IN THE CHANCERY COURT OF TENNESSEE
FOR THE TWENTIETH JUDICIAL DISTRICT

NICOLE BLACKMON; ALLYSON PHILLIPS; KAITLYN DULONG; K. MONICA KELLY; KATHRYN ARCHER; REBECCA MILNER; RACHEL FULTON; 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; MELANIE BLAKE, M.D., in her official capacity as President of the Tennessee Board of Medical Examiners; STEPHEN LOYD, M.D., in his official capacity as Vice President of the Tennessee Board of Medical Examiners; SAMANTHA MCLERRAN, M.D., in her official capacity as Secretary of the Tennessee Board of Medical Examiners; KEITH G. ANDERSON, M.D., in his official capacity as Member of the Tennessee Board of Medical Examiners; MICHAEL BITTEL, M.D., in his official capacity as Member of the Tennessee Board of Medical Examiners; DEBORAH CHRISTIANSEN, M.D., in her official capacity as Member of the Tennessee Board of Medical Examiners; JENNIFER CLAXTON, M.D., in her official capacity as Member of the Tennessee Board of Medical Examiners; JAMES DIAZ-BARRIGA, M.D., in his official capacity as Member of the Tennessee Board of Medical Examiners; JOHN W. HALE, M.D., in his official capacity as Member of the Tennessee Board of Medical Examiners; JOHN J. MCGRAW, M.D., in his official capacity as Member of the Tennessee Board of Medical Examiners; RANDALL E. PEARSON, M.D., in his official capacity as Member of the Tennessee Board of Medical Examiners; TODD TILLMANNS, M.D., in his official capacity as Member of the Tennessee Board of Medical Examiners;	CASE NO. 23-1196-I **THREE-JUDGE PANEL** Chancellor Moskal Chancellor Culbreath Judge Donaghy

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION; SHANT H. GARABEDIAN, D.O., in his official capacity as President of the Tennessee Board of Osteopathic Examination; OTIS B. RICKMAN, D.O., in his official capacity as Vice President of the Tennessee Board of Osteopathic Examination; PENNY GRACE JUDD, D.O., in her official capacity as Secretary of the Tennessee Board of Osteopathic Examination; J. MICHAEL WIETING, D.O., in his official capacity as Member of the Tennessee Board of Osteopathic Examination; JAN ZIEREN, D.O., in her official capacity as Member of the Tennessee Board of Osteopathic Examination; and MICHAEL BERNUI, D.O., in his official capacity as Member of the Tennessee Board of Osteopathic Examination,

Defendants.

PLAINTIFFS' FIRST AMENDED 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, K. Monica ("Monica") Kelly, Kathryn Archer, Rebecca Milner, Rachel Fulton, 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., are being chilled by the ban's vague language and the harsh penalties it imposes. Plaintiffs file this First Amended 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 Necessity Exception"), threatens doctors with arbitrary enforcement.

In support of their First Amended 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 patients in Tennessee have suffered needless physical and emotional pain and harm, including loss of their fertility. These pregnant patients are not imagined. They are not ideological talking points. They are real people, many with children who depend upon them. Seven 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.[1] 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 place Allie's own precarious health at risk. So, Allie started a GoFundMe campaign to raise the funds needed to travel to New York. There, she received

[1] This First Amended Complaint describes pregnancy using medical terminology unless describing a particular patient's pregnancy, in which case, consistent with principles of medical ethics, it adopts the terminology preferred by the patient.

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 before becoming 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. Monica Kelly was eagerly awaiting the birth of her second child when she received devastating news: the baby had a fatal fetal diagnosis. After weighing her options, Monica decided to pursue an abortion. Monica knew she did not want her baby to suffer and she did not want to risk leaving her two year-old son without a mother. Monica sought care in Tennessee but was told she could not get an abortion in the state, even though continuing the pregnancy would strain Monica's own health. Monica traveled to Florida for an abortion.

6. Kathryn Archer had only recently begun to try for a second child when she learned that she was pregnant. Initially, Kathryn's pregnancy proceeded without incident, but at her 20-week anatomy scan, Kathryn learned that her baby had several serious fetal anomalies and was unlikely to survive the pregnancy. If the baby did survive the pregnancy, she would die shortly after birth. After further testing and consultation with a specialist, Kathryn decided to terminate the

pregnancy rather than risking her own health and putting herself and her baby through the pain of demise after birth. With the assistance of friends and family, a supportive church, and an abortion fund, Kathryn was able to travel to Washington, D.C. for an abortion.

7. After six years of unsuccessful fertility treatments, Rebecca Milner and her husband were overjoyed when they learned in February, 2023 that she was pregnant with their first child. At her standard 20-week appointment, Rebecca learned that the amniotic fluid surrounding the baby was low; the next day, she consulted a specialist who gave her the devastating news that Rebecca's water had broken, likely several weeks before. Nothing could be done to save the baby, and Rebecca was at risk of developing an infection. Rebecca's doctor told her that Tennessee law prohibited abortion care in situations like hers and offered her information about abortion care outside of the state. Rebecca traveled to Virginia for a two-day abortion procedure; when she returned to Tennessee, however, she started to run a high fever and went to a local hospital, where she was diagnosed with sepsis. Doctors there told her the infection had started before the abortion and the delay in getting the procedure had allowed the infection to worsen. Rebecca spent the weekend in the hospital to treat the infection.

8. Rachel Fulton was eagerly awaiting the birth of her second son, whom she had begun calling Titus, when she received heartbreaking news: her son had several worsening fetal conditions and would never have sustained life. Rachel's doctor told her the fetal conditions put her at high risk of mirror syndrome, a life-threatening complication of pregnancy. Rachel was told she could not get an abortion in Tennessee until she was in mortal danger. Concerned that remaining pregnant could leave her two-year-old son motherless, Rachel made the long drive to Illinois for an abortion.

9. 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 or delayed under Tennessee's abortion ban. Second, Tennessee's abortion ban prevents pregnant people and those who may become pregnant from receiving the professionally recognized standard of care they need. And third, pervasive fear and uncertainty throughout the medical community regarding the scope of the Medical Necessity Exception have put patients' lives and doctors' liberty and livelihoods at grave risk.

10. Tennessee's abortion ban, with its vague Medical Necessity Exception, is hindering and delaying the delivery of necessary medical care. And, contrary to its stated purpose of furthering life, Tennessee's ban is exposing pregnant patients 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.

11. 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 patients like Nicole, Allie, Katy, Monica, Kathryn, Rebecca, and Rachel are being denied the 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 might have been to promote healthy babies and families, it does just the opposite.

12. Plaintiffs respectfully ask this Court to clarify the scope of Tennessee's Medical Necessity Exception to its abortion ban so that it is consistent with the requirements of the state constitution, and to issue all declaratory or injunctive relief necessary to protect the health and lives of pregnant Tennesseans with critical or emergent medical conditions.

PARTIES

I. PLAINTIFFS

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

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

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

16. Monica Kelly lives in Northern Tennessee. Monica sues on her own behalf.

17. Kathryn Archer lives in Nashville, Tennessee. Kathryn sues on her own behalf.

18. Rebecca Milner lives in Eastern Tennessee. Rebecca sues on her own behalf.

19. Rachel Fulton lives in Knoxville, Tennessee. Rachel sues on her own behalf.

20. 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.

21. 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

22. Defendant the State of Tennessee duly enacted the abortion ban and its Medical Necessity 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.

23. 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). The Attorney General has statutory authority to prosecute violations of state laws governing osteopath physicians. *See* Tenn. Code Ann. § 63-9-110(c). The Attorney General is also 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.

24. 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 Necessity 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.

25. 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.

26. Defendant Stephen Loyd, M.D. is the Vice President of the Tennessee Board of Medical Examiners. Dr. Loyd is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

27. Defendant Samantha McLerran, M.D. is the Secretary of the Tennessee Board of Medical Examiners. Dr. McLerran is sued in her official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

28. Defendant Keith G. Anderson, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. Anderson is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

29. Defendant Michael Bittel, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. Bittel is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

30. Defendant Deborah Christiansen, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. Christiansen is sued in her official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

31. Defendant Jennifer Claxton, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. Claxton is sued in her official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

32. Defendant James Diaz-Barriga, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. Diaz-Barriga is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

33. Defendant John W. Hale, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. Hale is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

34. Defendant John J. McGraw, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. McGraw is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

35. Defendant Randall E. Pearson, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. Pearson is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

36. Defendant Todd Tillmanns, M.D. is a Member of the Tennessee Board of Medical Examiners. Dr. Tillmanns is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

37. Defendant Tennessee Board of Osteopathic Examination ("TBOE") is the state agency mandated to regulate the practice of osteopathy by licensed doctors in Tennessee. *See, e.g.*, Tenn. Code Ann. § 63-9-101 (2020). The TBOE must initiate disciplinary action against a licensee who performs an abortion if the TBOE determines that the procedure did not meet the Medical Necessity Exception. *See, e.g.*, Tenn. Code Ann. § 63-9-110 (2020). The TBOE may revoke the license of a physician who is determined to have violated the Tennessee Abortion Ban. *See, e.g.*, Tenn. Code Ann. § 63-9-111 (2020); Tenn. Comp. R. & Regs. 1050-02-.10 (2023). Tennessee

Board of Osteopathic Examination may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

38. Defendant Shant H. Garabedian, D.O. is the President of the Tennessee Board of Osteopathic Examination. Dr. Garabedian is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

39. Defendant Otis B. Rickman, D.O. is the Vice President of the Tennessee Board of Osteopathic Examination. Dr. Rickman is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

40. Defendant Penny Grace Judd, D.O. is the Secretary of the Tennessee Board of Osteopathic Examination. Dr. Judd is sued in her official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

41. Defendant Michael Bernui, D.O. is a Member of the Tennessee Board of Osteopathic Examination. Dr. Bernui is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

42. Defendant J. Michael Wieting, D.O. is a Member of the Tennessee Board of Osteopathic Examination. Dr. Wieting is sued in his official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

43. Defendant Jan Zieren, D.O. is a Member of the Tennessee Board of Osteopathic Examination. Dr. Zieren is sued in her official capacity and may be served with process at 655 Mainstream Drive, Nashville, Tennessee 37243.

JURISDICTION AND VENUE

44. 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 Tennessee's abortion ban, codified at

Tenn. Code Ann. § 39-15-213, as applied to pregnant persons with critical or emergent medical conditions.

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

46. 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.

47. 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, Kathryn Archer, and Dr. Maune reside in Davidson County, Tennessee.

FACTUAL ALLEGATIONS

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

48. 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

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

50. 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.

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

52. 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.

53. 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.

54. The pregnancy posed medical challenges for Nicole. 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.

55. 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.

56. 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.

57. 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.

58. 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.

59. 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.

60. 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,[2] Nicole went to a routine appointment and for an ultrasound with her

[2] Consistent with standard medical practice, gestational ages as used in this First Amended Complaint are dated

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 LBWC 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."

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

62. 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

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.

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.

63. 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.

64. 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.

65. 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.

66. 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.

67. 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 her for superimposed preeclampsia. Nicole worried constantly about her health, including the possibility that she could suffer a stroke.

68. 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 more nightmares and trouble sleeping.

69. 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.

70. Nicole was in labor for more than 32 hours. She asked for a drape to shield her from viewing the fetus because since she did not want to be further traumatized by what she might see.

Eventually, Nicole gave birth to a stillborn 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.

71. 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.

72. 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.

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

B. Plaintiff Allie Phillips

74. 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.

75. 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.

76. 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.

77. 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.

78. 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 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.

79. 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.

80. 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, 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.

81. 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.

82. Allie was concerned about the risks continuing the pregnancy posed to her health. 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.

83. 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.

84. At some point between Allie's 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.

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

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

C. Plaintiff Katy Dulong

87. Katy Dulong is 27 years old. Katy began fertility treatments after trying unsuccessfully for two years to get pregnant. These treatments were unsuccessful until doctors discovered that Katy had Hashimoto's disease, an auto-immune disorder that 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.

88. 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.

89. 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.

90. 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.

91. 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.

92. 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.

93. 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 save the pregnancy. She was told that she would likely deliver her son within 48 hours.

94. 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.

95. 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.

96. 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 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.

97. 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.

98. 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).

99. 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.

100. Katy became pregnant again in 2023 and was in her third trimester when the Complaint in this action was filed on September 11, 2023. Since then, she has given birth to a healthy baby girl.

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

D. Plaintiff Monica Kelly

102. Monica Kelly is 34 years old and lives near Tennessee's border with Kentucky. She is a proud mother to a two-year-old son.

103. In February 2023, Monica was excited to learn that she was pregnant. Monica and her husband were eager to expand their family and had been trying to have another baby for around a year. Monica immediately began planning her pregnancy, making arrangements for prenatal care, and preparing for a home birth, which she had long dreamed of.

104. Monica went for her first ultrasound at about 10 or 11 weeks LMP, on March 9, 2023. She was excited to introduce her son to his new sibling and brought her son and husband with her to the appointment. Monica's best friend also accompanied her to the appointment but waited outside in the car for the results.

105. While Monica and her husband were busy showing their son the ultrasound images, the ultrasound technician asked Monica several times to confirm her last menstrual period. The technician explained that Monica's baby was measuring smaller than expected for its gestational

age and observed that her baby's nuchal translucency (the fluid-filled space behind a fetus's neck) appeared to be thicker than expected. Although Monica detected some concern in the technician's questions, the technician did not say that anything was wrong with the pregnancy.

106. Monica left the appointment and eagerly showed her friend sonogram photos of her baby and its heartbeat. Monica also began to tell family and other friends the exciting news that she was expecting. She also went for routine noninvasive prenatal testing ("NIPT") on March 13.

107. At an appointment with her midwife on March 15, Monica learned alarming news. According to the midwife, Monica's baby's nuchal translucency was much thicker than expected for its gestational age. The midwife initially suggested that a gestational age dating error could explain the nuchal thickness. But when Monica pressed her for other explanations, the midwife acknowledged that the nuchal thickness more likely signaled a serious fetal anomaly. Monica immediately felt overwhelmed and became dizzy. She rushed to the bathroom but fainted on the way there. The midwife referred Monica for a nuchal translucency scan.

108. Monica underwent the nuchal translucency scan the next day. After the scan, Monica met with two MFM physicians who told her that the results showed several serious structural fetal anomalies, including the absence of a nasal bone, large fluid-filled growths on the baby's neck and back (septated cystic hygroma), and severe swelling in tissues and organs (hydrops fetalis). They told her that they suspected her baby had Turner Syndrome and recommended further diagnostic testing, including a chorionic villus sampling ("CVS") test.

109. The results of those diagnostic tests were devastating. On March 21, 2023, Monica received a call from her midwife with the NIPT test results. Her midwife told her that the results were positive for Trisomy 13 (Patau syndrome), which is a severe fetal condition that usually results in a miscarriage. Along with the structural anomalies observed on the ultrasound, the positive NIPT

test result indicated with a high likelihood of certainty that Monica's baby had Trisomy 13. Monica's midwife explained to her and her husband that based on the NIPT result and the structural anomalies observed on the ultrasound, Monica's pregnancy would likely end in miscarriage, or spontaneous abortion.

110. A few days later, Monica went to see an MFM for her CVS results and received confirmation that her baby had Trisomy 13 (Patau syndrome). The MFM told her that the results indicated a type of Trisomy 13 caused by a genetic translocation that was possibly inherited from either Monica or her husband.

111. Monica and her husband had already begun researching their options prior to receiving the CVS results. Monica came to understand that very few babies with Trisomy 13 survive to birth, and that the vast majority of those who do survive only a few hours or days on perinatal life support and with multiple surgeries.

112. After her CVS results came back, Monica's doctor and a genetic counselor told her that because of Tennessee's new abortion laws, they could not offer her an abortion. However, they told Monica that as she continued to carry her pregnancy, the baby's organs would begin failing, its body would continue to swell, and eventually, it could even experience pain. They also told Monica that continuing her pregnancy would leave her at an elevated risk for preeclampsia and other maternal health conditions, as well as risks of infection if Monica had a missed or incomplete spontaneous abortion. They recommended monthly fetal growth monitoring and a fetal echocardiogram at 24 weeks LMP if she continued the pregnancy.

113. After weighing her options, Monica decided to pursue an abortion. Monica knew she did not want her baby to suffer and she did not want to risk leaving her two year-old son without a mother.

114. Monica considered a variety of abortion care options, including the possibility of ordering medication abortion from a foreign source. But after evaluating her various options, Monica made an appointment to have an abortion in Florida where she had family who could watch her toddler. Monica had lived in Florida and knew and trusted an OB/GYN there who was willing to perform the abortion.

115. On March 31, 2023, Monica received an abortion at a hospital in Northwest Florida from the same OB/GYN to whom she previously spoke. She was about 15 weeks pregnant.

116. After her abortion, Monica contacted Allie Phillips, whose story she had seen on TikTok. They bonded over the shared trauma of their pregnancy losses. Months later, Allie encouraged Monica to join this lawsuit. At the time, Monica was still processing her trauma and grief and was not ready to join a lawsuit. But she was inspired to act by seeing Allie and the other Plaintiffs after the case was filed. She wants to help make sure that she and other women are not forced to leave their communities for medically necessary abortions and to feel more secure herself if she again becomes pregnant in Tennessee.

117. Monica continues to grieve the loss of her baby.

118. Monica underwent testing that confirmed neither she nor her husband is a carrier of a gene for Trisomy 13. She is now pregnant again and is looking forward to a home birth in June, 2024. Monica remains fearful of being forced to leave Tennessee for necessary healthcare during this pregnancy.

E. Plaintiff Kathryn Archer

119. Kathryn Archer is 31 years old and lives in Nashville.

120. Kathryn is a mental health counselor and primarily works with individuals who are healing from trauma, addiction, and grief.

121. Kathryn and her husband have a four-year-old daughter and had only recently begun to try for a second child when she learned in the summer of 2022 that she was pregnant. Kathryn was excited but also concerned because *Roe* had just been overturned and she feared being denied medical care in Tennessee if she miscarried or if her pregnancy was ectopic.

122. Initially, Kathryn's pregnancy proceeded normally, and everything appeared to be going well. Kathryn and her husband told close friends and family about the pregnancy and celebrated the holidays with family who were overjoyed at the news.

123. On January 4, 2023, at her 20-week anatomy scan, Kathryn was told that her baby had several serious fetal anomalies and was unlikely to survive the pregnancy. Kathryn's doctor explained that her baby had a "large" "whole-lumbar" open "spina bifida," which is where the backbone does not close as it should and allows part of the spinal cord and nerves to protrude through an opening in the baby's back. Her doctor also explained that there were anomalies with the baby's brain development and a stomach omphalocele where certain organs appeared to protrude outside of her stomach. Kathryn's doctor told her that these anomalies appeared consistent with Edward's syndrome (Trisomy 18) and referred Kathryn to an MFM specialist for further testing that would include a detailed ultrasound and an amniocentesis to confirm the diagnosis.

124. At the anatomy scan, Kathryn also learned that she was having a girl. That night after the anatomy scan, Kathryn and her husband chose to name their daughter Cecilia.

125. Kathryn went to the MFM specialist the next day, January 5, where she underwent extensive testing. The specialist confirmed the severity of Cecilia's spina bifida and brain damage and that Cecilia had bladder exstrophy, genitalia with splayed appearance, and an abnormal umbilical cord insertion with herniation. The specialist further explained that Cecilia would have brain damage, potential cardiac issues, and most likely paralysis of her lower body. She advised

Kathryn that the various fetal anomalies made it unlikely that Cecilia would survive the pregnancy. Kathryn felt crushed.

126. Kathryn learned that even if Cecilia survived until birth, she would need multiple surgeries to repair her spine and to reconstruct her bladder, intestines, and genitalia. The specialist also shared that Cecilia would need a shunt in her brain to drain excess fluid that could otherwise threaten her survival if left untreated. Kathryn learned that even if Cecilia somehow survived the multiple surgeries, she would require catheter use for the rest of her life, exposing her to chronic UTIs and antibiotic-resistant bacteria that could then place her 4-year-old, her husband, and herself at risk. Given the intensity and amount of surgeries Cecilia would need, Kathryn decided she would not intervene at birth in the unlikely scenario she survived until full-term. Considering this and given Cecilia's lethal diagnosis, Kathryn decided to terminate the pregnancy. Without radical intervention, Cecilia would survive no more than a few minutes or hours. Kathryn knew that some people choose to continue their pregnancies so they could spend even that short time with their babies, but she could not imagine putting herself or Cecilia through such pain. She also considered how traumatic it could be to her four-year-old daughter if she and her husband were forced to split their time between the neonatal care unit and home. She also understood that continuing the pregnancy would pose more significant risks to her own health than an abortion, jeopardizing her ability to parent her four-year old.

127. On January 17, 2023, Kathryn returned to the specialist for the amniocentesis and an additional ultrasound. The ultrasound performed that day confirmed Cecilia's lethal diagnosis. When Kathryn received the amniocentesis results, the results ruled out Edward's syndrome and Cecilia was diagnosed with Arnold-Chiari Type 2 malformation.

128. Because of the increased demand for abortion in states where abortion remains accessible, Kathryn encountered difficulties making an appointment for an abortion. She was repeatedly told that hospitals and clinics did not have appointments for many weeks, and by the time these clinics did have availability, she would have been past the gestational age where these clinics could provide her with access to the procedure. She was also aware that the longer she waited, the more expensive and complicated the procedure would become. She had a doctor in Tennessee she trusted immensely and now she was forced to find another physician for an abortion away from her home, her family, and her community. Kathryn felt alone, and was now navigating additional stressors and sadness on top of an already tragic and traumatic pregnancy.

129. Kathryn ultimately made an appointment for an abortion in Washington, D.C. Kathryn's husband and his sister accompanied her to D.C., where one of Kathryn's friends was there to support her as well. Kathryn stayed in a hotel. She missed the comforts of home and her daughter.

130. Because she was forced to go out-of-state and spend multiple days in another location for the abortion, Kathryn incurred significant out-of-pocket expenses, including childcare, flights, and hotels. She is fortunate to have received some assistance from an abortion fund, friends and family, and a supportive church, and is grateful that she had resources to pay the rest.

131. Kathryn received information about this lawsuit from Dr. Laura Andreson when they both spoke at an event acknowledging the one-year-anniversary of the overturning of *Roe v. Wade*. Kathryn was nervous about telling her story publicly but did so because it felt like a way of honoring Cecilia.

132. Kathryn is pregnant again now with her long-awaited second child. She is due in May, 2024. Kathryn is apprehensive about getting necessary care in Tennessee during this pregnancy if she needs it.

F. Plaintiff Rebecca Milner

133. Rebecca Milner is 43 years old and lives in Eastern Tennessee.

134. Rebecca and her husband had long wanted to start a family. At the start of 2017, they began trying to have children and Rebecca began fertility treatments after encountering challenges in getting pregnant. Rebecca tried multiple rounds of fertility medications and intra-uterine insemination, all unsuccessful despite there never being an identified reason for infertility. After several disappointing years, the couple decided to end fertility treatments. They were astonished and overjoyed then to learn in February 2023, two days after Valentine's Day, that Rebecca was pregnant.

135. Rebecca began seeing her OB/GYN for normal pregnancy benchmark appointments. At her first appointment, on March 9, 2023, her doctor noted a "[s]mall subchorionic hematoma," but told Rebecca that this was common and often resolved on its own. On April 6, 2023, at 12 weeks, Rebecca underwent a second ultrasound with no noted concerns. She also received her results from an NIPT test; she was excited to learn she was having a girl and relieved that her daughter was at low risk for fetal conditions.

136. Rebecca and her husband had held back from telling their families about the pregnancy until after the 12-week scan. They understood that spontaneous abortion (miscarriage) in early pregnancy is common and wanted more confirmation that the pregnancy was developing as it should. Rebecca waited until she had the NIPT results and 12-week ultrasound in hand, and then traveled to her parent's house out of state in advance of a getaway weekend with her mother

and sister. Having experienced so many years of grief over infertility, Rebecca recalls taking a moment in her childhood bedroom to look at the sonogram picture and confirm again that her pregnancy was real before she could tell her parents and sister the exciting news.

137. In the weeks that followed, Rebecca and her husband began to tell their friends and colleagues about the pregnancy. Rebecca began to make plans for leave from her job; the nature of Rebecca's work requires her to plan any leave many months in advance. Rebecca's parents began looking at homes near Rebecca so they could be involved grandparents with their first grandchild and help with childcare. During this time, Rebecca and her husband also began to consider names for their beloved baby, make plans for the nursery, and receive meaningful baby hand-me-down items from friends who were eager to celebrate this joyful news.

138. Three days before Rebecca's benchmark 16-week appointment, in May 2023, she experienced major bleeding while in the shower. She also began cramping. She spoke to the on-call physician at her OB/GYN's office who told her that nothing could be done that night and that the best thing she could do is stay fully reclined in bed until she could get to the doctor's office first thing in the morning.

139. The next morning, Rebecca anxiously visited her OB/GYN's office for an ultrasound scan and evaluation. She was relieved to hear her daughter's heart beating strong and the doctor told her that everything looked fine with her daughter. But the doctor did tell Rebecca that she had a very large subchorionic hemorrhage, which is a form of internal bleeding. They did not observe any leaking fluid and Rebecca's cervix was closed. Her doctors recommended pelvic rest and return for "reevaluation at time of anatomy scan" at 20 weeks.

140. After a second night with some bleeding and a handful of days of tenderness, Rebecca began to feel better and more reassured. However, she continued to minimize activity and

stayed focused on maintaining a healthy pregnancy. Many mornings she experienced light spotting, which she had been advised is normal during pregnancy. She returned to the OB/GYN's office four weeks later on May 30, 2023, for her next benchmark appointment at 20 weeks' pregnant. The doctor explained that she saw a potential issue with her daughter's head shape but that she could not visualize the head clearly because the amniotic fluid levels were low. They also said the subchorionic hemorrhage had shrunk in size. They referred Rebecca to an MFM specialist for a consult, which they described as being common, and made an appointment for her there for the next day.

141. At her appointment with the MFM specialist on June 1, 2023, Rebecca received unexpected, crushing news. The specialist told Rebecca that there was no amniotic fluid protecting her daughter and that, from her daughter's appearance, there had not been any fluid for some time. He thought that Rebecca's water had likely broken at around 16 weeks when she had major bleeding, which he diagnosed as pre-term premature rupture of membranes ("PPROM"). He explained that her daughter was small for her gestational age, already getting compressed by Rebecca's uterus, and that her head was noticeably misshapen. He further explained that because there was no fluid, Rebecca's daughter lacked the conditions necessary to develop her lungs and that there was evidence that her lungs were already underdeveloped (pulmonary hypoplasia).

142. Rebecca asked the MFM specialist what could be done to save her baby. The specialist told Rebecca that, essentially, nothing could be done: the chances her daughter would survive to viability were extremely low and the odds that her daughter would survive labor and delivery were even lower. He explained that he believed there is a 90% chance she had already developed pulmonary hypoplasia, a condition that he said "is associated with nearly 100% mortality."

143. The MFM specialist told Rebecca she had three options: expectant management, monitor things at home and be seen weekly by the MFM, or abortion. He explained that although a purpose of expectant management is to prolong a pregnancy to viability, without amniotic fluid the baby's lung tissue would still not be able to properly develop and therefore she would not be viable outside the womb. Meanwhile, Rebecca would be at risk of potentially life-threatening infection and would need weekly assessment, strict pad counts, twice daily temperature checks, and antibiotics. He told Rebecca that 70% of patients in her scenario experience precipitous labor within two weeks. Further, if she were able to extend the pregnancy to 24 weeks and the baby had reached 350 grams, delivery would require a vertical cesarean section. Without proper lung tissue development, none of these efforts increased the baby's chance of survival. As for abortion, the doctor explained to Rebecca that "Tennessee state law precludes [abortion] unless there is a risk to maternal health," and offered her information on abortion services out-of-state. When asked what he would have advised a year ago before *Roe* was overturned, he was clear—she would have received an induction abortion immediately.[3] But now he believed doing so would have placed him in legal jeopardy. Rebecca received this news alone because her husband had been unable to come to the consult due to work obligations; he received the same information from the MFM later that afternoon. When Rebecca's husband asked the MFM about what he understood was an "affirmative defense" available for physicians who perform life-saving care, the MFM said he did not believe he would have an affirmative defense for a situation like Rebecca's.

[3] Induction is a slower, more painful, more costly, and less effective procedure than a D&E abortion, and when ineffective can lead to a patient like Rebecca undergoing a C-section. However, the doctors in Rebecca's community—as in many communities where abortion is deeply stigmatized—were not trained in D&E abortion because of its association with so-called "elective" abortions. Rebecca learned that she would have either needed to undergo induction or a C-section in her home community, or travel over 1.5 hours to the closest city in Tennessee with a physician trained in D&E abortions, even had abortion been permitted in her case.

144. In the middle of a devastating health crisis, Rebecca found herself researching information on her condition while investigating her options for an abortion out-of-state, all while in the throes of grief and in an extremely time sensitive situation. She is close to North Carolina, but abortion had recently been banned there after 15 weeks and so she could not get care in that state. Rebecca and her husband had supportive friends who had a similar experience with a non-viable pregnancy several years ago that they had terminated at a Central Virginia university hospital. Rebecca reached out to that hospital and initially was told that no appointments were available for two weeks. She made an appointment for June 7 at another facility in that same Virginia city. On Monday, June 5, she was grateful to get a call that an appointment opened up at the hospital on June 7, 2023, nearly a week after she was diagnosed with PPROM. Doctors at both the facility and the hospital agreed that due to the risks to Rebecca's health, she should receive treatment at the hospital. Rebecca had also decided that she wanted to get a second opinion MFM appointment to make sure she had pursued all options. The Virginia hospital was also able to schedule an appointment with an MFM on June 7.

145. In Virginia, Rebecca was treated by a wonderful and caring MFM specialist who provided information in a direct, compassionate manner. The MFM described the baby's condition: without amniotic fluid for her lungs to develop and evidence of pulmonary hypoplasia, in addition to fetal growth restrictions and premature gestational age, her daughter had a "lethal combination" of conditions. The MFM explained that "there are no known treatments for this scenario." Continuing the pregnancy, however, would put Rebecca at "significant risks" of life- and health-threatening infection and hemorrhage.

146. That was the first time Rebecca processed the risks to her own life. Until that point, she had only been thinking about the wellbeing of her daughter. But it finally got through. There

was nothing to be done for her daughter. She would not survive, but Rebecca's life could be saved. Rebecca began the two-day process to receive an abortion that same day.

147. Rebecca returned to Tennessee on Friday, June 9, the day after her abortion. She felt ill and at home her temperature measured as high as 102 degrees. She was burning up. She went to the hospital where a doctor told her that he could feel her fever just from a handshake. Rebecca was diagnosed with sepsis and began receiving IV antibiotic treatment.

148. Rebecca spent the entire weekend at the hospital and was not discharged until late Sunday, when the doctors finally felt confident that she had stabilized and that her infection had not spread. She was grateful the infection was caught early enough and that she has no lingering effects.

149. The hospital OB told her the infection was not due to the abortion but had started before the abortion. Another OB on call that weekend saw her and said that although he is a man of strong faith and is "pro-life", he believes "the pendulum has swung too far" because abortion is needed in situations like Rebecca's. He was frustrated by the State's abortion laws and wanted to use Rebecca's story to advocate for broader exceptions.

150. In Virginia, Rebecca had to pay $1700 up front for her abortion. Her insurance considered the procedure "elective" and thus refused to cover the costs. She had to pay out of pocket for a procedure that she had never wanted but that was necessary to save her life. Rebecca is aware that many people facing similar devastating situations do not have as many resources readily available, and she was grateful to have the resources to pay the cost, the ability to travel, a supportive and loving partner, and supportive friends who hosted her during her ordeal.

151. Rebecca heard about this lawsuit on the news. She had always supported abortion rights. Now, having been directly impacted by the severely restricted access to abortion care, she reached out to Plaintiffs' counsel to see how her story could help.

152. Rebecca would be overjoyed if she were to become pregnant again, but she fears being pregnant in Tennessee.

G. Plaintiff Rachel Fulton

153. Rachel Fulton is 34 years old and lives in Knoxville, Tennessee.

154. Rachel and her husband are parents to a three-year-old boy and love being parents. They were eager to expand their family and began trying in 2023 to have another child. They were excited to learn in the summer of 2023 that Rachel was pregnant. They decided to name the baby Titus if it was a boy.

155. In early October 2023, when she was 13 weeks pregnant, Rachel learned that her baby had a large fluid filled sac along its back (a cystic hygroma) and fluid surrounding the left fetal lung (a pleural effusion). Her OB/GYN recommended an anatomical survey at 16 weeks, which was one month earlier than usual, and referred Rachel for a genetic consultation the same day.

156. At the genetic consultation, Rachel learned that the fluid-filled sac on her baby's back and fluid around the lung is often a symptom of a chromosomal syndrome or non-chromosomal syndrome that could lead to fetal loss. The MFM specialist also explained that a cystic hygroma can resolve itself before delivery, which Rachel found encouraging. Rachel elected to have a NIPT test and the MFM specialist recommended she go for amniocentesis as well.

157. A few weeks later, Rachel received the NIPT test results by phone. They were positive for Trisomy 21, indicating a high likelihood that her baby had Down syndrome. When they received the results, Rachel and her husband were upset but nonetheless wanted to continue with the pregnancy. They began investigating Down syndrome and signed up with a parent support group. Rachel also reached out to a fellow parent in her community raising a child with Down

syndrome, who offered to send books on how to raise and care for a child with Down syndrome. Rachel also learned that the NIPT result predicted she would have a boy. She and her husband started to call the baby Titus.

158. Rachel was unprepared when she learned at her next ultrasound on November 1, 2023, that her pregnancy would very likely end in pregnancy loss, a stillbirth, or death shortly after birth. Her doctor explained to Rachel that the ultrasound now showed fluid building up throughout her baby's neck, abdomen, and around both lungs, and "suboptimal" development of the central nervous system, the lower spine, the lungs, abdomen, feet and hands. These observations were consistent with fetal hydrops, a condition where there is significant fluid throughout a baby's tissues and organs, leading to dangerous swelling (edema).

159. The doctor further explained to Rachel that the results put her at high risk for a life-threatening complication called mirror syndrome in which the pregnant patient develops severe swelling that "mirrors" fetal swelling. Rachel could potentially begin collecting fluid in her own lungs and limbs. In Rachel's case, doctors would find it challenging to monitor whether she was suffering from mirror syndrome because she has a circulatory condition known as neurocardiogenic syncope that can cause swelling that could not be distinguished from mirror syndrome.

160. Rachel recalls how understanding and compassionate her doctor was in that moment, and how he explained that these developmental conditions were not her fault. Rachel's mother, who had accompanied her to the appointment, told her "you have to take care of yourself, you have a little boy at home who needs you." Overwhelmed, Rachel was unable to make any decisions about what to do next. Her doctor recommended that if she continued the pregnancy, she would need close monitoring for mirror syndrome, including regular blood pressure monitoring.

161. That night, Rachel thought about her father, whose mother (Rachel's grandmother) had died delivering her eighth child. Rachel knew the lifelong impact of that tragic loss on her father and his six surviving siblings. That family experience made Rachel acutely aware of the importance of guarding her own health so she could raise her son.

162. The next day, Rachel called the doctor's office back to ask if further testing might change his diagnosis. Her doctor told her that he was as sure as possible, and said that Rachel had three options: Go out of state for an abortion, wait for her baby to die, or wait until she is in mortal danger so the doctors could legally intervene under Tennessee law. Rachel understood from her doctor that if it were not for Tennessee's ban on abortion, he would have her offered abortion care. But his hands were tied.

163. Rachel decided to have an abortion. She was now over 16 weeks pregnant. Rachel asked the genetic counselor at her doctor's office for a list of abortion clinics out-of-state. When discussing the places she might travel for abortion care, the genetic counselor explained that the law is rapidly shifting and so "what was true yesterday might not be true today." Rachel's impression was that the conversation was one that the genetic counselor was having with some frequency.

164. Rachel considered going to North Carolina for an abortion because it was a shorter drive; but was disappointed to learn that she was now past the gestational cut-off for abortion care in North Carolina. Rachel and her husband decided the best option was to go to southern Illinois for her abortion because Rachel has family in the St. Louis area who could look after her son. She wanted to have her son nearby after the procedure and to be surrounded by family.

165. One week later, Rachel and her husband took off from work and made the long drive for her abortion in Illinois. First, they drove eight hours to St. Louis to drop their son off with

Rachel's family. Then, Rachel and her husband drove another two hours to the clinic where she would have the abortion. On November 9, Rachel got her abortion over the course of one long day and drove back to St. Louis with her husband. Rachel was glad to go back to her son and her family after her abortion, before making the long trip home to Tennessee.

166. Rachel is an active member of her Methodist church and is grateful for the support she has received from her church community, as well as from her family and friends. Rachel met with her pastor soon after she returned from her abortion. She could see the disbelief on his face when she explained the lengths she had gone to get essential health care.

167. Rachel grew up in Tennessee and for many years assumed that everyone was anti-abortion. After having a child, however, Rachel changed her perspective. She does not think anyone should be forced to have a child if they do not want to become a parent. Rachel heard about this lawsuit after her abortion and reached out to counsel for the plaintiffs.

168. Rachel would like to have more children, but she fears being pregnant in Tennessee after how hard her last pregnancy was.

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

169. 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.

170. 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.

171. 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, 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 life or health threatening 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.

172. 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 and its exception 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 life or health threatening conditions.

173. Dr. Maune has also personally treated pregnant patients with life or health threatening 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 other

complex medical conditions. Before Tennessee's trigger ban, Dr. Maune would have offered abortion care to these patients. Now, Dr. Maune can only offer them information about where to seek abortion care out of state.

174. 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 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.

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

175. 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.

176. 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.

177. 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 life or health threatening 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.

178. 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 life or health threatening conditions.

179. Dr. Andreson has also personally treated pregnant patients with life or health threatening 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 offered abortion care to these patients. Now, Dr. Andreson can only offer information about where to seek abortion care out of state or counsel expectant management.

180. 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.

181. 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 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.

J. Other Pregnant Patients and Tennesseans of Reproductive Age

182. 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.

183. 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.[4]

184. 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.[5] Presently, a 6-week ban is in effect in Georgia.

185. 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.[6]

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.[7]

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[4] 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.

[5] 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.

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

[7] 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.

c. Four separate pharmacies denied another unnamed Tennessee woman medication prescribed by her doctor to complete a miscarriage and avoid possible hemorrhaging.[8]

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.[9]

e. A nurse-practitioner in Knoxville told a reporter "about women having to actually sit in parking lots in emergency rooms before coming in for care or being told to go back outside and sit in the parking lot . . . Because even though they're bleeding heavily, and there's a threat for their life, it's not serious enough. And so, they sit outside until their condition worsens. And then they're readmitted so that they can be seen."[10]

186. 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

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[8] 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.

[9] 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."

[10] Jacqui Sieber, et al., *A regional look at abortion access, one year after the fall of Roe v. Wade*, WUOT 91.9 FM (June 26, 2023, 11:05 a.m.), https://www.wuot.org/2023-06-26/a-regional-look-at-abortion-access-one-year-after-the-fall-of-roe-v-wade.

Methotrexate to treat a painful case of rheumatoid arthritis for over eight years when *Roe* was overturned.[11] 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.

187. 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 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.

188. 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.

189. 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.

[11] 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/.

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.

K. Similar Consequences in Other States that Have Banned Abortion

190. 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.

191. 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.[12] 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.[13]

192. 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."[14] Physicians found themselves unable to "provide evidence-based care for their patients and prevent medical emergencies" because of the risk of criminal prosecution.[15]

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

[13] *Id*. at 4.

[14] *Id.*

[15] *Id.*

193. 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."[16]

194. 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.[17] Those hospitals denied the patient abortion care even though 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.

195. 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

[16] 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.

[17] 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.

would preclude pregnant people from receiving necessary abortion care in connection with an emergent medical condition.[18]

II. ABORTION IS ESSENTIAL HEALTH CARE

196. 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 also 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.

197. The AMA recently updated Opinion 4.2.7 in its Code of Medical Ethics to clarify 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."[19] When it amended this opinion, the AMA stated that in the context of abortion, "physicians must have latitude to act in accord with their best professional judgment" and stated its opposition to criminal laws that purport to limit "the

[18] 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), appeal docketed, Defs.' Notice of Accelerated Interlocutory Appeal, *Zurawski et al. v. State of Texas*, Cause No. D-1-GN-000968 (Tex. Sup. Ct. Aug. 4, 2023).

[19] Am. Med. Ass'n, Code of Medical Ethics, 4.2.7 Abortion, https://code-medical-ethics.ama-assn.org/sites/default/files/2023-08/4.2.7.pdf.

appropriate exercise of professional judgment and physicians' fiduciary obligation to protect patients' well-being."[20]

198. 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."[21]

199. 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 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.[22]

200. 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

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[20] *AMA Announces New Adopted Policies Related to Reproductive Health Care*, AM. MED. ASS'N (Nov. 16, 2022), https://www.ama-assn.org/press-center/press-releases/ama-announces-new-adopted-policies-related-reproductive-health-care.

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

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

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.[23]

201. 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."[24] 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.[25]

202. 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.[26]

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

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

[25] *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.

[26] *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 98, 98 (2013), https://mh.bmj.com/content/39/2/98.

203. 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 patients, in consultation with their medical providers, should be able to choose the method of abortion appropriate for their circumstances.

A. Some Pregnancies Pose Critical or Emergent Medical Risks to Pregnant Patients' Lives and Health

204. Medically unnecessary delays in access to abortion care always harm pregnant patients. 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 patient. The American Board of Emergency Medicine ("ABEM") defines "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" and a "critical" medical conditions as when "[p]atient presents with symptoms of a life-threatening illness or injury with a high probability of mortality if immediate intervention is not begun to prevent further airway, respiratory, hemodynamic, and/or neurologic instability."[27]

205. ACOG has emphasized that "it is impossible to create an inclusive list of conditions that qualify" 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

[27] Michael S. Beeson et al., *The 2022 Model of the Clinical Practice of Emergency Medicine*, 64 J. OF EMERGENCY MED. 659, 661 (2023), https://www.jem-journal.com/article/S0736-4679(23)00063-X/fulltext.

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."[28] Nonetheless, medical organizations have identified some types of conditions in pregnancy that are life or health threatening.

206. 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).[29]

207. 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 births and are life-threatening to the pregnant patient 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.[30]

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[28] *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.

[29] *See* Beeson et al., *supra* note 27.

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

208. 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.[31]

209. 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.[32]

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

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[31] *SMFM Consult Series #63: Cesarean Scar Ectopic Pregnancy*, SOC'Y FOR MATERNAL FETAL MED. (Sept. 2022), https://www.smfm.org/publications/448-smfm-consult-series-63-cesarean-scar-ectopic-pregnancy.

[32] *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.

211. 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 patient's medical condition to become emergent. Premature dilation of the cervix, for example, dramatically increases a pregnant patient'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.[33]

212. 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.

213. 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 conditions include certain cancers requiring radiation or chemotherapy; transplants or other major surgery; and certain cardiac, autoimmune, respiratory, or endocrine diseases. Pregnant patients

[33] *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.

generally are not eligible for transplant surgery and thus may lose their only opportunity to receive life-saving care.

214. 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 previously 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.

215. 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."[34]

216. 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 each patient's circumstances are unique, when a pregnant patient is suffering from such an injury, it should be within the purview of the patient's medical provider to determine whether the patient's

[34] 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).

comorbidities and/or other circumstances make abortion part of the patient's recommended course of treatment—judgment that physicians may exercise for virtually all other forms of medical treatment.[35]

217. Finally, certain fetal conditions or diagnoses can increase the risks to a pregnant patient'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 patient'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.

218. Some fetal conditions present particularly acute risks to the pregnant patient. For example, mirror syndrome is an emergent complication of pregnancy where the pregnant patient 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 patient.

219. In the case of multiple pregnancies (twins, triplets, or more), a fetal condition in one or more of the fetuses, combined with the pregnant patient's other comorbidities, can lead to an emergent condition where an abortion (sometimes called "fetal reduction" or "fetal termination")

[35] *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. 765 (2022).

of one or more fetuses is necessary to give the pregnant patient and the remaining fetus(es) the best chance of survival.[36]

220. 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 giving physicians latitude to diagnose and treat emergent conditions is central to patient health.

221. Thus, where state law allows abortion care for the purpose of preserving the life or health (including fertility) of the pregnant patient, the wide range of medical conditions that could endanger the health of a pregnant patient 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 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

222. 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.[37] The vast majority of Black women's pregnancy-related deaths (91%) were determined to be preventable.[38] While maternal mortality rates in the white Tennessee population are lower than those of the white populations in other states, maternal mortality rates for every other racial and

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[36] *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.

[37] *Maternal Mortality in Tennessee 2017-2019,* TENN. DEP'T OF HEALTH (Aug. 2021), https://www.tn.gov/content/dam/tn/health/program-areas/maternal-mortality/Maternal-Mortality-Overall-2021.pdf.

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

ethnic group are higher.[39] 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.

223. 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.[40] 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.[41]

224. Barriers like Tennessee's abortion ban and the Medical Necessity Exception 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.[42] Black women in Tennessee also face disproportionate

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[39] Laura G. Fleszar, et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States*, 330 JAMA 52, 58 (2021).

[40] *CDC Press Release: Hypertensive Disorders in Pregnancy Affect 1 in 7 Hospital Deliveries*, CTRS. FOR DISEASE CONTROL & PREVENTION ("CDC") (Apr. 28, 2022), https://www.cdc.gov/media/releases/2022/p0428-pregnancy-hypertension.html; *Preterm Birth*, CDC (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 1673, 1676 (2021), https://doi.org/10.2105/AJPH.2021.306375.

[41] *Facts About Hypertension*, CDC (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 1 (2021), https://www.cdc.gov/mmwr/volumes/70/ss/ss7005a1.htm?s_cid=ss7005a1_w; *The Facts, Stats, and Impacts of Diabetes*, CDC (Jun. 20, 2022), https://www.cdc.gov/diabetes/library/spotlights/diabetes-facts-stats.html; *Data & Statistics on Sickle Cell Disease*, CDC (May 2, 2022), https://www.cdc.gov/ncbddd/sicklecell/data.html; Maria Dall'Era, *Systemic Lupus Erythematosus*, in John B. Imboden et al., CURRENT RHEUMATOLOGY DIAGNOSIS AND TREATMENT (3d ed. 2013).

[42] Michael T. Halpern & Debra J. Holden, *Disparities in Timeliness of Care for U.S. Medicare Patients Diagnosed with Cancer*, 19 CURRENT ONCOLOGY 404 (2012); Jasmine M. Miller-Kleinhenz et al., *Racial Disparities in*

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.[43] These disparities, coupled with Tennessee's restrictive Medicaid and insurance coverage policies, render healthcare unaffordable for many.[44]

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

225. In 2019, Tennessee enacted a "trigger ban" that would outlaw abortion if and when the United States Supreme Court reversed *Roe v. Wade.*[45] The bill had been proposed by Tennessee Right to Life. At the time, since a right to abortion was then recognized under the U.S. Constitution, 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.[46]

226. 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 patient, requiring physicians charged with performing such procedures to bear the burden of proving an "affirmative defense to prosecution" that the procedure was necessary.

227. 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

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Diagnostic Delay Among Women with Breast Cancer, 18 J. AM. COLL. RADIOL. 1384 (2021); Joe Feagin & Zinobia Bennfield, *Systemic Racism and U.S. Health Care*, 103 SOC. SCI. & MED. 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 270, 270-73 (2021); Brenda Pereda & Margret Montoya, *Addressing Implicit Bias to Improve Cross-Cultural Care*, 61 CLINICAL OBSTET. & GYNEC. 3, 3-5 (2018).

[43] *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.

[44] *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.

[45] 2019 Tenn. Acts, Ch. 351, § 2.

[46] 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.

Roe v. Wade.[47] 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.[48] 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."[49] 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."[50]

228. 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

[47] 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*.

[48] 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).

[49] 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).

[50] Surana, *supra* note 46.

> the mother's life—it forces health care providers to balance appropriate medical care with the risk of criminal prosecution.[51]

229. 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.[52] He claimed that some pregnancy complications "work themselves out" and said doctors should "pause and wait this out and see how it goes."[53] 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."[54] 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."[55]

230. 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 Necessity Exception.[56] The

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[51] 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/.

[52] 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).

[53] 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.

[54] Surana, *supra* note 46.

[55] *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).

[56] 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.[57] No Tennessee physician—including Dr. Maune, who attended the legislative session and was prepared to address the proposal—was given the opportunity to speak.

231. As enacted, the language of the Medical Necessity Exception imposes even greater limitations on physicians than the vague and confusing language of the medical necessity 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 "irreversible."[58] The amendment also excludes abortions performed "to terminate an ectopic or molar pregnancy" from the statutory definition of "abortion."[59] The amendment to Tennessee's abortion ban went into effect immediately.

A. Tennessee's Medical Necessity Exception

232. 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.[60] The complete text of the Medical Necessity 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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[57] *Hearing on HB 883: Hearing Before the House Health Comm.*, 2023 Leg., 113th (statement of Rep. Helton-Haynes at 1:00:52).

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

[59] 2023 Tenn. Acts, Ch. 313, § 1 (amending Tenn. Code Ann. § 39-15-213(a)(1)).

[60] 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.[61]

233. The "general objectives" of Tennessee's criminal code include to "[g]ive fair warning of what conduct is prohibited, and guide the exercise of official discretion in law enforcement, by defining the act and the culpable mental state that together constitute an offense."[62] The trigger ban and its Medical Necessity Exception do not provide this notice to physicians.

234. Many quantitative terms used in the statute are undefined. Nowhere in the code does Tennessee law give content to what constitutes a "serious risk" versus a "risk"; or a "substantial impairment" versus an "impairment." Nor does the code give any guidance as to what constitutes a "reversible impairment" versus an "irreversible impairment," or a "major bodily function" versus a "bodily function."

235. 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

[61] Tenn. Code Ann. § 39-15-213.

[62] Tenn. Code Ann. § 39-11-101.

function." None of this terminology has standardized meaning in the medical profession, leaving doctors to guess at how to translate it into clinical practice.

236. The statute is completely silent about the temporal aspect of the medical necessity determination: how close must a patient be to "death" or to a "substantial and irreversible impairment of a major bodily function" before her physician can perform a medically indicated abortion without fearing prosecution? Can a physician perform an abortion when the pregnant woman is diagnosed with an emergent medical condition, or must the physician wait until the patient is in critical condition?

237. Under Tennessee's trigger ban, a physician's best, good faith judgment 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." Determinations of medical necessity, however, are often complex, highly fact-specific, and inherently subject to disagreement. Doctors are thus put to an impossible choice under the Medical Necessity Exception: either (i) provide the care that they believe in their best medical judgment to be necessary for their patients' lives and health, and risk arbitrary enforcement of the law by politically-appointed regulators, elected prosecutors and the whims of juries; or (ii) refrain from providing the care and avoid the risk of prosecution while watching their patients sicken.

238. Even legislators who supported the bill creating the Medical Necessity Exception acknowledged that its language was "vague." Senator Richard Briggs, who sponsored the bill, admitted that "I think the bill, things are a little bit vague in the bill. . . ."[63] When asked to clarify

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

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—who is himself a heart surgeon—could only parrot the statutory language: "it's using reasonable medical judgment based upon the facts present to the physician at the time."[64]

239. 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."[65] 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." The statutory distinction between these two conditions and all other conditions that are equally dangerous to a pregnant patient's life or health compounds the statute's ambiguity.

240. Tennessee's abortion ban discriminates against pregnant patients. Pregnant women who suffer medical emergencies are precluded from receiving life or health-preserving abortion care, unless that care falls within the scope of the Medical Necessity Exception. Physicians who provide their pregnant patients with abortion care that the physicians believe in their best medical judgment is needed to avoid jeopardizing the patient's life or health are subject to criminal prosecution if a prosecutor questions whether the abortion was "reasonable." As a result, physicians are being chilled from providing medically necessary abortions. Someone experiencing a medical emergency who is not pregnant does not have their healthcare options limited in this way.

241. The current situation has no precedent in Tennessee law. Prior to the effective date of the trigger ban in 2022, Tennessee physicians were not subject to criminal penalties for providing abortion care that they deemed in their best medical judgment to be necessary to preserve their patients' lives or health. Tennessee's original abortion ban, enacted in 1883, permitted abortions

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[64] *Id.*

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

"done *with a view* to preserve the life of the mother."[66] After *Roe v. Wade*, Tennessee permitted a physician to perform an abortion after "viability of the fetus" upon his certification that, in "*his* best medical judgment" the procedure was "necessary to preserve the life or health of the mother."[67] More than 40 years later, in 2017, that standard was changed to an affirmative defense of "good faith medical judgment," rather than "best medical judgment," but even then, the judgment was still the "physician's."[68]

242. In no other context does Tennessee subject physicians to second-guessing by prosecutors for providing health care that the physician (i) deems necessary in their best medical judgment to preserve the patient's life or health and (ii) the patient consents to receive. Indeed, Tennessee law otherwise respects physicians' judgment to make fundamentally medical decisions that are beyond the competence of politicians.

a. By statute, in determining whether a terminally ill patient is sufficiently sick to be eligible to try an experimental drug, a biological product, or a device not yet approved by the U.S. Food and Drug Administration, Tennessee physicians may rely upon their own judgment to determine whether the patient has an advanced illness that "entails significant functional impairment, that is not considered by a treating physician to be reversible."[69] Patients may receive such care if they have an advanced illness "attested to by the patient's treating physician and confirmed by a second physician"—without any opportunity for second-guessing by a prosecutor.[70] Far from risking disciplinary action or loss of their licenses, physicians who recommend such care are immune from any disciplinary action by a licensing board or

[66] Tenn. Code § 5371 (1883) (emphasis added).

[67] 1973 Tenn. Pub. Acts, Ch. 235, § 1 (codified at Tenn. Code § 39 -301 (1973)) (emphasis added).

[68] Tenn. Code Ann. § 39-15-211(b)(2) (2017), superseded by 2023 Tenn. Pub. Acts, Ch. 313, § 3.

[69] Tenn. Code Ann. § 63-6-302(1) (2021) (emphasis added).

[70] Tenn. Code Ann. § 63-6-302(3)(A) (2021).

subcommittee.[71] Tennessee law even protects such physicians from civil liability, for the patients who receive such care are required to release the treating physician from liability for recommending it.[72]

b. By statute, physicians are excused from obtaining the consent of a parent to perform emergency medical care on a minor where the physician has a "good faith belief that delay in rendering emergency care would, to a reasonable degree of medical certainty, result in a serious threat to the life of the minor or a serious worsening of such minor's medical condition and that such emergency treatment is necessary to save the minor's life or prevent further deterioration of the minor's condition."[73] This includes consent for emergency abortion care, which can be provided without parental consent where there is a medical emergency "in the best medical judgment of the physician.[74]

c. By statute, physicians are immune from any disciplinary action by a licensing board or subcommittee for providing ivermectin "in good faith and with reasonable care."[75] Tennessee law even protects physicians who provide ivermectin from civil liability absent "gross negligence or willful misconduct."[76]

d. By statute, physicians "acting in good faith and with reasonable care" are immune from any disciplinary action by a licensing board or subcommittee for providing hormonal

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[71] Tenn. Code Ann. § 63-6-306 (2021).

[72] Tenn. Code Ann. § 63-6-302(5)(E) (2021).

[73] Tenn. Code Ann. § 63-6-222(a) (2021).

[74] Tenn. Code Ann. §§ 37-10-303, 305 (2020).

[75] Tenn. Code Ann. § 63-10-224(e) (2021).

[76] Tenn. Code Ann. § 63-10-224(f) (2021).

contraceptives.[77] Tennessee law even protects such physicians from civil liability absent "gross negligence or willful misconduct."[78]

243. Outside of the context of physicians who provide life-saving abortion care, Tennessee law generally acknowledges and respects the expertise and experience of practicing physicians. For example:

a. Healthcare practitioners who are "acting in good faith" may prescribe life-saving opioid antagonists to a wide range of persons and organizations that might be "in a position to assist an individual at risk of experiencing a drug-related overdose."[79]

b. By statute, nine out of twelve members of the TBME, which regulates physicians in Tennessee, must be "duly licensed physicians" who have a minimum "six (6) years of experience in the practice of either medicine or surgery or both."[80] By statute, the governor must consult with the Tennessee Medical Association and other medical associations to determine who is "qualified" to serve on the TBME.[81] The TBME may delegate certain of its duties to a consultant, who must also be a "licensed physician."[82]

c. Similarly, five out of six members of the TBOE, which regulates osteopathic physicians in Tennessee, must be osteopathic physicians who are "actively engaged in the practice of their profession for a period of at least five (5) years."[83]

244. The Medical Necessity Exception also discriminates among pregnant people whose lives are threatened by medical emergencies. There is no rational basis for allowing pregnant people

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77 Tenn. Code Ann. § 63-10-219(i) (2021).

78 Tenn. Code Ann. § 63-10-219(j) (2021).

79 Tenn. Code Ann. § 63-1-152(b)(2)-(3) (2021).

80 Tenn. Code Ann. § 63-6-101(a)(1) (2021).

81 Tenn. Code Ann. § 63-6-102(a)(1)(B)(4) (2021).

82 Tenn. Code Ann. § 63-6-101(c)(1) (2021).

83 Tenn. Code Ann. § 63-9-101(a) (2021).

whose lives are threatened by ectopic or molar pregnancies to receive abortion care while criminalizing it in other, similarly dangerous circumstances.

245. Similarly, physicians are prohibited from performing an abortion upon a pregnant patient 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 patient'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.

246. Ambiguity in the Medical Necessity Exception is preventing doctors from providing the care that their patients need. Inconsistent treatment of health risks to pregnant patients in the Medical Necessity Exception has no medical basis and deprives those suffering from critical or emergent medical conditions of equal treatment under the law.

B. Physician Judgment Under the Medical Necessity Exception

247. Physicians confronted with the question of whether a patient qualifies for the Medical Necessity 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).

248. Confusion regarding physicians' ability to use their own best medical judgment under Tennessee's abortion ban, and fear for the grave 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 and its harsh penalties, physicians are over-complying with the laws to the detriment of their patients' lives and health.

249. Tennessee's abortion ban can and should be read to ensure that doctors have sufficient latitude to use their best medical judgment in determining the appropriate course of treatment, including abortion care, for their patients who present with critical or emergent medical conditions—without being second guessed by the Attorney General, the TBME, the TBOE, a local prosecutor, or a jury. Such discretion is best assured through a physician's own "best medical judgment" standard for care, rather than a post hoc "reasonable medical judgment" standard.

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

250. 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.[84] The result is fewer doctors in Tennessee who are fully equipped to treat patients suffering from serious pregnancy complications.

251. 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% overall, while the number of medical school graduates applying for residencies in OB/GYN programs in ban states—including Tennessee—declined by 10.5%.[85]

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[84] 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.

[85] 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.

252. 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.[86] 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."[87] And more than two-thirds of the rural hospitals in Tennessee are at high risk of closing because of their financial condition.[88] *All* of these at-risk hospitals are "highly essential" to their communities.[89]

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

253. 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 patients 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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[86] 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.

[87] *Id.*

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

[89] *Id.*

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

254. 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 patient'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.

255. 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.

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

257. As applied to pregnant patients with critical or emergent medical conditions, Tennessee's abortion ban fails to comply with the Tennessee Constitution. Far from furthering life, it harms pregnant patients' 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 patients with critical or emergent medical conditions, there is none. As then-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 patients with critical or 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.

258. Pregnant Tennesseans' rights to life and health-saving care under the Tennessee Constitution were traditionally and consistently protected by the Tennessee General Assembly. In 1883, when the Tennessee General Assembly enacted its first criminal ban on abortion, it excluded abortion care "done with a view to preserve the life of the mother."[90] Nearly a century later, shortly after the U.S. Supreme Court decision in *Roe v. Wade* recognized a federal right to abortion, the Tennessee General Assembly enacted a criminal ban on abortions performed after "viability of the fetus," which excluded procedures performed after the physician had certified that in "his best medical judgment" the procedure was "necessary to preserve the life or health of the mother."[91] More than 40 years later, in 2017, that standard was changed to an affirmative defense of "good faith medical judgment," rather than "best medical judgment," but even then, the judgment was still the "physician's."[92]

259. In 2000, the Tennessee Supreme Court held that "[a] woman's termination of her pregnancy" was a fundamental right protected by the right to privacy under the Tennessee Constitution. *Planned Parenthood of Middle Tennessee v. Sundquist*, 38 S.W.3d 1, 15 (Tenn. 2000). This right was subject to "strict scrutiny," a more exacting form of judicial review than the "undue

[90] Tenn. Code § 5371 (1883).

[91] 1973 Tenn. Pub. Acts, Ch. 235, § 1 (codified at Tenn. Code § 39 -301 (1973)).

[92] Tenn. Code Ann. § 39-15-211(b)(2), superseded by 2023 Tenn. Pub. Acts, Ch. 313, § 3.

burden" standard applied by federal courts under the U.S. Constitution. *Id*. at 16–17. To eliminate this searching form of judicial scrutiny, the Family Action Council of Tennessee proposed an amendment to the Tennessee Constitution that, as described by its initial author, would "allow Tennesseans to vote in 2014 to amend the state constitution to again make it 'neutral' on abortion while still subject to the abortion rights rulings of the U.S. Supreme Court."[93]

260. The text of the proposed amendment, which later became art. I, § 36 of the Tennessee Constitution, provided that "Nothing in this Constitution secures or protects a right to abortion or requires the funding of an abortion. The people retain the right through their elected state representatives and state senators to enact, amend, or repeal statutes regarding abortion, including, but not limited to, circumstances of pregnancy resulting from rape or incest or when necessary to save the life of the mother." Proponents of this amendment in the Tennessee General Assembly repeatedly urged that it was intended to restore the Tennessee Constitution to "neutral ground" with respect to abortion.[94]

261. When some members of the Tennessee General Assembly expressed concern that the second sentence of the proposed amendment was confusingly worded and did not clearly permit life-saving abortion care to be provided to pregnant women, proponents of the amendment reassured them that the amendment was merely "returning the constitution to the way it was framed and the way it was interpreted" before *Planned Parenthood v. Sundquist.*[95] None of the proponents of the amendment suggested that it was intended to nullify pregnant women's rights to life and

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[93] David Fowler, *What Is Amendment 1?,* The Greeneville Sun (Oct. 31, 2014).

[94] *See, e.g.*, *Hearing on SJR 127: Hearing Before the Tenn. Sen. Judiciary Comm*., 2009 Leg., 106th Sess. 2 (statement of Sen. Black at 00:02:28); *Deb. SJR 127: Tenn. Sen*., 2009 Leg., 106th Sess. 2 (statement of Sen. Black at 00:04:00); *Hearing on SJR 127: Hearing Before the Tenn. H. Health Comm*., 2009 Leg., 106th Sess. 2 (statement of Rep. Maggart at 00:01:27); *Deb. SJR 127: Tenn. House*, 2009 Leg., 106th Sess. 2 (statement of Rep. Maggart at 00:00:50*); Deb. SJR 127: Tenn. Sen.*, 2011 Leg., 107th Sess. 2 (statement of Sen. Beavers at 00:02:03); *Hearing on SJR 127: Hearing Before the Tenn. H. Health Comm*., 2011 Leg., 107th Sess. 2 (statement of Rep. Maggart at 00:00:17); *Deb. SJR 127: Tenn. House*, 2011 Leg., 107th Sess. 38 (statement of Rep. Maggart at 00:12:25).

[95] *Deb. SJR 127: Tenn. House*, 2011 Leg., 107th Sess. 2 (statement of Rep. Dunn at 00:15:50).

equal protection as guaranteed by Tenn. Const. art. I § 8 and Tenn. Const. art. XI § 8, and as consistently recognized under Tennessee law. Nor did any of those proponents suggest that the amendment might license the Tennessee legislature license to narrow the scope of the medical necessity exception historically available under Tennessee's abortion bans.

262. Similarly, when the proposed amendment was put to a vote by the people of Tennessee during the gubernatorial election of 2014, its proponents dismissed as fanciful any concerns that it might eliminate the right to life-saving abortion care when a pregnant woman's life was at stake. An editorial by the Chattanooga Times Free Press argued that "[t]he left would have you believe abortion in Tennessee is in danger of being taken away completely, could become more unsafe, and would not be allowed in the cases of rape, incest and the life of the mother. Given current law, all of those are false."[96] Ron Blount, then Tennessee's Lieutenant Governor, urged that while the amendment's opponents "insinuate the amendment could end legal abortion in Tennessee," it does "no such thing. The amendment would merely allow the legislature to pass laws regarding abortion that many, many other states have passed."[97] Nothing in the public debate over the amendment hinted that it could someday be invoked to override a pregnant woman's rights under the Tennessee Constitution to life and to equal protection under the law.

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

263. The "law of the land" guarantee of Tenn. Const. article I § 8 precludes the enforcement of a criminal abortion ban against physicians who in their best, good faith medical judgment provide abortions for pregnant patients suffering critical or emergent medical conditions.

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[96] Editorial, *Vote Yes on 1, No on 3*, Chattanooga Times Free Press (Oct. 12, 2014).

[97] Ron Blount, *Vote "Yes" on One to Protect Women*, Chattanooga Times Free Press (Nov. 1, 2014).

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

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

266. 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 Necessity 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). Defendant TBOE has similar authority with respect to doctors licensed to practice osteopathy. *See, e.g.*, Tenn. Code Ann. § 63-9-110 (2020); Tenn. Code Ann. § 63-9-111 (2020); Tenn. Comp. R. & Regs. 1050-02-.10 (2023). Disciplinary actions are reported to the National Practitioner Data Bank[98] and can have collateral consequences on a physician's ability to practice in other U.S. states.

267. 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

[98] *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).

Tennessee medical schools will have an average of between $180,208 and $233,131 of student debt upon graduation);[99] 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.

268. 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.

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

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

271. 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.

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

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

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

273. 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 Necessity Exception acknowledged, Tennessee's abortion ban does not meet this standard.

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

275. Vague statutes also violate the due process clause of the Tennessee Constitution because they invite arbitrary enforcement. Under the Medical Necessity Exception, physicians could be subject to the loss of their livelihood or their liberty for providing abortion care that they believed in their best, good faith medical judgment to be necessary to preserve the life, fertility, or health of their patients. Enforcement of the abortion ban in such circumstances would be arbitrary and unconstitutional.

CLAIMS FOR RELIEF

CLAIM I: DECLARATORY JUDGMENT

276. Plaintiffs repeat and re-allege each and every allegation made in paragraphs 1 through 275 above as if set forth fully again here.

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

278. 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.

279. 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.

280. Plaintiffs thus seek a declaratory judgment that the Medical Necessity 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 best, good faith medical judgment and in consultation with the pregnant person, that the pregnant person has a critical or emergent physical medical condition, including a fetal diagnosis, that poses a risk of death or a risk to their health, including their fertility, without regard to when that risk may become manifest.

281. Plaintiffs have sued the State and the relevant state agencies, and seek to have this Court determine the validity under the Tennessee Constitution 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

282. Plaintiffs repeat and re-allege each and every allegation made in paragraphs 1 through 275 above as if set forth fully again here.

283. 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.

284. To the extent Tennessee's abortion ban bars the provision of abortion to pregnant people to treat critical or emergent physical 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.

285. As applied to prohibit abortion care for pregnant people with critical or emergent physical 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.

286. 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 a critical or emergent physical medical condition, including a fetal diagnosis, that poses a risk of death or risk to their health, including their fertility, without regard to when that risk may become manifest.

287. Any official's enforcement of Tennessee's abortion ban as applied to care provided to a pregnant person with a critical or emergent physical medical condition, including a fetal diagnosis, 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

288. Plaintiffs repeat and re-allege each and every allegation made in paragraphs 1 through 275 above as if set forth fully again here.

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

290. Tennessee does not prevent non-pregnant people or people unable to get pregnant from accessing essential 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.

291. To the extent Tennessee's abortion ban bars or delays the provision of an abortion to a pregnant person with a critical or emergent physical 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 critical or emergent physical medical conditions, Tennessee's abortion ban violates pregnant people's right to equal rights.

292. 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.

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

294. Plaintiffs seek a declaratory judgment that Article I, § 8 and Article XI, § 8 of the Tennessee Constitution guarantees a pregnant person the right to equal protection under law, including the right to an abortion where the pregnant person has a critical or emergent physical medical condition, including a fetal diagnosis, that poses a risk of death or risk to their health, including their fertility, without regard to when that risk may become manifest, and an abortion would prevent or alleviate such risk.

295. Any official's enforcement of Tennessee's abortion ban as applied to a pregnant person with a critical or emergent physical medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health 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

296. Plaintiffs repeat and re-allege each and every allegation made in paragraphs 1 through 275 above as if set forth fully again here.

297. By failing to give the Physician Plaintiffs fair notice of how to ensure their conduct falls within the Medical Necessity 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 Necessity Exception that will satisfy the requirements of the due process clause, the Court has a duty to adopt that construction.

298. 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 best, good faith medical judgment and in consultation with the pregnant person, the pregnant person has a critical or emergent physical medical condition, including a fetal diagnosis, that poses a risk of death or a risk to their health, including their fertility, without regard to when that risk may become manifest.

299. Any official's enforcement of Tennessee's abortion ban as applied to a physician treating a pregnant person with a critical or emergent physical medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health 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 Necessity Exception to Tennessee's abortion ban permits physicians to provide a pregnant person with abortion care when the physician determines, in their best, good faith medical judgment and in consultation with the pregnant person, that the pregnant person has a critical or emergent physical medical condition, including a fetal diagnosis, that poses a risk of death or a risk to their health, including their fertility, without regard to when that risk may become manifest;

B. To enter a judgment that Tennessee's abortion ban, as applied to pregnant people with critical or emergent physical medical conditions, including a fetal diagnosis, that poses a risk of death or a risk to their health, including their fertility, 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 critical or emergent physical medical conditions, including a fetal diagnosis, that poses a risk of death or a risk to their health, including their fertility, 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 grant appropriate declaratory relief that Defendants must interpret the scope of the Medical Necessity 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: January 8, 2024

Respectfully submitted,

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