

tial therapy or after failure of interferon treatment in patients with CML have shown that it is necessary to achieve a complete cytogenetic remission in order to maximize the long-term benefit. There remains some debate about whether the rapidity with which a complete cytogenetic remission is achieved or the “depth” of remission as assessed by RT-PCR will help identify patients in complete cytogenetic remission who are destined to have a relapse and require either transplantation or a switch to dasatinib or other new tyrosine kinase inhibitors. As Quintás-Cardama et al. emphasize, it is important to monitor the response serially during the first year. This can be done by means

of peripheral-blood examination with the use of either fluorescence in situ hybridization (FISH) or a reliable quantitative RT-PCR assay for *BCR-ABL*, with bone marrow cytogenetic analysis performed to confirm complete cytogenetic remission when the FISH result is negative or the transcript numbers have decreased to a level corresponding to a complete cytogenetic remission.

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## Tackling Medical Futility in Texas

**TO THE EDITOR:** As a physician and clinical ethicist involved in the development and use of the Texas Advance Directives Act, I believe Truog’s Perspective article (July 5 issue)<sup>1</sup> requires corrective focus. Most futility cases involve adults who can never recover and are subject to technologically prolonged deaths in the intensive care unit. Cases in which the family wants to continue such intervention but the physicians object are considered “futility” cases — the flip side of “right to die” cases. A due-process approach has been recommended for this troubling scenario, but the legal ramifications are uncertain. In 1999, Texas adopted legislation removing legal uncertainty when the approved process is followed.<sup>2</sup>

Truog expresses concerns about financial motivations, communication, and fairness. I agree that expense is an “ethically legitimate reason” to limit futile treatment, but how might society do this? Some dying patients receive three to six times as much treatment as others without having better outcomes.<sup>3</sup> Many physicians are trying to be more thoughtful about end-of-life resource expenditures, but it is difficult to steward resources ethically when families demand unlimited treatment for dying patients. Texas law encourages cultural change toward the communitarian value that no one has unlimited claims on the community; the resulting savings might not be “trivial.”

Suffering without a benefit for the patient is also an ethically legitimate reason to stop treatment, but comatose patients do not suffer, so why not maintain ventilator assistance indefinitely,

and when physiologically needed, add a pacemaker, dialysis, or a left ventricular assist device? Such questions are usually resolved collaboratively by the treatment team and the family, but when they cannot be settled, our experience shows that multidisciplinary ethics consultation helps families accept treatment limitation in 86% of cases.<sup>4</sup> Multi-institutional Texas data show that about 93% of futility disputes were resolved without the issuance of a 10-day-notice letter.<sup>5</sup> This is evidence not that ethics committees are biased or that the process is “too easy” but rather that further dialogue alone works. Truog sees ethics committees as “judge and jury,” but they are no more so than an organ-transplant review committee. Families may still pursue court intervention, but judges, not juries, hear these cases. Is a single judge, without medical, cultural, or spiritual care expertise, wiser than a multidisciplinary committee?

Finally, Truog questions the fairness of the Texas law. These disputes occur not between physicians and patients but between physicians and families. Some families are trapped in normal psychological responses to bad news, and others are divided. Some have dubious motives, and some engage in magical thinking. Ultimately, physicians must choose between the easy path of acceding to the family’s medically inappropriate request and the hard path of undertaking further committee review and possible unilateral action. We should respect the family’s preference when possible, but we should never use a patient as a means to the family’s end if the patient does not benefit.

This problem will not go away, but after 8 years of practice, the Texas process remains the best approach when family requests conflict with professional obligations at the end of life.

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2. Fine RL. The Texas Advance Directives Act of 1999: politics and reality. *HEC Forum* 2001;13:59-81.
3. Wennberg JE, Fisher ES, Stukel TA, Skinner JS, Sharp SM, Bronner KK. Use of hospitals, physician visits, and hospice care during the last six months of life among cohorts loyal to highly respected hospitals in the United States. *BMJ* 2004;328:607-9.
4. Fine RL, Mayo TW. Resolution of futility by due process: early experience with the Texas Advance Directives Act. *Ann Intern Med* 2003;138:743-6.
5. Ramshaw E. Bills challenge care limits for terminally ill patients. *Dallas Morning News*. February 15, 2007.

**THE AUTHOR REPLIES:** I agree with Fine that “futility cases” — situations in which patients or family members demand treatments that seem unreasonable to the clinicians involved — are an important and difficult problem. I also agree that the Texas legislation has been effective in facilitating the resolution of these cases in a very efficient manner. We disagree, however, over the question of whether this approach can withstand ethical scrutiny and whether it is the best way of handling these challenging cases.

Although it is true that the demands of some families are motivated by psychopathology or magical thinking, in some cases the dispute arises from a genuine disagreement about fundamental values. The problem with the Texas legislation is that it empowers the hospital ethics committee — mostly hospital employees — to adjudicate between the values of their fellow clinicians and

those of the family. Fine invokes the importance of “communitarian” values, but under the Texas approach, those values are defined solely by the medical community itself. The law does not even allow appeal of the determination to a judge; a judge can grant extensions to allow for more time to find an alternative provider but cannot question the determination itself. The law therefore fails to provide medical patients with basic due-process protections that are taken for granted in other settings.

Fine cites data showing that application of the law results in families’ ultimately accepting treatment limitations in the great majority of cases. These data show either that, as Fine suggests, “further dialogue alone works” — in which case, the law is not needed — or that when told that the law will be used to limit treatments regardless of the families’ preferences, families choose to give in and accept the inevitable rather than engage in a legal battle with the hospital.

Fine implies that the Texas law is most useful when families are making decisions that are not in the best interests of patients. This may be true, but then the remedy should be to use existing pathways to challenge the legitimacy of the surrogate to make these decisions and to seek appointment of another decision maker. Using a law about medical futility to solve problems about surrogate decision making reflects a misdirected and confused response to the issues at stake.

Fine and others have made a well-intentioned effort to make progress in the futility debate, but the Texas law is, in my opinion, a step in the wrong direction.

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## ERCC1-Specific Immunostaining in Non–Small-Cell Lung Cancer

**TO THE EDITOR:** In their letter to the editor, Nierdnhofer et al. (June 14 issue)<sup>1</sup> have doubts about the specificity of the monoclonal mouse antibody 8F1, which is used to detect the excision repair cross-complementation group 1 (ERCC1) protein. These doubts are important to reconcile, because two studies have reported that high levels of ERCC1

expression, as detected by means of immunohistochemical staining of primary tumors with the use of the 8F1 monoclonal antibody, are associated with a good prognosis in non–small-cell lung cancer yet negatively affect the response to chemotherapeutic agents.<sup>2,3</sup> Hence, the expression level of the epitope recognized by 8F1 (presumably