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"Anything above marijuana takes priority": Obstetric providers' attitudes and counseling strategies regarding perinatal marijuana use

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ABSTRACT

Objective: To describe obstetric provider attitudes, beliefs, approaches, concerns, and needs about addressing perinatal marijuana use with their pregnant patients.
Methods: We conducted individual semi-structured interviews with obstetric providers and asked them to describe their thoughts and experiences about addressing perinatal marijuana use. Interviews were transcribed verbatim, coded and reviewed to identify themes.
Results: Fifty-one providers participated in semi-structured interviews. Providers admitted they were not familiar with identified risks of marijuana use during pregnancy, they perceived marijuana was not as dangerous as other illicit drugs, and they believed patients did not view marijuana as a drug. Most provider counseling strategies focused on marijuana's status as an illegal drug and the risk of child protective services being contacted if patients tested positive at time of delivery.
Conclusions: When counseling about perinatal marijuana use, obstetric providers focus more on legal issues than on health risks. They describe needing more information regarding medical consequences of marijuana use during pregnancy.
Practice implications: Provider training should include information about potential consequences of perinatal marijuana use and address ways to improve obstetric providers' counseling. Future studies should assess changes in providers' attitudes as more states consider the legalization of marijuana.

1. Introduction

Marijuana is the most commonly used illicit drug during pregnancy in the United States [1–3]. In the 2009 National Survey on Drug Use and Health report, 4.6% of surveyed women reported using marijuana during pregnancy [4,5]. Population-based studies using biochemical testing noted rates as high as 12% [6]. In the past few years, there has been recent liberalization in public support of legalizing marijuana use [7]. As of April 2016, adults may legally use marijuana for recreational purposes in four states (Colorado, Washington, Alaska and Oregon) and in the District of Columbia. On April 27, 2016, Pennsylvania became the 24th state to legalize medical marijuana.

Research suggests an association between perinatal marijuana use and pregnancy complications such as shorter gestation, dysfunctional labor, meconium staining, preterm birth, low birth weights, and stillbirth [8–13]. Other research found associations between perinatal marijuana use and child neurobehavioral consequences such as cognitive, learning, and behavioral problems

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[14–17]. In young children, these manifest as hyperactivity, problems with attention, memory, or abstract thinking, or difficulties with reading and spelling [14–17]. Brain imaging studies of adolescents and young adults exposed to perinatal marijuana show negative impacts on the neural circuitry associated with executive functioning, including response inhibition and visual-spatial working memory [18,19].

Despite the potential adverse consequences, there has been little research conducted on physician and other healthcare providers' attitudes and beliefs regarding marijuana use. With the legalization of recreational marijuana in several states and broadening public acceptance regarding marijuana use, it is imperative to understand physician attitudes, beliefs and counseling practices about marijuana use during pregnancy. Given the number of states that have legalized medical marijuana, there has been some research focused on physician's attitudes toward, the acceptability of and prescribing practices for medical marijuana. A 2013 study assessed the attitudes of family physicians in Colorado and found that 46% thought marijuana should not be recommended as a medical therapy. Further, most of the responding physicians thought that there were significant physical and mental risks associated with marijuana use (61 and 64% respectively) [20,21].

To date, there have not been any studies focused on obstetric care providers' attitudes, beliefs, and self-described counseling approaches regarding marijuana use during pregnancy. We conducted semi-structured interviews with providers to identify their attitudes, beliefs and counseling practices around perinatal marijuana use.

2. Methods

2.1. Study overview

The data presented in this paper are part of a larger study that was conducted on patient-provider communication regarding substance use during pregnancy [22–25]. The study was approved by the University of Pittsburgh Institutional Review Board (IRB # PR008090530); data included in these analyses were collected from September 2011 through May 2015. Participants completed informed consent and were told that the study was protected by a National Institutes of Health (NIH) Certificate of Confidentiality. For this analysis, we used audio-recordings and transcripts of semi-structured interviews with obstetric care providers practicing in urban clinical sites in Pittsburgh, Pennsylvania.

2.2. Participants

Obstetric providers were eligible for follow-up interviews if they participated in the first phase of our parent study. These providers were asked to participate in a second phase of the study that involved semi-structured interviews focusing on their attitudes, beliefs, strategies, needs, and concerns regarding asking and talking about perinatal substance use. Interested providers then underwent a second, separate written informed consent process.

2.3. Data collection

Providers were invited to participate in a semi-structured interview and were compensated for their time. All interviews were conducted by trained research staff in a private office setting. Interviews lasted approximately 22–86 min (mean length = 39 min). Topics explored during the interviews included attitudes and beliefs toward patient use and disclosure of substances during pregnancy (i.e., tobacco, alcohol and illicit drugs), screening and counseling practices for substance use, provider concerns addressing substance use with patients, and barriers and facilitators to discussing substance use. In all interviews, providers were asked to reflect on specific substances including tobacco, alcohol, and recreational drugs. We asked all providers to speak about specific drugs such as opioids and marijuana. For this analysis, we focused only on the portions of the interview that addressed marijuana.

2.4. Data analysis

Two coders (MN and CH) independently reviewed and coded the first 26 transcripts. Coders met to review, compare and refine codes. The investigative team developed a codebook with definitions and coding scheme. For all 51 transcripts, two coders (PM and CH) then independently recoded the transcripts using the final codebook, meeting once more to reconcile any differences. No discrepancies in interpretation were noted. Focusing on all codes related to marijuana, a group of the authors (MN, CH, JT, PM, and JC) met several times to review the coding results and note thematic patterns in the codes. We then organized the codes into categories and themes. These themes were reviewed with all authors who expressed agreement in the interpretation. Atlas.ti © was used to organize and manage the qualitative data.

3. Results

3.1. Provider demographics

A total of 66 providers were eligible to participate in this phase of the study. We were unable to obtain interviews with fifteen providers due to challenges coordinating with their schedules; none of these fifteen directly refused participation in the interviews. Fifty-one participated in the semi-structured interviews. A majority of the providers were female (92%), white (83%) and obstetrics and gynecology residents (72%). Their characteristics are shown in Table 1. The characteristics of the subset of providers who participated in the interview portion of the study did not differ significantly from those who participated in the larger parent study.

3.2. Overview of key themes

Five key themes were identified from the provider interviews: (1) providers thought marijuana was not as dangerous as other illicit drug use in pregnancy; (2) providers stated they were not familiar with or were unaware of definitive evidence regarding potential risks related to perinatal marijuana use; (3) providers thought patients did not view marijuana as a drug; (4) providers described asking about marijuana separately and directly with patients, and (5) providers referenced marijuana's illegal status in Pennsylvania and the risk of child protective services' involvement as their primary method of motivating patients to stop their use. In the following section, we describe each of the key themes in more detail and provide illustrative quotes from the interviews.

3.3. Marijuana is not as dangerous as other illicit drugs

During the interviews providers were asked about screening and counseling approaches utilized with patients during first obstetric visits. Providers expressed a variety of medical concerns when patients disclosed to using opiates, cocaine and other drugs such as methadone and benzodiazepines. They identified medical risks and consequences for fetuses as a result of these other drugs such as abruption, prematurity, low gestational weight, and intrauterine growth restriction. Alternatively, providers did not feel there was clear evidence that marijuana is associated with