

EDITORIALS



Government in Medicine

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Although I am not a provider of reproductive medical services, I was alarmed to read of the recent decision of the Supreme Court in *Gonzales v. Carhart*. Why should I feel so concerned? The practical consequences of the “partial-birth abortion” bill are so far from my medical practice in pulmonary and intensive care medicine that the ruling should have no impact on me. Indeed, since most health care practitioners will not be directly affected by this decision, why should we care at all? It is because, as Charo¹ and Greene² point out in this issue of the *Journal*, with this decision the Supreme Court has sanctioned the intrusion of legislation into the day-to-day practice of medicine.

In 2005, we all saw the disastrous consequences of congressional interference in the case of Terri Schiavo. In that case, the courts wisely decided that Congress should not be practicing medicine. They correctly ruled that wrenching medical decisions should be made by those closest to the details and subtleties of the case at hand. Such decisions must be made on an individual basis, with the best in-

terests of the patient foremost in the practitioner’s mind.

It is not that physicians do not want oversight and open discussion of delicate matters but, rather, that we want these discussions to occur among informed and knowledgeable people who are acting in the best interests of a specific patient. Government regulation has no place in this process. In 1997, another editor of the *Journal*, Jerome Kassirer, took Congress to task for practicing medicine without a license.³ He cited a number of instances, including the passage of a forerunner of the bill that the Supreme Court upheld last week. With *Gonzales v. Carhart*, the judicial branch has regrettably joined the legislative branch in practicing medicine without a license.

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1. Charo RA. The partial death of abortion rights. *N Engl J Med* 2007;356:2125-8.
2. Greene MF. The intimidation of American physicians — banning partial-birth abortion. *N Engl J Med* 2007;356:2128-9.
3. Kassirer JP. Practicing medicine without a license — the new intrusions by Congress. *N Engl J Med* 1997;336:1747.

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Aspirin and Colon Cancer — Targeting Prevention?

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The compelling evidence that chronic use of aspirin or certain nonsteroidal antiinflammatory drugs (NSAIDs) can substantially lower the risk of colon cancer has important implications, especially because colon cancer is the second leading cause of cancer death. Aspirin and nonselective NSAIDs each inhibit the generation of prostaglandins by inhibiting the two cyclooxygenase

(COX) enzymes that initiate prostaglandin synthesis, COX-1 and COX-2. NSAIDs that are selective for COX-2 also inhibit the generation of prostaglandins. COX-1 is constitutively expressed in the colon, but COX-2 is inducible and markedly up-regulated in many colon cancers. Interventional trials have shown a decreased risk of the development of colon adenomas in high-risk subjects