RELUCTANT AND UNCERTAIN

Minnesota physicians’ opinions on medical cannabis

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In 2014, the Minnesota Legislature established the Minnesota Medical Cannabis Program, which allows the legal use of medical cannabis by patients with a qualifying condition, as certified by their provider. Minnesota’s medical cannabis program is notable for having taken measures to explicitly address prominent concerns from the medical profession surrounding medical marijuana. Yet five years since the program was established, only 6 percent of physicians licensed and located in the state have registered to certify patients.

In early 2017, with the assistance of a market research partner, we recruited physicians practicing in Minnesota to participate in online, bulletin-board focus groups on the topic of medical cannabis. In order to promote honest input, participants were separated into two groups, one made up of those who were registered and one of those who were not. The groups were convened over three days and followed a structured interview guide, administered by an independent moderator who posted the questions and interacted with respondents in real time. At the conclusion of the focus groups, the responses were compiled and de-identified. Research team members reviewed the data, identified qualitative themes and coded the transcripts.

Twenty-two physicians participated, eight of them registered and 14 unregistered, from eight different specialties with three to 40 years of experience. Themes identified included the sufficiency of evidence for medical cannabis, the role of cannabis in the therapeutic tool kit, non-scientific factors in physicians’ reasoning and understanding of the state law. Even though there is disagreement over whether the scientific evidence is sufficient for medical use, physicians widely agree that cannabis should not be a first-line option. Physicians consider not only the evidence, but also the cost of medical cannabis and the logistical barriers to access. Finally, there are still significant misperceptions about key aspects of the program.

The experiences and opinions we elicited from a range of physicians suggests they are still reluctant and somewhat uncertain about how to navigate this space. A variety of factors including logistics, liability and misperception make physicians hesitant to embrace medical cannabis, even as an option of last resort.

Background

Across the country, the medical use of cannabis (also referred to as “marijuana”) and its derivatives continues to be a frequent topic of debate in both legal policy and medical practice. As of July 2019, 34 states had passed legislation making it legal for medical use. Most Americans (62 percent) think that the use of marijuana should be legalized and 81 percent believe it has at least one benefit. But, despite growing scientific and public interest, cannabis remains a Schedule I drug under federal law with “high abuse potential” and “no accepted medical use.”

Physicians want to help patients mitigate symptoms while avoiding toxic side effects of pharmaceuticals, including opioids. But many unanswered questions remain about the efficacy and risks of using marijuana in the medical setting. There is moderately strong evidence to support its use in the treatment of chronic neuropathic pain, but only limited evidence for its use in ameliorating nausea and vomiting induced by chemotherapy, encouraging weight gain in HIV, and treating sleep disorders and Tourette syndrome. But studies have also found that heavy cannabis use increases risk of psychotic outcomes. While long-term marijuana use can lead to addiction, studies of THC-containing medications, dronabinol (synthetic) and sativex (plant extract), have concluded that those medicines have low abuse potential. This complex backdrop makes medical cannabis both a promising and a confounding drug for many physicians.

In 2014, the Minnesota Legislature passed a bill establishing the Minnesota Medical Cannabis Program, which allows the legal purchase, possession and use of medical marijuana by patients with a qualifying condition. Despite the program’s provisions for protecting physicians and preventing abuse and misuse, only 6 percent of licensed physicians in Minnesota have registered to certify their patients in the five years since the program was established. This low participation rate among physicians could reflect low patient demand, or it could suggest physician reticence to participate in the program. In order to better understand the experiences and opinions of the Minnesota medical community regarding medical cannabis, we recruited physicians practicing in the state to participate in online, bulletin-board focus groups on the topic of medical
cannabis. We invited physicians who had been practicing for at least one year, were aware of Minnesota’s medical cannabis program and practiced one of several specialties managing patients with at least one of the qualifying conditions.

We partnered with KJTgroup, a market research firm with expertise in moderating invitation-only online discussion boards. The bulletin boards followed a structured interview guide developed with content experts from our team and KJTgroup. Participants were clustered into two groups by their registration status at the time of recruitment in order to promote honest input. Each online focus group was open for three days and required a total of about 60 minutes of each physician’s time. Upon completion of the focus groups, the transcripts from the two groups were compiled and de-identified. Research team members independently reviewed the data, then together identified qualitative themes and coded the transcripts.

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The evidence for medical cannabis
There was a noteworthy lack of consensus about the available evidence supporting the use of cannabis derivatives for medical purposes. While all but one of our participants agreed that the evidence for medical cannabis is not conclusive, they were sharply divided over whether or not that limited evidence is sufficient to justify patient use. Among the 17 participants who commented directly on the sufficiency of the evidence for medical cannabis, nine explicitly stated that the evidence for medical cannabis is “sufficient” or “adequate” for justifying its use. Eight said the opposite.

• Sufficient: “I think the available studies are sufficient to allow patient use in certain circumstances, but not rigorous enough to be absolutely conclusive. Adequate evidence is clearly necessary and continued studies should be done to guide patient use.” (Registered)
• Insufficient: “I don’t think the current evidence [is] either conclusive or sufficient to use cannabis and may need further research and guidelines.” (Unregistered, would consider registration)

Not only were our participants sharply divided on whether or not the evidence is sufficient, their stated opinions about the sufficiency of the evidence did not always match their self-reported registration status and practices. Most (67 percent) of the physicians who said data was insufficient were not registered, and most (75 percent) of those who said it was sufficient were. But a handful of physicians in the group who stated that the data is sufficient do not certify patients. Still others who said that the data is not sufficient have certified patients that don’t respond to conventional, primary treatments.

The role of medical cannabis in the therapeutic toolkit
We asked participants to describe the role medical cannabis has in the “overall therapeutic toolkit.” Most participants (77 percent) described it as second-line or a last resort (i.e. “last option,” “supplemental,” “adjuvant” or “palliative”). Only two participants described it as an equally viable alternative to treatments that are conventional, primary treatments.

“In general, medical cannabis is recommended as a choice if other treatments have failed. I support this. I would not prescribe it as first line treatment for any of the above conditions until more evidence is available to support its efficacy and we know more of the side effects profile.” (Unregistered, would not consider registration)

“I have some experience with medical cannabis in cancer-related pain and anorexia, but I would only consider it in patients that don’t respond to conventional medications, which is a small minority of patients.”

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available standard treatments have been tried.” (Registered)

**Other factors**
Participants were also asked about whether or not other factors, including cost, were relevant in their consideration of medical marijuana. More than half (55 percent) affirmed that cost was a major consideration for them, while only one stated explicitly that cost was not a factor. Other than cost, travel to a state-approved distribution center was another frequently mentioned logistical issue. Many physicians in our study reported practicing one to two hours away from the nearest location.

- “Cost has been a major reason why my patients do not pursue medical cannabis.” (Unregistered, would not consider registration)
- “Cost is the number one logistical factor and second would be travel to a dispensary.” (Registered)

**Knowledge of the state program**
Our data also suggest significant gaps in physicians’ understanding of Minnesota’s medical marijuana program. Nearly half (43 percent) of the unregistered physicians in our study admitted to having little or no knowledge of the steps the law has taken to mitigate the risks of medical marijuana for both patients and providers. Both registered and unregistered physicians expressed concerns about patients smoking marijuana, even though the Minnesota law forbids smoking. Additionally, several unregistered physicians cited their concern about liability of “prescribing” among their reasons for not registering, despite the fact that the program does not expect physicians to prescribe the drug. This comment exemplifies the misconceptions of some participants about the program:

- “Lots of things might reduce my willingness to prescribe cannabis. These include legal problems related to prescribing and maybe not prescribing, side effects and habituation, lung damage if smoked, and being labeled a ‘pot doc’ who is a loose prescriber of this class of drugs.” (Unregistered, would not consider registration)

**Discussion**
Many of the perspectives expressed in our focus groups echo existing survey data on physicians’ views of medical marijuana. At the state level, a New York survey has found that a majority of physicians believe medical marijuana should be an option. A recent survey in Minnesota has shed light on physicians’ concerns about the impact of cost on the availability of medical cannabis. And studies from Colorado and Washington have revealed that physicians perceive a need for additional knowledge and guidelines.

The medical community’s stance on cannabis seems contradictory. Braun and colleagues found in a nationwide sample of oncologists that nearly half were recom-

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**Physicians who took part in focus group**

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<th>PRIMARY SPECIALTY</th>
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Mending cannabis, even though 70 percent felt inadequately informed to do so. Most physicians in our study acknowledge that the evidence for medical cannabis is far from conclusive, so they approach it only as a second- or third-line option for patients who have already failed to gain relief from more conventional therapies (that presumably have greater evidence or a more established clinical track record for their use). When patients face high symptom burdens and when conventional treatment options have failed, a lower evidence threshold begins to apply. In such circumstances, pragmatism takes priority over strength of evidence. What matters most to these practicing doctors is that options are available for their patients.

Physicians’ consideration of cost and travel raises important questions about other influences on their decision-making around medical cannabis. Physicians’ reasoning about the evidence appears to be coherent. However the limitations of our study—a group setting on a digital platform—prevent us from gauging whether physicians are reasoning to their conclusions or from them. In a space as ambiguous and socially charged as medical cannabis, considerations we observed of non-medical factors like cost and travel, together with mixed opinions about the evidence, create the possibility that some degree of paternalism may be impacting physicians’ decisions about whether or not to register and certify their patients.

Regardless of physicians’ opinions about the scientific evidence for medical cannabis, misperception and misunderstanding of the program abound. Our data highlight a lack of knowledge among Minnesota physicians about the program in which they would be participating. Further research could help clarify the ways that physicians are reasoning about medical cannabis by exploring the role these misperceptions may play. The need for further scientific study and legal rescheduling of cannabis has been well established. But we have found that those are not the only factors at play. To better engage physicians in programs like Minnesota’s, there is additional need to identify ways to effectively address the other factors, such as cost for patients and education for professionals, that impact physicians’ decision making.

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REFERENCES


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