Attitudes of family physicians towards adolescent cannabis users: a qualitative study in France

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Abstract

Background. GPs are the health professionals most frequently consulted by adolescents. However, discussion between GPs and adolescents regarding cannabis use does not occur spontaneously.

Objective. To identify obstacles to the identification and management of cannabis use by adolescents based on GPs’ experiences.

Methods. We conducted a qualitative study using focus groups of GPs from the Auvergne area (France). The GPs were selected according to descriptive and strategic variables. Three researchers—an anthropologist, a psychiatrist with expertise in addiction and a GP—performed a thematic analysis.

Results. Twenty-four GPs participated in three consecutive focus groups. The GPs were aware of the health risks of cannabis, yet ambivalent about its use by adolescents. The GPs also reported a lack of patient questioning during consultation. The obstacles to the identification and treatment of cannabis use by adolescents identified included lack of GP knowledge about cannabis (e.g. consumption patterns and laws); difficulties in addressing the issue with adolescents, evaluating adolescents’ consumption and its impact and proposing support and follow-up and the presence of parents. The GPs were aware that their role lies at the intersection between the medical, personal, familial and social fields.

Conclusion. Despite these barriers, GPs are willing to ask adolescents about their cannabis use. An adolescent’s awareness, environment and receptiveness favour a sustainable therapeutic relationship. Brief intervention is a tool that may be of assistance in this relationship and allow GPs to take the initiative.

Key words: Adolescents, cannabis, drug use, focus groups, general practitioners.

Introduction

The prevalence of cannabis use in France is one of the highest in Europe (1,2). In 2008, 42.2% of adolescents reported having smoked cannabis at least once (3). Overall, 18% of boys and 12% of girls reported smoking cannabis at least once per month and 5% of boys and 2% of girls reported regular use (≥10 sessions per month) (1).
Cannabis is an illegal product in France: to consume, possess or grow it, encourage its consumption and drive after consuming it are offences incurring criminal and financial penalties. In the event of an offence, the consumer is obliged to seek care from a practitioner (a GP or specialist) under legal supervision. The medical, social and psychobehavioural risks of regular cannabis use are established (4). Regular cannabis consumption reduces performance at school (5). It increases anxiety, can cause depression (6) and increases the risk of psychotic disturbance in vulnerable people. This risk is increased by early cannabis use (7). The risk of lung cancer is increased, whether cannabis is consumed on its own or with tobacco (8). The risk of road accidents is doubled (9).

Identification of cannabis use as early as possible is important, because the risks of psychosomatic illness and dependence increase with early use (10). The literature on the identification of and intervention for adolescent cannabis use in primary care is scant compared with that for tobacco and alcohol. In France, the organization of primary care relies primarily on GPs (11), the health professionals most frequently consulted by adolescents (12). Most adolescents visit their GP with an acute complaint. There are no organized preventive visits in France to routinely address behavioural risks and substance abuse. In 2005, 89% of individuals aged 15–24 years reported having visited a GP at least once in the preceding year. According to epidemiological data (12), one in seven adolescents was identified as having used cannabis within the preceding 30 days. Chronic cannabis use increases health care demands (13); paradoxically, however, a national study in France showed that only 4.9% of daily cannabis users have consulted their GP about their consumption (3).

The GP practice is the ideal place to interview young patients. In most cases, an adolescent’s GP has known the patient since childhood and is familiar with his/her family situation and environment. However, studies (14,15) have shown that discussion between GPs and adolescents about cannabis use does not occur spontaneously. The patient does not volunteer information related to the consumption of illegal substances and behavioural risks. Only 8% of French GPs report having addressed the issue during consultations (16). In this study, we aimed to understand GPs’ perceptions regarding cannabis and its consumption by adolescents, identify barriers to communication about cannabis between doctors and adolescents and determine whether GPs are willing to support and follow adolescent cannabis users.

Methods

Study design
We conducted a qualitative study because this methodology allows the exploration of many aspects of complex experiences and exposure of the reasoning behind GPs’ actions, beliefs and attitudes. This set-up is particularly suited to a study relating to an illegal substance (17). We chose a focus group method because it seemed appropriate to identify different perspectives through discussion (18). A particularly important effect of this design was the emergence of ideas unanticipated by the researchers, because this subject is rarely addressed in GP consultations in France.

Participants
The GPs were selected to obtain a diversified panel (17), according to descriptive variables (sex, age, mode and place of practice, with possible university connections) and strategic variables (specialized training in addiction). To identify the sample of family physicians, we conducted a snowball technique in the Clermont-Ferrand area (Auvergne, France). Of 50 GPs contacted initially, 21 agreed to participate. The reasons for refusal included lack of availability or knowledge about the subject. Three additional family physicians were contacted secondarily because of their expertise in addiction and they agreed to participate. The subject of the focus groups, conditions of participation and confidentiality agreement were explained to the GPs. They signed an informed consent form before being interviewed.

Data collection
The number of focus groups was determined by content saturation (19). No new information was gathered in the third focus group and data collection was terminated. The interviews were conducted by a health anthropologist (LM). A medical practitioner with expertise in addiction (VP) and a GP (PV) took notes. Non-verbal aspects of the exchanges were recorded and used to complete the analysis.

The discussions were guided by a topic guide (Table 1), which was based on a review of the literature and on interviews with a medical practitioner with expertise in the field of addiction, a GP trained in drug abuse screening and a GP without training in drug abuse screening. The moderator (LM) invited one of the participants to relate their experience of a consultation with a young cannabis user without mental disorder. After requesting

<table>
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<tr>
<th>Table 1. Interview guide used during the focus groups</th>
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<td>1. Describe your relationship with the adolescent.</td>
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<td>2. What knowledge do you have regarding cannabis?</td>
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<td>3. How do you approach the problem of cannabis with the adolescent?</td>
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<td>4. How do you evaluate the adolescent’s consumption of cannabis?</td>
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<td>5. What difficulties do you encounter in assessing the adolescent’s willingness to change his habit?</td>
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<td>6. Can you identify any obstacles to treatment?</td>
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participants’ reactions, the moderator led the discussion on the basis of open questions from the topic guide (Table 1). The discussions were recorded and transcribed word-for-word by the three researchers (VP, PV and LM). The research protocol respected the quality criteria recommended for qualitative research (20). The study received approval from the Ethics Committee of the Centers for Clinical Investigation of the Rhône-Alpes and Auvergne regions (Reference: 5044).

Data analysis

The three researchers (LM, VP and PV) coded each transcript independently. A thematic analysis was performed after each focus group session. Interpretation of the coded texts enabled classification of the codes and establishment of the relationships between the various codes or categories. After each focus group session, the codes were compared and discussed until agreement was reached. After classification, various themes were identified on the basis of descriptive hypotheses. When a new theme emerged, it was added to the interview guide. The analyses were cross-referenced. At the end of the data collection period, the results of the analyses were sent to the participants for validation. Participants were asked if they agreed with the analysis and conclusions of the study.

Results

Participants and procedure

Twenty-four GPs participated in three consecutive focus groups between February and December 2009. There were eight participants per group (58% male; 42% female). They had an average age of 41.7 years and an average period of clinical experience of 22 years (±10). The types and locations of their practices are described in Table 2. The focus group sessions lasted 90 minutes. Six themes emerged from the analysis of the data.

GPs’ perceptions of cannabis use among adolescents

The GPs viewed adolescence as a period of transformation and vulnerability. Most believed that cannabis use was not only recreational but also evidence of a specific psychological disorder in adolescence. Most thought that a young person might be susceptible to the health risks and psychological problems associated with cannabis use. They felt that cannabis use affected more boys than girls. They perceived a trivialization of cannabis use by adolescents and the media. However, the GPs considered cannabis use similar to alcohol use, i.e. both are typically used as entertainment in social situations. Some GPs were opposed to the idea of ‘soft’ drugs and feared that cannabis consumption led to the use of more dangerous drugs. Other GPs shared the view that cannabis was trivialized and considered a phenomenon of group membership.

In terms of recreational use, I may consider it too lightly. But on the rare occasions where it has been addressed, I think it has been trivialized both on the part of the adolescent and on my own ... GP21, Male, Focus Group (FG) 3

Communication with young cannabis users

The GPs expressed difficulties in asking adolescent patients whether they consumed cannabis and this was particularly the case for GPs who were unfamiliar with the drug. The GPs feared that they would not be able to suggest follow-up treatment in the case of a positive response. Being familiar with the adolescent was also an obstacle. The GPs often did not ask such patients about cannabis use for fear of personal repercussions.

I think that I must be lacking in judgement because I love this young patient ... I can’t believe that he would be capable of doing that, so I don’t ask him. And I am certainly afraid of hurting his feelings if I ask the question. GP20, Male, FG3

The GPs did not all agree on the frankness of the adolescents’ responses regarding their cannabis consumption. According to the GPs, privacy of medical information was one way to reassure patients of confidentiality.

The adolescents will be afraid that their secret will become public, and this can represent a real handicap with respect to screening for use. Above all, you have to have a sympathetic attitude, give them a sense of security, and reassure them

| Table 2. Description of the sample of GP participants in the focus group |
|-------------------|-----|------|
| GPs               | n   | %    |
| Gender            |     |      |
| Male              | 14  | 58   |
| Female            | 10  | 42   |
| Age               |     |      |
| 28–38             | 7   | 29   |
| 39–48             | 7   | 29   |
| 49–58             | 10  | 42   |
| Location of practice (H/F) |     |      |
| Urban             | 12 (7/5) | 50 |
| Semi-rural        | 4 (2/2)  | 17 |
| Rural             | 8 (6/2)  | 33 |
| Type of practice  |     |      |
| Individual        | 8   | 33   |
| Group             | 16  | 67   |
| Teaching GP       |     |      |
| Yes               | 13  | 54   |
| No                | 11  | 46   |
| Specialized addictions training |     |      |
| Yes               | 4   | 17   |
| No                | 20  | 83   |
| Total sample      | 24  | 100  |
about the confidentiality of what they will confide to you. GP12, Female, FG2

The GPs felt that the most favourable approach to addressing the subject was through questioning regarding health risks during a physical examination. Leaflets in the waiting room were considered helpful for opening the discussion. GPs with specific education in addiction medicine were proactive in questioning adolescents. All the GPs were in agreement that the best way to screen patients was simply to ask the question ‘What do you smoke?’, preferably when the adolescent was alone.

Consumption and impact assessment

Unlike alcohol or tobacco, the GPs had difficulties in evaluating the amount of cannabis consumed. They distinguished occasional or recreational consumption from chronic consumption. Most did not know the composition of a joint or the definition of water pipe smoking. None mentioned new synthetic cannabinoids or exceptionally strong strains of cannabis. The GPs also had difficulty evaluating the level of dependence. Some wondered whether there was a scoring system to identify cannabis consumption and whether quantitative tests for blood or urine existed. The GPs wanted to be able to evaluate the clinical and biological impacts of cannabis more accurately, in a similar way to tobacco and alcohol.

With cannabis, information is not obvious. With alcohol or tobacco, one has scores of information for evaluation. As far as I know, there is no such thing for cannabis. This would make our work easier. GP22, Male, FG3

The Fagerström test is very informative for determining tobacco dependence. We don’t have anything similar for cannabis … GP10, Female, FG2

The participating GPs stated that they were concerned by the frequent attitude of denial shown by young people, who attempted to reassure GPs that they were in control of their use and that the product was harmless. The GPs were aware of the need for vigilance in identifying the adverse effects of cannabis. As a group, they were aware of its physical impact, particularly on the lungs, and its psychological impacts, such as depression or acute delirium. According to the GPs, withdrawal or, in contrast, a tendency to combine cannabis with alcohol and/or other drugs at parties, the absence of involvement in sports or groups and difficulties at school appeared to be warning signs of cannabis use or dependence. They also believed that considering the possibility of the associated use of other drugs, such as alcohol, ecstasy or heroin, was important.

Management of adolescent patients

Some GPs believed that follow-up was necessary in addition to screening. Trained clinicians suggested meeting with the young people on fixed dates without their parents. The GPs who had not been trained in addiction did not feel competent to conduct follow-up sessions and referred their patients for a specialist consultation. The GPs’ priority was to systematically evaluate the psychological state of the young person, sometimes using score-based evaluations. The GPs were unanimous in their desire to turn to a psychiatrist in the event of co-morbid psychological issues. Preserving the connection with the adolescent appeared important, with the medical practice being an appropriate place for discussion.

As far as I am concerned, with respect to cannabis, I do not only investigate cannabis use but I also ask myself if this adolescent is OK or if he is having problems … GP9, Female, FG2

All of the GPs declared their willingness to devote their time to patients experiencing problems with cannabis. To overcome organizational problems, they suggested future appointments that would fit their schedules. All GPs regretted the lack of training in specific aspects of adolescent medicine during their studies, such as medical problems related to adolescence and drug use.

We could imagine creating a type of appointment for adolescents where matters like sexuality, contraception, and drugs could be discussed. A consultation package because these things take time. GP19, Female, FG3

As far as I am concerned, I believe that the first thing that is necessary is training. It’s all very well to address the subject, but if you have no answers to give, you seem incompetent! GP13, Male, FG2

Confidentiality: relationships with parents

The adolescent patients’ relationships with their parents appeared difficult. The GPs described two different parental profiles: those for whom cannabis use was trivial and those for whom it was a serious issue. Between the two extremes, the GPs expressed difficulties in being able to listen neutrally and maintain a neutral attitude. Some parents delegated their roles as educators; others demanded a repressive attitude or psychological follow-up that was out of proportion to the problem. The presence of parents was quite often a hindrance to the doctors. They sensed the young person’s unease in the presence of their parents, which prevented the GP from addressing the problems at hand effectively. Being aware of a favourable legal situation, they generally asked parents to leave to obtain a moment of privacy with the adolescent. The GPs attempted to evaluate the relationship between the young person and their parents. Several GPs reported acting as a conflict mediator between adolescents and their parents. Preventative appointments for adolescents prescribed by national health insurance, and a leaflet entitled ‘Cannabis Explained to Parents,’ appeared to have effectively encouraged parents to allow doctors to see adolescents alone.
When their child has reached the sixth grade, I explain to the parents that the child is now old enough to come by themselves to their sports appointment. If I feel that the teen has something they want to say or if I note something about their behaviour in the course of the exam, I try to ask the parents to leave, telling them it’s about respecting the privacy of their child. GP16, Male, FG2

**GPs’ attitudes**

The participating GPs agreed that their attitudes depended on their own adolescence, on their experiences as parents, on their views of adolescence and on possible personal experiences as cannabis users. Even the younger GPs did not feel connected to the adolescents because they were of the same generation as the adolescents’ parents. The GPs were fearful of appearing too paternalistic or moralizing, but they also had no desire to be the ‘buddies’ of their patients, which they viewed as implausible. The GPs deemed it necessary not to be involved if the patient was implicated in a court case associated with cannabis consumption.

In my practice, I define the roles of the law, the cops, and myself. My role is to help those who are suffering. GP4, Male, FG1

The idea of being a family doctor with knowledge of the adolescent and their environment was considered to be favourable for building trust but carried the risk of presenting the GP as the parents’ ally. Some GPs practising in rural areas reported that they did not raise the issue, considering it essentially an urban phenomenon.

In the open countryside, I am not confronted with this problem. It is a universe that I have no part in. GP2, Male, FG1

Trust in the relationship allowed the GP to inform the adolescent that, despite their health problems, the practitioner was interested in their well-being. It seemed necessary for the GPs to position themselves as health experts and to have, above all, a medical discourse that was neither moralizing nor trivializing. This position allowed them to maintain an appropriate distance and avoided an attitude that would be too emotional.

It is very important to counsel patients, we have the right to counsel patients, and we are not here to police our patients; the adolescent has to feel that, in some way, we give credit for this tiny, negligible use. GP13, Male, FG2

**Discussion**

While the GPs were aware of the harmful effects of cannabis, they showed an unwillingness to question adolescents during consultation. Although they regretted the trivialization of cannabis, they nevertheless felt that it was typically used for entertainment and was not harmful and that they did not have to address this issue with adolescents. For GPs, the main barriers to communication concerning cannabis were lack of education about the drug, lack of training on the management of its use and difficulties broaching the subject. Furthermore, Biddle et al. (21) stated that an absence of questioning by a GP was considered by adolescents to represent a lack of qualification to treat their health problems. Interventions for tobacco or alcohol use are conducted by GPs, whereas the prevention of cannabis use is not (16,22). This absence is unfortunate because adolescents who begin using alcohol or drugs early are at an increased risk of developing an addictive disorder later in life (23). The fear of having nothing to propose to adolescents after the identification of cannabis use is an obstacle. In contrast, other studies suggest that adolescents expect their GPs to ask them about this subject because they believe it is their role (15,24). Some GPs felt that patients in rural settings did not use cannabis, while studies have shown higher rates of consumption in rural areas (25).

As in the qualitative study by Van Hook et al. (26), lack of time was mentioned by GPs and they tended to suggest a further appointment to adolescents. In our study, the GPs were less comfortable talking about cannabis if they had known the adolescents for a long time, whereas, in a parallel study, the patients felt the opposite (27). Several studies (15,28,29) have shown that adolescents prefer to be alone with their GP to talk about cannabis because of the discomfort caused by the presence of their parents. Parents generally accept an invitation from the doctor to leave the consultation (30) and these findings have encouraged doctors to ask parents to leave the room. Therefore, GPs should receive adolescents alone and address cannabis issue systematically, even when they have known the patient since childhood. Physicians want to assure confidentiality and adolescents are more willing to communicate with and seek health care from physicians who assure confidentiality (31). Each GP must be aware of the laws of their state or country concerning confidentiality with regard to adolescence, which is defined by the World Health Organization (WHO) as the period between 10 and 19 years of age (32). In the UK, the Gillick jurisdiction and Fraser Guidelines authorize care to adolescents below the age of 16 without the permission of parents. In France, the law of 4th March 2002 allows confidentiality to be applied to those below the age of 18, without any specified lower age restriction. American guidelines (33,34) state that GPs must ask about drug use; by contrast, there are no specific guidelines in France. The GPs in this study stated that they wanted dedicated consultations on specific dates, as has also been recommended by the WHO (35) and is desired by young people (30).

For the GPs in this study, their perceptions were an important barrier. Indeed, the doctor’s position is sometimes difficult. There may be conflict between their scientific knowledge...
and their own values; the latter may lead to a judgmental or moralizing attitude that is totally counterproductive (36). The GPs showed their need to position themselves as health professionals to break away from the moral dimension and their own values. This neutral and empathic attitude should allow them to establish a reliable relationship with an adolescent patient and communicate objectively about cannabis or other psychoactive substances, including alcohol (e.g. binge drinking) (37). This attitude is consistent with the current position, which is centred on consumer behaviour rather than on substances (16,38).

Implications for further research and clinical practice

Beyond the school environment, only family interventions and motivational programmes have proven effective in reducing cannabis consumption among adolescents (39). Brief intervention could be an interesting tool to generate discussion with adolescents (40) and is considered feasible during a consultation (24,39). The effectiveness of this technique in decreasing cannabis consumption should be evaluated in future.

Strengths and limitations of this study

Data saturation was achieved after three focus groups, suggesting that all of the important criteria were identified. The moderator of the focus group, an anthropologist, was not known by most of the participants. He was careful to avoid letting the trained GPs impose their points of view on their colleagues. The role of the researchers who performed the analysis was important. On a subject such as illicit drug use, the statements of the researchers performing the data collection and analysis could influence the results (2). The danger of personal interpretation was neutralized by an independent analysis performed by three researchers with different professions (a GP, a health anthropologist and a psychiatrist specializing in addiction); this combination of researchers reinforced the internal validity of the study.

However, the results could have been reinforced using a combination of methods. For example, some individual interviews could have strengthened the internal validity of the study. In qualitative research, there is no concept of quantitative reproducibility and generalization of data. Sample diversification and data saturation, which were achieved in this study, allow the transferability of the understanding of the process and strengthen the external validity of the study. The sample included a large number of GPs with academic involvement, whose training and experience may have differed from those of non-teaching GPs. However, the results were unanimously validated by focus group participants following presentation by the researchers, thereby confirming the reactive validity of the study.

Conclusion

Our findings indicate that GPs are concerned about the consumption of cannabis by adolescents, although they have difficulties addressing the issue. Indeed, they feel a conflict between their role in preventing the use of cannabis and their respect for adolescents’ privacy. They feel uncomfortable at every step of cannabis management, from communicating with teenagers to the follow-up of their drug habit. Brief intervention could overcome this barrier to communication.

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Conflict of interest: none.

References


