

Amendment No. 2 to HB2263

Helton
Signature of Sponsor

AMEND Senate Bill No. 2196

House Bill No. 2263*

by deleting all language after the caption and substituting instead the following:

WHEREAS, depending on the gestational age of the pregnancy, it is standard medical practice to perform an ultrasound during the evaluation of a patient in consideration of an abortion. Determining accurate information regarding gestational development is important for purposes of informed consent, as well as making essential preparation for the procedure itself; in this state, ultrasounds are regularly provided to women seeking an abortion to determine if they are eligible for a medication abortion, and to review other factors related that cannot be determined prior to an examination of the patient; and

WHEREAS, in the forty-seven years since the United States Supreme Court's ruling in *Roe v. Wade*, 410 U.S. 113 (1973), there have been substantial advances in scientific methods and medical technology that have significantly expanded knowledge and understanding of prenatal life and development, and the effects of abortion on the physical and psychological health of women; and

WHEREAS, conception is the union of a sperm and egg to form a zygote, and at conception, a new and genetically distinct human being is formed; and

WHEREAS, the presence of a fetal heartbeat is medically significant because the heartbeat is a discernible sign of life at every stage of human existence. An unborn child's heart begins to beat at five weeks gestational age, and blood begins to flow during the sixth week. Depending on what type of equipment is utilized, an unborn child's heartbeat can be detected as early as six to eight weeks gestational age. An unborn child's heartbeat can consistently be made audible using a handheld Doppler fetal heart rate device by twelve weeks gestational age.

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A pregnancy can be confirmed through the detection of the unborn child's heartbeat. By the beginning of the second trimester, physicians view the absence of a fetal heartbeat as an instance of fetal death. It is standard medical practice to monitor an unborn child's heartbeat throughout pregnancy and labor to measure the heart rate and rhythm of the unborn child, which averages between one hundred ten and one hundred sixty beats per minute. This monitoring is used as an indicator of the health of the unborn child; and

WHEREAS, since the Supreme Court's decision in *Roe v. Wade*, medical professionals have expanded their understanding of life in utero to include, among other indicia, the presence of a heartbeat, brain development, a viable pregnancy or viable intrauterine pregnancy during the first trimester of pregnancy, and the ability to experience pain. The detectability of a fetal heartbeat is a key predictor of survivability to term, especially if the heartbeat is present at eight weeks gestational age or later. When a fetal heartbeat is detected between eight and twelve weeks gestational age, the rate of miscarriage is extremely low, with approximately ninety-eight percent of naturally conceived pregnancies carrying to term; and

WHEREAS, at eight weeks gestational age, an unborn child begins to show spontaneous movements, and reflexive responses to touch. The majority of an unborn child's body is responsive to touch by fourteen weeks gestational age. Peripheral cutaneous sensory receptors, which are the receptors that feel pain, develop in an unborn child at around seven to eight weeks gestational age. Sensory receptors develop in the palmar regions during the tenth week of gestational age, growing throughout the unborn child's body by sixteen weeks gestational age. An unborn child's nervous system is established by six weeks gestational age. At this stage, the basic patterning of the early nervous system is in place and is the basis for

tremendous growth and increased complexity built upon this basic pattern. The earliest neurons of the cortical brain, responsible for thinking, memory, and higher level functions, are established by the fourth week. Synapses are formed in the seventh week, and the neural connections for the most primitive responses to pain are in place by ten weeks gestation; and

WHEREAS, Substance P, a peptide functioning as a neurotransmitter in the transmission of pain, is present in the spinal cord of an unborn child at eight weeks gestational age, while enkephalin peptides, which serve as neurotransmitters in pain modulation, are present at twelve to fourteen weeks gestational age. There is significant evidence, based on peer-reviewed scientific studies, that unborn children are capable of experiencing pain by no later than twenty weeks gestational age. Pain receptor nerves are already present throughout the human body by twenty weeks gestation, and the cortex, which begins development at eight weeks, has a full complement of neurons at twenty weeks. There is evidence that an unborn child is capable of feeling pain as early as twelve to fifteen weeks gestational age. The scientific evidence shows that significant cortical neuronal connections are in place by ten to twelve weeks gestation, and that connections between the spinal cord and thalamus are nearly complete by twenty weeks gestation. A growing body of medical evidence and literature supports the conclusion that an unborn child may feel pain from around eleven to twelve weeks gestational age, or even as early as five and one-half weeks. At only eight weeks gestation, an unborn child exhibits reflexive movement during invasive procedures resulting from spinal reflex neuro pathways, showing that the unborn child reacts to noxious stimuli with avoidance reactions and stress responses. By sixteen weeks gestational age, pain transmission from a peripheral receptor to the cortex is possible. Significant evidence also shows hormonal stress responses by unborn children as early as eighteen weeks; and

WHEREAS, mothers considering abortion express concern over the medical information on fetal neurological development and an unborn child's ability to feel pain while in utero, and

providing this information to mothers who are considering abortion is an important part of empowering mothers to make a fully informed choice on whether or not to seek an abortion; and

WHEREAS, medical evidence shows that younger infants are hypersensitive to pain. Neuronal mechanisms that inhibit or moderate pain sensations do not begin to develop until thirty-four to thirty-six weeks gestation and are not complete until a significant time after birth. Newborn and preterm infants are hyperresponsive to pain compared to adults or older infants. The recognition of fetal pain has led to improvements and changes in how physicians approach fetal surgery and fetal anesthesia. The presence of neural connections and the ability to feel pain as early as the fifteenth week now necessitate treating the unborn child as a separate patient from the mother for purposes of utilizing direct analgesia to fetal patients, who clearly elicit stress responses to pain. Fetal surgeons at specialized units in St. Louis, Nashville, Cincinnati, Kansas City, Boston, and elsewhere, in response to their recognition of fetal pain, routinely use anesthesia and analgesia for unborn and premature infants undergoing surgery as young as eighteen weeks gestation; and

WHEREAS, the leading textbook on clinical anesthesia recognizes the significant body of evidence indicating the importance of mitigating fetal stress responses to pain stimuli. It is presumed that an unborn child's ability to fully experience pain occurs between twenty and thirty weeks, and that the fetal experience of pain may be even greater than that of term neonate or young children due to the immaturity of neurodevelopment that helps inhibit pain; and

WHEREAS, the infliction of unnecessary pain upon a living being is generally prohibited by state and federal law. The legislature has prohibited the unnecessary infliction of pain on living beings in a variety of circumstances in an effort to protect the innocent from harm. The life of an unborn child is recognized and protected from violence by federal law and by the laws of most states. The killing of an unborn child is considered homicide in thirty-eight states, with at least twenty-eight of those states criminalizing the act from conception. Nearly every state and the District of Columbia have wrongful death statutes that allow for liability and recovery for the

death of an unborn child or subsequent death of an infant who is born and later dies because of injuries caused while in utero; and

WHEREAS, since the Supreme Court's decisions in *Roe v. Wade* and *Planned Parenthood v. Casey*, advances in science, technology, and treatment methods have resulted in children surviving and thriving at younger preterm ages than ever before. In recent years, scientific advances and advances in neonatal care have lowered the gestational limits of survivability well into the second trimester; and

WHEREAS, the age at which a preterm infant can survive has decreased from twenty-eight weeks to less than twenty-two weeks. Survival of preterm infants has increased significantly over time assuming physicians provide active care for the young infants, lowering the age of survival from twenty-eight weeks to twenty-four weeks. Moreover, infants born as early as twenty-two weeks can survive with the provision of care and treatment. The youngest preterm infant to survive was born at only twenty-one weeks and four days. In 1978, the first infants weighing less than seven hundred fifty grams were successfully ventilated. By the 1990s, survival of infants born weighing between five hundred and seven hundred grams, roughly between twenty-four to twenty-six weeks, became possible. Technological developments in the 1980s and 1990s, such as improved tracheal instillation of surfactant for respiratory distress syndrome and antenatal corticosteroids, resulted in survival of infants born between twenty-three to twenty-four weeks. In recent years, resuscitation and survival of infants born weighing less than four hundred grams, or approximately twenty-two to twenty-three weeks gestational age, has further decreased the age of viability. The provision of active prenatal and postnatal care has significantly increased the number of prematurely born children who survive until hospital discharge; and

WHEREAS, abortions performed at any gestational age pose a risk to the mother. Abortion increases the risks of subsequent preterm birth and placenta previa, life-threatening hemorrhage, postpartum hemorrhage, and cesarean delivery. Abortions performed later in

pregnancy pose an even higher medical risk to the health and life of women, with the relative risk increasing exponentially at later gestational ages after eight weeks gestational age. The relative risk of death for pregnant women who had an abortion performed or induced upon her at eleven to twelve weeks gestational age is between three and four times higher than an abortion at eight weeks gestational age or earlier; and

WHEREAS, the relative risk of death for pregnant women who had an abortion performed or induced upon her at thirteen to fifteen weeks gestational age is almost fifteen times higher than an abortion at eight weeks gestational age or earlier. The relative risk of death for pregnant women who had an abortion performed or induced upon her at sixteen to twenty weeks gestational age is almost thirty times higher than an abortion at eight weeks gestational age or earlier. The relative risk of death for pregnant women who had an abortion performed or induced upon her at twenty-one weeks gestational age or later is more than seventy-five times higher than an abortion at eight weeks gestational age or earlier; and

WHEREAS, women who have an abortion suffer from post-traumatic stress disorder at a rate slightly higher than veterans of the Vietnam War. Women who have an abortion have an eighty-one percent increased risk of mental trauma after an abortion. Abortion has been shown to correlate with many other mental health disorders as well; and

WHEREAS, the historical development of abortion is undeniably tied to bias and discrimination by some organizations, leaders, and policies toward impoverished and minority communities, including the imposition of forced sterilization of the intellectually disabled, poor, minority, and immigrant women. These historic policies should be rejected and left on the ash heap of history; and

WHEREAS, Planned Parenthood founder Margaret Sanger argued in the early twentieth century that birth control would open the way to the eugenicist. Sanger argued that birth control could be used to reduce the "ever increasing, unceasingly spawning class of human beings who never should have been born at all." This argument was later adopted by abortion advocates,

such as Planned Parenthood President Alan Guttmacher, who endorsed abortion for eugenic purposes. Guttmacher argued in the 1950s that abortion should be used to prevent the birth of disabled children. Legal scholar Glanville Williams, whose book was cited in the majority opinion in *Roe v. Wade*, argued in a book published in the 1950s that a "eugenic killing by a mother . . . cannot confidently be pronounced immoral." Some continue to support the goal of reducing undesirable populations through selective reproduction. Today, the individualized nature of abortion creates a significant risk that prenatal screening tests and new technologies will be used to eliminate children with unwanted characteristics. Recent evidence also suggests that sex-selective abortions of girls are common among certain populations in the United States; and

WHEREAS, sex-selective abortion results in an unnatural sex ratio imbalance that can impede members of the numerically predominant sex from finding partners, encourage the commoditization of humans in the form of human trafficking, and create other societal harms. Sex-selective abortion also reinforces discriminatory and sexist stereotypes toward women by devaluing and dehumanizing females; and

WHEREAS, in this State, from 2008 through 2017, the rate of abortion per one thousand women was nearly four times higher for nonwhite women than white women, with a rate of 7.6 on average for all women, 4.6 for white women, and 16.0 for nonwhite women. The ratio of abortions to one thousand live births in this State from 2008 to 2017 was nearly three times higher for nonwhite women than white women, with an average of 138.2 for all women, 85.1 for white women, and 294.4 for nonwhite women; and

WHEREAS, the use of abortion as a means to prefer one sex over another or to discriminate based on disability or race is antithetical to the core values of equality, freedom, and human dignity enshrined in both the United States and Tennessee constitutions. The elimination of bias and discrimination against pregnant women, their partners, and their family members, including unborn children, is a fundamental obligation of government in order to

guarantee those who are, according to the Declaration of Independence, "endowed by their Creator with certain unalienable Rights" can enjoy "Life, Liberty, and the pursuit of Happiness"; and

WHEREAS, this State has historically protected its interest in preserving the integrity of the medical profession by enacting a comprehensive statutory framework for ensuring the integrity of the medical profession in title 63. The General Assembly first adopted an act creating the Board of Medical Examiners in 1901, with the mission to protect the health, safety, and welfare of the people of this State and to ensure the highest degree of professional conduct; and

WHEREAS, physician involvement in medical practices that cause fetal pain has been rejected by the international community. Physician involvement in medical practices that facilitate discrimination is antithetical to the United States and Tennessee constitutions' affirmation of equal protection under the law. The integrity and public respect of the medical profession are significantly harmed by physician involvement in practices that facilitate discrimination, or otherwise create a disdain for life; and

WHEREAS, this State has a legitimate, substantial, and compelling interest in:

- (1) Valuing and protecting unborn children;
- (2) Protecting the physical and mental health of the mother;
- (3) Promoting human dignity;
- (4) Encouraging childbirth over abortion;
- (5) Safeguarding an unborn child from the serious harm of pain by an abortion method that would cause the unborn child to experience pain;
- (6) Resolving untenable inconsistencies and incongruities in state law which permits some unborn children to be killed by abortion, while requiring that unborn children be protected and valued in non-abortion circumstances, including, but not limited to, criminal provisions related to the infliction of harms against persons, state

programs intended to aid prenatal health care, and state-sponsored health care for unborn children;

(7) Protecting the integrity and ethics of the medical profession, including by prohibiting medical practices that might cause the medical profession to become insensitive, even disdainful, to life, including the life of the unborn child; and

(8) Preventing discrimination; and

WHEREAS, the unique nature of abortion and its potential physical and mental health risks, as well as the ultimate result of the death of an unborn child, necessitates that this State ensure every woman considering an abortion is provided with adequate comprehensive information before deciding to obtain an abortion. The mandatory provision of an ultrasound prior to the abortion substantially furthers this compelling State interest; and

WHEREAS, the presence of a fetal heartbeat is a medically significant indicator of life and the potential successful development of an unborn child. This State's legitimate, substantial, and compelling interest in protecting unborn children warrants the restriction of abortion in cases where the heartbeat is detectable; and

WHEREAS, the unnecessary infliction of pain upon the life of an unborn child is inconsistent with Tennessee law that would otherwise protect the life and health of an unborn child, undermines the integrity of and public trust in the medical profession, and conflicts with this State's legitimate, substantial, and compelling interest in protecting the life of an unborn child, protecting the integrity of the medical profession, resolving the conflict in state laws intended to protect the health of the unborn child, and protecting the life, physical health, and mental health of women. Therefore, it is necessary to enact protections against the infliction of pain, and death, upon an unborn child who is capable of experiencing pain; and

WHEREAS, advances in science and medical practice have decreased the gestational age of an unborn child's viability to survive. This State's legitimate, substantial, and compelling interest in protecting the life of an unborn child, protecting the integrity of the medical profession,

resolving the conflict in state laws intended to protect the health of the unborn child, and protecting the life, physical health, and mental health of women require the enactment of a series of gestational age restrictions on the provision of an abortion; and

WHEREAS, the historical use of abortion as a means to discriminatory ends is fundamentally objectionable and conflicts with this State's legitimate, substantial, and compelling interest in preventing discrimination and discriminatory practices. Therefore, it is necessary for this State to enact protections that prevent sex, racial, and disability discrimination against unborn children; and

WHEREAS, life begins at conception, and nothing in this act shall be interpreted or construed to suggest that it is the intent or purpose of the legislature to condone abortion of an unborn child at any time after conception. The legislature specifically acknowledges the provisions of § 39-18-105(a) that will prohibit all abortion effective on the thirtieth day after issuance of a judgment overruling, in whole or in part, *Roe v. Wade*, as modified by *Planned Parenthood v. Casey*, or adoption of an amendment to the United States Constitution, restoring state authority to prohibit abortion; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The headings to sections, chapters, and parts in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act and to label the new chapter added pursuant to Section 2 of this act as "**Offenses Against the Unborn**".

SECTION 2. Tennessee Code Annotated, Title 39, is amended by adding the following new chapter:

39-18-101. Definitions.

As used in this chapter:

(1) "Abortion" means 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, or to remove a dead fetus;

(2) "Auscultate" means to examine by listening for sounds made by internal organs of the fetus, including a fetal heartbeat, in accordance with standard medical practice utilizing current medical technology and methodology;

(3) "Down syndrome" means a chromosome disorder associated either with an extra chromosome twenty-one or an effective trisomy for chromosome twenty-one;

(4) "Fertilization" means that point in time when a male human sperm penetrates the zona pellucida of a female human ovum;

(5) "Fetal heartbeat" means cardiac activity or the steady and repetitive rhythmic contraction of the heart of an unborn child;

(6) "Gestational age" or "gestation" means the age of an unborn child as calculated from the first day of the last menstrual period of a pregnant woman;

(7) "Medical emergency" means a condition that, in the physician's good faith medical judgment, based upon the facts known to the physician at the time, so complicates the woman's pregnancy as to necessitate the immediate performance or inducement of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman that delay in the performance or inducement of the abortion would create; however, "medical emergency" does not include a claim or diagnosis related to the woman's mental health or a claim or diagnosis that the woman will engage in conduct which would result in her death or substantial and irreversible impairment of a major bodily function;

(8) "Obstetric ultrasound" or "ultrasound" means the use of ultrasonic waves for diagnostic or therapeutic purposes, specifically to monitor a developing fetus;

(9) "Pregnant" means 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;

(10) "Ultrasound technician" means a person at least eighteen (18) years of age who at the time of the commission of the acts constituting the offense:

(A) Has earned a technical certificate from a sonography program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or Canadian Medical Association (CMA);

(B) Is currently certified by the American Registry for Diagnostic Medical Sonography (ARDMS) in the specialty in which the person is currently practicing;

(C) Is currently certified by the American Registry of Radiologic Technologists (ARRT) in sonography;

(D) Is in the process of applying for registration with the ARDMS, provided that the applicant satisfies the requirements for registration within ninety (90) days of becoming employed as a sonographer; or

(E) Is in the process of applying for registration with the ARRT, provided that the applicant satisfies the requirements for registration within ninety (90) days of becoming employed as a sonographer;

(11) "Unborn child" means an individual living member of the species, homo sapiens, throughout the entire embryonic and fetal stages of the unborn child from fertilization to full gestation and childbirth; and

(12) "Viable" and "viability" mean that stage of fetal development when the unborn child is capable of sustained survival outside of the womb, with or without medical assistance.

39-18-102. Severability.

If any provision or provisions of this chapter or chapter 15, part 2, or the application of the provision to any person, or circumstance, is found to be unenforceable, unconstitutional, or invalid by a court of competent jurisdiction, then the provision or application is declared to be severable and the remainder of the provision or application remains in effect.

39-18-103. Savings clause.

This chapter is not an express or implied repeal of any provision in chapter 15, part 2.

39-18-104. Prosecution of offenses.

A person shall not be prosecuted for a violation of more than one (1) subsection of § 39-18-105 based upon the same set of facts.

39-18-105. Offense committed against the unborn.

(a)

(1) A person who performs or attempts to perform an abortion commits the offense of criminal abortion.

(2) It is an affirmative defense to prosecution under subsection (a), which must be proven by a preponderance of the evidence, that:

(A) The abortion was performed or attempted by a licensed physician;

(B) The physician determined, in the physician's good faith 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. No abortion is authorized under this subdivision (a)(2) if performed on the

basis of a claim or a diagnosis that the woman will engage in conduct that will result in her death or substantial and irreversible impairment of a major bodily function or for any reason relating to her mental health; and

(C) The physician performs or attempts to perform the abortion in the manner which, in the physician's good faith medical judgment, based upon the facts known to the physician at the time, 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. No such greater risk exists if it is based on a claim or diagnosis that the woman will engage in conduct that will result in her death or substantial and irreversible impairment of a major bodily function or for any reason relating to her mental health.

(3) Medical treatment provided to the pregnant woman by a licensed physician which results in the accidental death of or unintentional injury to or death of the unborn child does not constitute a violation of subdivision (a)(1).

(b) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child has a fetal heartbeat.

(c)

(1) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is six (6) weeks gestational age or older unless, prior to performing or inducing the abortion, or attempting to perform or induce the abortion, the physician affirmatively determines and records in the pregnant woman's medical record that, in the

physician's good faith medical judgment, the unborn child does not have a fetal heartbeat at the time of the abortion.

(2) For purposes of subdivision (c)(1), "good faith medical judgment" means judgment utilizing generally accepted standards of medical practice and using current medical technology and methodology applicable to the gestational age of the unborn child and reasonably calculated to determine the existence or non-existence of a fetal heartbeat as determined at the time of the commission of the act.

(d) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is eight (8) weeks gestational age or older.

(e) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is ten (10) weeks gestational age or older.

(f) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is twelve (12) weeks gestational age or older.

(g) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is fifteen (15) weeks gestational age or older.

(h) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is eighteen (18) weeks gestational age or order.

(i) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is twenty (20) weeks gestational age or older.

(j) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is twenty-one (21) weeks gestational age or older.

(k) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is twenty-two (22) weeks gestational age or older.

(l) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is twenty-three (23) weeks gestational age or older.

(m) A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman whose unborn child is twenty-four (24) weeks gestational age or older.

39-18-106. Ultrasound requirements.

(a)

(1) Prior to a pregnant woman giving informed consent to have an abortion, as required by § 39-15-202, the physician who is performing or inducing, or attempting to perform or induce, an otherwise lawful abortion, shall:

(A) Determine the gestational age of the unborn child in accordance with generally accepted standards of medical practice;

(B) Inform the pregnant woman the gestational age of the unborn child;

(C) Perform an obstetric ultrasound applicable to the gestational age of the unborn child, using medical technology and methodology current at the time the ultrasound is performed, and reasonably calculated to determine whether a fetal heartbeat exists;

(D) Auscultate the fetal heartbeat of the unborn child, if any, so that the pregnant woman may hear the heartbeat if the heartbeat is audible;

(E) Provide a simultaneous explanation of what the ultrasound is depicting, which must include the presence and location of the unborn child within the uterus, the dimensions of the unborn child, the presence of external members and internal organs if present and viewable, the number of unborn children depicted, and, if the ultrasound image indicates that fetal demise has occurred, inform the woman of that fact;

(F) Display the ultrasound images so that the pregnant woman may view the images;

(G) Record in the pregnant woman's medical record the presence or absence of a fetal heartbeat, the method used to test for the fetal heartbeat, the date and time of the test, and the estimated gestational age of the unborn child; and

(H) Obtain from the pregnant woman prior to performing or inducing, or attempting to perform or induce, an abortion, a signed certification that the pregnant woman was presented with the information required to be provided under this subsection (a), that the pregnant woman viewed the ultrasound images or declined to do so as allowed pursuant to subsection (c), and whether the pregnant woman listened to the heartbeat if the heartbeat was audible or declined to do so as allowed pursuant to subsection (c). The signed certification must be in addition to any other documentation requirements under this chapter and must be on a form prescribed by the commissioner of health that is retained in the woman's medical record.

(2) The requirements of this subsection (a) shall be separate and do not substitute for any of the requirements set out in § 39-15-202.

(b)

(1) A physician may delegate the responsibility to perform the obstetric ultrasound to an ultrasound technician pursuant to subdivision (a)(1)(C) who is qualified and permitted by law to perform an obstetric ultrasound that complies with the requirements of subdivision (a)(1)(C). An ultrasound technician performing an obstetric ultrasound under this subdivision (b)(1) must perform the obstetric ultrasound in a manner that complies with subsection (a), and the physician may rely on the signed certification obtained by the qualified technician under subdivision (a)(1)(C) to establish that an ultrasound was performed in compliance with this section, unless the physician knows, or in the exercise of reasonable care should know, that an ultrasound was not performed in accordance with this section.

(2) A physician who is to perform or induce, or attempt to perform or induce, an abortion may accept a certification from a referring physician that the referring physician has performed an obstetric ultrasound that complies with the requirements of subsection (a). The referring physician performing an obstetric ultrasound under this subdivision (b)(2) must perform the obstetric ultrasound in a manner that complies with subsection (a), and the physician may rely on the signed certification obtained by the referring physician under subdivision (a)(1)(H) to establish that an ultrasound was performed in compliance with this section, unless the physician knows, or in the exercise of reasonable care should know, that an ultrasound was not performed in accordance with this section.

(c) It is not a violation of this section for a physician or ultrasound technician to allow a pregnant woman to avert her eyes from the ultrasound images or request the

volume of the heartbeat be made inaudible. It is not a violation of this section if the pregnant woman refuses to look at the displayed ultrasound images or to listen to the heartbeat if the heartbeat is audible.

39-18-107. Eugenics.

A person shall not perform or induce, or attempt to perform or induce, an abortion upon a pregnant woman if the person knows that the woman is seeking the abortion because of the unborn child's sex, race, or prenatal diagnosis, test, or screening indicating a genetic abnormality or potential genetic abnormality that does not threaten the life of the mother.

39-18-108. Exception to offenses in this chapter.

(a) Subject to compliance with subsection (b), it is an exception to § 39-18-105 and § 39-18-106 that, in the physician's reasonable medical judgment, a medical emergency prevented compliance with the section.

(b) In order for the exception in subdivision (e)(1) to apply, a physician must comply with the following conditions at the time of commission of the act, unless the medical emergency prevents compliance with any of the conditions set out in subdivisions (b)(1) – (5):

(1) The physician certifies in writing that, in the physician's good faith, reasonable medical judgment, based upon the facts known to the physician at the time of commission of the offense, compliance with the charged offense was prevented by a medical emergency;

(2) The physician certifies in writing the available methods or techniques considered and the reasons for choosing the method or technique employed;

(3) If the unborn child is presumed to be viable under § 39-15-211 or determined to be viable under § 39-15-212, the physician performs or induces, or

attempts to perform or induce, the abortion in a hospital. For purposes of this subdivision (b)(3), a "hospital" means a facility:

(A) With neonatal services for premature infants at the time an abortion is performed or induced, unless there is no facility within thirty (30) miles with neonatal services of where the abortion is performed or induced; and

(B) Where the physician has admitting privileges;

(4) If the unborn child is presumed viable under § 39-15-211 or determined to be viable under § 39-15-212, the physician terminates or attempts to terminate the pregnancy in the manner that provides the best opportunity for the unborn child to survive, unless that physician determines, in the physician's good faith medical judgment, based upon the facts known to the physician at the time, that the termination of the pregnancy in that manner poses a significantly greater risk of the death of the pregnant woman or a significantly greater risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman than would other available methods of abortion; and

(5) If the unborn child is presumed viable under § 39-15-211 or determined to be viable under § 39-15-212, the physician who performs or induces, or attempts to perform or induce, the abortion has arranged for the attendance in the same room in which the abortion is to be performed or induced, or attempted to be performed or induced, at least one (1) other physician who is to take control of, provide immediate medical care for, and take all reasonable steps necessary to preserve the life and health of the unborn child immediately upon the child's complete expulsion or extraction from the pregnant woman.

39-18-109. Penalties.

(a) Except as otherwise provided in this section, a violation of any provision of this chapter by a person is a Class C felony.

(b) A violation of § 39-18-106 by an ultrasound technician or referring physician whose performance of an ultrasound is relied upon by a physician in performing or inducing, or attempting to perform or induce, an abortion is a Class E felony.

(c) A pregnant woman upon whom an abortion is performed or induced, or attempted to be performed or induced, in violation of any provision of this chapter is not guilty of violating, or of attempting to commit or conspiring to commit a violation of, any provision of this chapter.

(d) When a physician is criminally charged with a violation of this chapter, the physician shall report the charge to the board of medical examiners in writing within seven (7) calendar days of acquiring knowledge of the charge. The report must include the jurisdiction in which the charge is pending, if known, and must also be accompanied by a copy of the charging documents, if available. A district attorney general shall promptly notify the board of medical examiners when a physician is charged with a violation of this chapter. It is not a violation of this chapter for a district attorney general to fail to notify the board of medical examiners pursuant to this subsection (d).

SECTION 3. Tennessee Code Annotated, Section 39-15-213, is amended by deleting the section in its entirety.

SECTION 4. Tennessee Code Annotated, Section 37-10-304(c)(2), is amended by deleting the subdivision.

SECTION 5.

(a) Section 39-18-105(a) of this act shall take effect on the thirtieth day following the occurrence of either of the following circumstances, the public welfare requiring it:

(1) The issuance of the judgment in any decision of the United States Supreme Court overruling, in whole or in part, *Roe v. Wade*, 410 U.S. 113

(1973), as modified by *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), thereby restoring to the states their authority to prohibit abortion; or

(2) Adoption of an amendment to the United States Constitution that, in whole or in part, restores to the states their authority to prohibit abortion.

(b)

(1) The attorney general and reporter shall notify in writing the Tennessee Code Commission of the occurrence of either of the circumstances in (a)(1) or (a)(2) and what date is the thirtieth day following such occurrence.

(2) The attorney general and reporter shall notify in writing the Tennessee Code Commission if any prohibition in § 39-18-105 (b) – (m) are enjoined by a court.

(c) All other provisions of this act not listed in subsection (a) shall take effect upon becoming a law, the public welfare requiring it.