

EDITORIALS



Physicians and the First Amendment

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In the November elections, the citizens of three states resoundingly defeated initiatives aimed at curtailing reproductive rights. In Colorado, a proposed amendment to the state's Constitution would have given the same legal rights to fertilized eggs as to living persons. This amendment, which was rejected by a wide margin, would have had broad ramifications for abortion rights, the use of contraceptive agents, and stem-cell research. In California, a parental notification proposition backed by antiabortion forces was also rejected. In South Dakota, a ballot measure that would have effectively banned all abortions in the state was defeated, as was a similar measure 2 years ago.

Those who support the principle of reproductive freedom can take heart in the overwhelming failure of these initiatives. But unbeknownst to many, there remains on the books in South Dakota another law, known as the informed consent to abortion law, that is cause for concern.

The details of the law were recently described in the *Journal* by Lazzarini.¹ Opponents of the law call it the script law, because it mandates that a physician use specific language when discussing abortion with a woman who has requested one. The physician must tell the woman that she will be terminating the life of a "whole, separate, unique, living human being" with whom she has an "existing relationship," that her "relationship enjoys protection under the United States Constitution," and that abortion terminates both that relationship and her "existing constitutional rights with regards to that relationship."² There must also be a discussion of what the law calls the risks of abortion, including depression and suicide, although their alleged link to abortion is unsup-

ported by scientific evidence. Physicians who fail to adhere to the "script" may lose their medical licenses and may be charged with a criminal misdemeanor.

Irrespective of one's views on abortion, the speech mandated by the South Dakota law is extraordinary and unprecedented. Under their authority to regulate the practice of medicine, states can legally set standards for communication between physicians and patients. But as the U.S. Supreme Court has ruled, "the right of freedom of thought protected by the First Amendment . . . includes both the right to speak freely and the right to refrain from speaking at all."³ With respect to communication about abortion, the Supreme Court in *Planned Parenthood v. Casey* granted states considerable latitude in requiring physicians to provide women requesting abortion with "truthful and nonmisleading information" about their health and the life of the unborn fetus.⁴ But even in the context of *Casey*, South Dakota's "script law" goes much too far.

Robert Post, a specialist in First Amendment law at Yale, concluded in a review of the South Dakota law that it infringes physicians' First Amendment rights in at least two ways.⁵ Post notes that although *Casey* allows states to mandate some language about abortion, the South Dakota law is a transparent effort by the state to eliminate abortions by requiring specific ideological speech. In the context of the doctor-patient relationship, mandated ideological speech "runs afoul of the First Amendment."⁵ First Amendment law would also stipulate that any mandated speech not be false or misleading, but the requirement in the South Dakota law that physicians tell

women that abortion may increase their risk of depression and suicide is exactly that — false and misleading.

The South Dakota law should alarm physicians and the public. If states are permitted to mandate ideological speech about abortion, what is to stop them from doing the same for end-of-life decisions, contraception, stem-cell therapies, vaccination, or any procedure or treatment that does not conform to the political ideology of the statehouse? The doctor–patient relationship is predicated on a foundation of trust. Doctors have an ethical responsibility to provide their patients with accurate medical information. But can a patient trust any interaction with his or her physician knowing that the physician’s very words have been mandated by the state? Patients should not accept, and our profession should not allow, physicians to become a mouthpiece of state-sponsored ideology.

The amendment stating that “Congress shall make no law . . . abridging the freedom of speech” was the first amendment to the Consti-

tution for a reason: It is the bedrock principle of our democracy. The South Dakota “script law” is an affront to the First Amendment rights of physicians and an embarrassment to the people of South Dakota. Although the law is currently in force, the merits of a challenge to its constitutionality will soon be addressed by Judge Karen Schreier of the Federal District Court of South Dakota. To preserve the integrity of the doctor–patient relationship, which is fundamental to the practice of medicine, this law should be summarily overturned.

This article (10.1056/NEJMe0809669) was published at www.nejm.org on November 19, 2008.

1. Lazzarini Z. South Dakota’s abortion script — threatening the physician–patient relationship. *N Engl J Med* 2008;359:2189-91.
2. HB 1166, 2005 Leg., 80th Sess. (S.D. 2005).
3. *Wooley v. Maynard*. 430 U.S. 705, 713 (1977).
4. *Planned Parenthood v. Casey*. 505 U.S. 833 (1992).
5. Post R. Informed consent to abortion: a First Amendment analysis of compelled physician speech. *Univ Ill Law Rev* 2007; April 12:939-90.

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Does It Matter How Hypertension Is Controlled?

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Hypertension is one of the most important risk factors for cardiovascular and renal diseases. Currently, approximately 73 million adults in the United States and approximately 1 billion adults worldwide have hypertension, and the prevalence is increasing.¹ Many clinical trials have examined the effects of antihypertensive drugs. Studies comparing the effects of antihypertensive medications with those of placebo have shown consistently that lowering blood pressure is associated with major reductions in the incidence of coronary events, strokes, and congestive heart failure.² These benefits have been observed irrespective of age, sex, severity of the hypertension, presence or absence of associated risk factors or concomitant diseases, or class of antihypertensive drug used. However, the results of trials comparing the effects of different antihypertensive drugs or drug regimens have not been as consistent.

The initial findings from a new drug comparison study, the Avoiding Cardiovascular Events through Combination Therapy in Patients Living with Systolic Hypertension (ACCOMPLISH) tri-

al (ClinicalTrials.gov number, NCT00170950), are reported in this issue of the *Journal*.³ The ACCOMPLISH trial was a randomized, double-blind, industry-sponsored study involving subjects with hypertension that examined the effects on cardiovascular outcomes of treatment with the angiotensin-converting-enzyme (ACE) inhibitor benazepril combined with either the calcium-channel blocker amlodipine or the diuretic hydrochlorothiazide. Somewhat surprisingly, as compared with the benazepril–hydrochlorothiazide group, the group that was treated with benazepril and amlodipine had a relative risk reduction of approximately 20%, and an absolute risk reduction of 2.2%, in the primary end point, a composite of illness and death from cardiovascular causes. The secondary end point of death from cardiovascular causes and nonfatal myocardial infarction and stroke showed a similar benefit.

The ACCOMPLISH study population was at high risk for cardiovascular diseases. The average age at entry was 68 years, and participants with a history of ischemic heart disease, peripheral vas-