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 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.

Jose M. Bordon, MD, PhD
Washington, DC
Timothy Wiemken, MPH
Paula Peyrani, MD
Julio A. Ramirez, MD
Louisville, KY

**Affiliations:** From the Department of Medicine (Dr Bordon), Section of Infectious Diseases, Providence Hospital and the Division of Infectious Diseases (Drs Wiemken, Peyrani, and Ramirez), University of Louisville Medical School.

**Financial/nonfinancial disclosures:** The authors have reported to CHEST the following conflicts of interest: Dr Ramirez participates in the speakers bureaus for Pfizer, Cubist, Astellas, and Ortho-McNeil. He also has received grants from Pfizer, Merck, Johnson and Johnson, and Cubist Pharmaceuticals. Drs Bordon, Wiemken, and Peyrani have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

**Correspondence to:** Jose M. Bordon, MD, PhD, Department of Medicine, Section of Infectious Diseases, Providence Hospital, 1150 Varnum St, Medical Affairs, Washington, DC 20017; e-mail: jbordon@provhosp.org

© 2011 American College of Chest Physicians. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (http://www.chestpubs.org/site/misc/reprints.xhtml).

DOI: 10.1378/chest.10-2494

---

**References**

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 decision-making capacity, a seemingly necessary, but not sufficient element of 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.”

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 applies 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.

Hugh Black, MD, FCCP
Brian Morrissey, MD, FCCP
Sacramento, CA

References


