ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

TENNESSEE

Since *Roe v. Wade* was overturned in June 2022, medical providers across the country have struggled to understand their state's abortion laws, which contain undefined terms and non-medical language.

Fear and confusion throughout the medical community has led some hospitals to adopt policies that are overly strict or burdensome, causing patients to be denied care in emergencies. While the law remains in flux and some questions have no clear answers, this document aims to provide clarification, where possible, of what conduct is still permitted in your state. Know what your state's law does and does not require, so you can advocate for yourself and your patients.

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Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for ectopic pregnancies, molar pregnancies, and pregnancies with no cardiac activity is legal.

Providing information to adults about how to obtain a legal abortion in another state is legal. Tennessee law forbids providing certain support to minors seeking a legal abortion in another state without written and notarized parental consent. Litigation regarding that law is ongoing.

Abortion is prohibited under Tennessee law unless the patient has a “medical emergency,” meaning abortion is necessary to “prevent the death” of the patient or to prevent a “serious risk of substantial and irreversible impairment of a major bodily function.”

Litigation seeking clarification of the exception is ongoing.

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Definition of Abortion & Contraception

ABORTION

The legal definition of abortion in Tennessee is "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."[1] The state defines "pregnant" as "the human female reproductive condition of having a living unborn child within her body throughout the entire embryonic and fetal stages of the unborn child from fertilization until birth."[2]

This means that the following terminations are not abortions under Tennessee law: (1) removal of an ectopic pregnancy; (2) removal of a molar pregnancy; and (3) removal of a "dead fetus." While undefined, it is generally understood that the term "dead" means that there is no cardiac activity present in the embryo or fetus.[3] As a result, treating an incomplete miscarriage is not considered providing an abortion under Tennessee law and is therefore not prohibited by Tennessee's abortion bans as long as there is no embryonic or fetal cardiac activity at the time the care is provided.

Tennessee law does not contain specific requirements related to miscarriage care or treatment following a stillbirth. Provided that an embryo or fetus does not have detectable cardiac activity, however, Tennessee law permits all necessary treatment and medical management following a miscarriage, including use of intact D&E. Further, Tennessee law does not require that a parent or guardian of a young person under 18 consent before the patient may obtain necessary miscarriage treatment.[4]

With respect to self-managed abortion, it is legal for providers to give medical care to a pregnant person who has initiated or recently completed a self-managed abortion provided there is no embryonic or fetal cardiac activity or the patient is experiencing a complication that would qualify as a medical emergency (see below). A pregnant person cannot be convicted under Tennessee's abortion ban for self-managing their abortion because the state's criminal abortion ban explicitly exempts pregnant people from liability.[5]

CONTRACEPTION

Contraception is not illegal in any state in the country. Tennessee law permits the provision and use of all contraceptives, including intrauterine devices and emergency contraceptives such as Plan B. "Contraceptive supplies" are defined as "medically approved items designed to prevent conception through chemical, mechanical or other means."[6] "Contraceptive procedures" are defined as "any medically accepted procedure designed to prevent conception."[7] Tennessee defines "abortion-inducing drug," "abortion," and "chemical abortion" in a manner which would seem to exclude drugs that are used to *prevent* pregnancy, like emergency contraception.[8]

Abortion Bans

Trigger Ban: Tennessee began enforcing its trigger ban on August 25, 2022, approximately two months after the U.S. Supreme Court's decision and one month after issuance of the judgment in *Dobbs v. Jackson Women's Health Organization*.[9] The trigger ban prohibits performing or attempting to perform an abortion at any gestational age.[10] The only exception to the ban is if a licensed physician performs an abortion in a licensed hospital or ambulatory surgical treatment center after the physician determines, in their reasonable medical judgment, that the pregnant person is experiencing a medical emergency (explained in more detail below).[11] It is not a

violation of Tennessee's abortion ban if a licensed physician provides medical treatment to a pregnant person "which results in the *accidental* death or *unintentional* injury to or death of the unborn child."[12]

Providing an abortion that violates Tennessee's trigger ban is a Class C felony,[13] punishable by three to fifteen years' imprisonment and up to a $5,000 fine.[14]

Other Bans and Restrictions: Tennessee's trigger ban explicitly supersedes Tennessee's other gestational age and reason-based abortion bans, which include a gestational age ban at approximately six weeks from the pregnant person's last menstrual period;[15] a gestational age ban at eight, ten, twelve, fifteen, eighteen, twenty, twenty-one, twenty-two, twenty-three, and twenty-four weeks;[16] a ban after viability of a fetus;[17] and a ban on abortion if the physician knows the abortion is sought due to the race, sex, or diagnosis or potential diagnosis of Down syndrome in the fetus.[18] Although these bans are currently superseded and therefore not currently in effect,[19] they remain on the books and can spring back into effect if the trigger ban is ever enjoined.

Additionally, Tennessee law prohibits intact D&E procedures (sometimes called D&X procedures),[20] and continues to include requirements that pregnant people who seek abortion care must undergo a mandatory forty-eight hour waiting period[21] and counseling.[22] The state maintains prohibitions on public funding for abortions[23] and does not require private insurance coverage for abortion services.[24] Finally, it continues to require that a parent, legal guardian, or judge consent to an abortion for a young person under 18.[25] It is possible that these laws do not apply if an abortion meets the medical emergency exception, but as explained below, it is not clear whether that will always be the case.

"Medical Emergency" Exception to Abortion Bans

The only exception to Tennessee's abortion ban is for medical emergencies.[26] Tennessee does not have exceptions for rape or incest, and the state legislature rejected proposed legislation to create these exceptions.[27]

Language of Exception: Tennessee's trigger ban provides that abortion is legal if (1) the abortion is performed by a licensed physician, (2) the abortion is provided in either a licensed hospital or an ambulatory surgical treatment center, (3) the physician determines, based on reasonable medical judgment, that the abortion is "necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman," and (4) when performing the abortion, the physician "provides the best opportunity for the unborn child to survive," unless, in the provider's 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."[28]

Tennessee law specifically provides that the medical emergency exception to the abortion ban does *not* apply if the provider's determination that the pregnant person is at serious risk is based on "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."[29] Thus, the provider may only provide an abortion under Tennessee's trigger ban if the pregnant person's physical health is at serious risk from a cause other than suicide or self-harm.

Interpretation of Exception: The medical emergency exception does not require that the risk of death or serious impairment of a major bodily function be imminent. It does, however, require that the impairment of the major bodily function be "substantial and irreversible." A lawsuit seeking to clarify the scope of the medical exception is currently pending in Tennessee state court.[30]

Legal Requirements in Emergencies: When acting to save the life of a pregnant person or prevent substantial and irreversible impairment to a major bodily function, it is possible that other provisions of Tennessee law do not apply in the event of a medical emergency. The following provisions of Tennessee law also have exceptions in the event of a medical emergency: the prohibition on intact D&E procedures (sometimes called D&X procedures);[31] informed consent counseling and mandatory 48-hour delay requirements;[32] and Tennessee's parental consent law for young people under 18 seeking abortion care.[33] However, each of those laws define the exception somewhat differently than the Tennessee trigger ban's medical emergency exception. The intact D&E ban applies if the patient's "life is endangered," which may not apply if there is a "serious risk of substantial and irreversible impairment of a major bodily function."[34] Additionally, the informed consent law's medical emergency requires that the need for an abortion is "immediate."[35] And the parental consent exception applies if a medical emergency "complicates" a pregnancy such that an immediate abortion is required.[36] Because each definition is somewhat distinct, there may be cases where those laws need not be followed in the event that there is a medical emergency under the Tennessee trigger ban, but there may be cases where they must still be followed. Litigation is ongoing to determine the scope of the medical emergency exception.

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act (EMTALA) requires emergency abortion care in some cases. EMTALA requires Medicare-participating hospitals with emergency departments (which is most hospitals), to provide medical screening[37] and stabilizing medical treatment to individuals experiencing an emergency medical condition,[38] including people in labor or with emergency pregnancy complications.[39] Under the EMTALA statute, "to stabilize" means to provide medical treatment "as may be necessary" to ensure, "within reasonable medical probability, that no material deterioration of the condition is likely."[40] A person experiencing an emergency medical condition can only be transferred to a different hospital once they are stable or if certain conditions are met such as the medical benefits of transfer outweigh the increased risks to the person experiencing the medical emergency.[41] Even where a hospital is permitted to transfer such a person without first stabilizing them, the hospital still must provide "the medical treatment within its capacity which minimizes the risks to the individual's health . . . ."[42] EMTALA defines medical emergency to include "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."[43] The stabilizing treatment required by EMTALA can include abortion care in certain circumstances.

HHS reaffirmed these requirements in guidance issued after *Roe v. Wade* was overturned. That guidance emphasizes that stabilizing treatment required by EMTALA could include abortion care if the examining physician or other qualified medical

personnel determines that such treatment is required to stabilize a patient experiencing an emergency medical condition, including a condition that is "likely or certain to become emergent without stabilizing treatment."[44] The guidance made clear those conditions might include, but are not limited to: "ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features."[45] The guidance reiterates that if EMTALA requires the provision of abortion care, then EMTALA expressly preempts any state law prohibiting or restricting access to abortion.[46] Indeed, HHS has recently cited hospitals in Kansas, Missouri and Florida for violating EMTALA by failing to provide abortion care to a patient with preterm premature rupture of membranes ("PPROM").[47]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, there is ongoing litigation relating to attempts by state officials in Idaho and Texas to restrict hospitals from complying with their federal legal obligations. In 2022, a federal district court in Idaho issued a preliminary injunction ensuring that Idaho's abortion ban could not be enforced to prohibit health-saving emergency abortions required under EMTALA. While that injunction was temporarily stayed by the U.S. Supreme Court, that stay was lifted in June 2024 and the preliminary injunction restored while the case continues in the lower courts.[48] In July 2024, following that order, HHS issued a statement reiterating that EMTALA requires hospitals to provide emergency abortion care when it is necessary stabilizing treatment.[49] Meanwhile, HHS has asked the U.S. Supreme Court to review a Fifth Circuit decision that affirmed a lower court decision temporarily blocking federal enforcement of HHS' guidance in Texas. HHS has petitioned the Supreme Court to reverse the preliminary injunction.[50] The government's petition will be considered by the Supreme Court in the next term.

Other Federal Laws & Professional Guidelines

In addition to EMTALA, hospitals and/or medical providers are required to abide by the following:

Conditions of Participation in Medicare and Medicaid (COP): The federal COP regulations require hospitals that participate in Medicare and Medicaid to inform patients of their rights in advance of furnishing or discontinuing care which include: the right to be informed of their health status, be involved in care planning and treatment, and participate in the development of their plan of care.[51]

Protection Against Discrimination in Employment: The federal law known as the Church Amendments prohibits hospitals that receive certain federal funds from discriminating against health care providers who participate or are willing to participate in abortion care or sterilization procedures.[52]

Medical Malpractice: While this document does not detail state-specific medical malpractice law, medical providers should be aware that they risk liability under state medical malpractice law for failing to provide pregnant patients with the standard of care.[53]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[54] The federal law known as the Coats-Snowe Amendment both protects medical professionals in learning to provide abortion, and limits the government's ability to penalize programs or institutions that fail to comply with ACGME requirements.[55]

Documentation & Reporting

Generally, state law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it explicitly require reporting to law

enforcement patients who receive abortions out of state or self-manage their own abortion.[56] Some hospitals may impose additional documentation requirements for abortions performed as medical emergencies, including attestations by multiple physicians and/or approvals by an ethical review board. While intended to insulate the hospital from liability, these are not legal requirements.

The only abortion-specific reporting requirements are:

Induced Termination & Fetal Tissue Disposition Reporting: Under Tennessee law, a physician providing an abortion must keep a record of each abortion and a record of the disposition of the "aborted fetus or aborted fetal tissue" for each abortion.[57] There is no such requirement for treatment for ectopic and molar pregnancies as these conditions are exempted from the definition of "abortion" under Tennessee law. Additionally, there is no reporting requirement for medication abortions where "the expulsion of the aborted fetus or aborted fetal tissue does not take place at the facility or clinic."[58] Where reporting is required, each abortion must be reported to the Commissioner of Health.[59] The reports must be made within ten days after the abortion is provided.[60] If the abortion is a procedural rather than medication abortion, the provider must include information in the report of the location of the fetal or embryonic tissue, including the name and address of the third party who will be disposing of the tissue.[61] The reports that are provided to the Commissioner of Health are consolidated and reported quarterly to the Governor, the Speaker of the Senate, the Speaker of the House of Representatives, and the chairs of the Health and Welfare Committee of the Senate and the Health Committee of the House of Representatives.[62]

Sexual Abuse Reporting in the Context of Abortions: Tennessee law requires providers to report the suspected child abuse of a young person if they have been asked to provide an abortion for a young person under thirteen years old and they have reasonable cause to believe the young person is a victim of sexual abuse.[63] The physician must also notify the official to whom the report is made of the date and time of the scheduled abortion and provide an extraction of the fetal or embryonic tissue to law enforcement for the purpose of "conducting the investigation into the rape of the minor."[64]

Complication Reporting: The Tennessee Department of Health keeps track of data related to complications from induced abortions, including "the number of complications and the types of complications."[65] However, Tennessee's laws do not appear to impose any obligations on healthcare providers to report abortion-related complications to the state.

Fetal Death Reporting: Tennessee law requires medical providers to report each death of a fetus that is either 350 grams or more than twenty weeks' gestational age to the Office of Vital Records within ten days after removal of the dead fetus.[66] If the death occurs within a hospital or other institution, the institution must report the death.[67] If the death occurs outside of an institution, the physician in attendance at or immediately after the delivery must prepare and file the report.[68] Finally, if a fetal death occurs without medical attendance, the medical examiner must investigate the cause and report the death accordingly.[69] The fetal reporting law is not specific to abortions and does not mention abortion.

Other Mandatory Reporting: All other general mandatory reporting to the Department of Children's Services, local law enforcement, etc., also applies for abortion patients.[70] This includes reporting of sexual abuse of young people, child abuse, and vulnerable adult abuse.

Electronic Medical Records: Many electronic

medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[71] While EMRs have settings that allow patients to choose how and when their records are shared, hospital systems often instead use their EMR's default settings that widely share patient records. Though often done for continuity of care purposes, these settings may put abortion providers and patients (or patients obtaining other sensitive care) at risk, and many patients do not know their records are shared in this way.[72]

The federal government has taken steps to address this concern by issuing a new HIPAA rule, effective June 25, 2024.[73] The rule prohibits the use or disclosure of protected health information (PHI) if sought to conduct a criminal, civil, or administrative investigation into or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.[74] A provider who receives a request for disclosure of PHI potentially related to reproductive care must obtain a signed attestation from the requestor that the request is not for a prohibited purpose.[75] The attestation is required when the request is for: law enforcement purposes, disclosures to coroners and medical examiners, judicial and administrative proceedings, and health oversight activities.[76] If the abortion care—self-managed or otherwise—was provided by someone else, a provider is allowed to assume the care was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.[77]

The new rule only applies to healthcare providers who are subject to HIPAA. Separate from HIPAA, interoperability rules may apply when a healthcare provider uses EMRs.[78] Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions with your institution's compliance officers, counsel, and/or technology officers, who may be able to offer customized solutions.[79]

Counseling & Referral

Speech about abortion is legal in Tennessee. Medical professionals in Tennessee can thus (1) provide accurate options counseling, including about abortion; and (2) refer patients to medical providers in states where abortion is legal.

Tennessee law also provides that no physician shall be required to provide or participate in the performance of an abortion, and no hospital shall be required to permit abortions to be performed therein.[80]

In March 2023, the United States Department of Health and Human Services revoked Tennessee's Title X funding because Tennessee Department of Health policy prohibited Title X clinics from counseling patients about pregnancy termination outside of the narrow exceptions in Tennessee's abortion ban.[81] The Tennessee Department of Health took the position that Title X clinics were only permitted to counsel patients about "options that are legal in the State of Tennessee," which eliminated abortion in nearly all circumstances.[82] Despite losing federal funding, the Tennessee Department of Health has not changed its policy regarding abortion referral in Title X clinics.[83]

Assisting Young People: On July 1, 2024, Tennessee's abortion assistance ban for young people under 18 (unemancipated minors) took effect. This law prohibits adults from "intentionally recruit[ing], harbor[ing], or transport[ing] a pregnant unemancipated minor" within the state of Tennessee without the written notarized consent of the minor's parent or guardian if, in engaging in these activities, the adult has at least one of three purposes: (1) concealing an abortion from the minor's parents or guardian; (2) procuring "an act that would constitute" an abortion for the pregnant minor, even if abortion is lawful in the state where the care is to

be provided; and/or (3) obtaining abortion medications for a pregnant minor, even if abortion is lawful in the state where the medications are obtained.[84] The terms "recruit," "harbor," and "transport" are undefined, leading to confusion as to what exactly would constitute an offense under this law. Violation is punishable by imprisonment for eleven months and twenty-nine days.[85] The assistance ban is currently the subject of two lawsuits that assert that the statute is vague and violates First Amendment.[86] The law is currently in effect while litigation proceeds.

Medication Abortion

Tennessee law defines a "chemical abortion" as "the use or prescription of an abortion-inducing drug dispensed with intent to cause the death of the unborn child."[87] Like other laws referenced above, Tennessee's law pertaining to abortion medications was superseded by the Tennessee trigger ban, which bans abortion in most cases. Therefore, it is no longer in effect as long as the trigger ban is in effect.[88]

Disposition of Fetal Tissue Remains

Tennessee law requires abortion facilities—defined as "ambulatory surgical centers, private offices, or other facilities in which abortion is legally provided"—to comply with specific requirements related to the disposition of embryonic and fetal tissue.[89] Specifically, fetal remains from a procedural abortion must be disposed of by cremation in a licensed crematory facility or by interment.[90] The pregnant person may choose to have the tissue disposed of by cremation or interment and may also choose the location for the final disposition.[91] The pregnant person's choice must be provided in writing, and must indicate whether the final disposition of the fetal remains will be at the abortion facility or another location.[92] If the pregnant person does not make a selection, the abortion facility can decide whether to select cremation or interment.[93] The abortion facility is required to pay for and provide for the cremation or interment unless the disposition determination made by the pregnant person "identifies a location for final disposition other than a location provided by the abortion facility."[94] Tennessee's tissue disposition requirements only apply to "a surgical abortion that occurs at an abortion facility."[95]

Need legal advice?

This document should not be construed as legal advice. If you need individualized legal advice, please contact the Abortion Defense Network, where you will be matched with a pro bono attorney.

The Abortion Defense Network is managed by the Lawyering Project in partnership with the American Civil Liberties Union, Center for Reproductive Rights (CRR), If/When/How: Lawyering for Reproductive Justice, National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

ACLU

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References

[1] TENN. CODE ANN. § 39-15-213(a)(1).
[2] *Id.* § 39-15-213(a)(3).
[3] *See, e.g.*, *id.* § 39-15-214(a)(7) (describing the presence of a "fetal heartbeat" as "medically significant because the heartbeat is a discernible sign of life at every stage of human existence"); *id.* § 39-15-214(a)(12) ("By the beginning of the second trimester, physicians view the absence of a fetal heartbeat as an instance of fetal death.").
[4] *See* TENN. CODE ANN. § 37-10-302 (excluding the removal of "a dead fetus" from the definition of abortion under Tennessee's parental consent law).
[5] *Id.* § 39-15-213(e) ("This section does not subject the pregnant woman upon whom an abortion is performed or attempted to criminal conviction or penalty.").
[6] *Id.* § 68-34-102(3).
[7] *Id.* § 68-34-102(2).
[8] *Id.* § 63-6-1102(2)(A); *id.* § 39-15-213(3); *id.* § 39-15-218(a)(2). *See also* Daniel Dale, *Fact Check: Tennessee didn't ban Plan B morning-after pill*, CNN (May 10, 2022).
[9] *Id.* § 39-15-213.
[10] *Id.* § 39-15-213(b).
[11] *Id.* § 39-15-213(c)(1)(A).
[12] *Id.* § 39-15-213(d) (emphasis added).
[13] *Id.* § 39-15-213(b).
[14] *Id.* § 40-35-111(b)(3).
[15] *Id.* § 39-15-216(c)(1) (forbidding performing, inducing, or attempting to perform or induce an abortion if embryonic or fetal cardiac activity can be detected); *id.* § 39-15-216(c)(2) (forbidding performing, inducing, or attempting to perform or induce an abortion "upon a pregnant woman whose unborn child is six (6) weeks gestational age or older").
[16] *Id.* § 39-15-216(c)(3)-(c)(12); *see also id.* § 39-15-212 (prohibiting abortion "after the beginning of the twentieth week of pregnancy, as measured by gestational age").
[17] *Id.* § 39-15-216(d)(2); *see also id.* § 39-15-211(b)(1).
[18] *Id.* § 39-15-217(b)–(d).
[19] *Id.* § 39-15-213(f) ("While this section is in effect, this section supersedes §§ 39-15-211, 39-15-212, 39-15-214, 39-15-215, 39-15-216, 39-15-217, and 39-15-218.").
[20] *Id.* § 39-15-209(b).
[21] *Id.* § 39-15-202(d)(1).
[22] *Id.* § 39-15-202(b).
[23] *Id.* § 9-4-5116.
[24] *Id.* § 56-26-134.
[25] *Id.* § 37-10-303.
[26] TENN. CODE ANN. § 39-15-213(a)(1).
[27] *See, e.g.*, Adam Mintzer, *Bill Narrowly Scaling Back Abortion Ban Passes TN House; Attempts to Add Rape, Incest Exceptions for Minors Fails*, WKRN NEWS 2 (Mar. 21, 2023), https://www.wkrn.com/news/tennessee-politics/bill-narrowly-scaling-back-abortion-ban-passes-tn-house-attempts-to-add-rape-incest-exceptions-for-minors-fails.
[28] TENN. CODE ANN. § 39-15-213(c)(1). Though different health-related exceptions are stated in different parts of the code, the exception that applies to Tennessee's trigger ban should govern provider behavior.
[29] *Id.* § 39-15-213(c)(2).
[30] Complaint of Plaintiff. *Blackmon v. State of Tennessee*, No. 23-1196-1 (Tenn. Ct. Ch. 2023)
[31] TENN. CODE ANN. § 39-15-209(c) (providing that the prohibition does not apply "to a partial-birth abortion that is necessary to save the life of the mother whose life is endangered by a physical disorder, illness or injury").
[32] *Id.* § 39-15-202(d)–(f) (defining "medical emergency" as a condition that, "on the basis of the physician's good faith medical judgment, so complicates a medical condition of a pregnant woman as to necessitate an immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of

major bodily function").
[33] *Id.* § 37-10-305 (providing that a provider is not obligated to obtain consent of the young person's parent or guardian when, in the "best medical judgment of the physician . . . a medical emergency exists that so complicates the pregnancy as to require an immediate abortion").
[34] *Id.* § 39-15-209(c); *see also id.* § 39-15-213(c)(1).
[35] *Id.* §§ 39-15-202(d)-(e), (f); *see also id.* § 39-15-213(c)(1).
[36] TENN. CODE ANN. § 37-10-305; *see also* TENN. CODE ANN. § 39-15-213(c)(1).
[37] EMTALA, 42 USC § 1395dd(c)(1)(A).
[38] EMTALA, 42 USC § 1395dd(b)(1)(A).
[39] EMTALA, 42 USC § 1395dd(e)(1).
[40] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[41] EMTALA, 42 USC § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).
[42] EMTALA, 42 USC § 1395dd(c)(1)(B)-(c)(2)(A).
[43] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[44] CMS, Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (updated July 2022).
[45] *Id.*
[46] *Id.*; *see also* EMTALA, 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.").
[47] CMS, Freeman Health System—Freeman West, Statement of Deficiencies and Plan of Correction (April 10, 2023); CMS, University of Kansas Hospital, Statement of Deficiencies and Plan of Correction (April 10, 2023); HHS Secretary Xavier Becerra Statement on EMTALA Enforcement (May 1, 2023).
[48] *Moyle v. United States*, No. 23-726, slip op. (U.S. June 27, 2024) (per curiam).
[49] Press Release, U.S. Dep't of Health and Human Servs., Biden-Harris Administration Reaffirms Commitment to EMTALA Enforcement (July 2, 2024), https://www.hhs.gov/about/news/2024/07/02/biden-harris-administration-reaffirms-commitment-emtala-enforcement.html.
[50] *Texas v. Becerra*, No. 23-10246, 2024 WL 20069 (5th Cir. Jan. 2, 2024), *petition for cert. filed* (U.S. Apr. 1, 2024) (No. 23-1076).
[51] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[52] Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment, NAT'L WOMEN'S LAW CTR. (Feb. 9, 2023), https://nwlc.org/resource/know-your-rights-existing-laws-may-protect-health-care-professionals-who-provide-or-support-abortion-from-discrimination-in-employment/.
[53] TENN. CODE ANN. § 29-26-101, *et seq.*
[54] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (Sept. 17, 2022), https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_9-17-2022_tcc.pdf.
[55] 42 U.S.C. § 238n.
[56] There is no reason to report a self-managed abortion to the police. Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.
[57] *Id.* § 39-15-203(a).
[58] *Id.* § 39-15-203(a).
[59] *Id.*
[60] TENN. CODE ANN. § 68-3-505(a).
[61] TENN. CODE ANN. § 39-15-203(b)(2).
[62] *Id.* § 39-15-203(e).

[63] *Id.* § 39-15-210(b)(1).
[64] *Id.*
[65] TENN. CODE ANN. § 68-1-140.
[66] *Id.* § 68-3-504(a)(1).
[67] *Id.* § 68-3-504(a)(2).
[68] *Id.* § 68-3-504(a)(3).
[69] *Id.* § 68-3-504(c).
[70] Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.
[71] For example, one EMR, Epic, uses a tool called Care Everywhere to securely share information between health care institutions (e.g., from one hospital system to another) and allows robust sharing within a single institution (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital within the same system).
[72] For example, if a patient travels from a ban state to an access state for abortion care, or obtains an abortion in the ban state under an exception, then later obtains any type of healthcare at a different provider that uses the same EMR, the patient's records may be automatically shared with the second provider. If the second provider believes that the care violated the state's abortion ban, they may report it to authorities.
[73] Although effective on June 25, 2024, compliance with this rule is not required until December 23, 2024, except for the applicable requirements for revising Notice of Policy Practices (as required by 45 CFR 164.520), which must be complied with by February 16, 2026.
[74] 42 U.S.C. § 164.502(a)(5)(iii). *See also HIPAA Privacy Rule Final Rule to Support Reproductive Health Care Privacy: Fact Sheet*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html (content last reviewed April 22, 2024).
[75] 42 U.S.C. § 164.509. The U.S. Department of Health & Human Services (HHS) recently released a model attestation, available here: https://www.hhs.gov/sites/default/files/model-attestation.pdf.
[76] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).
[77] 42 U.S.C. § 164.502(a)(5)(iii).
[78] 21st Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification Program, 85 Fed. Reg. 25642 (May 1, 2020) (amending 45 C.F.R. §§ 170, 171), 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking, 89 Fed. Reg. 54662 (July 1, 2024) (amending 42 C.F.R. §§ 171 414, 425, 495). Not all healthcare providers are currently subject to the disincentives included in the 2024 rule. However, the Centers for Medicare & Medicaid Services (CMS) may apply disincentives to certain hospitals and merit-based incentive payment system (MIPS) eligible clinicians. The U.S. Department of Health and Human Services intends to expand disincentives to other groups of health care providers in future rulemaking.
[79] In the past year, states and the federal government have taken steps to address these vulnerabilities, specifically for abortion and gender-affirming care. Maryland and California have passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. As these laws are implemented, the landscape for how electronic abortion records are handled may change.
[80] TENN. CODE. ANN. § 39-15-204.
[81] *See* Jeff Keeling, *Tennessee to Backfill Title X Family Planning Funding that Feds Pulled Over Abortion*, WJHL (Apr. 12, 2023), https://www.wjhl.com/news/local/tennessee-to-backfill-title-x-family-planning-funding-that-feds-pulled-over-abortion.
[82] *Id.*
[83] *Id.*
[84] S.B. 1971(1)(a) (Tn. 2023).
[85] *Id.* § 1(b).
[86] *See* Compl. *SisterReach, Inc. v. Skrmetti*, No. 2:24-cv-02446-SHL-tmp (W.D. Tenn. June 27, 2024); Compl., *Whelty v. Dunaway*, No. 3:24-cv-00768 (M.D. Tenn. June 25, 2024).
[87] TENN. CODE. ANN. § 39-15-218(a)(2).
[88] *See id.* § 39-15-213(f).

[89] *Id.* § 39-15-219(a). Because the trigger ban requires that abortions that meet the medical emergency definition are performed in a hospital or ambulatory surgical treatment center, the other locations are likely not relevant to abortion care provided in Tennessee.
[90] *Id.* § 39-15-219(b).
[91] *Id.* § 39-15-219(c)(1).
[92] *Id.* § 39-15-219(d)(1).
[93] *Id.* § 39-15-219(d)(2).
[94] *Id.* § 39-15-219(h).
[95] *Id.* § 39-15-219(b)(1). Although Tennessee law is not explicit, the fetal disposition requirement does not appear to apply to a medication abortion where the patient passes pregnancy tissue outside the medical facility. *See, e.g.*, *id.* § 39-15-219(c)(2) (referring only to a "surgical abortion"); *id.* § 39-15-203(a) (providing that, for the purpose of the abortion reporting form, a provider is not required to report the disposition of the fetal tissue if the abortion is a medication abortion and the "expulsion of the aborted fetus or aborted fetal tissue does not take place at the facility or clinic where the procedure took place"). Additionally, because the law refers to fetal remains from an "aborted fetus or fetal tissue that results from an abortion of an unborn child," the law does not seem to apply to fetal tissue from a miscarriage. *Id.* § 39-15-219(a)(4). As a result, if a provider provides treatment to a patient following a self-managed abortion, they are not required to comply with the requirements related to fetal and embryonic tissue disposition.