

[Jackie](#): Thank you for joining me here today and taking the time to listen to this talk, which I have titled, "Is 'Do Not Consume' Really Doing No Harm? The Cannabis Pregnancy Double Standard."

The core message I want you to leave here today with is that the rigid, abstinence-only approach to medical cannabis in pregnancy is a failed policy that actively harms patients by creating dangerous double standards. We must evolve to a model of individualized, evidence-based harm reduction guidance.

First, I want you to imagine a woman named Sarah. Here's a little bit about Sarah. She lives with a severe form of epilepsy. After years of trying pharmaceuticals that didn't work, medical cannabis is the only thing that has stopped her seizures. She just found out she's pregnant. This should be a moment of pure joy, but unfortunately for many women, it's not. It's often a complicated, complex rush of emotions. And for Sarah, one of those emotions is dread. "Why would someone dread being pregnant?" you ask. Well, in her condition, she is likely to get an ultimatum from her doctor: either stop taking medical cannabis, which has kept her safe, and possibly get reported to child protective services if she doesn't stop, or she has to stop taking her medication.

This is an impossible choice. Imagine how scary it must be to have to face the choice of stopping taking a medication that has been life-saving for you or risk losing your child because of legal repercussions.

Sarah's story is the direct result of a well-intentioned but deeply flawed policy. Today, I'll show you how our abstinence-only approach to cannabis—medical cannabis specifically—in pregnancy is ineffective, inconsistent, and unethical. And I will propose a better, more compassionate path forward.

The current approach of abstinence-only is one we've seen before. If you remember sex education for some of us, it involved abstinence-only messaging. What we've learned from that is that it didn't make teens stop having sex, it just made it more dangerous by withholding information about safety. We are repeating this exact same mistake when it comes to medical cannabis in pregnancy. By simply saying, "No, you must stop," we aren't stopping its use, we're driving it underground.

This fear-based model destroys patient-provider trust. It prevents doctors from offering crucial harm reduction evidence and advice, like safer, regulated products, and can even cause patients to avoid prenatal care altogether for fear of judgment, endangering both parent and child.

Now, a lot of proponents of abstinence-only often use the phrase, "The absence of evidence of harm is not evidence of its absence." They argue that because we lack perfect data (which there is none in pregnancy), we must prohibit it entirely. We must err on the side of extreme caution. While this sounds prudent, it becomes a shield for a glaring double standard when we see how we treat substances where there *actually is* clear evidence of risk.

Let's take caffeine, for example. Caffeine in high doses has been shown to have extreme adverse effects in pregnancy and fetal health. But we don't just tell patients, we don't just tell women to stop using it all together. We apply a dose-based guidance that focuses on harm and risk reduction.

We also... let's take chemotherapy, for example, something that's on the complete other end of the spectrum that is known to have extreme risks. But often, to save a mother's life, a team of

experts will perform a complex risk-benefit analysis—that's the key here, risk-benefit analysis—and often even proceed with treatment during pregnancy.

Now let's talk about Sarah, who has epilepsy. Many epilepsy drugs carry the black box warning by the FDA, which is the most serious warning for birth defects. Yet, we still use them in pregnancy. Why? Because the risk of an uncontrolled seizure is deemed greater.

So let's just go back to Sarah for our example for a moment. She's managing her condition on medical cannabis after epilepsy drugs, which carry an extreme risk, couldn't control... and now her choice is to stop taking it three months before or stop taking it all together, or risk losing her child. But if she was taking a conventional drug, which can't even control her condition, she would be more likely to be able to continue with her medication.

A patient with cancer gets a team. A patient with conventional epilepsy gets a conversation. But a patient like Sarah, using medical cannabis for the same condition, receives a threat. This isn't a consistent standard of care; it's a moral judgment disguised as medical advice.

Now to my third point, where we see the extreme double standard when it comes to preconception. If this policy were truly about protecting the fetus at all costs, the conversation would start long before pregnancy, and it would include both parties, both parents.

Science now shows that we have evidence that a father's cannabis use can impact sperm quality and the epigenetic markers passed on to a child. His DNA is 50% of the equation and 50% responsible for the fetal health. Yet the conversation is 100% focused on women. Are men who are trying to conceive counseled to stop using cannabis? Possibly, but not nearly to the extent women are. Are they threatened with legal action? I've yet to hear it happen.

The intense scrutiny is reserved exclusively for the person who carries the child. This reveals this policy about abstinence-only isn't just about fetal health; it's about controlling pregnant bodies. And I'm going to pause there to let that one sink in.

So let's take a look at what we've discussed today. We have a policy that fails, just like abstinence-only education. The approach itself has proven not successful, yet we still use it. Not only that, we add a punitive double standard, where we are employing legal, serious legal repercussions for mothers and their children, but not men. And we're doing it when they're at their most vulnerable. These women who are being targeted are the most vulnerable of our population in the sense that they are not only pregnant and creating a new being, but they are also managing chronic conditions, which also has mental health implications. And we are adding stress, which also harms fetuses and the mother.

This abstinence-only mandate is breaking the first oath of medicine: First, do no harm. It's time to demand a new standard, one that moves away from simply "do not consume" and getting back to providers doing no harm.

There are patients with epilepsy whose doctors choose partnership over punishment. The good news, the hope, is that Sarah is actually based on a real-life case study of a woman who had epilepsy and her doctor worked with her and provided one-on-one, personalized patient care to ensure the highest quality and to ensure the health of the fetus and the mother. And they are doing just fine. They are healthy and thriving because of a collaborative doctor-patient partnership. Because they worked together to manage her condition with cannabis, they monitored both the mother and the baby closely. They had a healthy pregnancy. This is what can happen when we work together. This is the standard of care we must fight for.

Let's stop creating impossible choices for patients like Sarah and many others and start creating

compassionate partnerships that lead to healthy families. Stop harmful messaging like "do not consume" and get back to "first, doing no harm."