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Counseling About Cannabis Use During Pregnancy and Lactation: A Qualitative Study of Patient and Clinician Perspectives

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ABSTRACT

Introduction: Legalization in many jurisdictions has increased the prevalence of cannabis use, including during pregnancy and lactation. Accordingly, clinicians providing perinatal and infant care are increasingly required to counsel about this topic, even if they do not feel comfortable or prepared for this conversation. The aim of this research was to explore how prenatal clinicians and pregnant and lactating women interact with cannabis consumption.

Methods: Using qualitative description, we conducted semi-structured interviews with 75 individuals in Canada: 23 clinicians who provide pregnancy and lactation care, and 52 individuals who made cannabis consumption decisions during pregnancy and/or lactation. Data were analyzed using inductive content analysis.

Results: Three phases of the clinical encounter influenced decision-making about cannabis consumption: initiation of a discussion about cannabis, sense-making, and the outcome of the encounter. Patients and clinicians described similar ideals for a counseling encounter about cannabis consumption during pregnancy or lactation: open, patient-centered conversation grounded in an informed decision-making model to explore the benefits, risks, and alternatives to cannabis. While clinicians described these values as reflecting real clinical interactions, patients reported that in their experience, actual interactions did not live up to these ideals.

Conclusion: Clinicians and pregnant and lactating people report desiring the same things from a counseling interaction about cannabis: sharing of information, identification of values, and facilitation of a decision. Both groups endorse an open, nonjudgemental counseling approach that explores the reasons why a patient is considering cannabis consumption and reflects these reasons against available evidence and alternatives known to be safe.

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1 | Introduction

Cannabis consumption in the general population has become increasingly common, likely reflecting both cultural normalization and greater availability following legalization [1, 2]. A corresponding rise in cannabis use has been observed among pregnant and lactating people, with the prevalence of perinatal cannabis consumption growing over the past decade [3–5]. Reported estimates of cannabis consumption during pregnancy range from 2% to 36%, varying by population and methodology [3–7]. However, consumption may be underreported due to stigma, criminalization, and social desirability bias [8]. The prevalence of cannabis use during lactation has not been closely examined, but one study found that 5% of people who breastfed reported early postnatal cannabis consumption [6].

Cannabis consumption during pregnancy and lactation is a complex clinical counseling topic due to inconsistent evidence about safety, risk, and harm reduction. While it is generally accepted that there is evidence associating prenatal cannabis use with pre-term birth and low birth weight, additional studies are needed to confirm this relationship after controlling for potential confounders like tobacco and other substance use and to investigate the impacts of dose, timing, and formulation on clinical outcomes [9–14]. Additionally, it is unclear whether cannabis use during pregnancy affects cognitive development in early childhood [12, 15, 16]. There is limited and conflicting evidence on the effects of cannabis exposure during lactation [14, 17, 18].

Clinical guidelines from many organizations recommend that due to a lack of evidence to support safe consumption, clinicians should recommend that recreational cannabis consumers abstain during pregnancy and postpartum [12, 19–21]. However, while some pregnant and lactating people use cannabis for sensation-seeking reasons like enjoyment [22], many reports using cannabis for therapeutic purposes, for example, to manage symptoms of chronic conditions like pain, mental illness, or seizure disorders; alleviate pregnancy-related symptoms including nausea, vomiting, and fatigue; cope with unpleasant but nonpathologized experiences of life; or reduce the use of more harmful substances such as alcohol, tobacco, and cocaine [7, 22–26]. When counseling a patient who perceives therapeutic benefit from cannabis consumption, some clinicians may prefer a harm reduction approach to counseling; however, evidence-based harm reduction strategies do not exist [27]. These challenges may help explain recent findings that clinicians counseling about perinatal cannabis lack a unified approach and are likely to use punitive counseling strategies, particularly when they do not feel confident in their own knowledge about the topic [19].

Clinicians are often viewed as trusted sources of information and valued partners in decision-making [28], but this may not be the case for perinatal cannabis consumption [19, 29]. Patients' reluctance to discuss cannabis with clinicians may reflect fear of stigma, judgment, or initiation of child welfare surveillance, and may be particularly acute for racialized patients [26, 28, 30]. This indicates that evidence is not the only barrier to high-quality clinical counseling, and the nuances of these fears may differ across jurisdictions governed by different policies about the legality and acceptability of cannabis.

Previous research has found many clinicians lack confidence in counseling about consumption due to the absence of strong evidence about the effects of use and standardized approaches for discussing this substance [19, 31, 32]. To help inform the counseling process, we conducted a qualitative study of pregnant and lactating patients who made a decision to continue, cease, or adapt their cannabis use once becoming pregnant, as well as clinicians who counsel about perinatal cannabis consumption. Our objective was to understand experiences of this counseling encounter and synthesize recommendations from both groups for improving this interaction.

2 | Methods

2.1 | Study Design

We conducted a qualitative descriptive study [33] to explore how prenatal clinicians and patients interact with perinatal cannabis consumption. Qualitative description permits analysts to remain close to explicitly stated views of participants, with little interpretive inference [33].

2.2 | Study Context

This study was conducted in Canada, where cannabis has been legal for medical use since 2001 and for recreational use since 2018 [34]. Cannabis can be purchased by adults through government-run or licensed private retailers. Canada has a publicly funded healthcare system that covers all prenatal, intrapartum, and postpartum care received in hospitals or provided by physicians and midwives. Patients may access other complementary care services (e.g., lactation consultant and social work) in interprofessional primary care teams or hospitals [35]. Others may choose to pay privately for the services of providers such as naturopaths or doulas.

2.3 | Population

Previously [22, 29, 36] we interviewed people who had experienced pregnancy or birth in Canada within the past year; were 19 years of age or older; and decided to start, stop, or continue cannabis after becoming pregnant. Participants in this study identified a gap between the counseling they experienced and desired. To further understand this gap, we recruited health and social care providers who care for pregnant and lactating people in Canada, including family physicians and obstetricians, midwives, nurses, doulas, and lactation consultants. For brevity, we refer to these groups as "patients" and "clinicians."

Patients were recruited through social media, prenatal clinics, and chain referral (snowball) sampling. Clinicians were recruited through social media, professional networks and associations, research team networks, and chain referral sampling. Maximum variation sampling progressed to purposive sampling operationalized through an online intake survey.

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2.4 | Data Collection

Eligible participants completed a semi-structured interview with one of six interviewers unknown to them, trained in qualitative research, and employed as researchers. Interviewers were all women of reproductive age and represented several racial identities (White, Black, South Asian, and Indo-Caribbean). Patient interviews were conducted between November 2020 and March 2021; clinician interviews occurred between May and October 2022. Interviews took place via phone or video conference and were recorded, de-identified, and transcribed verbatim. Data collection continued until saturation was reached, that is, until when no new thematically relevant insights were seen in new data [37]. The interview guides were developed based on findings from previous systematic reviews [19, 28], and through clinician consultations. Interview guides were refined after piloting, and as analysis progressed. Interviewers wrote reflective memos throughout data collection and analysis.

2.5 | Data Analysis

Using a conventional (inductive) approach to content analysis [38], the research team met throughout the coding process to discuss insights and findings. Four analysts open-coded patient transcripts and three open-coded clinician transcripts. Once open coding was completed, a team of analysts developed conceptual categories through discussion and recoded the data according to this schema, which evolved through subsequent rounds of coding. The multiple perspectives of analysts were supplemented with multiprofessional clinical perspectives from the broader research team. Triangulation was achieved across data sources and across analysts. An audit trail of data collection and analysis memos and meeting minutes was maintained. N-Vivo software (versions 12 and 13) was used for data management.

3 | Results

A total of 75 people participated in this study, including 52 patients and 23 clinicians (Tables 1 and 2). Among clinician participants, there were eight nurses, seven midwives, six physicians (two obstetricians and four family physicians), one physician assistant, and one doula.

Patients and clinicians described three phases of the counseling encounter as meaningful to decision-making about cannabis consumption: (i) initiation of discussion about cannabis use; (ii) sense-making; and (iii) outcome of the encounter (Figure 1). Each phase is influenced by factors related to cannabis and characteristics of the individuals involved in the interaction. The figure represents encounters where clinicians and patients work together, and those where the patient engages in sense-making and decision-making without discussion with their clinician.

Patients and clinicians described similar ideals for the counseling encounter in each phase; they diverged in their reports of whether their real-life experiences resembled that encounter. We describe below what both groups desired in each phase of counseling and the barriers they perceive to achieving this optimal interaction.

TABLE 1 | Demographic information about participating patients ($n = 52$).

Variable	Number of patients ($n = 52$)
Self-reported gender	
Woman	51
Nonbinary	1
Self-reported race/ethnicity[a]	
White	36
Indigenous	7
Black	3
Hispanic	1
Indian/Guyanese	1
Jewish	1
Multiple races	3
Province or territory	
British Columbia	17
Alberta	3
Saskatchewan	1
Manitoba	1
Ontario	21
Quebec	2
Nova Scotia	2
New Brunswick	1
Newfoundland and Labrador	2
Prince Edward Island	1
Northwest Territories	1
Age	
19–24	2
25–29	12
30–34	25
35–39	11
40+	2
Type(s) of clinician(s) seen during pregnancy[b]	
Family Physician	37
Obstetrician-gynecologist	28
Midwife	17
Other[c]	12
Other children (beyond current pregnancy or breastfed infant)	
Yes	31
No	21

[a]Participants were asked to self-identify their race or ethnicity. No categories were imposed on this self-identification.
[b]Some patients saw multiple clinicians during the perinatal period.
[c]Other types of clinicians mentioned include pain specialists, lactation consultants, gastroenterologists, hematologists, physiotherapists, chiropractors, psychologists, and public health nurses.

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TABLE 2 | Demographic information about participating clinicians ($n = 23$).

Variable	Number of clinicians ($n = 23$)
Self-reported gender	
Woman	19
Man	3
She/they	1
Self-reported race/ethnicity[a]	
White	14
Indigenous	2
South Asian	2
Black	1
Chinese	1
Jewish/white	1
Multiple races	2
Province or territory	
British Columbia	2
Alberta	2
Saskatchewan	2
Ontario	12
Nova Scotia	1
Prince Edward Island	3
Nunavut	1
Practice location	
Urban	14
Rural	7
Suburban	2
Type of clinician	
Nurse	8
Midwife	7
Obstetrician-gynecologist	2
Family doctor	4
Physician assistant	1
Doula	1
Time in independent practice	
Less than 1 year	2
1–5 years	4
5–10 years	6
10+ years	11

[a]Participants were asked to self-identify their race or ethnicity. No categories were imposed on this self-identification.

3.1 | Initiation of Discussion About Cannabis Use During Pregnancy or Lactation

Discussion of cannabis was variably initiated by patients and clinicians, or sometimes not at all. Nearly half of patients reported that one of their clinicians asked about cannabis use either by asking specifically about cannabis or more generally about substance use. While many patients reported *not* being asked about cannabis use during pregnancy, clinicians reported they always inquired about this topic during early pregnancy visits, prompted by standardized antenatal record forms and knowledge that this information is essential to clinical management: "We screen everybody, so when they're coming into care, the beginning of their pregnancy, there is like, they're called the OPR, the Ontario Prenatal Record, and one of the questions on it is 'Do you use marijuana?' … we ask everybody." (Midwife013) Only clinicians who saw patients exclusively later in pregnancy or postpartum said they do not routinely inquire about cannabis use, typically because this information was already documented in the antenatal record. Clinicians and patients agreed it was unusual for a clinician seeing patients during lactation to inquire about consumption.

When asked about cannabis, patients had to decide whether to disclose consumption. This decision was a function of *comfort* and *relevance*. Those who felt comfortable speaking with their clinician attributed their comfort to a positive relationship with that person, experience consuming cannabis during prior pregnancies, or confidence in what they considered a "closed" decision to cease or change cannabis consumption patterns. Some patients who considered continuing cannabis use did not feel comfortable disclosing, expressing fear of judgment, stigma, or involvement of child welfare services: "nobody can be honest with their healthcare provider [for fear] that they're going to lose their kids." (P43) Comparative analysis by race and age did not yield differences in comfort discussing cannabis consumption for either the clinician or patient participants.

Clinical and decisional relevance influenced patient choice to disclose cannabis use. Those who determined that a discussion about cannabis use was relevant to the health of their pregnancy sometimes disclosed even if they felt uncomfortable: "It was a tough thing to disclose, but I felt like medically, it was important that I be as honest as I can be." (P16) Conversely, some who had decided a discussion about cannabis would not be relevant to their decision-making chose not to disclose.

Patients and clinicians noted that anticipating stigma or judgment may prevent fulsome conversations about cannabis, and each group offered several strategies to facilitate comfort, as summarized in Table 3.

3.2 | Sense-Making Phase

Both patients and clinicians entered a sense-making phase where they relied on specific factors to organize, process, and comprehend the health information presented to them [39].

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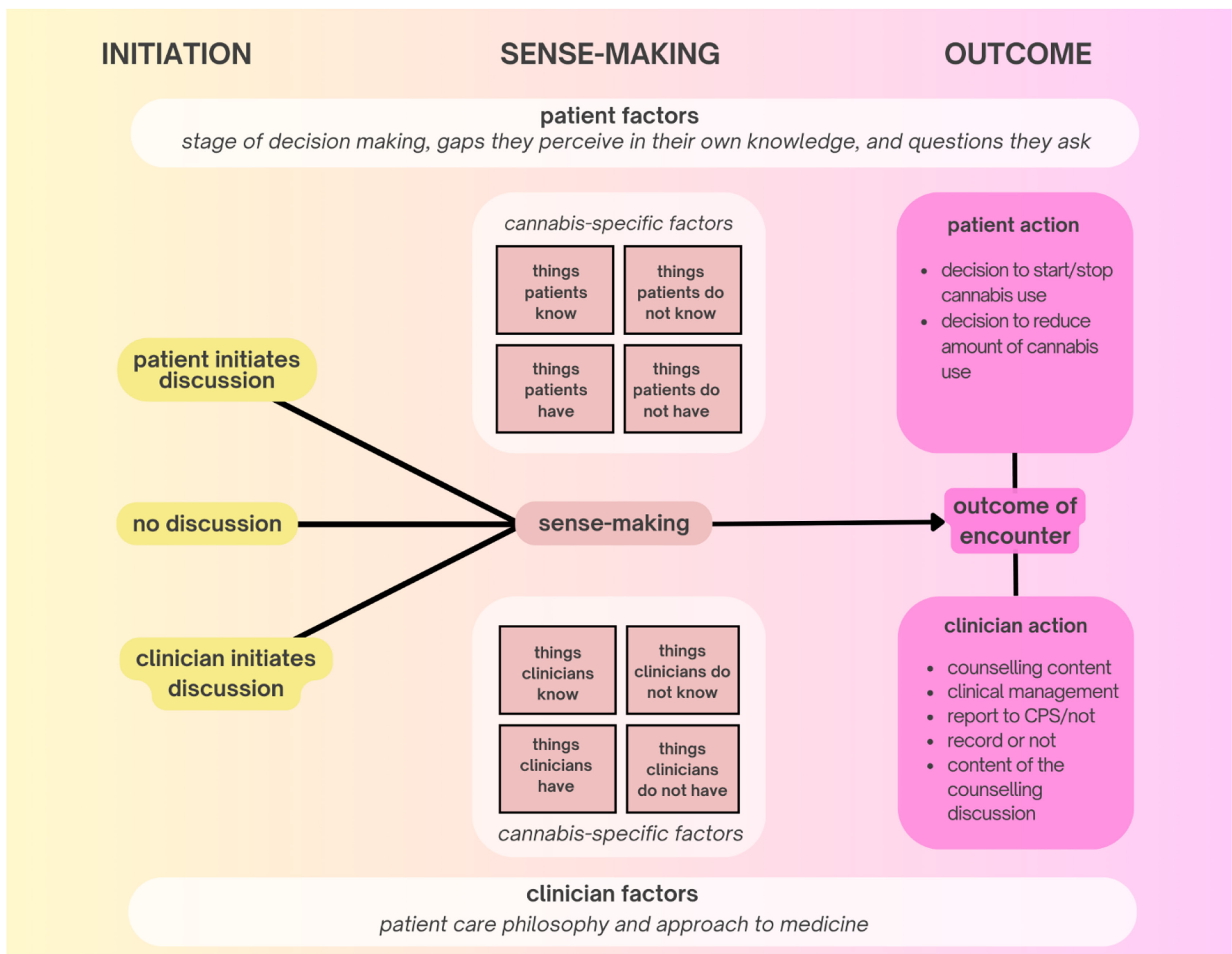

FIGURE 1 | The process of counseling about cannabis consumption during pregnancy or lactation. CPS, Child Protection Services.

For patients, these factors included their knowledge and beliefs about cannabis, as well as the information available to them. Patients drew on their knowledge and resources (or lack thereof) to comprehend the information available and make decisions. Some had already decided to cease cannabis consumption upon learning of their pregnancy, declaring they would rather be "safe than sorry" (P25). Others conducted deliberate information work to decide about continuing or ceasing cannabis use, described elsewhere [29], typically yielding dissatisfaction about the existing evidence: "I'm a very research- and information-motivated person and for me there just wasn't enough of those peer-reviewed, consistent studies to see what the effects would be." (P11) Patients arrived at the encounter in different points of sense-making and decision-making, some integrating information from clinicians alongside prior knowledge, with others knowing little about perinatal cannabis consumption until their clinician prompted a discussion.

Meanwhile, clinicians described how their knowledge of cannabis, patient care philosophy, and overall approach to care influenced their counseling interactions. Clinicians described a lack of up-to-date research as a challenge and identified several knowledge priorities: which doses, timing, or forms of cannabis consumption might be safer; effective harm reduction strategies; and concrete information regarding clinical outcomes in infancy and childhood. Patients and clinicians described insufficient educational materials for translating existing evidence: "I was going to say it would be nice to have the option to sort of give [patients] something, and ... I don't believe we actually have anything. We haven't developed anything." (Physician 033).

Nearly all clinicians described taking a patient-centered approach to clinical care by remaining nonjudgemental, neutral, and focusing on the patient's well-being. For many, this meant not counseling about cannabis consumption if patients did not disclose use to avoid communicating a judgment about credibility. Many clinicians explicitly stated their aim was to provide information and help patients make informed choices. Clinicians strongly endorsed the principles of evidence-based medicine, relying on academic sources and guidance from professional organizations to inform their conversations with patients. When these sources fell short, clinicians relied on the precautionary principle, and their varied knowledge and comfort with harm reduction strategies, such as one clinician who worked with polysubstance use in pregnancy and prioritized cessation of what they deemed to be the more harmful substance:

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TABLE 3 | Patient and clinician suggestions for improving counseling encounters about cannabis use during pregnancy and lactation.

Strategy	Suggested By	Explanation	Targets	Exemplar Quote
Asking all patients the same question	Clinicians	Making it clear that the question about cannabis use is routine and asked of everyone may increase comfort in disclosing use. Developing standard wording for this question will prevent question formulations that may obstruct disclosure	Comfort	I ask it like, it's a question. And again, I ask all the questions. I'm not like weird about it. I'm not like, 'Oh, but you don't use any drugs, right?' (Midwife 049)
Asking about the reasons or motivations for cannabis use and the perceived benefits	Clinicians and patients	Understanding why a person is considering cannabis use can help with exploring values and motivations. Counseling about cannabis as if it were a medication with an unknown safety profile may more closely match the way many patients think about this substance. Alternatives with documented safety profiles may be explored	Comfort and relevance	Maybe it's an opportunity to try to understand what's going on. Like, is it like a social-recreational thing, or is it treating underlying anxiety that's not been treated appropriately, or is there some other reason that this person feels the – you know, is using – if someone's using a lot, maybe there's a reason and maybe that's an opportunity to open up another conversation about what are other treatments for the symptoms they're trying to treat. (Physician 027)
Considering asking about cannabis on a medical history form	Clinicians	Some clinicians suggested that comfort with disclosing use may be improved if cannabis use is queried outside of a first meeting	Comfort	I often find it easier for patients or for clients ... to reveal things when they don't have to tell you the first time they're meeting you in person. (Midwife 016)
Using a trauma-informed approach to counseling	Clinicians and patients	It is important to recognize that patients may have past experiences with medical mistreatment, shame, or stigma. This conversation should be approached in a nonjudgemental, patient-focused way	Comfort	I find it ideal because if I need – to understand the patient, I need to know their, what they're taking prescribed and if they're taking non-prescribed. It tells me a lot about the severity of their mental health concerns and risks. So, just for their safety, I really need to know the first session. But it also helps the client, in my experience, it helps the client to know that I'm not going to judge them for drug use or I'm not going to – they can maybe hold things back. Like, 'maybe she'll deny me care or won't take me seriously'. So, once we get that out of the way and they see that I'm still in their court, I'm still in this – like for the long haul here. I'm going to help them. It just kind of gets that taboo away. (Nurse 042) Ideally, they would ask the question without putting their opinion or bias on it and have room for discussion. (P47)

(Continues)

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TABLE 3 | (Continued)

Strategy	Suggested By	Explanation	Targets	Exemplar Quote
Discussing why this information is relevant to medical management	Clinicians	Patients and clinicians may have different understandings of why information about perinatal cannabis use is clinically relevant. Explaining why this information is relevant, for example, may change medical management and provoke more regular screenings for fetal growth, and may both inspire disclosure and more helpfully focus the conversation	Relevance	I usually just say like I'm not here to judge in here to gather factual information so that we can make the best decisions for yourself and your baby and I just say like sometimes there's extra screening that's needed for babies that may have been exposed to drugs at the early stages so if that's something that you have done and would like that extra screening then I would need more of a forthcoming answer so I just try to keep it open and honest and just be open to communication. (Nurse 005)
Being explicit about what will happen with this information	Patients	Many patients are worried that disclosing prenatal cannabis use may result in a referral to child protection or welfare services. Clinicians described cannabis use as not constituting an independent reason to refer. Making it clear why this information is requested and what will be done with it (e.g., medical management and not invoking surveillance) could increase comfort	Comfort and relevance	it is so taboo and looked down upon and you know like, I asked at first is this a trap? Are you going to call CPS on me? (P42)

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> I mean, we know cocaine has much bigger effects during pregnancy, right. So, I think that's an appropriate sort of stratification in people's minds and if they can only figure out how to get one drug in.
>
> (Obstetrician 057)

3.3 | Outcome of the Counseling Encounter

Patient action occurred prior to and after the counseling encounter, and included continuing, ceasing, reducing, or adapting their cannabis use, for example, by enacting risk mitigation strategies (described further elsewhere [36]). Overwhelmingly, patients reported making this decision independently from their clinician, as they were often unsatisfied with the counseling encounter: "My doctors, of course, they were saying 'you know it's not well [understood]' and I asked multiple times and I said 'well, why?' and they're like 'well it's just not good' and I was like 'okay well that didn't really answer anything'." (P48).

Clinician action commonly included decision-making around what information, resources, or referrals to provide patients in follow-up and how to change clinical management throughout pregnancy and postpartum. Aligned with a near-ubiquitous belief that perinatal cannabis consumption was more harmful than helpful, all clinicians reported discussing risks with their patients. When counseling a patient who wished to continue cannabis, most clinicians described a harm reduction approach, encouraging a reduction in use if cessation was not possible. Most clinicians reported recognizing that cannabis is often used during pregnancy for therapeutic reasons. Data from patients affirmed this assumption [22], although few patients reported counseling encounters that included discussion of perceived benefits or took a harm reduction approach. Instead, patients described advice to abstain from cannabis in favor of prescribed medication:

> they [clinicians] don't realize that there is possible benefits to it [cannabis]. They would rather have me on, you know, Zoloft … and Adderall and all these stupid drugs instead of one plant that can make me feel better and take care of all my symptoms and not provide me with the laundry list of possible side effects, and, you know, other things that I'm going to have to take other pills for.
>
> (P42)

One patient spoke about cannabis use as reducing perceived harm of other medications:

> I really don't want to [give up cannabis]. Because I know what the alternative would be, and I really didn't want to be on prescription antidepressants and anti-anxiety meds while pregnant. I felt the safer decision for me was definitely smoking as opposed to going the prescription route because of the documented stuff that we know can happen.
>
> (P42)

Some clinicians described referring patients to colleagues with more knowledge about cannabis consumption. Clinicians unanimously asserted they would not contact child protection services based on cannabis use alone, and would only initiate a report if they believed a child was in danger:

> With an individual who primarily is the only concern we'll say, is smoking cannabis during pregnancy, then I don't know if you would have a duty to report. Of course, you're counselling on the long-term outcomes of the developing fetus and the future person. But in the same way that I wouldn't have a duty to report someone who is smoking cigarettes in pregnancy, which is not great for a fetus, but it's something an individual can do. … So, with cannabis use being the primary concern, then I don't see a reason to have a duty to report, unless the cannabis use was so extensive or it was in a broader context of me having concerns about the individual's ability to parent.
>
> (Physician 058)

At the conclusion of the encounter, clinicians decided whether and how to document cannabis use in the medical record. Most reported always recording this information and stated there was no reason to do otherwise. A subset of clinicians highlighted circumstances in which recording cannabis use could cause harm, particularly to marginalized groups: "I'll say, 'I won't put it on your chart. Like, I'll know it, I won't put it on your chart because it might raise flags that you don't need raised.' You know, they are Inuit women going into a white world, they don't need any more flags pointed at them." (Midwife 052).

4 | Discussion

This qualitative study of 75 individuals (52 patients, 23 clinicians) identified that both groups have a common vision of what an optimal counseling session should look like. Both desired an open, nonjudgemental conversation to explore patients' perceptions of benefit and harm, supplemented with credible information about risks, alternative solutions, and strategies to reduce harm. Clinicians described facilitating sessions that looked like this, limited only by the availability of scientific evidence to support clear counseling about risks and harm reduction strategies. However, patients described experiencing very different interactions with prenatal clinicians around cannabis. Some were uncomfortable disclosing their desire to consume cannabis, fearing stigma, judgment, or referral to child welfare services. Patients did not describe clinicians as trusted partners in decision-making, recognizing gaps in clinical evidence and sometimes remarking that the information provided by clinicians seemed constrained by the individual's opinion about the topic or medico-legal guidelines. Both patients and clinicians reported that conversations about cannabis consumption during lactation were unusual.

Both groups endorsed an informed choice model of decision-making. Demonstrating respect for autonomy, informed decisions are rooted in relevant knowledge and are congruent

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with a person's values [40]. The clinician's role in an informed decision-making process is to facilitate the patient's decision-making by providing comprehensible information and eliciting patient values relevant to these complex decisions [41, 42]. While clinician participants described attitudes toward counseling resonant with this role, patients described encounters with clinicians whose own values were shared implicitly or explicitly, constraining disclosure or fulsome conversation. This finding echoes other studies where patients describe reluctance to disclose and negative responses from clinicians after disclosure [26, 43, 44].

Informed decision-making about perinatal cannabis use is stymied not just by a fear of disclosure to clinicians but also by limited clinical evidence. Accordingly, patients may not be able to obtain information to guide their decisions on matters that mean most to them, such as effective harm reduction strategies [29, 36, 43]. Future research relevant to decision-making about cannabis use in pregnancy or during lactation should be translated to clinicians and patients in a form relevant to those audiences [45]. Participants marked several important gaps in knowledge: clinical effects of dose, timing, and formulation of cannabis; clinical outcomes associated with perinatal cannabis consumption; and ways to reduce risk while still receiving perceived benefits. These topics are congruent with those identified in other research [43, 44, 46]. The development of this evidence base may be stymied by ethical considerations.

Several concrete strategies to improve counseling interactions around prenatal cannabis use were suggested by participants (Table 3). Beyond these, we offer additional implications for clinical practice. First, both patients and clinicians agreed it was unusual to discuss cannabis use during lactation. The question about cannabis use was typically asked and documented early in pregnancy, and clinicians were unlikely to return to this conversation after birth, although previous research has shown some people who cease consuming cannabis during pregnancy may resume after birth [22, 47]. This may represent different understandings of the risk profile of cannabis consumption, reflecting the challenges of accessing authoritative research on the topic; it also provides an opportunity for further counseling and conversation [17]. Second, data from patients would support a counseling encounter that explores motivations and perceived benefits. Clinicians may find it helpful to focus the discussion on how those benefits might be achieved in a safe way, discussing the known safety profiles of evidenced-based treatments including pharmaceutical and nonpharmaceutical options. This model would encourage patients and clinicians to explore alternative therapies known to be safe in pregnancy to achieve the same benefits the patient experiences from cannabis [23, 25, 30, 48].

4.1 | Strengths and Limitations

This study provides specific, actionable suggestions for counseling about perinatal cannabis use in a way that facilitates informed decisions, generated by and responsive to the concerns of patients and clinicians. Our findings are specific to the socio-historical context in which they were generated and may not be transferable to other contexts, particularly to countries where cannabis has not been legalized. Volunteer bias may have influenced our sample of clinicians who endorse fulsome, patient-centered conversations about cannabis. Our physician sample did not include any pediatricians, as typically developing healthy infants in Canada are cared for by family physicians.

5 | Conclusion

As more people consume cannabis regularly, perinatal consumption is likely to increase. Both clinicians and pregnant and lactating people desire the same things from a counseling interaction about cannabis: sharing of information, identification of values, and facilitation of a decision. However, patients indicate that many clinicians are not counseling in this way. Focusing the clinical encounter on identifying safe alternatives that offer the same benefits patients perceive from cannabis may encourage more fulsome conversations that strengthen the therapeutic alliance. The development of evidence-based harm reduction strategies will help further improve these counseling sessions.

Acknowledgments

We appreciate the conceptual contributions of Dr. Tejal Patel and Dr. Taryn Taylor to the larger study.

Conflicts of Interest

From April to December 2019, J.P. was employed as a Research Analyst at PureSinse Inc (a licensed cannabis producer). She does not hold any remaining financial or personal connection to PureSinse, which is no longer in operation. From May 2021 to February 2022, J.P. was employed as a freelance research coordinator by Avail Cannabis Clinics, a privately owned network of medical clinics, to prepare and submit research ethics applications for research related to the use of cannabis to alleviate posttraumatic stress disorder (PTSD) symptoms in military populations. J.P. was compensated hourly for this work and no longer holds any financial interests or personal connection to Avail or their research. The other authors have no conflicts to declare.

Ethics Statement

This study was approved by the Hamilton Integrated Research Ethics Board (Project #10976 and #14299) and informed consent was recorded for all participants.

Data Availability Statement

Research data are confidential and not shared. Complete interview transcripts may yield identifiable information and participants did not consent to having transcripts shared beyond the research team.

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