long-term outcomes in elderly and very elderly patients hospitalized with CAP.

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REFERENCES


Alternative Therapy
Cupping for Asthma

To the Editor:

A 35-year-old white man with severe, poorly controlled asthma was seen in the ED at the Firestone Institute (Hamilton, Ontario, Canada) with an acute exacerbation of his condition. He is a current smoker of 1 pack/d with a 20-pack-year history. He had no family physician and was noncompliant with visits to his respirologist. His asthma required prednisone for exacerbations a few times annually, and he had required intubation within the past 2 years. The patient had been prescribed numerous asthma inhalers but found only salbutamol to be effective. During his current exacerbation, he supplemented 30 to 40 puffs of salbutamol per day with alternative therapy, with no improvement in his symptoms. When the patient presented, he exhibited unusual lesions on his back from this alternative therapy known as cupping (Fig 1). An evidence-based approach to the patient’s care with corticosteroids and maximal bronchodilation produced rapid improvement in this case of near-fatal asthma.

Cupping refers to an ancient Chinese practice in which cups are applied to the skin to suck out noxious materials. The technique today involves the use of small glass cups in which a small amount of alcohol is put into the cup and ignited followed by pressing the cup against the skin to create a vacuum.

This therapy was used widely in the United States in the 18th and 19th centuries. In fact, as late as 1931, Osler indicated cupping for the treatment of bronchopneumonia and acute myelitis. The therapy is still used today in many cultures. A study of Vietnamese refugees living in San Diego, California, showed that although the signs and symptoms of asthma were well recognized, traditional health beliefs and practices such as herbal ingestion, oil inhalation, bleeding, and cupping were found to be more frequently used in asthma subjects in the refugee population.

Many patients turn to alternative therapies for asthma, with approaches ranging from chiropractic to breathing exercises. There remains a paucity of studies of these treatments, but to date, the evidence indicates that none, including cupping, is efficacious. Physicians must be sensitive to patients’ therapeutic preferences because Western medicine is practiced in a continually diversifying cultural climate. However, in asthma, anything more than an individual psychologic benefit is lacking.

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Figure 1. Lesions caused by cupping. The patient provided written consent for the use of this photograph.
Autonomy

To the Editor:

In a recent issue of CHEST (April 2010), Tonelli and Misak1 offered a thought-provoking meditation about the limitations of autonomy in the critically ill patient. We believe that the authors’ attempt in this article falls short on first principles.

The authors state, “The principle of autonomy rests upon the ability of individuals to make autonomous decisions.” Such a tautology does not help to provide a foundation for the clinician who encounters the patient in a context where autonomy is limited, nor does it further his or her understanding about why autonomy is limited in these contexts.

The authors link autonomy to rational judgment, termed decision-making capacity, but there is a difference:

“Autonomous choices must also be free from undue influence, neither coerced nor induced…..One may decide, for instance, that on balance it is better to confess to a crime and end the pain of interrogation, but that decision is not made in a way that is free from undue restraint.”

At minimum, the analogy fails to grasp the complexity of the issue. Tortured individuals are undergoing external corruption of their liberty. Patients are not intentionally subject to external coercive measures. It is an internal defect in which, among other things, the patient’s full awareness of his or her situation limits autonomy. The relationship between autonomy and decision-making capacity, a seemingly necessary, but not sufficient element of autonomy in the authors’ view, is not elucidated.

The authors claim that there are some decisions that are more and some that are less autonomous in the same patient: “No clear threshold exists. Similarly, autonomy is not present or absent entirely, but can be variably compromised.” This is not self-evident, and it does not derive from the account of autonomy as presented by the authors.

Even if we accept this assertion without clarity as to what a fully autonomous decision might be, the clinician has little guidance about which decisions are autonomous and which are not. The authors point to more-complex and grave decisions as signposts of limited autonomy, especially where they are in conflict with the best interest of the patient as defined by the clinician. Here, the best interest of the patient might rightly take precedence. But if the well-meaning clinician knows neither where nor whence autonomy comes or how to recognize it, important decisions that are autonomous may be overruled. The possibility remains that the best-interest doctrine improperly applied makes the clinician an unwilling agent in the undue influence and coercion that are the hallmark of nonautonomous decision making.

The authors prescribe “Formalizing the application of the best-interest standard and making it more transparent…” in order to avoid the conundrum presented herein. However, a more rigorous account of the principle of autonomy must be rendered, one that focuses on the ethical and moral status of the patient rather than on the weight of the decision.

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Response

To the Editor:

Drs Black and Morrissey assert that our cautionary note regarding overreliance on the notion of individual autonomy in the care of the critically ill does not contain a rigorous account of the principle of autonomy, rendering our conclusions suspect and our recommendations unhelpful. Although we certainly agree that much more has and can be said regarding what autonomy is and what autonomy means, a full explication of autonomy was not our purpose nor necessary to our argument. Descriptions of the conceptual evolution and competing theories of autonomy in medical ethics can be found elsewhere. For our purposes, it is enough to note that autonomy, regardless of formulation, always means more than decisional capacity and requires both moral agency and freedom from undue influences. Patients who are critically ill, however, will virtually always have their autonomy compromised by both internal and external factors. The fact that we do not intend to interfere with our patients’ autonomy does not alter the fact that we invariably do as we strive to exert control over the physiologic perturbations that threaten their existence. If we are successful, we will ultimately restore to the patient the capacity of autonomous choice.

Our primary exhortations to clinicians, then, were to avoid confusing decisional capacity with autonomy and to not cleave too closely to the notion that exercising a patient’s autonomous choice is the only way to be certain that one is acting in a morally defensible manner. Agreement on a more rich and rigorous understanding of the notion of autonomy is not necessary. While we wish we could offer clinicians a simple tool for assessing the capacity of individuals to make truly autonomous decisions, for now at least, the assessment requires a clinician to make a conscientious attempt

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References


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