Ethical Conflicts for Clinicians under Tennessee Abortion Law

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On August 25, 2022, Tennessee implemented one of the most restrictive abortion laws in the United States[1]; it had been enacted in 2019, to be triggered if *Roe v. Wade* was overturned. Under this law, abortion, defined as "the use of any instrument, medicine, drug, or any other substance or device with the 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, or to remove a dead fetus," is a criminal act, without exception.[2]

A clinician charged with performing an abortion faces 3 to 10 years in prison and a fine of up to $10,000. Physicians charged under this law can avoid conviction only if they successfully mount an "affirmative defense," which requires proving by a preponderance of the evidence that "the physician determined, in the physician's good faith medical judgment . . . 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." No abortion may be performed for any other reason. Furthermore, any abortion must be performed in a way that "provides the best opportunity for the unborn child to survive, unless in the physician's good faith medical judgment, termination of the pregnancy in that manner would pose a greater risk of the death of the pregnant woman or substantial and irreversible impairment of a major bodily function."

Various media outlets have covered the grave harms to pregnant patients resulting from this law. But this law also conflicts with ethical commitments that any medical professional participating in the care of pregnant patients should be able to endorse.[3]

First, the assessment of benefits, risks, and burdens for a pregnant patient must always incorporate considerations of how pregnancy might create new conditions to be managed or affect management of preexisting medical conditions.

Second, fetal benefit and harm are ethically significant, not least because the pregnant patient may attribute considerable weight to fetal benefit or harm in deliberation.

Third, in cases in which maternal medical benefit and fetal benefit directly conflict, maternal medical benefit takes priority by default; being pregnant does not mean that the patient's own life and health become subordinate to those of the fetus.

Fourth, only pregnant patients can freely and capably choose to prioritize fetal benefit over their own medical benefit. Pregnant patients may accept risk to their own life and health for the sake of the fetus, but it is their choice that makes it permissible for clinicians to expose them to additional risk.

And fifth, the pregnant patient's perspective is always of ethical importance. Even when medical professionals cannot fulfill a patient's request, they nonetheless have an obligation to be responsive to the patient's goals when establishing medically appropriate options.

Tennessee's law has created serious conflicts with these basic commitments. Consider the following case: a 21-year-old White woman with a history of lupus nephritis presents for her first obstetrical visit at 9 weeks' gestation. She informs the physician that hers is an unintended and undesired pregnancy, but because of limited resources and support, she cannot travel to access abortion care. After referral to a perinatologist who discusses her risk of worsening disease, the patient requests termination of pregnancy.

Though pregnancy in someone with lupus nephritis poses substantial risks of harm to the patient's health, does it rise to the level of "serious risk of substantial and irreversible impairment of a major bodily function"?[4] Physicians must determine whether offering clearly medically indicated care to a pregnant patient is worth a potential criminal conviction. Deprioritizing maternal medical benefit effectively spares the physician from such risk. The law also prevents pregnant patients who cannot travel from

deciding whether to take the risk of continued pregnancy, shifting that choice to the physician alone.

Under the new law, physicians must also worry about being perceived as having offered pregnancy termination in "bad faith." Even if the medical reasons for termination of pregnancy are compelling, a patient's independent desire to terminate pregnancy might lead prosecutors and juries to question whether the physician's clinical judgment was actually a good-faith medical judgment. A pending amendment that would excuse clinicians who exercised "reasonable medical judgment" would make little difference: physicians would remain at risk for considering the patient's views.

Consider another case: A 34-year-old pregnant Black woman at 29 weeks' gestation learns that her fetus is affected by limb–body wall complex, an unsurvivable anomaly. She would like to avoid intrauterine fetal demise, having experienced it in a previous pregnancy. She requests delivery, given worsening findings on Doppler studies of the umbilical artery. She desires a vaginal delivery and declines cesarean section because of the increased risk to her health, even if it would ensure a live birth.

Since abortions because of fetal anomalies are not permitted in Tennessee, a decision to proceed with pregnancy termination in this circumstance has no legal protection. The law thus subjects patients to continued pregnancy even when it only confers risks and burdens on them — considerations that the law does not treat as relevant to medical judgment in the absence of risk of irreparable harm.

At the time of delivery, questions remain about which method of delivery provides the best opportunity for fetal survival. Must this woman's medical team pursue all measures to attempt and achieve a live birth, at the expense of maternal well-being, to avoid committing the crime of abortion even in the face of an unsurvivable fetal diagnosis? Can her request for induction of vaginal delivery be honored? Must the medical team recommend fetal monitoring during labor, and if there is evidence of fetal distress, must they recommend a cesarean delivery? The unfortunate reality that these interventions would confer only risk and no benefit for the pregnant patient seems even more tragic in light of the long history of higher rates of cesarean delivery, at times performed over patients' objections, and higher maternal morbidity and mortality among Black and Latinx women.[5]

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These cases illustrate the ways in which the Tennessee abortion ban places physicians in situations in which they can meet their core ethical commitments to their patients only by actively disregarding the law. Since people with more resources can travel out of Tennessee, the law will also widen disparities in access and outcomes between pregnant patients of different racial and ethnic backgrounds and socioeconomic statuses, as well as the already disparate outcomes in maternal mortality and morbidity among pregnant patients from marginalized groups. The law thus requires professionals to act in ways that directly exacerbate existing social injustices, despite their professional commitment to addressing them.

Tennessee legislators have passed a bill that removes treatment of ectopic or molar pregnancy from the definition of "abortion," replaces the language of "good faith" with "reasonable medical judgment," and converts the affirmative-defense provision into an exception. Performance of abortion "necessary to prevent death or serious risk of substantial and irreversible impairment of a major bodily function" would no longer be a crime. Unfortunately, these changes will not resolve the conflicts we have outlined between the law and professional ethical commitments.

Editor's note: The bill described at the end of the article was signed into law on April 28, 2023.

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