Abigail Chen 06/11/2025

Moxibustion and the Ethical Duty to Protect Children from Harm

A young child arrives in your pediatric office with minor burn marks on their body. Quickly, the mother explains that this is a result of moxibustion, a traditional healing practice used to treat illnesses (Xu et al., 2014). The United States is an extremely diverse country and healthcare providers must strive to honor diverse cultural beliefs. However, when those beliefs cause lasting burns, pain, or trauma, especially to children, a line must be drawn. Clinicians must navigate between two key responsibilities, honoring cultural values and parental autonomy while also preventing suffering, nonmaleficence. I believe that while families have autonomy and culture that should be respected, this must not come at the expense of a child's well-being. When a cultural practice causes harm beyond reason to a child who can not consent to the treatment, it crosses an ethical boundary. Therefore I believe when cultural practices result in physical harm, even if they intend to heal, the ethical principles of nonmaleficence and historical limits on autonomy guides clinicians to intervene and prioritize the child's well-being.

By choosing not to intervene in a cultural practice harming the child, the clinician is violating the ethical principle of nonmaleficence as they are enabling ongoing harm to the child. While recovery while using moxibustion does occur in many cases, that is not always the outcome. According to Ji Xu et al. (2014), " Li reported 37 cases of newborn burns and infections associated with improper moxibustion from 1990 to 1997, … All patients showed varying degrees of burns, 34 mild and 3 moderate. Eight patients were diagnosed with secondary systemic infections, including one case of staphylococcal scalded skin syndrome (SSSS), six cases of septicemia, and one case of pyemia." Despite its potential benefits, the variability in practice and potential for harm require clinicians to carefully evaluate when it is necessary to intervene to protect children. This case shows how failing to intervene can lead to preventable harm. If a clinician were to accept these cultural practices without question, knowing the child was at risk, it would go against the principle of nonmaleficence by allowing harm to continue.

Autonomy is another fundamental ethical principle that guides how clinicians interact with and support patient decision-making. In this case autonomy is what creates conflict with

nonmaleficence. In pediatrics, the right to make decisions is passed to the parents as children are not capable of full decision making and parents are expected to act in their children's best interest. Parents ethically may choose traditional cultural healing practices like moxibustion becauses of autonomy, but their right to decide is limited when those practices cause significant harm, especially for a child. There is the precedent of courts limiting a parent's autonomy and decision-making. According to Carrion and Bramstedt (2023), the Supreme Court case of Prince v. Massachusetts (1944) ruled that "the right to practice religion freely does not include liberty to expose the child to ill health or death." This case was used to protect children from parental requests such as refusing blood transfusion due to Jehovah's Witness beliefs. This demonstrates how parental autonomy does not override a clinician's ethical responsibility to prevent harm. In the case of potentially dangerous cultural healing practices, physicians have an ethical duty to intervene. Although patient autonomy is important, there are cases when a parent's right to choose their child's treatments are limited.

Some may argue this view lacks cultural competence, but I'm not rejecting all traditional medicine. I believe in respecting culture and allowing for parental autonomy to choose traditional healing practices given they do not harm the child. For example, acupuncture, which is not known to create lasting scars and unreasonable pain, I believe is acceptable. Others might say Western practices like male circumcision or vaccinations are also painful and traumatic, however, I believe these should be accepted as they are done in controlled settings and strong evidence of benefit (Patrick, 2007). On the other hand, moxibustion often lacks oversight and therefore has greater risks. Autonomy must be balanced with safety, and children deserve protection regardless of the treatment's cultural origin.

To conclude, respect for patients autonomy is important, but not at the expense of a child's safety. When traditional practices cause harm, clinicians have an ethical duty to intervene. Children cannot consent, and parental rights have limits. Protecting them from preventable harm is not rejecting culture or autonomy, it's fulfilling our responsibility to do no harm.

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