

# Virtual Mentor

American Medical Association Journal of Ethics  
April 2014, Volume 16, Number 4: 252-256.

## ETHICS CASE

### Is Parental Smoking Neglect of an Asthmatic Child?

Commentary by Bahareh Keith, DO, and Kimberly B. Handley, MSW, LCSW

A mother carrying a coughing child walks into the emergency room. She hysterically flags down a triage nurse and tells her that her daughter, Rose, is having trouble breathing. The nurse directs mother and child to a bed in the emergency room cordoned off by a light blue curtain. Less than five minutes later, Tricia, a third-year medical student on her pediatrics rotation, shows up to do a thorough history and physical of the patient. The first thing Tricia notices is that both mother and daughter are saturated in the scent of cigarettes. Upon questioning, the mother admits to smoking two packs a day in the house.

“Have you tried quitting?” Tricia asks.

The mother scowls. “The smoking’s not a problem. I keep all the windows open.” At that moment, her daughter has a severe coughing fit. She scoops Rose into her arms, and rubs soothing circles on her back. “My daughter has asthma. That’s why we’re here,” she tells the student.

Tricia jots a note in the patient’s record and sees Rose has been admitted multiple times in the past for asthma. After flipping through these notes, Tricia sees that the mother has been counseled repeatedly about the need to stop smoking for the sake of Rose’s health. Tricia goes to find her attending and presents Rose’s case, highlighting signs of neglect. She then asks whether or not this would be grounds to notify child protective services.

## Commentary

Neglect is failure to satisfy a child’s basic needs, not only those for food, clothing, and shelter but also those for appropriate and timely medical care and shielding from exposure to family violence and substance abuse in the home, among other things. Implicit in these is the classification of lack of parental supervision or failure to protect a child from harm as neglect. In considering whether Rose’s mother’s behavior is neglectful, we must ask whether Rose’s asthma exacerbations can be tied solely to the mother’s smoking or whether other factors that could contribute to the problem, such as allergens or other environmental triggers, are present.

Neglect can be categorized as mild, moderate, or severe depending on the degree of harm (or risk of harm) to the child and the frequency and length of time of the neglectful behavior. The Children and Families Safe Act of 2003 defines child maltreatment as “any recent act or failure to act on the part of a parent or caregiver

which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm” [1]. So we must consider: what is the effect of Rose’s mother’s smoking on her health, safety, and well-being?

Studies are now demonstrating that secondhand smoke (SHS) can exacerbate or cause children to develop asthma. In a meta-regression review, Vork et al. demonstrated that the duration of secondhand smoke exposure can incite asthma. After adjusting for confounding factors they found a 33 percent higher incidence of asthma among those exposed to secondhand smoke [2]. In a recent large meta-analysis Burke et al. found that there may be a 28-70 percent increased risk of incidence of wheezing due to SHS [3]. This is also supported by findings that anti-SHS legislation has resulted in an overall decrease in asthma-related visits to local emergency rooms [4].

The US Department of Health and Human Services includes asthmatic children exposed to secondhand smoke as an example of exposure to hazard, which can be categorized as inadequate supervision and neglect [5]. This means HHS considers secondhand smoke to belong to the same category as poisons, loaded guns, unsanitary living conditions, and lack of vehicle safety restraints. It also means that parents’ failure to follow a physician’s instructions can be defined as medical neglect according to some state laws [6]. Family courts, too, have been receptive to information about SHS exposure, particularly when a child suffers from a chronic respiratory illness such as asthma [7]. In *Lizzio v. Lizzio* [8], the Supreme Court of New York reversed a custody decision and assigned physical custody to one parent because the other parent refused to provide a smoke-free environment for him. Ultimately, then, the scenario of Rose and her mother is a recognized example of neglect.

### **Interventions**

So what should we do? First and foremost, we must remember that we are in a partnership with the families that we care for. When the care of a child is suboptimal, we must first look at ourselves to ensure that we have done our best to provide families with the tools they need to keep their children healthy. We must summon the optimist in ourselves and assume that the parents are doing what they feel is best for their children. If what they are doing does not appear to be adequate care, then perhaps we have not done our best to educate them or give them the tools to be successful.

Next we must do our part in a noncritical and helpful manner and record what we have done so that the caregivers who follow us have an accurate record of the situation.

In this case, the mother clearly does not believe there is a connection between her child’s asthma and her smoking, a not-uncommon misperception. Fifty-eight percent of parents surveyed by Farber et al. who smoked and had asthmatic children reported

that tobacco smoke exposure had little or no negative effect on their child's asthma [9]. The medical student's review of Rose's record reveals that the mother has been told this before, but our duty is to be certain that she understands it. On the other hand, preaching at our patients and families is not always the most effective tactic. We must meet them where they are in terms of education level, with consideration of psychosocial factors and readiness to stop smoking.

Lack of resources or psychosocial burdens may contribute to this mother's behavior [10]. Suppose, for example, that she is a single mother who lives in an apartment complex that does not allow smoking in public spaces and has a high crime rate. She may have decided that smoking inside with the window open is safer for her and her child than taking the risk of going across the street from her apartment to smoke.

A second place we may have failed this mother is by not giving her feasible options. Smoking is an addiction and, if she is unable to quit, merely counseling her to do so is not an effective way to reduce Rose's secondhand smoke exposure. If a parent is not ready to quit, then other solutions should be offered. Hennessey et al. found that many families intend to ban smoking in their homes but encounter obstacles to doing so [11]. They concluded that it may be more effective to focus on considering alternative locations to smoke. Having the smoker take small steps—focusing on eliminating or reducing smoke exposure—could be more feasible and better received. For example, we may ask if it is possible for the mother to smoke outside. Other concrete practical instructions would include no smoking in the car, using a smoking jacket that is left outside, and washing hands after smoking.

It is also important to discern whether there are other neglectful actions—such as failure to fill the child's prescriptions regularly or missed medical appointments—that could be contributing to Rose's frequent exacerbations.

Once all this is done, if the child is still repeatedly harmed by the parent's behavior then we must involve others to ensure that the child is safe. Reporting to child welfare authorities is mandatory if the effects on the child are severe. The state child welfare agency is more likely to provide services if the harm to the child is severe or if there is a pattern of neglect; e.g., the mother is not keeping doctor's appointments or not filling the child's medications. If there is uncertainty, then we must consider whether it would be beneficial to report. Reporting may cause a family to feel accused, become uncomfortable disclosing pertinent information accurately in the future for fear of repercussions, or even sever the therapeutic relationship. The essential and difficult question that physicians must ultimately answer is whether exposure to secondhand smoke is more harmful to Rose than being removed from her home would be.

### **Conclusion**

Overall, employing supportive measures that augment parents' natural tendency to protect their children may be the most effective approach to reducing secondhand smoke exposure in children. We must begin by providing parents with adequate,

timely, and easily understandable education. Next we need to give them palatable options for decreasing their children's smoke exposure. If we have helped the mother troubleshoot obstacles to reducing Rose's smoke exposure and the child continues to be harmed by SHS, then we are ethically and legally bound to report that Rose is being neglected.

On a larger scale we can protect children by advocating for policy change; for example, a ban on smoking in cars and homes. Smoking in a vehicle in the presence of children is already banned in numerous areas of the world, including Australia, the United Arab Emirates, South Africa, and 5 American states [12]. Physicians could, for example, advocate for smoke-free laws governing all indoor spaces where children may be exposed.

### References

1. US Department of Health and Human Services Office on Child Abuse and Neglect. *Child Neglect: A Guide for Prevention, Assessment, and Intervention* [2006].  
<https://www.childwelfare.gov/pubs/usermanuals/neglect/neglect.pdf>. Accessed January 10, 2014.
2. Vork KL, Broadwin RL, Blaisdell RJ. Developing asthma in childhood from exposure to secondhand tobacco smoke: insights from a meta-regression. *Environ Health Perspect*. 2007;115(10):1394-1400.
3. Burke H. Prenatal and passive smoke exposure and incidence of asthma and wheeze: systematic review and meta-analysis. *Pediatrics*. 2012;129(4):735-744.
4. Rayens MK, Burkhart PV, Zhang M, et al. Reduction in asthma-related emergency department visits after implementation of a smoke-free law. *J Allergy Clin Immunol*. 2008;122(3):537-541.e3.
5. US Department of Health and Human Services. Definition and scope of neglect. *Child Neglect. A Guide for Prevention, Assessment and Intervention*.  
<https://www.childwelfare.gov/pubs/usermanuals/neglect/chaptertwo.cfm>  
Accessed February 27, 2014.
6. Proceedings relating to children, Fla Stat 39.
7. Daschille KH, Callahan K. *Secondhand Smoke and the Family Courts: The Role of Smoke Exposure in Custody and Visitation Decisions*. Tobacco Control Legal Consortium; 2005.  
<http://publichealthlawcenter.org/sites/default/files/resources/tclc-syn-family-2005.pdf>. Accessed February 25, 2014.
8. *Matter of Lizzio v Lizzio*, 162 Misc 2d 701 (1994), 618 NYS2d 934.
9. Farber HJ, Knowles SB, Brown NL, et al. Children with asthma sources of and parental perceptions about exposure in children and parental readiness to change. *Chest*. 2008;133(6):1367-1374.
10. Radic SD, Gvozdenovic BS, Pesic IM, Zivkovic ZM, Skodric-Trifunovic V. Exposure to tobacco smoke among asthmatic children: parents' smoking habits and level of education. *Int J Tuberc Lung Dis*. 2011;15(2):276-280.

11. Hennessey M, Bleakley A, Mallya G, Romer D. Beliefs associated with intention to ban smoking in households with smokers. *Nicotine Tobacco Res.* 2014;16(1):69-77.
12. Jarvie JA, Malone RE. Children's secondhand smoke exposure in private homes and cars: an ethical analysis. *Am J Public Health.* 2008;98(12):2140-2145.

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