risks it posed to her physical and mental health, even after she began to exhibit the warning signs of preeclampsia, a dangerous condition that can lead to a stroke. In the seventh month of her pregnancy, she gave birth to a stillborn baby after more than 32 hours of labor.

3. Allie Phillips was eagerly looking forward to the birth of her second daughter, whom she had just named Miley Rose, when she received devastating news: the baby had multiple fatal fetal diagnoses. Allie sought care in Tennessee but was told she could not get an abortion, even though continuing the pregnancy would strain Allie's own precarious health. So, Allie started a GoFundMe campaign to raise the funds needed to travel to New York. There, she received the care she needed, but had to grieve her loss far from her own home without the support of her family and friends back in Tennessee.

4. Katy Dulong underwent fertility treatment in order to get pregnant. She was looking forward to the birth of her first child when she was diagnosed with cervical insufficiency. Although Katy was told that she would inevitably lose the pregnancy, she was not given the medication that

would have allowed her body to expel the pregnancy promptly without further risk to her own health. Instead of receiving the care she wanted, Katy was sent home with absorbent pads. It was not until ten days after her diagnosis, by which time Katy's cervix was fully dilated, there was no discernible amniotic fluid, the placenta bore signs of severe infection, and almost all of the fetus's body was in her vaginal canal, that Katy was finally offered the medication she had requested. Katy could have died from the lengthy delay in receiving the care that she would have promptly received but for Tennessee's abortion ban.

5. Common themes emerge from the stories of Plaintiffs and other pregnant Tennesseans whose stories have become public. First, abortion is necessary healthcare that is being denied under Tennessee's abortion ban. Second, Tennessee's abortion ban prevents pregnant people and those who may become pregnant from receiving the nationally recognized standard of care they need. And third, pervasive fear and uncertainty throughout the medical community regarding the scope of the Medical Condition Exception have put patients' lives and doctors' liberty and livelihoods at grave risk.

6. Vague abortion bans like Tennessee's inevitably hinder or delay the delivery of necessary medical care. And, contrary to its stated purpose of furthering life, Tennessee's abortion ban exposes pregnant people to grave risks of death, injury, and illness, including loss of fertility—making it *less* likely that every family that wants to bring a child into the world will be able to do so.

7. The Plaintiffs in this case are only the tip of the iceberg. Since July 2022 (and earlier in some states), millions of people of reproductive capacity across this country have been denied dignified treatment as equal human beings. This Court need not guess at the impact that abortion bans might have. Each day, in states across the country, pregnant people like Nicole, Allie, and

Katy are being denied their ability to control their reproductive lives and to build their families according to their own values and beliefs. Doctors, like Dr. Maune and Dr. Andreson, are being forced to forgo practicing their profession and fulfilling their ethical duties to patients in the face of catastrophic risks to their liberty and ability to practice medicine. Plaintiffs' experiences illustrate that, while the stated purpose of Tennessee's abortion ban may have been to promote healthy babies and families, it has done just the opposite.

8. Plaintiffs respectfully ask this Court to issue a declaratory judgment clarifying the scope of Tennessee's Medical Condition Exception to its abortion ban, and to issue all declaratory or injunctive relief necessary to protect the health and lives of pregnant Tennesseans with emergent medical conditions.

PARTIES

I. PLAINTIFFS

9. Nicole Blackmon lives in Nashville, Tennessee. Nicole sues on her own behalf.

10. Allie Phillips lives in Clarksville, Tennessee. Allie sues on her own behalf.

11. Katy Dulong lives in Chapel Hill, Tennessee. Katy sues on her own behalf.

12. Heather Maune, M.D., is an obstetrician/gynecologist who practices in Nashville, Tennessee. Dr. Maune sues on her own behalf and on behalf of her patients.

13. Laura Andreson, D.O., is an obstetrician/gynecologist who practices in Franklin, Tennessee. Dr. Andreson and Dr. Maune are jointly referred to as the "Physician Plaintiffs." Dr. Andreson sues on her own behalf and on behalf of her patients.

II. DEFENDANTS

14. Defendant the State of Tennessee duly enacted the abortion ban and its Medical Condition Exception and may be served with process through the Tennessee Attorney General at John Sevier Building, 500 Dr. Martin L. King Jr. Blvd., Nashville, TN 37243.

15. Defendant Johnathan Skrmetti is the Attorney General of Tennessee. He is responsible for defending Tennessee laws against constitutional challenge. *See* Tenn. Code Ann. § 8-6-109(b)(9). As Attorney General, he is empowered to petition the Tennessee Supreme Court to appoint a district attorney general pro tem to enforce Tennessee's criminal abortion ban where the elected district attorney general has categorically declined to enforce the ban. *See* Tenn. Code. Ann. § 8-7-106(a)(2). Glenn Funk, the District Attorney for Davidson County, where Dr. Maune practices, issued a press release on June 24, 2022 in which he categorically declined to enforce Tennessee's criminal abortion ban. On information and belief, Stacey Edmonson, the District Attorney for Williamson County, where Dr. Andreson practices, has made private statements in which she categorically declined to enforce the criminal abortion ban with respect to abortions performed to preserve the life or health of a pregnant person. Defendant Johnathan Skrmetti is sued in his official capacity and may be served with process at John Sevier Building, 500 Dr. Martin L. King Jr. Blvd., Nashville, TN 37243.

16. Defendant Tennessee Board of Medical Examiners ("TBME") is the state agency mandated to regulate the practice of medicine by licensed doctors in Tennessee. The TMBE must initiate disciplinary action against a licensee who performs an abortion if the TBME determines that the procedure did not meet the Medical Condition Exception. *See, e.g.*, Tenn. Code Ann. § 63-6-214(b)(6). The TBME may revoke the license of a physician who is determined to have violated the Tennessee Abortion Ban. *See, e.g.*, Tenn. Code Ann. §§ 63-6-214(a), 63-6-217; Tenn. Comp. R. & Regs. 0880-02-.12(1). Tennessee Board of Medical Examiners may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

17. Defendant Melanie Blake, M.D is the President of the Tennessee Board of Medical Examiners. Dr. Blake is sued in her official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

JURISDICTION AND VENUE

18. This matter should be heard by a three-judge panel pursuant to T.C.A. §§ 20-18-101, *et seq*., because it challenges the constitutionality of the Medical Condition Exception to Tennessee's abortion ban, codified at Tenn. Code Ann. § 39-15-213.

19. The empaneled three-judge court has jurisdiction pursuant to T.C.A. §§ 20-18-101, *et seq*.

20. The empaneled three-judge court has jurisdiction to grant the injunctive and declarative relief sought herein pursuant to T.C.A. § 20-18-101 and Tenn. R. Civ. P. 65.

21. Venue is proper in the Twentieth Judicial District, and before a three-judge panel seated therein, pursuant to T.C.A § 20-18-102 and Tennessee Supreme Court Rule 54 because Plaintiffs Nicole Blackmon and Dr. Maune reside in Davidson County, Tennessee.

FACTUAL ALLEGATIONS

I. THE IMPACT OF TENNESSEE'S ABORTION BAN ON PLAINTIFFS AND OTHER TENNESSEANS

22. Tennessee's abortion ban has imperiled the lives of pregnant Tennesseans and challenged the ability of Tennessee's physicians to provide them with the necessary standard of care.

A. Plaintiff Nicole Blackmon

23. Nicole Blackmon is 31 years old. She has several serious, chronic health conditions that posed particular risks to her health during pregnancy.

24. In May 2021, Nicole was diagnosed with a pseudotumor cerebri (idiopathic intracranial hypertension), where elevated cerebrospinal fluid levels cause pressure in the brain, similar to a brain tumor, that can result in severe headaches and vision problems. If left untreated, the condition can lead to permanent vision loss. Nicole had previously received a spinal tap to relieve the pressure on her brain and had been taking an anti-inflammatory medication called Diamox (Acetazolamide) to manage her pseudotumor.

25. Nicole also suffered from chronic hypertension and high body mass index (BMI). She took a beta blocker medication to manage her hypertension.

26. In early July 2022, shortly before moving from Alabama to Tennessee with her fiancé, Nicole realized that she was pregnant. Nicole was surprised by the news; her periods had been irregular, and her doctors had told her it would be more difficult for her to conceive because of the severe swelling associated with her hypertension and high BMI.

27. Although Nicole had not been trying to conceive a child, Nicole and her fiancé felt that the pregnancy was a blessing. Just a few months earlier, on February 15, 2022, Nicole's only child, her 14-year-old son Daniel, was sitting outside a friend's home when he became the unintended victim of a drive-by shooting. Nicole was still grieving the tragic loss of Daniel, but she was excited by the possibility of having another child. She loved being a mother.

28. The pregnancy posed medical challenges for Nicole, however. Nicole's chronic medical conditions would make her pregnancy high-risk. But, to minimize any potential risk the medications might have on her developing pregnancy, Nicole stopped taking most of her medications until she could be seen and advised by her doctors.

29. Nicole's neurologist confirmed that she should stop taking Diamox while pregnant because Diamox has teratogenic effects that affect fetal limb development. Nicole's doctors told

her that the pseudotumor would make labor and delivery higher risk because labor pain and contractions could lead to transient increases in intracranial pressure that could cause severe headaches and permanent vision loss.

30. Doctors also advised Nicole that her chronic hypertension put her at increased risk of superimposed preeclampsia, where a person with chronic hypertension develops worsening high blood pressure, excess protein in urine, severe headaches, changes in vision, shortness of breath, and other symptoms during the course of pregnancy. Preeclampsia can result in serious complications for a pregnant person, including death or damage to organs, and may cause a stroke. Because of this serious risk, Nicole's doctors told her that she would need regular monitoring of her blood pressure and to be on the lookout for other signs of preeclampsia.

31. The combination of Nicole's chronic hypertension and pseudotumor cerebri put her at serious risk of pregnancy complications and made continuing her pregnancy high-risk for her health. Nicole quickly began to experience adverse consequences. She experienced regular and severe headaches, nausea, blurred vision, and throbbing pains in her head and chest. The symptoms were sometimes so severe that they prevented Nicole from working.

32. Nicole had been diagnosed with major depressive disorder and post-traumatic stress disorder (PTSD) after Daniel's murder and already was experiencing severe anxiety prior to her pregnancy. To manage these conditions, Nicole was seeing a therapist. Her doctor had also prescribed her anti-depressant medication.

33. Between her pseudotumor cerebri, hypertension, depression, PTSD, and anxiety, Nicole felt like she was constantly seeing doctors and taking new medications to manage her symptoms. Nonetheless, Nicole wanted to continue her pregnancy.

34. Because Nicole's medical conditions made her pregnancy high-risk, she was referred to a maternal-fetal medicine ("MFM") specialist. In late August, at around 15 weeks since her last menstrual period,[1] Nicole went to a routine appointment and for an ultrasound with her MFM specialist. The results were devastating. The MFM told Nicole that the ultrasound showed that her baby's stomach, intestines, and other major organs were contained within a sac outside the baby's abdomen. The MFM told Nicole this finding was consistent with omphalocele, a condition affecting the development of the fetal abdominal wall. The ultrasound also showed that the baby's feet were positioned atypically. The MFM told Nicole that these findings may indicate a fetal condition called limb-body-wall complex ("LBWC"), a severe fetal diagnosis where a fetus's organs develop outside the fetus's body and are attached to the placenta and the umbilical cord is short. Fetuses with limb-body-wall complex are very unlikely to survive to birth. Nicole's MFM told her that there was a chance that the hole in the baby's abdominal wall could be surgically repaired if it remained the same size and if her baby did not have LBWC, but advised Nicole that she would need ongoing monitoring and that LBWC is a "lethal anomaly."

35. Nicole's MFM also told her that, while her fetal diagnosis coupled with her existing medical conditions made her pregnancy high risk, she did not have the option of an abortion in Tennessee. Nicole was shocked to learn that Tennessee law did not contain an exception for her situation. Nicole would have preferred to have an abortion to preserve her health, but she felt that she had no choice but to continue the pregnancy due to Tennessee's abortion ban. She did not have the money to leave Tennessee, travel to another state, and pay out of pocket for an abortion. She felt like her only option was to take a chance and continue the pregnancy, while being actively

[1] Consistent with standard medical practice, gestational ages as used in this Complaint are dated from the first day of the patient's last menstrual period ("LMP"), which is typically approximately two weeks before the estimated date of fertilization of an ovum.

monitored by her doctors for serious health risks. Nicole was scared that her pregnancy would be fatal to both her and her baby.

36. Nicole returned a few weeks later and her MFM confirmed that her baby likely had LBWC, based on the condition of its abdominal wall and the way its legs were positioned. She was also told she had oligohydramnios, or low amniotic fluid around her baby, likely because of LBWC. At an appointment with an OB/GYN, these findings were confirmed, and Nicole was again told about her limited healthcare options in Tennessee.

37. Because of the increasing complication of and health risks associated with her pregnancy, Nicole began receiving care in late October at a hospital specializing in the treatment and care of high-risk pregnancies and severe fetal diagnoses.

38. At 24 weeks, 5 days, Nicole received confirmation of her fetal diagnosis from her new MFM specialist and healthcare providers. Nicole's doctors told her that the hole in her baby's abdominal wall had increased in size and now extended from the abdomen to the chest cavity, that an ultrasound could not visualize an umbilical cord, and that they suspected significant scoliosis.

39. Nicole met with her new doctors for a long time to discuss the diagnosis and her options. Her doctors and a genetic counselor advised Nicole to consider an abortion because her baby was no longer receiving nutrients through the placenta, was extremely unlikely to survive to birth, and continuing the pregnancy would put increasing strain on Nicole's body. The genetic counselor gave Nicole resources and information regarding out-of-state abortion, and Nicole investigated abortion providers in the Washington, D.C., area. She learned that having an abortion at her baby's gestational age would require that she stay over for at least one night and that the procedure itself would cost thousands of dollars. Ultimately, Nicole concluded that even with assistance funding the medical costs of the procedure, she could not afford the travel and lodging

costs of an out-of-state abortion or the time off work. Instead, she was scheduled for an induction in late January 2023, at 37 weeks of her pregnancy, which was the earliest date at which her doctors felt they could lawfully induce labor in Tennessee.

40. As the pregnancy progressed, Nicole could feel her baby's organs moving around in her body. Each time Nicole felt movement, it was painful. Eating was painful. She could not sleep, as she felt like there was no comfortable position in which to lie down. Her back became swollen and would regularly seize up on her. She found that she was unable to stand up after sitting down. Because she was not taking medication for her pseudotumor, her vision deteriorated. To this day, she still suffers from blurry vision, headaches, and increased eye pressure. Nicole still does not know whether her vision will ever be fully restored.

41. In mid-November, Nicole went to the hospital because she began to experience severe headaches and increased blood pressure—warning signs of the preeclampsia she had been told she was at risk of developing. Although she was not diagnosed with preeclampsia at that time, the doctors advised her to follow up within a week and to continue serial blood pressure monitoring to assess for superimposed preeclampsia. Nicole worried constantly about her health, including the possibility that she could suffer a stroke.

42. Knowing that she was now losing a second child in the same year worsened Nicole's depression and anxiety. She began increasing her visits to her therapist, and she started to have increasing nightmares and trouble sleeping.

43. Shortly before Christmas, at 31 weeks, 4 days, Nicole's water broke prematurely. She rushed to the hospital where doctors gave her medications to speed her labor out of concern for placental abruption, a condition where the placenta separates from the uterine wall pre-delivery,

and bleeding. She was diagnosed with chorioamnionitis, an infection of the placenta and amniotic fluid.

44. Nicole was in labor for more than 32 hours. She asked for a drape to shield her from viewing the fetus, since she did not want to be further traumatized by what she might see. Eventually, Nicole gave birth to a still-born baby. Hospital personnel gave her blue keepsakes, from which she surmised that the baby was a boy. She named him Ethan. His body was cremated and Nicole keeps his ashes at her home.

45. Nicole is now grieving the loss of two children within a year. She is still recovering from the depression caused by both tragic losses and still has nightmares and panic attacks to this day. She grows numb and shakes when she becomes overwhelmed with feelings of grief.

46. Nicole fears being pregnant again. She does not believe she can go through another pregnancy. Her pregnancy was the most serious health scare she has ever experienced. If she were to become pregnant again, she would again have to discontinue taking the medication needed to manage her pseudotumor cerebri. Earlier this year, she chose to undergo a tubal ligation rather than take those risks.

47. Nicole feels blessed to still be alive and wants to help ensure no one else needs to suffer like she did.

B. Plaintiff Allyson Phillips

48. Allie Phillips is 28 years old. When Allie and her husband realized she was pregnant in the fall of 2022, they were delighted. They had been trying for a baby and were excited to learn that Allie's five-year-old daughter would become a big sister.

49. At first, the pregnancy proceeded typically, and Allie had no cause for concern. At around 15 weeks, Allie learned that she would be having a girl and began to think about potential

names with her husband as they also prepared a nursery for her. Allie and her husband eventually settled on a name they were both excited about—Miley Rose.

50. At 18 weeks, 5 days of pregnancy, Allie went to a routine anatomy scan. Allie did not expect anything but normal results. Allie was in the room with her husband and her daughter. A few minutes into the test, the ultrasound technician stopped the ultrasound, looked at Allie, and said that she needed to go grab the doctor. This terrified Allie. Her husband said that the technician looked sad and like she wanted to cry. The technician said, "I don't want to give anyone bad news," and left.

51. When Allie's doctor entered, she delivered somber news: there was "no amniotic fluid" protecting Miley. Miley now measured at 15 weeks, 2 days, instead of 18 weeks, 5 days, and her kidneys had developed atypically. Allie's doctor referred her to a high-risk MFM specialist in Nashville for a second opinion. Allie remained hopeful that there would be a treatment for Miley's conditions, and she was ready to undergo any necessary treatment for Miley.

52. Allie saw the MFM specialist the same week. Just as had happened at her OB/GYN's office, the ultrasound technician left the room during the ultrasound to go get the MFM specialist. When this happened, Allie texted one of her friends, who was also pregnant and had seen the same MFM, to ask whether this had ever happened to her. Her friend told her, "Never." When the MFM entered the room, the news she delivered was life changing. The MFM specialist told Allie that the ultrasound revealed several fetal conditions that made it extremely unlikely that her baby would survive to birth. The MFM explained that Miley's kidneys, bladder and stomach had not properly developed, which meant that Miley was unable to urinate and therefore produce amniotic fluid. Miley's heart contained only two chambers instead of four, Miley had stunted growth overall, and, most devastatingly, her brain had not developed into separate hemispheres.

The MFM showed Allie on the ultrasound where Miley's brain was and pointed to a line in the skull that showed Miley's brain had not appropriately split into hemispheres. Allie was stunned and devastated.

53. The MFM diagnosed Miley with a condition called semi-lobar holoprosencephaly, a congenital defect where the brain does not develop two hemispheres. Allie was told that the combination of holoprosencephaly and Miley's other structural conditions meant that Miley was unlikely to survive to birth and that there was no available treatment for Miley's constellation of conditions. The doctor told Allie that babies with holoprosencephaly ordinarily had a three percent chance of surviving to birth, but Miley also had several other fetal conditions that made survival to birth even less likely. The MFM further explained that Miley's condition would continue to deteriorate as the pregnancy progressed, and she told Allie and her husband that continuing the pregnancy posed serious risks to Allie's physical and mental health.

54. The MFM broached the subject of abortion but only to tell Allie that, as she understood Tennessee law, she could not offer Allie any advice on how to obtain an abortion. If an abortion was something that Allie wanted to pursue, Allie was told she would need to investigate the option independently. The MFM then left the room to allow Allie and her husband to discuss their options. As they understood it, Allie had two options: leave Tennessee for an abortion; or continue the pregnancy until Allie either miscarried or delivered a stillborn while prolonging Miley's suffering and putting herself at a higher risk of infection or other serious health conditions. In the unlikely event that Miley survived to birth, Allie would have to make sure that Miley received palliative hospital care before her inevitable death.

55. To make things worse, Allie and her husband had to explain the situation to their five-year-old daughter who had been excited about having a sister and had been at the previous appointment with Allie's OB/GYN.

56. Allie was concerned about the risks to her health of continuing the pregnancy. She already worried that her health was not at its best. She had a gastric sleeve installed and, as a result of that procedure, had trouble getting enough hydration and nutrients. Even before she was pregnant, she had to visit the hospital multiple times for severe dehydration. She understood that continuing the pregnancy would further increase the demands on her body and that she would potentially need to return to the hospital for hydration and nutrient support as the pregnancy progressed. She also knew that her five-year-old daughter needed Allie to remain alive and healthy. Allie decided that an abortion was the right decision for her and her family.

57. Allie and her husband began investigating options out of state. They considered four or five states before finding a clinic in New York where they could afford the uninsured costs of the procedure. Waiting just one more week meant the procedure would be more complex and thus more expensive, but Allie could not coordinate the travel any sooner and made an appointment for the following week. Allie set up a GoFundMe to help with costs. She began to put the infant clothes and toys that she had bought for Miley Rose into storage. She also bought a stuffed animal that could play a recording of Miley Rose's heartbeat as a keepsake of the baby she would never know.

58. At some point between her last doctor's appointment in Tennessee and her arrival at the clinic in New York, Miley died in utero. Allie was not aware of Miley's death before she arrived at the clinic for her planned abortion. But Allie was nonetheless grateful for the care she received in New York. There, at what was supposed to be the first part of a two-day procedure,

the doctor informed Allie that she was at a high risk of infection and blood clots because her baby had remained in Allie's uterus after demise. Allie was told by the doctor that she would need to complete the procedure that same day to minimize the risks to her own health.

59. Allie continues to grieve Miley's death. Her daughter also continues to grieve the loss of a wanted sister.

60. Allie fears being pregnant again in Tennessee. She wants to prevent any other person from having to go through the same experience she did.

C. Plaintiff Kaitlyn Dulong

61. Katy Dulong is 27 years old. Katy began fertility treatments after trying unsuccessfully for two years to get pregnant. These treatments were also unsuccessful until it was discovered that Katy had Hashimoto's disease, an auto-immune disorder which interfered with Katy's ovulation. After starting treatment for this disease, in the summer of 2022 Katy and her husband were overjoyed to discover that she was pregnant.

62. Katy and her husband learned they were having a boy and enthusiastically began to furnish their future son's nursery. Initially, the pregnancy was proceeding without incident. But in late October or early November, Katy noticed that she had lost a portion of the mucous plug that seals the cervical canal closed during pregnancy. She called her obstetrician's office and spoke to a nurse who told her that the plug could regenerate from additional mucus secretions.

63. On November 7, 2022, Katy went to her obstetrician's office for a standard checkup. By this time, she was experiencing cramps and a sharp stabbing pain in her cervix which dissipated when she took Tylenol. The nurse told Katy that she was experiencing round ligament pain, a kind of "growing pain" that is common during pregnancy. Katy's obstetrician said she was not concerned because Katy was not bleeding.

64. Katy left the obstetrician's office and, while shopping for baby gear, realized that she was spotting. She called her obstetrician's office and was told by the office staff not to worry.

65. The bleeding became heavier throughout the day. Katy contacted her obstetrician's office again and was told to go to the emergency room. When she got there, she had to wait to see a doctor at the hospital surrounded by sick people who were waiting for COVID testing. Katy was not comfortable waiting there and eventually went home and went to bed. She woke up at 2 a.m. because she was cramping again and then realized that she had lost a lot of blood and mucus.

66. Katy went to her obstetrician's office early the morning of November 8. An ultrasound examination revealed that her cervix already was dilated 2 to 3 centimeters. The amniotic sac was bulging out of the cervix into Katy's vaginal canal; the cervix had started to "funnel" and its thickness was not measurable. Katy's obstetrician determined that Katy was experiencing cervical insufficiency and sent her to the hospital to explore the possibility of getting an emergency cerclage, a procedure to temporarily sew the cervix closed to prevent preterm birth.

67. Katy arrived at the hospital emergency room that afternoon. There, another ultrasound confirmed that there was no measurable amount of cervix and that membranes and the fetus's feet were in Katy's cervical canal. Katy was told that it was not possible to perform an emergency cerclage because of the high risk in her case that forceps or another instrument would puncture the amniotic sac and that, even if one could be performed, it would not be effective to save the pregnancy. She was told that she would likely deliver her son within 48 hours.

68. Katy asked for medication to progress labor because she did not want to continue carrying a doomed pregnancy or risk infection or hemorrhage if she were to deliver at home. Katy and her husband live 40 minutes away from the nearest hospital. Hospital personnel told Katy that they could not induce labor because of Tennessee's abortion ban, since there was still a fetal

heartbeat, even though there was no possibility that her son would survive to make it into this world.

69. Instead of giving her the abortion medication she had requested, the hospital administered intravenous antibiotics to fight infection. On November 10, after no progress on labor, Katy was sent home with pads to absorb any bleeding, but no antibiotics.

70. Seven days later, Katy still had not expelled the pregnancy. She returned to her obstetrician's office on November 17, 2022. An ultrasound showed that Katy's cervix was now fully dilated. Her baby still had a heartbeat and was in breech position. Almost his entire body—everything but his head—was in her vaginal canal. Her water already had broken without Katy being aware of it and there was no amniotic fluid surrounding her baby. Katy showed the nurse a sanitary pad she had been wearing, and the nurse noted to the doctor that the fluid had a bad odor, suggesting infection. Katy's obstetrician told her that she would deem Katy to be infected "so we can do something." While Katy sat there, her obstetrician spent two hours on the phone calling various legal and ethics personnel at the hospital and other medical providers to seek support for a decision to provide Katy with the medication to begin an induction abortion.

71. Katy went to the hospital that night. The next morning, she finally received four Cytotec (misoprostol) pills to induce labor. About forty minutes after taking the Cytotec, Katy felt as if she had to go the bathroom. Sitting on the toilet, she felt her baby coming out; she caught him between her hands. As Katy made her way back to the hospital bed, blood started rushing out of her. A nurse came into the room and confirmed that her son was dead. Her husband cut the umbilical cord and laid the baby—who they named Grayson—on her chest.

72. Katy later learned that a pathology report concluded that her placenta exhibited grade 2 acute chorioamnionitis, a severe form of inflammation of the placenta, and subchorionic

hemorrhage (bleeding between the uterine wall and the chorioamniotic membranes that enclose the embryo).

73. Katy is lucky to have survived and to have retained her fertility. One of the doctors at the hospital told her that if she had not taken Cytotec when she did, she would have been dead in another day or two from a septic infection. Katy was also told that prior to Tennessee's enactment of an abortion ban, even the Catholic hospital where her abortion was performed would have given her Cytotec when she was first diagnosed with an incompetent cervix, instead of risking septicemia or hemorrhaging at home.

74. Katy became pregnant again in 2023 and has been able to carry her pregnancy into the third trimester. She now expects to give birth in November.

75. Katy was raised as a Baptist. When she was younger, she believed that all abortion was wrong. Now, Katy wants to ensure that other people in Tennessee are not denied or delayed in receiving medically essential abortions.

D. Plaintiff Heather Maune, M.D., and Her Patients

76. Plaintiff Heather Maune, M.D., is a board-certified OB/GYN in private practice in Nashville, Tennessee. She is licensed to practice medicine in the state of Tennessee.

77. Dr. Maune was born and raised in Tennessee. She has practiced obstetrics and gynecology in Nashville since 2010: four years as a resident at Vanderbilt and nine years in private practice. As part of her practice, Dr. Maune provides gynecological care, prenatal care, and obstetric care to her patients. She is also trained to provide abortion care. Before Tennessee's trigger ban went into effect, she routinely provided abortions to her patients as part of their comprehensive reproductive healthcare needs.

78. Over the course of her career, Dr. Maune has personally treated pregnant patients with a wide variety of obstetrical and other health complications that develop during pregnancy,

including but not limited to: miscarriage; ectopic pregnancy; management of fetal demise; complications of pregnancy, including cervical insufficiency, pre-term premature rupture of membranes ("PPROM"), bleeding, preeclampsia, hyperemesis gravidarum; maternal comorbidities such as hypertension, diabetes, heart disease, sickle cell disease, kidney disease, endocrine disorders, cancer, rheumatologic disorders, psychiatric conditions, including those that may lead to suicide; complicated twin pregnancies; lethal fetal anomalies; various genetic diagnoses, including trisomy 13, 18, and 21; structural fetal conditions; and molar pregnancy. Dr. Maune consults with specialists in the care of such patients—including but not limited to emergency medicine hospitalists, cardiologists, hematologists, oncologists, anesthesiologists, and MFMs—and actively participates in the care of her patients who are treated for emergent health conditions during their pregnancies. Dr. Maune wishes to be able to provide the full scope of medical care to her pregnant patients in the future.

79. Since Tennessee's trigger ban went into effect, Dr. Maune has seen the devastating impact of the ban on her patients. In Dr. Maune's experience, widespread fear and confusion regarding the scope of Tennessee's abortion ban has chilled the provision of necessary obstetric care, including abortion care. Dr. Maune and her peers fear that prosecutors and politicians will target them personally if they provide abortion care to pregnant people with emergent conditions.

80. Dr. Maune has also personally treated pregnant patients with emergent medical conditions since Tennessee's abortion ban went into effect, including patients with placenta previa, patients carrying pregnancies with lethal fetal conditions, including trisomy 18 and 21, patients carrying fetuses with complex cardiac conditions, and patients with complex medical conditions. Before Tennessee's trigger ban, Dr. Maune would have been able to offer abortion care to these

patients. Now, Dr. Maune can only offer them information about where to seek abortion care out of state.

81. Dr. Maune was one of the co-authors of an open letter to Tennessee legislators urging them to revise the Tennessee trigger ban to permit physicians to provide the full scope of care to their pregnant patients experiencing medical emergencies. In Dr. Maune's experience, the emergent conditions or emergency situations for which abortion would be an appropriate treatment cannot be formulaically defined in a single list but will always depend on the patient's unique health and situation.

E. Plaintiff Laura Andreson, D.O., and Her Patients

82. Plaintiff Laura Andreson, D.O., is a board-certified OB/GYN in private practice in Franklin, Tennessee. She is licensed to practice medicine in the state of Tennessee. Dr. Andreson has been elected by her peers to serve on the 15-member Board of Trustees of the Tennessee Medical Association.

83. Dr. Andreson has 21 years of experience in obstetrics and gynecology and has practiced in Franklin since 2018. As part of her practice, Dr. Andreson provides gynecological care, prenatal care, and standard and high-risk obstetric care to her patients. She is also trained to provide abortion care. Before Tennessee's trigger ban went into effect, she routinely provided abortions to her patients as part of their comprehensive reproductive healthcare needs.

84. Over the course of her career, Dr. Andreson has personally treated pregnant patients with a wide variety of obstetrical and other health complications that develop during pregnancy, including but not limited to: miscarriage; ectopic pregnancy; management of fetal demise; complications of pregnancy, including cervical insufficiency, PPROM, bleeding, preeclampsia, hyperemesis gravidarum; maternal comorbidities such as hypertension, diabetes, heart disease, sickle cell disease, kidney disease, cancer, rheumatologic disorders, endocrine disorders,

psychiatric conditions, including those that may lead to suicide; complicated twin pregnancies; lethal fetal anomalies; various genetic diagnoses, including trisomy 13, 18, and 21; structural fetal conditions; and molar pregnancy. Dr. Andreson consults with specialists in the care of such patients—including but not limited to emergency medicine hospitalists, cardiologists, oncologists, hematologists, anesthesiologists, and maternal fetal medicine doctors—and actively participates in the care of her patients who are treated for emergent health conditions during their pregnancies. Dr. Andreson wishes to be able to provide the full scope of medical care to her pregnant patients in the future.

85. Since Tennessee's trigger ban went into effect, Dr. Andreson has seen the devastating impact of the ban on her patients. In Dr. Andreson's experience, widespread fear and confusion regarding the scope of Tennessee's abortion bans has chilled the provision of necessary obstetric care, including abortion care. Dr. Andreson and her peers fear that prosecutors and politicians will target them personally if they provide abortion care to pregnant people with emergent conditions.

86. Dr. Andreson has also personally treated pregnant patients with emergent medical conditions since Tennessee's abortion ban went into effect, including patients carrying fetuses with complex cardiac defects. Before Tennessee's trigger ban, Dr. Andreson would have been able to offer abortion care to these patients. Now, Dr. Andreson instead can only either offer information about where to seek abortion care out of state or counsel expectant management.

87. Many of Dr. Andreson's patients live in rural areas and drive over an hour to see her. Dr. Andreson is concerned that deferring abortion care for such patients could result in life-threatening situations.

88. Dr. Andreson was one of the signatories of an open letter to Tennessee legislators urging them to revise the Tennessee trigger ban to permit physicians to provide the full scope of care to her pregnant patients experiencing medical emergencies. In Dr. Andreson's experience, the emergent conditions or emergency situations for which abortion would be an appropriate treatment cannot be formulaically defined in a single list but will always depend on the patient's unique health and situation.

F. Other Pregnant Patients and Tennesseans of Reproductive Age

89. Plaintiffs' experiences cannot be dismissed as mere aberrations. Published reports from throughout the state reveal that pregnant people and other Tennesseans of reproductive age are being denied, or delayed in receiving, necessary healthcare.

90. Mayron Hollis, a Tennessee resident, was 8 weeks pregnant when she was diagnosed with a cesarean scar ectopic pregnancy. It was just days before Tennessee's trigger ban took effect. Mayron was told that continuing the pregnancy was extremely dangerous and could lead to hemorrhage or a life-threatening placenta disorder. Mayron's doctors offered an abortion before the new law took effect, but Mayron needed time to think. By the time she decided she wanted an abortion, Tennessee's abortion ban had gone into effect and Mayron had no choice but to continue the pregnancy. At 26 weeks, Mayron started bleeding. Doctors were able to save Mayron's life but had to remove her uterus in the process. Her baby survived but has been in and out of the hospital ever since with severe health problems. Mayron now struggles to balance her job, care for her older children, and her new baby's frequent hospital stays.[2]

[2] Kavitha Surana, *Doctors Warned Her Pregnancy Could Kill Her. Then Tennessee Outlawed Abortion*, PROPUBLICA (March 14, 2023), https://www.propublica.org/article/tennessee-abortion-ban-doctors-ectopic-pregnancy?utm_source=sailthru&utm_medium=email&utm_campaign=majorinvestigations&utm_content=feature.

91. Madison Underwood, a Tennessee resident, was nearly 17 weeks pregnant when, during a routine ultrasound, she was informed that her fetus had not formed a skull. She was advised that continuing the pregnancy could lead to sepsis, critical illness, or even death. Madison postponed her wedding to schedule her abortion. But while undergoing a pre-abortion ultrasound, Madison was informed that her procedure had been canceled because it had been determined that the legal risks in Tennessee were too high. Madison remembered wondering: "They're just going to let me die?" Madison was forced to travel hundreds of miles to receive care in Georgia, where, at the time, abortion was legal until 20 weeks.[3] Presently, a 6-week ban is in effect in Georgia.

92. Other pregnant patients harmed by Tennessee's abortion ban remain anonymous, although their stories are a matter of public record.

a. Dr. Kim Fortner, an MFM in Knoxville, testified at a legislative hearing about a pregnant patient with PPROM who had no choice but to continue the pregnancy after the trigger ban went into effect. After going home, the patient became septic and began to hemorrhage.[4]

b. One Tennessee woman whose fetus was diagnosed with a genetic condition putting her at risk of preeclampsia was forced to take a 6-hour ambulance ride to North Carolina where, on arrival, her blood pressure was dangerously high and she was showing signs of kidney failure.[5]

c. Four separate pharmacies denied another unnamed Tennessee woman medication prescribed by her doctor to complete a miscarriage and avoid possible hemorrhaging.[6]

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[3] Neelam Bohra, *'They're Just Going to Let Me Die?' One Woman's Abortion Odyssey*, N.Y. TIMES (Aug. 1, 2022), https://www.nytimes.com/2022/08/01/us/abortion-journey-crossing-states.html?referringSource=articleShare.

[4] *Hearing on HB 883: Hearing Before the H. Population Health Subcomm.*, 2023 Leg., 113th Sess. (testimony of Dr. Kim Fortner at 49:50).

[5] Susan Rinkunas, *A Tennessee Woman Had to Take a 6-Hour Ambulance Ride to Get an Abortion*, JEZEBEL (Oct. 17, 2022), https://jezebel.com/a-tennessee-woman-had-to-take-a-6-hour-ambulance-ride-t-1849668907.

[6] Frances Stead Sellers & Fenit Nirappil, *Confusion Post-Roe Spurs Delays, Denials for Some Lifesaving Pregnancy Care*, WASH. POST (July 16, 2022), https://www.washingtonpost.com/health/2022/07/16/abortion-miscarriage-ectopic-pregnancy-care; Stephanie Wenger, *Tennessee Doctor Details Patient's Experience Being Unable to Get Pills to Complete Her Miscarriage*, PEOPLE (July 8, 2022), https://people.com/health/tenn-doctor-details-patients-experience-being-unable-to-get-pills-to-complete-her-miscarriage.

d. "Sarah," a Tennessee resident, went to the emergency room with severe abdominal pain. Even though she had an IUD, tests revealed that she had an ectopic pregnancy—a relatively common occurrence when an IUD fails—and was bleeding internally. Instead of receiving the immediate treatment she needed, however, Sarah was forced to endure hours of pain and severe bleeding while hospital attorneys attempted to determine whether providing her with abortion care would be prohibited under the state's ban. Almost 10 hours later, after drafting 20 paragraphs of rationale for why an abortion was necessary, the hospital finally performed an abortion and was forced to remove part of one of her fallopian tubes to save her life.[7]

93. Tennessee's criminal abortion ban has also endangered the health of women of reproductive age who are not pregnant. Becky Hubbard had been using the medication Methotrexate to treat a painful case of rheumatoid arthritis for over eight years when *Roe* was overturned.[8] Becky is 46 and lives near Johnson City, Tennessee. Methotrexate is a highly effective anti-inflammatory, but it is also an abortion-inducing drug commonly used to terminate ectopic pregnancies. Becky had no idea; she was not using it for abortion.

94. After the U.S. Supreme Court overturned *Roe*, however, Becky was unable to access the medication she needed. Becky's rheumatologist told her that she had a choice: she could continue taking Methotrexate if she either started taking hormonal birth control or underwent a tubal ligation or hysterectomy, or she could find another medication to treat her rheumatoid arthritis. This choice was not driven by any change in Becky's medical condition or any concern

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[7] Steve Cavendish, *Sarah Needed an Abortion. Her Doctors Needed Lawyers*, NASHVILLE SCENE (Dec. 20, 2022), https://www.nashvillescene.com/news/citylimits/sarah-needed-an-abortion-her-doctors-needed-lawyers/article_472a621e-7fdb-11ed-bf8d-0797b6012be2.html. At the time, Tennessee's criminal abortion ban did not explicitly exclude ectopic pregnancy from the definition of "abortion."

[8] Katie Shepherd & Frances Stead Sellers, *Abortion Bans Complicate Access to Drugs for Cancer, Arthritis, Even Ulcers*, WASH. POST (Aug. 8, 2022, 11:10 AM), https://www.washingtonpost.com/health/2022/08/08/abortion-bans-methotrexate-mifepristone-rheumatoid-arthritis/.

about the efficacy or safety of Methotrexate to treat Becky's rheumatoid arthritis. Rather, her doctor feared that he could be prosecuted under Tennessee's strict antiabortion laws for prescribing Methotrexate because Becky was of reproductive age.

95. Becky had not been able to get pregnant for nearly two decades, despite not using any form of birth control. She did not understand why she now needed to take hormonal birth control when she already had been taking Methotrexate for years. It was frustrating. Becky, however, could not go on birth control because the last time she took it, it negatively impacted her health. So, Becky made an appointment for a hysterectomy.

96. Becky recalls that the gynecological surgeon who performed the hysterectomy told her: "This is stupid. This is unnecessary. I should not have to be doing this." Her OB/GYN, on the other hand, dismissed her concern and told her: "You're the first person I've seen to have this effect [from the new abortion laws], but *everything has ill effects*." Becky's first surgery was unsuccessful. After receiving sedation, Becky's oxygen level crashed and her blood pressure increased dangerously, and she had to be woken up. A month later, Becky successfully underwent the procedure to remove her uterus. By that point, Becky had been deprived access to Methotrexate for months; her pain had significantly worsened and she could barely walk. She finally received her prescription after her surgery and attempted to return to her pre-*Dobbs* life.

G. Similar Consequences in Other States that Have Banned Abortion

97. The confusion and fear seen in Tennessee is far from unique; politicians' efforts to restrict critical abortion care have wrought the same results in other states.

98. Researchers at the University of California and University of Texas have documented 50 cases of patient care that deviated from the usual medical standard of care because

of state laws in Tennessee and thirteen other states that restricted abortion.[9] These patients' cases, reported from September, 2022 through March, 2023, fell into the categories of: obstetric complications in the second trimester; ectopic pregnancies (including cesarean-scar ectopics); underlying medical conditions that made it dangerous to continue a pregnancy; fatal fetal diagnoses; early miscarriage; extreme delays in obtaining abortion care; and delays in obtaining medical care unrelated to abortion.[10]

99. The ANSIRH Study demonstrated "a wide range of harm to people with the capacity for pregnancy in states with bans or severe restrictions on abortion care."[11] Physicians found themselves unable to "provide evidence-based care for their patients and prevent medical emergencies" because of the risk of criminal prosecution.[12]

100. A "simulated patient" study surveyed Oklahoma's 37 hospitals to determine the policies used for providing abortions in obstetrical emergencies. "[N]ot a single hospital appeared to be able to articulate clear, consistent policies for emergency obstetric care that supported their clinicians' ability to make decisions based solely on their clinical judgment and pregnant patients' stated preferences and needs."[13]

101. The U.S. Department of Health and Human Services is currently investigating two of the hospitals that failed to treat a pregnant patient for violations of the federal Emergency Medical Treatment & Labor Act.[14] Those hospitals denied the patient abortion care even though

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[9] Daniel Grossman, MD, et al., *Care Post-Roe: Documenting Cases of Poor-quality Care Since the Dobbs Decision.* Advancing New Standards in Reproductive Health, ("ANSIRH") (2023).

[10] *Id*. at 4.

[11] *Id*.

[12] *Id*.

[13] Physicians for Human Rights, The Oklahoma Call for Reproductive Justice & Center for Reproductive Rights, *No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-Roe Oklahoma* 12 (April 2023), https://phr.org/wp-content/uploads/2023/04/Oklahoma-Abortion-Ban-Report-2023.pdf.

[14] Letter from Xavier Becerra, HHS Secretary, to Hospital and Provider Associations (May 1, 2023), https://nwlc.org/wp-content/uploads/2022/11/Letter-to-Hospitals-FINAL.docx_Completed.pdf.

her water broke at nearly 18 weeks, and even though hospital physicians concluded that her pregnancy would not survive and that she was at risk of sepsis, maternal thrombosis, hemorrhaging or even death. The hospitals nonetheless refused to provide necessary abortion care because they were uncertain whether the patient's condition was a medical emergency under state law.

102. On March 6, 2023, five women who had been denied abortions under Texas's abortion laws filed a lawsuit against the State of Texas, its Attorney General, and its Medical Board. Each of the five women had suffered dangerous pregnancy complications but were forced either to seek abortion care outside Texas or wait until they were critically ill to receive an abortion. On May 22, 2023, eight more women joined the original lawsuit against the State of Texas. On August 4, 2023, the Texas District Court enjoined the enforcement of Texas's abortion bans in a manner that would preclude pregnant people from receiving necessary abortion care in connection with an emergent medical condition.[15]

II. ABORTION IS ESSENTIAL HEALTH CARE

103. Every major mainstream medical organization, including the American Medical Association ("AMA"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Emergency Physicians ("ACEP"), and the Society for Maternal-Fetal Medicine ("SMFM"), recognizes that abortion is necessary healthcare. These organizations oppose governmental interference into the patient-physician relationship. Such interference is contrary to the appropriate exercise of professional judgment used to protect patients' well-being. As the Plaintiffs' experiences demonstrate, abortion bans are a paradigmatic example of such governmental interference.

[15] Temporary Injunction Order at 5, *Zurawski v. State of Texas et al.* D-1-GN-23-000968 (Travis County Dist. Ct. Aug. 4, 2023) (temporarily enjoining enforcement of Texas's abortion bans in instances of emergent medical conditions).

104. The AMA recently updated its Principles of Medical Ethics to clarify that in the context of abortion, "physicians must have latitude to act in accord with their best professional judgment" and be "expressly permitt[ed] . . . to perform abortions in keeping with good medical practice."[16] The AMA also states that "[l]ike all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment."[17]

105. ACOG, the nation's leading organization of physicians who provide obstetric or gynecologic care, has long maintained the following policy on abortion: "All people should have access to the full spectrum of comprehensive, evidence-based health care. Abortion is an essential component of comprehensive, evidence-based health care."[18]

106. The overwhelming majority of abortions in the United States are accomplished either through use of medications (medication abortion) or via an outpatient procedure (procedural abortion). Medication abortions are typically indicated up to 11.0 weeks LMP and, in the most commonly used protocol, involve the administration of two medications (mifepristone and misoprostol) to terminate the pregnancy and expel it via vaginal bleeding, akin to a spontaneous miscarriage. Procedural abortions are feasible throughout pregnancy and involve a two-step process where the medical provider first partially dilates the patient's cervix and then evacuates the uterus using suction aspiration, instruments, or some combination of the two. The evacuation

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[16] *AMA Announces New Adopted Policies Related to Reproductive Health Care*, AM. MED. ASS'N (Nov. 16, 2022), AMA announces new adopted policies related to reproductive health care | American Medical Association (ama-assn.org).

[17] *Amendment to Opinion 4.2.7, Abortion H-140.823*, AM. MED. ASS'N (2022), https://policysearch.ama-assn.org/policyfinder/detail/%224.2.7%20Abortion%22?uri=%2FAMADoc%2FHOD.xml-H-140.823.xml.

[18] *Abortion Policy*, ACOG (May 2022), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy.

phase of a procedural abortion is done the same day or a day or two after the dilation phase begins, and typically takes around 5 minutes if done in the first trimester of pregnancy and 10-20 minutes if done during the second trimester.[19]

107. The other medically proven abortion method is induction abortion, where a physician uses medication to induce labor and delivery of a non-viable fetus. Induction of labor accounts for only about 2% of second-trimester abortions nationally. Induction abortions are usually performed in a hospital or similar facility that has the capacity to closely monitor a patient and provide adequate pain management (*e.g.*, intravenous pain medication or an epidural). Induction abortions can last anywhere from five hours to three days; are extremely expensive; entail more pain, discomfort, medical risks, and recovery time for the patient—similar to giving birth—than procedural abortion.[20]

108. Like other states, Tennessee has adopted its own definition of the term "abortion": "the use of any instrument, medicine, drug, or any other substance or device with intent to terminate the pregnancy of a woman known to be pregnant with intent other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, to terminate an ectopic or molar pregnancy, or to remove a dead fetus."[21] This definition is different from the standard medical definition of an abortion, which is the termination and removal from the body of a pregnancy such that the pregnancy will not result in the birth of a living baby.[22]

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[19] *See The Safety and Quality of Abortion Care in the United States*, NAT'L ACADS. OF SCI., ENG'G, & MED. (2018) at 51-65.

[20] *See id.* at 5-8, 66-68.

[21] Tenn. Code Ann. § 39-15-213(a)(1).

[22] *See, e.g.*, "Induced Abortion," reVITALize: Gynecology Data Definitions, ACOG, https://www.acog.org/en/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions.

109. While the medical treatment is generally the same, doctors may draw a distinction from the patient's perspective between a "spontaneous abortion" or "miscarriage"—where the embryo or fetus has no discernible cardiac activity—and an "induced abortion"—where the embryo or fetus has cardiac activity. The pregnant person's desire to have a baby, however, has no bearing on whether or not an abortion is considered spontaneous or induced.[23]

110. Efforts to distinguish "miscarriage management" from "elective abortion" are harmful and stigmatizing; these terms do not accurately reflect the complexities of pregnancy or the difficult questions that patients confront when thinking about ending a pregnancy. Mainstream medical professionals understand that patients in any number of circumstances need abortions and that pregnant people, in consultation with their medical providers, should be able to choose the method of abortion appropriate for their circumstances.

A. Some Pregnancies Pose Emergent Medical Risks to Pregnant People's Lives and Health

111. Medically unnecessary delays in access to abortion care always harm pregnant people. All pregnancy care, including abortion, is time sensitive. Yet pregnancy can lead to any number of situations where especially prompt termination of pregnancy is necessary to preserve the life, health, and/or future fertility of the pregnant person. The American Board of Emergency Medicine ("ABEM") defines such "emergent" conditions as cases where the "[p]atient presents with symptoms of an illness or injury that may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly."[24]

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[23] *See Practice Bulletin 200: Early Pregnancy Loss*, ACOG (Nov. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss; Andrew Moscrop, *Miscarriage or Abortion? Understanding the Medical Language of Pregnancy Loss in Britain; A Historical Perspective*, 39 MED. HUMANITIES, 2013, at 98, https://mh.bmj.com/content/39/2/98.

[24] Michael S. Beeson et al., *The 2019 Model of the Clinical Practice of Emergency Medicine*, 59 J. OF EMERGENCY MED., 2020, at 96, https://www.jem-journal.com/article/S0736-4679(20)30154-2/fulltext.

112. ACOG has emphasized that "it is impossible to create an inclusive list of conditions that qualify" as emergent or emergencies and thus fall under an exception to a state's abortion ban. Moreover, "it is dangerous to attempt to create a finite list of conditions to guide the practice of clinicians attempting to navigate their state's abortion restrictions." This is true for many reasons, including: "The practice of medicine is complex and requires individualization—it cannot be distilled down to a one-page document or list that is generalizable for every situation; No single patient's condition progresses at the same pace; A patient may experience a combination of medical conditions or symptoms that, together, become life-threatening; Pregnancy often exacerbates conditions or symptoms that are stable in nonpregnant individuals; There is no uniform set of signs or symptoms that constitute an 'emergency'; Patients may be lucid and appear to be in stable condition but demonstrate deteriorating health."[25] Nonetheless, medical organizations have identified some types of conditions in pregnancy that are emergent.

113. ABEM's Model of Clinical Practice of Emergency Medicine, the definitive source and guide to the core content found on emergency physicians' board examinations, addresses "Complications of Pregnancy," "Complications of Labor," and "Complications of Delivery." The conditions include: (1) ectopic pregnancy; (2) conditions that can lead to dangerous bleeding or hemorrhage, including placental issues; (3) severe forms of hypertension; (4) conditions that can lead to dangerous infection, including premature rupture of membranes; and (5) extreme hyperemesis gravidarum (dangerous nausea and vomiting leading to hospitalization).[26]

114. An ectopic pregnancy is a pregnancy where a fertilized egg implants and grows outside the uterine cavity, usually in the fallopian tube. Ectopic pregnancies cannot result in live

[25] *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, ACOG (Aug. 15, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions.

[26] *See* Beeson et al., *supra* note 24.

births and are life-threatening to the pregnant person because the pregnancy can rupture and cause massive internal bleeding. Ectopic pregnancies must be terminated with medication or surgery as soon as possible after diagnosis.[27]

115. A cesarean-scar ectopic pregnancy occurs when a pregnancy implants in the uterus, but in the scar from a previous cesarean delivery. It is considered an emergent condition where, like any other ectopic pregnancy, the recommended treatment is often termination of pregnancy.[28]

116. Hemorrhaging during pregnancy is particularly dangerous for patients, as it can lead to organ damage, organ failure, or even death. A variety of preexisting chronic health conditions and health conditions that develop during pregnancy can become emergent due to the risk of hemorrhage during pregnancy. These conditions include, but are not limited to: placenta previa (when the placenta covers the cervix); placental abruption (when the placenta prematurely detaches from the uterine lining); placenta accreta (when the placenta grows into the uterine wall); uterine fibroids (that inhibit the uterus from contracting effectively and stopping bleeding from the placental implantation site); and other forms of first or second trimester bleeding.[29]

117. Severe forms of hypertension in pregnancy can also lead to life-threatening conditions. For example, preeclampsia is a complication of pregnancy which, when severe, can cause seizures, injury to the pregnant person's liver and kidneys, stroke, and death. Hemolysis, Elevated Liver Enzymes and Low Platelets syndrome (HELLP) is a particularly dangerous variant of preeclampsia. For some patients, other forms of hypertension (sometimes in conjunction with

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[27] *See Practice Bulletin 193: Tubal Ectopic Pregnancy*, ACOG (Mar. 2018), https://www.fertilehealthexpert.com/wp-content/uploads/2021/11/Ectopic-Pregnancy-ACOG.pdf.

[28] *SMFM Consult Series #63: Cesarean Scar Ectopic Pregnancy*, SOC'Y FOR MATERNAL FETAL MED. (Sept. 2022), Publications & Guidelines | SMFM.org - The Society for Maternal-Fetal Medicine.

[29] *See Practice Bulletin 222: Gestational Hypertension and Preeclampsia*, ACOG (June 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/06/gestational-hypertension-and-preeclampsia; *Practice Bulletin 203: Chronic Hypertension in Pregnancy*, ACOG (Jan. 2019), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/01/chronic-hypertension-in-pregnancy.

other chronic conditions like obesity and diabetes) can increase in severity and cause the same complications seen with severe preeclampsia.

118. Infection of the reproductive organs, which can lead to chorioamnionitis (infection of the placenta or amniotic fluid) or sepsis (where the body's response to infection damages its own tissue), is another risk that can cause a pregnant person's medical condition to become emergent. Premature dilation of the cervix, for example, dramatically increases a pregnant person's risk of infection and can be caused by conditions like an insufficient cervix (weak cervical tissue) and/or PPROM before the onset of labor. PPROM has a relatively high incidence, occurring in approximately 2% to 3% of pregnancies in the United States, and is an emergent condition itself due to the high risk of infection it entails.[30]

119. Other medical conditions can become emergent during pregnancy because being pregnant causes or exacerbates a chronic condition or increases health risks associated with the chronic condition. One such condition that almost exclusively afflicts patients of African descent is sickle cell disease. As a general matter, pregnant patients with sickle cell disease are at an increased risk of multiple complications, including but not limited to developing high blood pressure, blood clots and infections, and pregnancy loss. Dr. Deva Sharma, a hematologist practicing in Nashville, provides medical care for Tennessee patients with sickle cell disease and other blood disorders. She has seen how the forced continuation of a pregnancy compels individuals living with sickle cell disease to accept a risk of irreversible end-organ injury and death from pregnancy that is considerably higher than the general population.

120. Many other conditions pose special risks to pregnant patients because the treatment for those conditions is unsafe for the developing fetus while they are pregnant. Examples of such

[30] *See Practice Bulletin 217: Prelabor Rupture of Membranes*, ACOG (Mar. 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/03/prelabor-rupture-of-membranes.

conditions include certain cancers requiring radiation or chemotherapy; transplants or other major surgery; and certain cardiac, autoimmune, respiratory, or endocrine diseases. Pregnant patients generally are not eligible for transplant surgery and thus may lose their only opportunity to receive life-saving care.

121. Certain psychiatric conditions like bipolar disorder, major depressive disorder, anxiety disorders, and psychotic disorders can all be emergent, depending on the circumstances. For example, a pregnant patient who has experienced postpartum psychosis, a condition related to bipolar disorder that is often characterized by delusional thinking, typically focused on the infant, is at serious risk of developing that condition again, risking the patient's life as well as the lives of her children.

122. The Chair of the Department of Psychiatry at the University of North Carolina's School of Medicine testified about a patient who came to her with debilitating postpartum psychosis during a trial challenging the constitutionality of Georgia's six-week abortion ban. This patient was still being treated for bipolar disorder when she learned she was again pregnant. The patient was faced with the choice of stopping her medication during pregnancy and experiencing a resurgence of her bipolar disorder, or continuing her medication and exposing the fetus to serious teratogenic risks. As the physician explained, the patient was "terrified at the thought of experiencing postpartum psychosis again and potentially hurting her child or herself. This patient told me repeatedly that she felt such overwhelming distress at the thought of continuing the pregnancy that she would rather die than go on."[31]

123. Accidents and intentional acts of violence, such as car crashes, gunshots, intimate partner violence and substance use disorder can also lead to emergent medical conditions. Because

[31] Aff. of Samantha Meltzer-Brody, M.D. ¶¶ 40-41, *SisterSong Women of Color Reprod. Just. Collective v. Georgia*, No. 2022CV367796, 2022 WL 3335938 (Ga. Super. Ct. July 23, 2022).

each patient's circumstances are unique, when a pregnant person is suffering from such an injury, it should be within the purview of the patient's medical provider to determine whether the patient's comorbidities and/or other circumstances make abortion part of the patient's recommended course of treatment—discretion that is available for virtually all other medical treatment.[32]

124. Finally, certain fetal conditions or diagnoses can increase the risks to a pregnant person's health such that, when combined with the patient's other comorbidities, a medical provider may determine that an abortion is necessary or recommended to prevent serious jeopardy to the pregnant person's health. For example, neural tube defects (including anencephaly); certain trisomies (the presence of an extra chromosome), such as trisomy 13 and 18; triploidy (the presence of an extra set of chromosomes); certain gastric and cardiac defects; and Potter syndrome (where the fetus does not properly develop kidneys), are all conditions where the fetus will not survive delivery or likely will not survive more than a few hours or days after birth. Cystic hygromas may indicate the presence of one or more of these fetal conditions.

125. Some fetal conditions present particularly acute risks to the pregnant person. For example, mirror syndrome is an emergent complication of pregnancy where the pregnant person and fetus both experience severe fluid retention that can lead to both fetal and maternal demise. Partial molar pregnancy is a condition where the placenta transforms into an invasive cancer, thus creating an emergency for the pregnant person.

126. In the case of multiple pregnancies (twins, triplets, or more), a fetal condition in one or more of the fetuses, combined with the pregnant person's other comorbidities, can lead to

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[32] *See High-Risk Pregnancy*, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/diseases/22190-high-risk-pregnancy (last updated Dec. 14, 2021) (describing how certain preexisting conditions exacerbate the risks of the pregnancy); *Practice Bulletin 189: Nausea and Vomiting of Pregnancy*, ACOG (Jan. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/01/nausea-and-vomiting-of-pregnancy; Nicole T. Christian & Virginia F. Borges, *What* Dobbs *Means for Patients with Breast Cancer*, 387 N. ENGL. J. MED., Sept. 1, 2022, at 765-67.

an emergent condition where an abortion (sometimes called "fetal reduction" or "fetal termination") of one or more fetuses is necessary to give the pregnant person and the remaining fetus(es) the best chance of survival.[33]

127. These are just some of the emergent medical conditions requiring prompt abortion care, but the list is by no means exhaustive. Mainstream medical associations emphasize that physician discretion to diagnose and treat emergent conditions is central to patient health.

128. Thus, where state law allows abortion care for the purpose of preserving the life or health (including fertility) of the pregnant person, the wide range of medical conditions that could endanger the health of a pregnant person requires that medical providers be authorized to offer every patient the most appropriate course of treatment. When a physician determines that such treatment includes abortion, the physician must be authorized to offer and provide that treatment without fear that a disciplinary board, prosecutor or lay jury second guessing their medical judgment will revoke their medical license or send them to prison.

B. Pregnancy Risks Are Greater for People of Color

129. Statistics published by the Tennessee Department of Health show that there were 222 pregnancy associated or pregnancy related deaths in the state from 2017-2019. Black women were found to be almost four times as likely as white women to die from pregnancy-related causes.[34] The vast majority of Black women's pregnancy-related deaths (91%) were determined to be preventable.[35] While maternal mortality rates in the white Tennessee population are

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[33] *Practice Bulletin 231: Multifetal Gestations Twin Triplet and Higher-Order Multifetal Pregnancies*, ACOG (June 2021), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2021/06/multifetal-gestations-twin-triplet-and-higher-order-multifetal-pregnancies.

[34] *Maternal Mortality in Tennessee 2017-2019,* TENN. DEP'T OF HEALTH, tn.gov/content/dam/tn/health/program-areas/maternal-mortality/Maternal-Mortality-Overall-2021.pdf (last visited June 22, 2023).

[35] *Racial Inequities in Pregnancy-Related Deaths,* TENN. DEP'T OF HEALTH, https://www.tn.gov/content/dam/tn/health/program-areas/maternal-mortality/Racial-Inequities-Providers-2021.pdf (last visited June 22, 2023).

comparable to those of the white populations in other states, maternal mortality rates for every other racial and ethnic group are higher.[36] Pregnant people with sickle cell disease, which is largely found among people of African descent, are at particularly heightened risk of developing an emergent medical condition.

130. Racial and ethnic disparities in pregnancy-related health outcomes are well-documented throughout the medical literature. Research has shown that, as compared to non-Hispanic white women, Black women in the United States are considerably more likely to experience obstetric complications like hypertensive disorders and preterm birth and to die from complications like preeclampsia, eclampsia, obstetric embolism, hemorrhage, and postpartum cardiomyopathy.[37] Additionally, Black people in the United States are more likely to have preexisting conditions that may be exacerbated by pregnancy such as high blood pressure, asthma, diabetes, sickle cell disease, and lupus.[38]

131. Barriers such as these disproportionately impact Black patients. Black patients face significant barriers to quality, equitable healthcare, including delays in care, systemic discrimination, and implicit biases in their interactions with healthcare providers.[39] Black women

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[36] Laura G. Fleszar, et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States*, 330 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (JAMA), no. 1, July 3, 2021, at 52, 58.

[37] *CDC Press Release: Hypertensive Disorders in Pregnancy Affect 1 in 7 Hospital Deliveries*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 28, 2022), https://www.cdc.gov/media/releases/2022/p0428-pregnancy-hypertension.html; *Preterm Birth*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 1, 2022), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm; Marian F. MacDorman, *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016–2017*, 111 AM. J. PUBL. HEALTH, no. 9, 2021, at 1673, 1676, https://doi.org/10.2105/AJPH.2021.306375.

[38] *Facts About Hypertension*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 5, 2023), https://www.cdc.gov/bloodpressure/facts.htm; Cynthia A. Pate et al., *Asthma Surveillance — United States, 2006–2018*, 70 MORBIDITY & MORTALITY WEEKLY REPORT, no. 5, at 1, https://www.cdc.gov/mmwr/volumes/70/ss/ss7005a1.htm?s_cid=ss7005a1_w; *The Facts, Stats, and Impacts of Diabetes*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jun. 20, 2022), https://www.cdc.gov/diabetes/library/spotlights/diabetes-facts-stats.html; *Data & Statistics on Sickle Cell Disease*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 2, 2022), https://www.cdc.gov/ncbddd/sicklecell/data.html; Maria Dall'Era, *Systemic Lupus Erythematosus*, in John B. Imboden et al., (eds.), CURRENT RHEUMATOLOGY DIAGNOSIS AND TREATMENT 3rd ed, New York, NY: McGraw-Hill (2013).

[39] Michael T. Halpern & Debra J. Holden, *Disparities in Timeliness of Care for U.S. Medicare Patients Diagnosed*

in Tennessee also face disproportionate poverty: 22.2% of Black Tennesseans live in poverty compared to 11.2% of white Tennesseans. And 14.9% of Tennessean women live in poverty compared to 12.3% of Tennessean men.[40] These disparities, coupled with Tennessee's restrictive Medicaid and insurance coverage policies, render healthcare unaffordable for many.[41]

III. TENNESSEE'S ABORTION BAN IMPEDES THE DELIVERY OF ESSENTIAL HEALTHCARE

132. In 2019, Tennessee enacted a "trigger ban" that would outlaw abortion if and when the United States Supreme Court reversed *Roe v. Wade,* "thereby restoring to the states their authority to prohibit abortion."[42] The bill had been proposed by an anti-abortion lobbying group, Tennessee Right to Life. At the time, since there was still a right under the U.S. Constitution to abortion care, many Tennessee legislators considered the bill to be a "political statement," not a law that would ever go into effect and have an impact on real patients' lives.[43]

133. As originally enacted, the trigger ban provided no exceptions whatsoever. The statute even criminalized abortions necessary to preserve the life or health of the pregnant person, requiring physicians charged with performing such procedures to bear the burden of proving an "affirmative defense to prosecution" that the procedure was necessary.

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with Cancer, 19 CURRENT ONCOLOGY, no. 6, 2012, at 404-13; Jasmine M. Miller-Kleinhenz et al., *Racial Disparities in Diagnostic Delay Among Women with Breast Cancer*, 18 J. AM. COLL. RADIOL. 1384, no. 10, 2021; Joe Feagin & Zinobia Bennfield, *Systemic Racism and U.S. Health Care*, 103 SOC. SCI. & MED., no. 7, 2013; Bani Saluja & Zenobia Bryant, *How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States*, 30 J. WOMEN'S HEALTH, no. 2, 2021, at 270-73; Brenda Pereda & Margret Montoya, *Addressing Implicit Bias to Improve Cross-Cultural Care*, 61 CLINICAL OBSTETRICS & GYNECOLOGY, no. 2, 2018, at 3-5.

[40] *American Community Survey S1701: Poverty Status in the Past 12 Months*, U.S. CENSUS BUREAU (last visited June 22, 2023), https://data.census.gov/table?q=gender+poverty+in+tennessee.

[41] *The State of Reproductive Health and Rights: A 50-State Report Card*, POPULATION INSTITUTE (Feb. 2021), https://www.populationinstitute.org/resource/the-state-of-reproductive-health-and-rights-a-50-state-report-card.

[42] 2019 Tenn. Acts, Ch. 351, § 2.

[43] Kavitha Surana, *"We Need to Defend This Law": Inside an Anti-Abortion Meeting with Tennessee's GOP Lawmakers,* PROPUBLICA (Nov. 15, 2022), https://www.propublica.org/article/inside-anti-abortion-meeting-with-tennessee-republican-lawmakers.

134. The trigger ban went into effect on August 25, 2022, 30 days after judgment was entered in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), which reversed *Roe v. Wade*.[44] The statutes of only two other states—Idaho and North Dakota—banned abortion without providing an exception for life-saving care, and the enforcement of those states' bans against certain life-saving abortion care was enjoined for that reason.[45] Multiple members of the Tennessee General Assembly who had voted for the trigger ban in 2019 said they supported an amendment to create exceptions where "the life of the mother could be in jeopardy" or where "the fetus won't survive outside of the womb."[46] In the words of Senator Richard Briggs, a heart surgeon and one of the state senators who had voted for the trigger ban, "there has to be medical judgment."[47]

135. After the trigger ban went into effect, more than 700 Tennessee medical professionals—including both Physician Plaintiffs—urged state legislators to reconsider the absolute ban on abortion. On October 10, 2022, they sent an open letter to the Tennessee General Assembly urging them to amend the law in the next legislative session. As asserted in the letter:

> Tennesseans should have the right to make personal healthcare decisions with the assistance of their doctors and healthcare team—without the intrusion of politicians. This law puts the government in charge of deciding which healthcare options are available to patients, setting a dangerous precedent that violates the sacred physician-patient relationship. And because it includes zero exceptions—not for rape, incest, fetal anomaly, or even to protect

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[44] 2019 Tenn. Acts, Ch. 351, § 2 (stating that the trigger ban would take effect thirty days after "the issuance of the judgment…of the United States Supreme Court" which took place on July 28, 2022); H.B. 883, 2023 Leg., Reg. Sess. (Tenn. 2023); *see also* Tenn. Code Ann. §63-6-1101 *et seq*.

[45] Order granting prelim. inj., *United States v. Idaho*, No. 1:22-cv-00329-BLW (D. Idaho Aug. 24, 2022)*;* Order granting prelim. inj., *Access Indep. Health Serv. Inc v. Wrigley*, No. 08-2022-CV-1608 (N.D. S. Cent. Dist. Ct. Oct 31, 2022), *aff'd sub nom*. *Wrigley v. Romanick, et al.*, 2023 N.D. 50, No. 20220260, 1 (N.D. Mar. 16, 2023).

[46] Vinay Simlot, *East TN Lawmakers Talk Next Steps with Tennessee's Abortion Trigger Law*, WBIR NEWS (Aug. 25, 2022), https://www.wbir.com/article/news/local/next-steps-with-tennessees-abortion-trigger-law/51-76a2d56c-6635-4594-9267-48b3ecbac5ee (quoting Sen. Briggs, Sen. Massey and Rep. Zachary); *see* https://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=HB1029&GA=111 (reflecting that Sen. Briggs, Sen. Massey and Rep. Zachary voted in favor of the trigger ban).

[47] Surana, *supra* note 43.

> the mother's life—it forces health care providers to balance appropriate medical care with the risk of criminal prosecution.[48]

136. Tennessee Right to Life opposed the amendment supported by the Tennessee Medical Association. Tennessee Right to Life's chief lobbyist argued that the amendment was designed to allow doctors to "game the system" by providing life-saving care, and averred—without a shred of medical support—that diagnoses of fatal fetal conditions were often mistaken or reversed.[49] He claimed that some pregnancy complications "work themselves out" and said doctors should "pause and wait this out and see how it goes."[50] At a webinar held by Tennessee Right to Life, lawmakers were urged to instead stay the course, retain the nation's "strongest" abortion ban and, if necessary, "hide behind the skirts of women" and "[c]hallenge the other side to demonstrate that abortion actually benefits women."[51] Tennessee Right to Life even threatened lawmakers who voted for the amendment supported by the Tennessee Medical Association, expressly stating that its political action committee, which raises money to elect and defeat legislative candidates "would score this negatively for members that vote for it."[52]

137. On April 28, 2023, Tennessee rejected the amendment supported by the state's physicians. Instead, it enacted a much narrower amendment to the abortion ban that eliminated the "affirmative defense to prosecution" and replaced it with the Medical Condition Exception.[53] The

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[48] Vivian Jones, *700 Doctors Ask Legislature to Reconsider Abortion Ban*, MAIN STREET NASHVILLE (Oct. 10, 2022), https://mainstreetmediatn.com/articles/mainstreetnashville/700-doctors-ask-legislature-to-reconsider-abortion-ban/. The letter was ultimately signed by more than 1,000 medical professionals living throughout the state. *See* https://www.tnmedicalopenletter.org/.

[49] Brian HornbackdotCom, *Will Brewer TN Right to Life Legal Counsel/Lobbyist at West Knox Republican Club 3/13/2023*, YOUTUBE (Mar. 13, 2023), https://youtube.com/watch?v=ehClefotPmc (Brewer statement at 8:59).

[50] Kavitha Surana, *Tennessee Lobbyists Oppose New Lifesaving Exceptions in Abortion Ban*, PROPUBLICA, (Feb. 24, 2023), https://www.propublica.org/article/tennessee-lobbyists-oppose-new-life-saving-exceptions-abortion-ban.

[51] Surana, *supra* note 43.

[52] *Hearing on HB 883: Hearing Before the House Population Health Subcomm.*, 2023 Leg., 113th (testimony of Will Brewer, Director of Tenn. Right to Life, at 27:05).

[53] 2023 Tenn. Acts, Ch. 313, § 2 (amending Tenn. Code Ann. § 39-15-213); H.B. 883, 2023 Leg., Reg. Sess. (Tenn. 2023).

amendment enacted was proposed by Tennessee Right to Life and, on information and belief, did not receive any serious scrutiny by Tennessee state legislators. Indeed, when one of the bill's sponsors was asked to explain the rationale for one provision of the bill, she could not do so, responding only that it had been vetted by Tennessee Right to Life.[54] No Tennessee physician—including Dr. Maune, who attended the legislative session and was prepared to address the proposal—was given the opportunity to speak.

138. As enacted, the language of the Medical Condition Exception imposes even greater limitations on physicians than the vague and confusing language medical condition exception used in Texas's abortion bans—recently held to run afoul of the Texas Constitution—because the Texas laws do not require that impairment of a major bodily function be either "irreversible" or "permanent."[55] The amendment also excludes abortions performed "to terminate an ectopic or molar pregnancy" from the statutory definition of "abortion."[56] The amendment to Tennessee's abortion ban went into effect immediately.

A. Tennessee's Medical Condition Exception

139. Criminal abortion is a Class C felony, which can result in a prison sentence of 3 to 15 years under Tennessee law and fines of up to $10,000.[57] The complete text of the Medical Condition Exception to Tennessee's criminal abortion ban is as follows:

> (c)(1) [A] person who performs or attempts to perform an abortion does not commit the offense of criminal abortion if the abortion is performed or attempted by a licensed physician in a licensed hospital or ambulatory surgical treatment center and the following conditions are met:

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[54] *Hearing on HB 883: Hearing Before the House Health Comm.*, 2023 Leg., 113th (statement of Rep. Helton-Haynes at 1:00:52).

[55] *See, e.g.*, Tex. Health & Safety Code §§ 170A.001–002; Tex. Health & Safety Code §§ 171.002(3), 171.203–05.

[56] 2023 Tenn. Acts, Ch. 313, § 1 (amending Tenn. Code Ann. § 39-15-213(a)(1)).

[57] Tenn. Code Ann. §§ 40-35-111, 40-35-112.

> (A) The physician determines, using reasonable medical judgment, based upon the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman; and
>
> (B) The physician performs or attempts to perform the abortion in the manner which, using reasonable medical judgment, based upon the facts known to the physician at the time, provides the best opportunity for the unborn child to survive, unless using reasonable medical judgment, termination of the pregnancy in that manner would pose a greater risk of death to the pregnant woman or substantial and irreversible impairment of a major bodily function.
>
> (2) An abortion is not authorized under subdivision (c)(1)(A) and a greater risk to the pregnant woman does not exist under subdivision (c)(2)(B) if either determination is based upon a claim or a diagnosis that the pregnant woman will engage in conduct that would result in her death or the substantial and irreversible impairment of a major bodily function or for any reason relating to the pregnant woman's mental health.[58]

140. Nowhere in the code does Tennessee law define any of the following distinctions: "risk" versus "serious risk"; "insubstantial impairment" versus "substantial impairment"; "reversible" versus "irreversible"; or "minor bodily function" versus "major bodily function." Nor does Tennessee law define what it means to have a "serious risk of substantial and irreversible impairment" or a "substantial and irreversible impairment of a major bodily function." None of this terminology has standardized meaning in the medical profession, leaving doctors to guess at how to translate it into clinical practice. Nor does any other Tennessee statute impose comparable restrictions on the provision of other forms of emergency healthcare.

141. Even legislators who supported the bill creating the Medical Condition Exception acknowledged that its language was "vague." Senator Richard Briggs, who sponsored the bill (and is himself a heart surgeon), admitted that "I think the bill, things are a little bit vague in the

[58] Tenn. Code Ann. § 39-15-213.

bill. . . ."[59] When asked to clarify whether the bill could create "a circumstance where the doctor will have to choose the life of the fetus over the life of the mother," Senator Briggs could only parrot the statutory language: "it's using reasonable medical judgment based upon the facts present to the physician at the time."[60]

142. A physician's good faith belief that an abortion is necessary to prevent death or a "serious risk of substantial and irreversible impairment of a major bodily function" is not sufficient to protect the physician from losing their medical license or criminal liability. Rather, those consequences turn on an after-the-fact assessment of whether the physician's determination was a "reasonable medical judgment." Medical emergency determinations, however, are often complex and inherently subject to disagreement. Doctors are thus put to an impossible choice under the Medical Condition Exception: either (i) provide the care that they believe in good faith to be necessary for their patients' lives and health, and risk arbitrary enforcement of the law by regulators, prosecutors and the whims of lay juries swayed by paid professional expert witnesses; or (ii) refrain from providing the care and avoid the risk of prosecution while watching their patients sicken.

143. One matter that is relatively clear is that termination of ectopic pregnancies and molar pregnancies are excluded from the criminal statute's definition of "abortion."[61] Yet this definition does not adequately authorize some necessary medical care because it is unclear whether cesarean scar ectopic pregnancies, which are intrauterine, can be considered "ectopic."

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[59] *Deb. HB 883: Tenn. Senate*, 2023 Leg., 113th Sess. 23 (statement of Sen. Briggs at 1:01:52).

[60] *Id*.

[61] Tenn. Code Ann. § 39-15-213(a)(1).

144. The Medical Condition Exception also discriminates against pregnant people. People who are not pregnant who suffer medical emergencies are not barred by statute from receiving care needed to prevent risks to their lives or their health.

145. The Medical Condition Exception also discriminates among pregnant people whose lives are threatened by medical emergencies. There is no rational basis for allowing pregnant people whose lives are threatened by ectopic or molar pregnancies to receive abortion care while criminalizing it in other, similarly dangerous circumstances.

146. Similarly, physicians are prohibited from performing an abortion upon a pregnant person who is at risk of death or substantial and irreversible impairment of a major bodily function "for any reason relating to the pregnant woman's mental health." There is no rational basis for criminalizing abortion care when a pregnant person's life or health is at risk because of a mental health issue when it would be allowed where those same risks are posed by a physical condition.

147. Ambiguity in the Medical Condition Exception is preventing doctors from providing the care that their patients need. Inconsistent treatment of health risks to pregnant people in the Medical Condition Exception has no medical basis and deprives those suffering medical emergencies of equal treatment under the law.

B. Physician Discretion Under the Medical Condition Exception

148. Physicians confronted with the question of whether a patient qualifies for the Medical Condition Exception must consider not only their ethical responsibilities as physicians and potential medical malpractice liability if they do not follow the standard of care, but the risk of loss of liberty and fines they will face, Tenn. Code Ann. §§ 39-15-213(b), 40-35-111(b)(3), and the potential loss of their license to practice medicine and pursue their chosen profession if they are found guilty of violating Tennessee's abortion ban, Tenn. Code Ann. §§ 63-6-101(a)(3), 63-6-214(b), 68-11-207(a)(3); Tenn. Comp. R. & Regs. 0880-02-.12(1), 1200-08-10-.03(1)(d).

149. Confusion regarding physicians' level of discretion under Tennessee's abortion ban, and fear for the legal consequences if they are wrong, is leading physicians to deny care to patients—including patients presenting with emergent conditions—even when such care likely would fall within the exception. As Plaintiffs' experiences show, because of the laws' uncertainty, physicians are over-complying with the laws to the detriment of their patients' lives and health.

150. Tennessee's abortion ban can and should be read to ensure that doctors have wide discretion to determine the appropriate course of treatment, including abortion care, for their patients who present with emergent medical conditions—without being second guessed by the Attorney General, the Tennessee Board of Medical Examiners, a local prosecutor, or a lay jury. Such discretion is best assured through a "good faith" standard for care, rather than a "reasonable medical judgment" standard.

C. Tennessee's Abortion Ban Impacts All Reproductive Healthcare in Tennessee

151. Tennessee's abortion ban hampers all reproductive healthcare in the state. Some highly trained OB/GYNs have left Tennessee for states that do not purport to restrict their ability to provide necessary abortion care. For example, Dr. Leilah Zahedi-Spung, an MFM specialist, moved from Chattanooga to Colorado, where abortion remains legal.[62] The result is fewer doctors in Tennessee who are fully equipped to treat patients suffering from serious pregnancy complications.

152. Medical school graduates who wish to pursue reproductive healthcare as a career are starting to shun Tennessee and other states where abortion is banned. Data shows that the number of medical school graduates who applied for residencies in ban states declined by 3%

[62] Poppy Noor, *'I Cried with her': the Diary of a Doctor Navigating a Total Abortion Ban*, THE GUARDIAN (Feb. 22, 2023), https://www.theguardian.com/world/2023/feb/22/diary-doctor-navigating-total-abortion-ban-tennessee.

overall, while the number of medical school graduates applying for residencies in OB/GYN programs in ban states—including Tennessee—declined by 10.5%.[63]

153. Tennessee's healthcare delivery system can ill afford a loss of professionals who can perform such essential care. Maternity care deserts are already a fact of life in Tennessee. In rural areas across the state, 55.1% of women live over 30 minutes from a birthing hospital.[64] Women living in counties with the highest travel times (top 20 percent) could travel up to 64.2 miles and 77.1 minutes, on average, to reach their nearest birthing hospital. According to a recent March of Dimes report, "the farther a woman travels to receive maternity care, the greater the risk of maternal morbidity and adverse infant outcomes, such as stillbirth and NICU admission."[65] And more than two-thirds of the rural hospitals in Tennessee are at high risk of closing because of their financial condition.[66] *All* of these at-risk hospitals are "highly essential" to their communities.[67]

IV. THE TENNESSEE CONSTITUTION PROTECTS PREGNANT PEOPLE WITH EMERGENT MEDICIAL CONDITIONS AND THEIR PHYSICIANS FROM STATE DEPRIVATION OF THEIR RIGHTS

154. The U.S. Supreme Court may have relegated the availability of abortion to states in *Dobbs*, but that does not mean that the Tennessee legislature can deprive pregnant people of their fundamental rights to life or discriminate against them. Nor can the Tennessee legislature deprive physicians of their livelihood or their liberty without due process of law, which includes proper notice of criminal prohibitions and protections against arbitrary enforcement of criminal laws.

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[63] Kendal Orgera, MPH, MPP et al., *Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health Organization Decision*, Ass'n of Am. Med. Coll. (Apr. 13, 2023), www.aamc.org/advocacy-policy/aamc-research-and-action-institute/training-location-preferences.

[64] March of Dimes, *Where You Live Matters: Maternity Care in Tennessee* (2023), https://marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Tennessee.pdf.

[65] *Id.*

[66] David Mosley et al., 2020 Rural Hospital Sustainability Index, https://guidehouse.com/-/media/www/site/insights/healthcare/2020/guidehouse-navigant-2020-rural-analysis.ashx.

[67] *Id.*

A. Pregnant Tennesseans Have Fundamental and Equal Rights Under the Tennessee Constitution

155. The Tennessee Constitution guarantees all of its citizens certain fundamental rights, specifically: "That no man shall be taken or imprisoned, or disseized of his freehold, liberties or privileges, or outlawed, or exiled, or in any manner destroyed or deprived of his life, liberty or property, but by the judgment of his peers, or the law of the land" Tenn. Const. art. I, § 8. Nobody forgoes their own right to life when they become pregnant. Moreover, Tennessee law cannot sacrifice a pregnant person's life, fertility, or health for any reason, let alone in service of the "unborn," particularly where a pregnancy will not or is unlikely to result in the birth of an infant with sustained life.

156. The Tennessee Constitution further prohibits the legislature from enacting "any law granting to any individual or individuals, rights, privileges, immunitie[s], or exemptions other than such as may be, by the same law extended to any member of the community, who may be able to bring himself within the provisions of such law." Tenn. Const. art. XI, § 8.

157. To the extent Tennessee's abortion ban bars the provision of abortion to pregnant people to treat all medical conditions that pose a substantial risk to the pregnant person's life, fertility or health, the ban violates pregnant people's fundamental right to life and their right to equality under the law under Tenn. Const. art. I § 8 and Tenn. Const. art. XI § 8.

158. As applied to pregnant people with emergent medical conditions, Tennessee's abortion ban fails to comply with the Tennessee Constitution. Far from furthering life, it harms pregnant people's lives, and the lives of their families, without furthering potential life at all. Tennessee law demands that there be a real and substantial connection between a legislative purpose and the language of the law as it functions in practice. For pregnant people with emergent medical conditions, there is none. As Justice Rehnquist stated in dissent in *Roe*: "If the [abortion

ban] statute were to prohibit an abortion even where the mother's life is in jeopardy, I have little doubt that such a statute would lack a rational relation to a valid state objective under the test stated in *Williamson* . . . ." *Roe v. Wade*, 410 U.S. 113, 173 (1973) (Rehnquist, J., dissenting). Because Tennessee's abortion ban forces pregnant people with emergent medical conditions to surrender their lives, health, and/or fertility, it has no rational relationship to protecting life, health, or any other legitimate state interest.

B. Tennessee-Licensed Physicians Have Liberty and Property Rights to Provide Care to Pregnant People with Emergent Conditions

159. The "law of the land" guarantee of Tenn. Const. article I § 8 precludes the enforcement of a criminal abortion ban against physicians who in good faith provide abortions for pregnant people suffering emergent medical conditions.

160. Article I § 8 of the Tennessee Constitution affords Tennessee-licensed physicians the right to practice their profession, including by treating emergent medical conditions that the physician determines pose a risk to a pregnant patient's life or health by performing an abortion.

161. To fulfill this guarantee, physicians must be able to exercise their good faith judgment in the care of their pregnant patients with emergent conditions without threat that the state will take their license and/or liberty if a prosecutor or lay jury second guesses their medical judgment.

162. Tennessee law authorizes Defendant TBME to institute disciplinary and licensing proceedings against any physician who performs an abortion that the TBME determines did not meet the Medical Condition Exception. *See, e.g.*, Tenn. Code Ann. § 63-6-214(b)(6). These proceedings may result in a provider losing their license to practice medicine. *See, e.g.*, Tenn. Code Ann. §§ 63-6-214(a), 63-6-217; Tenn. Comp. R. & Regs. 0880-02-.12(1). Disciplinary actions are

reported to the National Practitioner Data Bank[68] and can have collateral consequences on a physician's ability to practice in other U.S. states.

163. Physicians must make a substantial investment to obtain a medical license in Tennessee. According to the TBME, to be eligible for a physician's license in Tennessee, individuals must graduate from an accredited medical school, having gained admission through a highly competitive application process which often necessitates incurring significant amounts of debt (the American Association of Medical Colleges projects that in 2024, graduates from Tennessee medical schools will have an average of between $180,208 and $233,131 of student debt upon graduation);[69] complete at least one continuous year of graduate medical training or a fellowship; pass rigorous state examinations; practice medicine full-time for one year; and, *inter alia*, have no relevant disciplinary or criminal history. Tenn. Comp. R. & Regs. 0880-02-.03.

164. If physicians meet these requirements and incur the substantial associated costs, they are eligible for full licensure in Tennessee, for which they must apply. Tenn. Comp. R. & Regs. 0880-02-.03. Once granted, a physician may practice medicine within Tennessee and has a vested property interest in their license.

165. Revoking or suspending a physician's license based on a flawed interpretation of the Medical Condition Exception is improper interference with the physician's vested property interest in their license.

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[68] *See* 42 U.S.C. § 11132 (requiring state medical boards to report all revocations or suspensions of physician licenses); *see also* Nat'l Practitioner Data Bank, *Guidebook*, at Ch. E: Reports, Table E-1 (Oct. 2018), https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp (explaining state medical boards and hospitals have mandatory reporting obligations).

[69] *See, e.g.*, *Medical School Admissions Requirement Debt Information,* ASSOC. OF AM. MED. COLLEGES (March 2023), https://students-residents.aamc.org/media/7061/download.

166. Further, sending a physician to prison for up to 15 years for providing timely and appropriate medical care to a pregnant person with an emergent medical condition is improper interference with the physician's liberty.

167. Physicians have constitutional rights under Article I § 8 of the Tennessee Constitution including rights to liberty, property, and substantive due process. Even for laws that touch only on economic rights, § 8 requires a rational relationship to the purpose of the law.

168. Tennessee's abortion ban works an excessive burden on physicians treating patients with emergent conditions relative to their purported purpose.

C. Tennessee-Licensed Physicians Cannot Be Prosecuted Under a Vague Statute that Fails to Provide Proper Notice of Prohibited Conduct and Invites Arbitrary Enforcement

169. The due process clause in article I, § 8 of the Tennessee Constitution prohibits the use of vague, standardless statutes to deprive physicians of their liberty or property. It does not matter if the individual words of a statute are comprehensible; rather, a statute must clearly state what conduct is prohibited and, where the prohibition allows for an exception, what conduct is allowed. As the chief legislative proponent of the Medical Condition Exception acknowledged, Tennessee's abortion ban does not meet this standard.

170. Tennessee physicians should not be required to guess a statute's meaning at the peril of losing their liberty or their livelihood. Rather, the due process clause requires that they be given reasonable notice of what conduct is prohibited and what is allowed under the Medical Condition Exception.

171. Vague statutes also violate the due process clause of the Tennessee Constitution because they invite arbitrary enforcement. Under the Medical Condition Exception, physicians could be subject to the loss of their livelihood or their liberty for providing abortion care that they

believed in good faith to be necessary to preserve the life, fertility or health of their patient. Enforcement of the abortion ban in such circumstances would be arbitrary and unconstitutional.

CLAIMS FOR RELIEF

CLAIM I: DECLARATORY JUDGMENT

172. Plaintiffs repeat and re-allege each and every allegation made in paragraphs 1 through 171 above as if set forth fully again here.

173. Plaintiffs petition the Court for a declaratory judgment pursuant to Tenn. Code Ann. §§ 29-14-101, *et seq*.

174. Declaratory judgment is a remedy designed to settle and afford relief from uncertainty and insecurity with respect to rights, status, and other legal relations. Pursuant to Tenn. Code Ann. § 29-14-113, the declaratory judgment statute is to be liberally construed and administered.

175. Under Tenn. Code Ann. § 29-14-102, this Court has the power to declare rights, status, and other legal relations regardless of whether further relief is or could be claimed. The declaration may be either affirmative or negative in form and effect, and the declaration has the force and effect of a final judgment or decree.

176. Plaintiffs thus seek a declaratory judgment that the Medical Condition Exception to Tennessee's abortion ban, codified at Tenn. Code Ann. § 39-15-213, permits physicians to provide a pregnant person with abortion care when the physician determines, in their good faith judgment and in consultation with the pregnant person, that the pregnant person has a physical emergent medical condition that poses a risk of death or a risk to their health (including their fertility), including without limitation where the pregnant person has: a physical medical condition or complication of pregnancy that poses a risk of infection, bleeding, or otherwise makes continuing a pregnancy unsafe for the pregnant person; a physical medical condition that is

exacerbated by pregnancy, cannot be effectively treated during pregnancy, or requires recurrent invasive intervention; and/or a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth.

177. Plaintiffs have sued the State and the relevant state agencies, and seek to have this Court determine the validity of Tennessee's abortion ban as applied in circumstances arising from emergent medical conditions. Therefore, the State and its agencies are necessary parties to this suit and governmental immunity does not apply.

CLAIM II: RIGHT TO LIFE OF PREGNANT PEOPLE UNDER THE TENNESSEE CONSTITUTION

178. Plaintiffs repeat and re-allege each and every allegation made in paragraphs 1 through 171 above as if set forth fully again here.

179. Under the Tennessee Constitution, "no man shall be taken or imprisoned, or disseized of his freehold, liberties or privileges, or outlawed, or exiled, or in any manner destroyed or deprived of his life, liberty or property, but by the judgment of his peers, or the law of the land" Tenn. Const. art. I, § 8.

180. To the extent Tennessee's abortion ban bars the provision of abortion to pregnant people to treat emergent medical conditions that pose a risk to pregnant people's lives or health (including their fertility), the ban violates pregnant people's fundamental right to life under article I, § 8 of the Tennessee Constitution.

181. As applied to prohibit abortion care for pregnant people with emergent medical conditions, Tennessee's abortion ban does not serve a compelling or important state interest and is not sufficiently tailored to serve any compelling interest. As applied in those circumstances, Tennessee's abortion ban also lacks any rational relationship to protecting life, health, or any other legitimate state interest.

182. Plaintiffs seek a declaratory judgment that article I, § 8 of the Tennessee Constitution guarantees a pregnant person the right to life, including by means of necessary abortion care, where the pregnant person has an emergent medical condition that poses a risk of death or risk to their health (including their fertility).

183. Any official's enforcement of Tennessee's abortion ban as applied to care provided to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with article I, § 8 of the Tennessee Constitution and therefore would be *ultra vires*.

CLAIM III: RIGHT TO EQUAL PROTECTION OF PREGNANT PEOPLE UNDER THE TENNESSEE CONSTITUTION

184. Plaintiffs repeat and re-allege each and every allegation made in paragraphs 1 through 171 above as if set forth fully again here.

185. Article I, § 8 and Article XI, § 8 of the Tennessee Constitution provide Tennesseans with equal rights under law.

186. Tennessee does not prevent non-pregnant people or people unable to get pregnant from accessing critical medical treatments, nor does it force them to unnecessarily suffer severe illnesses and injuries and undergo mental and emotional anguish prior to receiving such treatment.

187. To the extent Tennessee's abortion ban bars or delays the provision of an abortion to a pregnant person with an emergent medical condition that poses a risk of death or risk to their health (including their fertility), while allowing non-pregnant people and people unable to get pregnant to access medical treatment for emergent medical conditions, Tennessee's abortion ban violates pregnant people's right to equal rights.

188. Thus applied, Tennessee's abortion ban does not serve a compelling or important state interest and is not sufficiently tailored to serve any compelling interest.

189. Thus applied, Tennessee's abortion ban also lacks any rational relationship to protecting life, health, or any other legitimate state interest.

190. Plaintiffs seek a declaratory judgment that Article I, § 8 and Article XI, § 8 of the Tennessee Constitution guarantees a pregnant person the right to an abortion where the pregnant person has an emergent medical condition that poses a risk of death or risk to their health (including their fertility), and an abortion would prevent or alleviate such risk.

191. Any official's enforcement of Tennessee's abortion ban as applied to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with Article I, § 8 of the Tennessee Constitution and therefore would be *ultra vires*.

CLAIM IV: PHYSICIANS' RIGHTS TO DUE PROCESS UNDER THE TENNESSEE CONSTITUTION

192. Plaintiffs repeat and re-allege each and every allegation made in paragraphs 1 through 171 above as if set forth fully again here.

193. By failing to give the Physician Plaintiffs fair notice of how to ensure their conduct falls within the Medical Condition Exception to Tennessee's abortion ban and permitting arbitrary enforcement of that ban, the abortion ban is unconstitutionally vague and violates the Physician Plaintiffs' right to due process as guaranteed by article I, § 8 of the Tennessee Constitution. If there is a reasonable construction of the Medical Condition Exception that will satisfy the requirements of the due process clause, the Court has a duty to adopt that construction.

194. Plaintiffs seek a declaratory judgment that, at a minimum, Tennessee's abortion ban must be construed to permit a physician to provide abortion care where, in the physician's good faith judgment and in consultation with the pregnant person, the pregnant person has a physical emergent medical condition that poses a risk of death or a risk to their health (including

their fertility), including without limitation where the pregnant person has: a physical medical condition or complication of pregnancy that poses a risk of infection, bleeding, or otherwise makes continuing a pregnancy unsafe for the pregnant person; a physical medical condition that is exacerbated by pregnancy, cannot be effectively treated during pregnancy, or requires recurrent invasive intervention; and/or a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth.

195. Any official's enforcement of Tennessee's abortion ban as applied to a physician treating a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with Article I, § 8 of the Tennessee Constitution and therefore would be *ultra vires*.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs ask this Court:

A. To enter a judgment declaring that the Medical Condition Exception to Tennessee's abortion ban permits physicians to provide a pregnant person with abortion care when the physician determines, in their good faith judgment and in consultation with the pregnant person, that the pregnant person has a physical emergent medical condition that poses a risk of death or a risk to their health (including their fertility), including without limitation where the pregnant person has: a physical medical condition or complication of pregnancy that poses a risk of infection, bleeding, or otherwise makes continuing a pregnancy unsafe for the pregnant person; a physical medical condition that is exacerbated by pregnancy, cannot be effectively treated during pregnancy, or requires recurrent invasive intervention; and/or a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth;

B. To enter a judgment that Tennessee's abortion ban, as applied to pregnant people with emergent medical conditions, violates their rights to life guaranteed by the Tennessee Constitution;

C. To enter a judgment that Tennessee's abortion ban, as applied to pregnant people with emergent medical conditions, violates their rights to equal protection guaranteed by the Tennessee Constitution;

D. To enter a judgment that Tennessee's abortion ban must be interpreted in a manner to protect physicians' rights to due process guaranteed by the Tennessee Constitution and granting appropriate declaratory relief that Defendants must interpret the scope of the Medical Condition Exception to Tennessee's abortion ban in a manner consistent with those rights;

E. To issue permanent injunctive relief that restrains Defendants, their agents, servants, employees, attorneys, and any persons in active concert or participation with Defendants, from enforcing Tennessee's abortion ban or instituting disciplinary actions related to alleged violations of the abortion ban in a manner violating the Court's judgment;

F. To retain jurisdiction after judgment for the purposes of issuing further appropriate injunctive relief if the Court's declaratory judgment is violated; and

G. To award such other and further relief as the Court deems just and proper.

Dated: September 11, 2023

Respectfully submitted,

_/s/ *Scott P. Tift*_____
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