An Open Letter from Tennessee Physicians to the Leadership of the Tennessee Medical Association

Regarding TMA's Amicus Brief in Phillips v. State of Tennessee

October 21, 2026

To: Gene Huffstutter, MD, President; Michelle Allmon, MD, Chair, and the Members of the Board of Trustees; Russ Miller, Chief Executive Officer; and A. Yarnell Beatty, Senior Vice President and General Counsel, Tennessee Medical Association, 701 Bradford Avenue, Nashville, TN 37204

Dear Dr. Huffstutter, Dr. Allmon, Mr. Miller, Mr. Beatty, and Members of the Board:

We are Tennessee physicians, many of us longtime TMA members, and many who care for pregnant women and their children every day. We write about the "Brief of Amici Curiae Medical Associations in Support of Appellees and Cross-Appellants" that the TMA filed on October 7, 2026, together with the American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal-Fetal Medicine (SMFM), and the American Medical Women's Association (AMWA), in Phillips v. State of Tennessee, No. M2026-00578-COA-R3-CV, in the Court of Appeals of Tennessee, Middle Section at Nashville [1]. TMA's General Counsel signed the brief along with outside counsel, the Democracy Forward Foundation, and ACOG's in-house attorneys.

We share the goal the brief states: no woman in Tennessee should be denied timely care for a dangerous pregnancy complication, and no physician acting in good faith should fear prison for providing it. We object to how the brief pursues that goal, to the medical picture it gives the Court, to the TMA's decision to file it in the name of Tennessee's physicians without asking them, and to its failure to notify members until the deadline for amicus filings had passed.

Some in TMA leadership have described the brief as only asking for clarity in the law, not as an effort to change Tennessee's position on abortion. We have read it closely. The case does concern the statute's medical-necessity exception, but the brief goes further. It asks the Court to "affirm the decision below" and declares that "[a]ccess to abortion is essential" (p. 31). It argues that abortion is the standard of care for lethal fetal conditions and lists "certain psychiatric conditions" among the indications (pp. 8–11), even though the General Assembly excluded mental-health conditions and made no exception for fetal diagnoses [2]. It also describes ACOG as "committed to ensuring access to … abortion care" (pp. 2–3). That is advocacy for a broader policy, not a neutral request for clarity.

Medical and Scientific Concerns

1. The brief never defines "abortion," and it conflates miscarriage care and medically necessary delivery with elective abortion.

In medicine, "abortion" has several meanings. "Spontaneous abortion" means miscarriage, and "threatened," "inevitable," "incomplete," and "missed" abortion are stages or types of pregnancy loss [6]. Elective abortion is different. The CDC defines it for surveillance purposes as an intervention "intended to terminate a suspected or known ongoing intrauterine pregnancy and that does not result in a live birth," and the definition "excludes management of intrauterine fetal death, early pregnancy loss, ectopic pregnancy, or retained products of conception" [5, 7].

Tennessee law draws the same line. Under Tenn. Code Ann. § 39-15-213(a)(1), "abortion" requires the "intent to terminate the pregnancy of a woman known to be pregnant," and the definition excludes acts intended "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." The statute defines "pregnant" as having "a living unborn child" in the womb (§ 39-15-213(a)(4)), and it provides that medical treatment resulting in the accidental or unintentional death of the unborn child "shall not be a violation" (§ 39-15-213(d)) [2]. The viability statute, § 39-15-211(a)(1), uses a parallel definition [3].

The brief neither cites nor explains these definitions. It uses "abortion," "abortion care," "pregnancy termination," and "termination of the pregnancy" interchangeably, and it repeatedly folds miscarriage into its argument:

- On pages 9–10, it presents miscarriage, which it says occurs in about 10% of clinically recognized pregnancies, as part of the case against the law, and it asserts that "[m]iscarriage care may be precluded under the law when embryonic or fetal cardiac activity is still observed." Its only support is a general clinical reference, not any Tennessee legal authority. Removing a fetus after demise is excluded from the statute's definition. A previable miscarriage in progress with cervical dilation is "inevitable abortion," which the 2025 amendment names as a qualifying condition (§ 39-15-213(a)(3), (a)(5)(B)).
- On page 9, it lists placenta previa with bleeding, placenta accreta spectrum, and placental abruption as conditions for which "abortion might be the standard of care." These conditions are often managed by delivery, frequently after viability, with the aim of saving both patients. Under § 39-15-213(a)(1), a delivery intended to increase the probability of a live birth is not an abortion.
- On page 29, it justifies induced-abortion training as necessary "to properly manage miscarriages (i.e. spontaneous abortion)." The ACGME requirement the brief cites distinguishes the two: residents with religious or moral objections may opt out of training in induced abortion, while uterine evacuation for miscarriage remains part of core training [8].

- On pages 30–31, it describes mifepristone and misoprostol as the standard of care for miscarriage and attributes pharmacies' reluctance to dispense misoprostol to the law. Miscarriage management is not abortion under Tennessee law.

These distinctions matter. When a court, a hospital attorney, or a pharmacist is told that ordinary miscarriage care is "abortion," the result is the very hesitation the brief laments. A medical society's first duty here is to use the law's medical terms accurately instead of using them loosely, which itself causes harm.

2. Serious maternal conditions are treated by delivery, not by an act intended to end the child's life.

The brief repeatedly presents serious maternal conditions as requiring "abortion" (pp. 5, 8–9, 14–18). In practice, these conditions are treated by ending the pregnancy through delivery: induction of labor or cesarean delivery, including delivery before viability. The dividing line is intent. Elective abortion is intended to end the life of the child. Delivery is intended to end the pregnancy to protect the mother's life or health. It does not target the child, who receives care appropriate to gestational age, from full neonatal resuscitation to comfort care [7]. We acknowledge plainly that a delivery before viability will not result in a surviving child. The intent and the method still differ. The principle of double effect, long used in medical ethics, holds that a foreseen but unintended harm may be permissible when it results from an act aimed at a proportionate good, but not when the harm is itself the means to that good [7, 20]. The Dublin Declaration on Maternal Healthcare (2012), issued by obstetricians and researchers, affirms "that there is a fundamental difference between abortion, and necessary medical treatments that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child" [21].

Tennessee law reflects this distinction. A delivery intended to increase the probability of a live birth is outside the definition of abortion (§ 39-15-213(a)(1)). A previable delivery needed to prevent the mother's death or serious and irreversible harm falls within the exception, and the statute requires the method that "provides the best opportunity for the unborn child to survive," unless that method would pose a greater risk to the mother (§ 39-15-213(c)(1)(B)) [2]. That provision writes the intent distinction into law. AAPLOG's guidance accepts induction of labor and, in emergencies after 14 weeks, hysterotomy as methods of previable delivery. It also acknowledges that pro-life physicians differ on whether suction D&C or D&E is permissible in a truly emergent case with a living embryo or fetus when no other option remains [7]. The statute's method provision leaves room for that clinical judgment when another method would pose a greater risk to the mother.

For each condition the brief cites, the standard of care is available under Tennessee law:

- Previable PPROM (pp. 9, 14–17). SMFM describes two options: expectant management with close surveillance, or ending the pregnancy [9]. When the pregnancy is ended, induction allows delivery of an intact child, whom the family can hold [7]. The statute names previable PPROM (§ 39-15-213(a)(5)(B)).

- Intraamniotic infection (chorioamnionitis) and sepsis (pp. 9, 15–16). Treatment is antibiotics plus source control, which means emptying the uterus [7, 22]. As AAPLOG notes, the treatment of chorioamnionitis at or near term is delivery, not feticide; before viability, the same source control is required [7]. The statute names "an infection that can result in uterine rupture or loss of fertility," and sepsis threatens life.
- Preeclampsia with severe features (pp. 9, 18), including the hemolysis, low platelets, and liver failure the brief lists (p. 9), as seen in HELLP syndrome. Preeclampsia is a placental disease, so delivery is the definitive treatment. ACOG advises against expectant management when neonatal survival is not anticipated and calls for delivery after maternal stabilization when the mother deteriorates [10, 7]. The statute names severe preeclampsia.
- Previable cervical dilation (p. 9). This is "inevitable abortion," a spontaneous pregnancy loss in progress, which the statute defines and names (§ 39-15-213(a)(3), (a)(5)(B)). Care consists of managing the delivery and its complications.
- Placenta previa with bleeding, placenta accreta spectrum, and placental abruption (p. 9). These are managed by stabilization, transfusion, and delivery. For accreta spectrum in a stable patient, ACOG and SMFM suggest scheduled cesarean delivery or hysterectomy at 34 0/7 to 35 6/7 weeks, earlier if bleeding or other complications require it [23]. That is delivery, not abortion. Before viability, life-threatening hemorrhage is treated by delivery, and the exception for preventing death applies [2, 7].
- Fetal anomalies with maternal complications such as polyhydramnios or hemorrhage (p. 12). The maternal complication is treated directly, and delivery proceeds when the mother's health requires it. Perinatal palliative care is a recognized option for the child [11].
- Chronic maternal disease, including cardiac, renal, and autoimmune disease (pp. 10–11). The disease is treated during pregnancy where possible. If the mother decompensates, delivery, including previable delivery, is available under the exception [2, 7].

3. The statute already names the conditions the brief highlights.

The brief's central examples are previable preterm prelabor rupture of membranes (PPROM), severe preeclampsia, and previable cervical dilation (pp. 9, 14–18). Since April 2025, § 39-15-213(a)(5)(B) has provided that a serious risk of substantial and irreversible impairment of a major bodily function "may include previable preterm premature rupture of membranes; inevitable abortion; severe preeclampsia; mirror syndrome associated with fetal hydrops; and an infection that can result in uterine rupture or loss of fertility" [2]. The brief objects to the word "may" (pp. 17–18). Yet it also reports that the State's own expert "could not identify any circumstance where a patient with one of those conditions would not face such a 'serious risk'" (p. 18 n.17). That concession supports treating the listed conditions as covered. It does not show that physicians must wait for sepsis.

The brief's main example (pp. 14–15) describes a patient whose cervix was no longer present at about 17 weeks and whose membranes ruptured at 20 weeks. That is previable PPROM, which the statute now names. The brief does not say whether these events occurred before the April 2025 amendment. If a hospital still required infection before intervening after the amendment,

the remedy is clear institutional guidance, not a court ruling that the Legislature's text is unworkable.

4. "Reasonable medical judgment" is medicine's ordinary standard, and the statute requires intent.

The brief argues that the "reasonable medical judgment" standard exposes good-faith physicians to prosecution (pp. 18–21). This is the standard by which physicians are judged in every other clinical setting: a judgment "made by a reasonably prudent physician knowledgeable about the patient's case and the treatment possibilities" (§ 63-6-1102(14)) [4]. The statute applies it "based upon the facts known to the physician at the time" (§ 39-15-213(c)(1)(A)), which rules out judging a physician by hindsight. Contrary to the brief's suggestion that the offense lacks a culpable mental state (p. 20), the definition of abortion requires intent to terminate a known pregnancy, and unintended fetal death resulting from medical treatment is excluded (§ 39-15-213(a)(1), (d)). The brief's main authority on this point, Memphis Center for Reproductive Health v. Slatery, 14 F.4th 409 (6th Cir. 2021) (p. 19), was vacated when the Sixth Circuit granted rehearing en banc on December 1, 2021 [15]. The brief does not tell the Court that.

5. Fetal diagnoses, chronic disease, and mental health are presented as indications the law does not recognize.

The brief argues that abortion should be available for lethal fetal anomalies (pp. 11–12) and for "certain psychiatric conditions" (p. 10). Those are questions of policy, not of vagueness. TMA has already taken the lethal-anomaly question to the General Assembly. In 2025 it supported HB 1241/SB 1425, which would have created an exception for a lethal fetal anomaly [29]. That bill failed. The General Assembly instead enacted the 2025 amendment that names previable PPROM, inevitable abortion, severe preeclampsia, mirror syndrome, and certain infections [2]. Tennessee law still excludes conditions related to the woman's mental health (§ 39-15-213(a)(5)(C), (c)(2)), and a fetal diagnosis is not by itself a threat to the mother. Having lost that argument in the legislature, TMA should not ask the Court to grant what the General Assembly declined to enact. The brief's own source, ACOG Committee Opinion 786, lists perinatal palliative comfort care as one of the options that should be offered to families facing a life-limiting fetal diagnosis [11]. When a fetal condition does endanger the mother, as with mirror syndrome or hemorrhage, the exception applies. On cancer (p. 10), many malignancies can be treated during pregnancy. A multicenter study in the New England Journal of Medicine found that prenatal exposure to maternal cancer, with or without treatment including chemotherapy, did not impair cognitive, cardiac, or general development in early childhood [12]. Mental illness and substance use in pregnancy are urgent problems. They call for perinatal psychiatric and addiction care, which the brief does not discuss.

6. The maternal-mortality data do not show what the brief implies.

The brief leads with Tennessee's maternal mortality rate (pp. 5, 7–8). The CDC reports 41.1 maternal deaths per 100,000 live births in Tennessee for 2018–2022 (166 deaths), compared with 23.2 nationally [13]. That period almost entirely predates the law, which took effect in

August 2022, and the CDC warns that differences in data quality limit state-to-state comparisons [13]. The Tennessee Department of Health's 2024 report found that the leading causes of pregnancy-related death in 2020–2022 were mental health conditions (28%, of which 70% involved substance use disorder), cardiovascular conditions (22%), and infection (20%). It also found that the pregnancy-related death rate fell 15% from 2021 to 2022 [14]. These deaths are real and demand action on addiction treatment, cardiovascular care, postpartum follow-up, and rural access. The brief does not show that the medical-necessity exception causes them.

7. Tennessee law does not prevent complete OB/GYN residency training.

The brief says that "ob-gyn residents must leave the state for portions of their residency training to receive abortion training" (p. 6), that the ACGME requires abortion training "as a core competency" (p. 28), and that Tennessee programs "must now send them to other regions of the country to obtain the required training" (p. 29). That overstates what the ACGME requires. The current Program Requirements state that programs "must provide clinical experience or access to clinical experience in the provision of abortions as part of the planned curriculum," and that a program in a jurisdiction where this is unlawful "must provide access to this clinical experience in a different jurisdiction where it is lawful" (Req. 4.11.i.4) [8]. The ACGME does require an opt-out rather than an opt-in curriculum, and programs must support out-of-state experience for residents who choose it (Req. 4.11.i.4.b). But the same requirement states that "[r]esidents who have a religious or moral objection may opt out and must not be required to participate in training in or performing induced abortions" (Req. 4.11.i.4.a) [8]. No resident is required to perform an elective abortion or to leave Tennessee to complete residency. The procedural skills the brief invokes are taught here. The ACGME separately requires every resident to have clinical experience in "the comprehensive management of spontaneous abortion and pregnancy loss, including ... uterine evacuation," in both the operating room and outpatient settings (Req. 4.11.j, 4.11.j.1) [8]. Suction D&C and D&E for miscarriage, missed or incomplete abortion, and fetal demise use the same technique as an induced abortion, are lawful in Tennessee because no living child is present (§ 39-15-213(a)(1), (a)(4)) [2], and differ from it in intent, not in technique.

Concerns About How the TMA Made This Decision

The TMA does not speak for us on this issue. The brief tells the Court that the amici are "leading medical societies representing physicians and other clinicians who serve patients in Tennessee," that the TMA "is comprised of approximately 10,000 members," including "ob-gyns, family physicians and emergency physicians who provide care to pregnant women in Tennessee," and that the TMA "protects the health interests of patients" (p. 1). It says the TMA has been "hearing from its members on the impact of the law" (p. 2), that "many of TMA's members report that they lack sufficient clarity" (p. 13), and that the amici support "the Plaintiff physicians' right to be free from the risk of arbitrary prosecution" (p. 7). The brief does not tell the Court how TMA decided to file, or that many Tennessee physicians, including every signer of this letter, reject the brief's position. TMA's Board of Trustees approved submission of the brief at its July 17–19, 2026 retreat [27]. TMA has pointed to a 2024 survey in which, it says, nearly 83 percent of physician respondents felt the Human Life Protection Act does not offer sufficient legal

protections to terminate a pregnancy to save the mother's life or prevent serious and irreversible impairment of a major bodily function [28]. That is not a vote of the membership or the House of Delegates on this filing, nor is it a survey asking whether TMA should join an appellate brief that calls access to abortion "essential," treats lethal fetal conditions and "certain psychiatric conditions" as indications, and asks the Court to affirm the decision below. Members are entitled to see that survey's questions, sample size, response rate, and dates, and to know whether anyone was asked about this brief before it was filed. Physician organizations such as the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) and the Christian Medical & Dental Associations (CMDA), which is headquartered in Bristol, Tennessee, hold the opposite view: both mother and unborn child are patients, and delivery to save a mother's life, even before viability, is distinct from induced abortion [7, 19].

The TMA also presents itself as protecting physicians. Yet it co-filed with organizations that, by the brief's own description, advocate for abortion access: ACOG is "committed to ensuring access to … abortion care" (pp. 2–3), and AMWA, through a coalition it co-founded, "advocates for full, comprehensive reproductive health care access" (p. 4). The brief says nothing about the physicians who believe they are caring for two patients, or about protecting their consciences. The brief invokes the Hippocratic principles of beneficence and non-maleficence but omits the Oath's traditional prohibition on inducing abortion.

The brief's choice of words points the same way. It refers to Tennessee's statute as the "criminal abortion law" about 20 times, beginning in its statement of interest (p. 1) and its introduction (p. 4), and it calls the medical-necessity provision the "criminal abortion 'medical necessity' exception" (p. 14). The statute does sit in the criminal code, and the offense it defines is called "criminal abortion" (§ 39-15-213(b)). But the brief applies that label to the whole law, including the provisions that protect physicians. The law reaches only an act intended to end the pregnancy of a woman carrying a living unborn child. It excludes treatment of ectopic and molar pregnancy, removal of a child who has died, and unintended fetal death from medical treatment, and it expressly permits delivery to prevent the mother's death or serious and irreversible harm. Repeating "criminal" at every turn tells physicians that ordinary obstetric care is a crime. That is not neutral language for a medical society that claims to represent all its members, and it feeds the very fear that delays care.

On a question that divides the profession and the public, the TMA committed the association's name and its members' dues and contributions, through its General Counsel's time and outside counsel, without putting this filing to the membership or the House of Delegates. Presenting this filing as the voice of Tennessee's physicians misrepresents the TMA's membership. Other Tennessee physicians and healthcare providers who agree with the plaintiffs have a proper way to be heard. Fifty-one of them filed their own amicus brief on October 7, 2026, in their own names [33]. That is how physicians who hold a contested view should speak to a court. It is not how a membership association should commit its name, or the names of members who were never asked, to the same cause.

TMA's choice of counsel points the same way. Neither the ACLU nor Planned Parenthood is a party or an amicus on this brief. However, TMA's outside counsel of record, Stella Yarbrough of

Herzfeld, Suetholz, Gastel, Leniski and Wall, previously served as Legal Director of the ACLU of Tennessee. Her firm biography states that she led the legal team in L.W. v. Skrmetti, the challenge to Tennessee's SB1, which restricts gender-transition medical treatment for minors, and she is listed with the ACLU Foundation of Tennessee on the plaintiffs' briefs in the U.S. Supreme Court in United States v. Skrmetti, No. 23-477 [24, 25]. Co-counsel Carrie Flaxman of the Democracy Forward Foundation spent nearly two decades as a litigator and legal adviser at Planned Parenthood Federation of America, most recently as its Senior Director of Public Policy, Litigation, and Law [26]. Democracy Forward is not merely a former employer of a Planned Parenthood lawyer. In July 2026, while this appeal was pending, it appeared as counsel for Planned Parenthood Federation of America in Planned Parenthood Federation of America v. U.S. Department of Health and Human Services, the challenge to Title X funding rules [31]. Democracy Forward's own announcement of TMA's filing states that it filed the brief "on behalf of" TMA, ACOG, SMFM, and AMWA [31]. The same organization has served as counsel to ACOG and SMFM on other abortion-related amicus briefs and represents GenBioPro, the manufacturer of generic mifepristone, as a party in federal litigation over that drug [32]. We do not question any lawyer's integrity or skill. But for an association that claims to represent all Tennessee physicians, retaining a national advocacy organization that currently represents Planned Parenthood, and choosing counsel with these prior roles, signals alignment with one side of a contested advocacy debate rather than neutral representation of its members.

One further fact bears on the claim that this case is only about giving physicians clarity. The lead plaintiff, Allyson ("Allie") Phillips of Clarksville, has been a plaintiff since the suit was filed in September 2023. On November 3, 2026, with all 39 precincts reporting, she was elected to represent House District 75, defeating incumbent Rep. Michael Lankford, 7,822 to 6,396, according to the Secretary of State's election-night returns [30]. She has publicly described her campaign as an effort to change Tennessee law [30]. We do not criticize her for seeking office. We note the implication. The brief asks the Court to treat lethal fetal diagnoses and certain psychiatric conditions as indications the General Assembly has not enacted. Changing that policy is work for the legislature, a body one of the plaintiffs will now join.

The timing compounds the problem. The brief was filed on October 7, and TMA announced it by email to its members on October 14, following a public announcement on October 8 [17]. Under Tenn. R. App. P. 31(b), an amicus brief must be filed within seven days after the brief of the party it supports [16]. By the time most members learned of TMA's position, physicians who disagreed had no practical opportunity to give the Court a timely response.

Members are also entitled to know how conflicts were handled. The brief relies on declarations from Dr. Laura Andreson, a named plaintiff, and Dr. Nicole Schlechter (p. 31). Both currently serve on TMA's Board of Trustees, Dr. Schlechter as Vice-Chair [17]. We do not question their sincerity or their care for patients. But members deserve to know whether they took part in the decision to file.

Our Requests

We respectfully ask the Board to take these steps:

1. Withdraw TMA's name from the brief. If withdrawal is not procedurally available, state publicly, and inform the Court, that TMA's participation does not represent the views of its membership as a whole.
2. Within 30 days, disclose to members who authorized the filing, when, and by what vote; what House of Delegates policy, if any, it relied on; whether trustees with a personal stake recused; the total cost, including staff time and outside counsel fees; and whether any other organization paid any part of it.
3. Adopt a policy that requires advance notice to members, a reasonable comment period, and approval by the House of Delegates or a supermajority of the Board before TMA files or joins any amicus brief or litigation on a contested ethical question, with public disclosure of votes and conflicts.
4. Put TMA's resources behind what unites us. Work with the Board of Medical Examiners, the Department of Health, the Attorney General's office, hospitals, and pharmacists to publish clear clinical guidance confirming that miscarriage management, treatment of ectopic and molar pregnancy, and the emergencies the statute lists are lawful care.

The TMA is at its best when it speaks for all Tennessee physicians. On this question it spoke for some of us and against many of us, using an incomplete account of the medicine and the law. We ask you to correct that, and we stand ready to work with you on guidance that protects every patient we serve.

Respectfully,
Name: Omar L. Hamada, MD, MBA, FACOG, FAAFP, FICS
Specialty: OB/GYN and Family Medicine
City: Franklin, TN

Disclosure: Dr. Hamada has served as a medical consultant to the Office of the Tennessee Attorney General, which represents the State in this litigation. He signs this letter in his personal capacity as a physician and TMA member.

Name: Stephen D. Hammond, Sr., MD
Specialty: OB/GYN (Retired)
City: Jackson, TN

Name: Lisa W. Rogers, MD, FACOG
Specialty: OB/GYN
City: Humboldt, TN

Name: David T. McKnight, MD, FACOG
Specialty: OB/GYN
City: Murfreesboro, TN

Name: Bethany Reynolds, MD, FACOG
Specialty: OB/GYN
City: Johnson City, TN

Name: Eddie Reynolds, MD, ABEM
Specialty: Emergency Medicine
City: Johnson City, TN

Name: Jenny Weaver, MD, FACS, ABOM
Specialty: General/Bariatric Surgery and Obesity Medicine
City: Germantown, TN

Name: Theresa Morrison, MD, FAAFP
Specialty: Family Medicine/OB
City: Fayetteville, TN

Name: Ron Kirkland, MD (Past TMA President)
Specialty: Otolaryngology (Retired)
City: Jackson, TN

Name: Thomas Gray, MD, FACOG
Specialty: OB/GYN
City: Germantown, TN

Name: Carrie Ballard, MD, FACOG
Specialty: OB/GYN
City: Johnson City, TN

Name: Ken Berry, MD, FAAFP
Specialty: Family Medicine
City: Holladay, TN

Name: Graham Warr, MD, FACP
Specialty: Internal Medicine/Pediatrics
City: Memphis, TN

References

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30. Tennessee Secretary of State, County Breakdown for Tennessee House of Representatives District 75 (Nov. 3, 2026 election-night returns, all 39 precincts reporting) (elections.tn.gov); Chris Smith, "'My door will always be open': Phillips flips state House District 75 seat to Democrat," Clarksville Now (Nov. 3, 2026); Adrian Mojica, "She sued Tennessee over the abortion law and now she's running for state office," FOX 17 (Oct. 16, 2023).
31. Democracy Forward, "Planned Parenthood Sues Trump-Vance Administration Over Ideologically-Driven Changes to Funding Application for Title X Family Planning Program" (July 29, 2026); Democracy Forward, "Medical Experts Tell Court Tennessee's Abortion Ban Unlawfully Endangers Patients and Physicians" (stating that Democracy Forward filed the brief on behalf of ACOG, TMA, SMFM, and AMWA).

32. Democracy Forward, statements that it represents GenBioPro, the manufacturer of generic mifepristone, in federal litigation including Missouri et al. v. FDA and Louisiana et al. v. FDA (democracyforward.org); see also Brief of Amici Curiae American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, and Society of Family Planning, Arizona Right to Life v. Fontes (counsel listing Democracy Forward Foundation).
33. Fried, Frank, Harris, Shriver & Jacobson LLP, "Fried Frank Files Amicus Brief on Behalf of Tennessee Medical Professionals" (Oct. 7, 2026) (friedfrank.com).