Ethics of Over the Counter Syringe Sales To Injection Drug Users

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Pharmacists Attitudes

Getting right to the heart of the subject, a supplemental article published in the Journal of the American Pharmacists Association in 2002 states:

Surveys and in-depth studies of the attitudes of pharmacists and pharmacy students about selling syringes without a prescription to IDUs have repeatedly found pharmacists to be divided into three groups: one that strongly favors such sales, a second that vigorously opposes such sales, and a third that is unsure. These positions result from an interaction of individual factors (e.g., beliefs that selling syringes conflicts with efforts to reduce drug use) and structural issues (e.g., regulations that limit syringe sales).¹

The key point here is that as pharmacists (or future pharmacists) we are so unsure of the positions that we take and what the long-term effects of those positions will be. It is also difficult to know if there is even an ethical issue for you to consider if you are unaware of the laws and regulations surrounding the issue.

The American Pharmacists Association has made their position on the subject clear. As the major professional organization for pharmacists, I think it’s important to note that the APhA is in support of access of sterile syringes to IDUs.

<table>
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<tr>
<th>POLICY STATEMENT</th>
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### American Pharmaceutical Association Policies on Syringe Access and Syringe Disposal

1999 APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.

2001 APhA supports collaboration with other interested health care organizations, public health and environmental health groups, waste management groups, syringe manufacturers, health insurers and patient advocacy groups to develop and promote safer systems and procedures for the disposal of used needles and syringes by patients outside of healthcare facilities.

Here, I will examine the evidence in favor of providing access to sterile syringes to IDUs (or injection drug users). I will first give an overview of some barriers, including laws and other regulations. I will then discuss the HIV epidemic, which has prompted the development of newer laws and syringe exchange. I will also discuss some of the thoughts that led to development of better programs, and then finally I will wrap it all up with the ethical issues that need to be taken into consideration.
Background of Legal Issues Affecting Syringe Sales

Each state has the ability to regulate the sales of syringes. Some have addressed the issue in a straightforward manner; others have been not so clear. For example, Pennsylvania requires a prescription to obtain or be in possession of syringes. In that state, it is not a law, but rather a regulation by the Board of Pharmacy. In Connecticut, Illinois, New Hampshire, New York and Maine have addressed the issue by limiting the number of syringes a person can get without a prescription. In California, Delaware, Massachusetts, New Jersey, Pennsylvania, and the Virgin Islands there exists a barrier to syringe access because of prescription requirements.

States have also tried to deter access and possession by way of drug paraphernalia laws, making it illegal to be in possession of syringes or a certain quantity of syringes. Following is a table showing the drug paraphernalia law restrictions by state.

<table>
<thead>
<tr>
<th>Exempts some or all syringes (10)</th>
<th>Exempts some types of sellers (9)</th>
<th>Omits reference to syringes or injection (5)</th>
<th>Other significant exemption (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT (&lt;31)</td>
<td>CA (MDs &amp; pharmacists)</td>
<td>CO</td>
<td>IA (syringes sold for “lawful purpose”)</td>
</tr>
<tr>
<td>IN (items customarily used to inject lawful substances)</td>
<td>GA (pharmacists)</td>
<td>MI</td>
<td>LA (items for medical use)</td>
</tr>
<tr>
<td>IL (&lt;21)</td>
<td>HI (MDs, pharmacists &amp; health care institutions)</td>
<td>NV</td>
<td>MA (does not criminalize paraphernalia possession)</td>
</tr>
<tr>
<td>ME</td>
<td>MT (MDs &amp; pharmacists)</td>
<td>SC</td>
<td>MI (does not criminalize paraphernalia possession)</td>
</tr>
<tr>
<td>MN</td>
<td>NM (pharmacists)</td>
<td>WY</td>
<td>SC (does not cover items used with heroin)</td>
</tr>
<tr>
<td>NH</td>
<td>OH (MDs &amp; pharmacists)</td>
<td></td>
<td>VA (does not criminalize paraphernalia possession)</td>
</tr>
<tr>
<td>NY (syringes legally obtained from pharmacy or SEP)</td>
<td>TN (MDs &amp; pharmacists)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>WA (pharmacists)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RI</td>
<td>WV (licensees such as pharmacists)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WI</td>
<td></td>
<td></td>
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</tbody>
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The following table represents changes in laws that have been enacted by states or changed to allow for better access to syringes. This table is taken form the University of San Francisco Law Review. It illustrates how on a state by state basis, there has been a general realization that better access needs to be provided to sterile syringes.
<table>
<thead>
<tr>
<th>State</th>
<th>Year</th>
<th>Prior Law(s)</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR</td>
<td>1987</td>
<td>Paraphernalia law</td>
<td>Syringes explicitly excluded from paraphernalia law</td>
</tr>
<tr>
<td>WI</td>
<td>1989</td>
<td>Paraphernalia law</td>
<td>Syringes explicitly excluded from paraphernalia law</td>
</tr>
<tr>
<td>CT</td>
<td>1992</td>
<td>Prescription law</td>
<td>Allowed purchase of 10 or fewer syringes without prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraphernalia law</td>
<td>Allowed possession of 10 or fewer syringes without a prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(raised to 30 or fewer in 1999 amendment)</td>
</tr>
<tr>
<td>ME</td>
<td>1993</td>
<td>Prescription law</td>
<td>Allowed the sale of 10 or fewer syringes without a prescription</td>
</tr>
<tr>
<td></td>
<td>1997</td>
<td>Paraphernalia law</td>
<td>Allowed possession of 10 or fewer syringes</td>
</tr>
<tr>
<td>MN</td>
<td>1997</td>
<td>Paraphernalia law</td>
<td>Allowed pharmacy sale of up to 10 syringes without a prescription and the possession of up to 10 unused syringes at a time</td>
</tr>
<tr>
<td>NY</td>
<td>2000</td>
<td>Prescription law</td>
<td>Allowed the sale of 10 or fewer syringes without a prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraphernalia law</td>
<td>Allowed the possession of legally obtained syringes (during two-year experiment)</td>
</tr>
<tr>
<td>NH</td>
<td>2000</td>
<td>Prescription law</td>
<td>Allowed the purchase of 10 or fewer needles in a pharmacy without a prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraphernalia law</td>
<td>Syringes excluded from paraphernalia law</td>
</tr>
<tr>
<td>RI</td>
<td>2000</td>
<td>Prescription law</td>
<td>Repealed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraphernalia law</td>
<td>Syringes excluded from paraphernalia law</td>
</tr>
<tr>
<td>NM</td>
<td>2001</td>
<td>Paraphernalia law</td>
<td>Allowed the sale of syringes by licensed pharmacists</td>
</tr>
<tr>
<td>HI</td>
<td>2001</td>
<td>Paraphernalia law</td>
<td>Exempts sale by medical professionals to IDU for disease control purposes; exempts possession by IDU</td>
</tr>
<tr>
<td>WA</td>
<td>2002</td>
<td>Paraphernalia law</td>
<td>Allows pharmacy sale and IDU possession “for the purpose of reducing the transmission of bloodborne diseases”</td>
</tr>
<tr>
<td>IL</td>
<td>2003</td>
<td>Prescription law</td>
<td>Allowed pharmacy purchase and subsequent possession of up to 20 syringes without a prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paraphernalia law</td>
<td>Allowed the possession of legally obtained syringes</td>
</tr>
</tbody>
</table>
Of special note should be the 2002 Washington law, which specifically states that the reason pharmacy sale is allowed is to reduce spread of diseases.

**The Epidemic**

In the HIV testing survey (HITS) assessed needle use behaviors of HIV negative, at risk persons and found that approximately three in ten respondents reported use of non-sterile needles at least some of the time during the 12 months prior to the survey.3

Why does this matter to me? I’m straight. I don’t inject drugs. But the point is this: When considering the effect of IV drug users (commonly referred to as IDUs in the literature) “on the HIV/AIDS epidemic, it is important to note that this group is additionally linked to heterosexuals, infants, and MSM (men that have sex with men). Almost half (47 percent) of the reported cases among non-MSM IDUs also had high-risk heterosexual sex partners.” According to a 2006 report by the Michigan Department of Community Health.3 The CDC also confirms this and illustrates4 it in the following pie chart:

![Figure 23: In the last 12 months, how often have you used a dirty needle?](image)

An April 2006 report prepared for the Michigan AIDS Fund stated the following regarding interviews conducted with board members and those who work in other AIDS related areas:

The consensus of all interviewees was that the most important public policy issue facing the HIV/AIDS community nationwide and in Michigan is the lack of access to needle or syringe exchange. Syringe exchange has been proven to be the most effective prevention method, and it has contributed significantly to a decrease in new infections. At the current time, however, federal funds may not be used for syringe or needle exchange programs. Interviewees familiar with results from the government approved, value based (abstinence only) prevention programs believe that these simply do not work and are “a waste of public funds.” Changing public policy to assure that needle exchange programs are legitimized and receive ongoing funding is a pressing task for HIV/AIDS advocacy organizations.5
Currently, the state of Michigan has 3 syringe exchange programs (SEP). The first was started in 1996, by the Michigan AIDS Fund in Detroit. This project is called the Life Points Needle Exchange Program. There are also now programs in Benton Harbor and Grand Rapids.

I feel that it is important to point out that these needle exchange programs do not simply take a syringe and give a syringe. These programs are fully committed to stopping the spread of HIV as is evident by the services provided. The Clean Works exchange program, which is run out of Grand Rapids, lists the following additional services on their website: HIV and Hepatitis C counseling and testing, safer sex tools (condoms, lube, dental dams), written information to protect health (HIV and STD prevention, overdose prevention, wound care), Substance Abuse Counseling, hygiene, wound care and bleach/water kits, skills building on safer practices, someone to talk to about protecting your health and the health of your friends and family. All of these services are free to the public and funded by grants. It is important to note that there is no federal funding however for SEPs, only state funding and private funding.

I also feel that it is important to point out the difficulty I had finding this information. I am not an IDU, so I am unaware as to how well know the programs are in their communities among those who need them. Using Yahoo and Google, it is nearly impossible to find information on the Detroit SEP. Using a search on the Harm Reduction Collation website (harmreduction.org), the only Michigan listings that are returned are the Benton Harbor and Grand Rapids programs. This just illustrates another barrier to SEPs.

This is alarming considering the statistics. 42% of our AIDS cases in Detroit are attributable to injection drug use.

The Evidence of HIV/AIDS reduction

Many reports have concluded that the provision of sterile syringes helps to reduce spread of HIV and also hepatitis C along with other blood borne illnesses. A 2004 report by the World Health Organization summarizes the finding of multiple studies. This report highlights that the evidence points to a reduction in the spread of HIV, no increase in the amount of persons using injection drugs, and no more frequent use with availability of sterile syringes.

In an article titled “Structural Interventions to Reduce AIDS Transmission Among Injection Drug Users” it is stated “Increasing the availability of sterile injection equipment, through pharmacy sales or syringe exchange or both, is the most common and best-studied structural intervention for injecting drug users. The studies to date indicate that this usually, but not always, leads to large reductions in HIV-risk behavior.”

In a 2001 article published in AIDS, the authors reviewed articles from 1989 to 1999 that looked at effectiveness of SEPs in reducing HIV transmission. The authors ended up reviewing a total of 42 articles. This review concluded that there is sufficient evidence to support that SEPs are effective in preventing exposure to HIV.

Even the CDC specifically points out that the use of a sterile syringe is the most effective approach for limiting HIV transmission in the case of failure of abstinence. Interesting, the CDC also makes the point that while drug treatment with the goal of abstinence is necessary, the number of programs and the number of people they can help are limited.
Economics

A report in 2003 from New Jersey addressed the economics of the situation. New Jersey is a state that has some of the strictest restrictions to sterile syringes. There were no SEPs at the time of this report and pharmacy access is limited by the requirement of a prescription. This is reflected by the fact that 46% of AIDS cases in the state are IDU related whereas the nationally it is only about 25%.¹⁰

As of December 12, 2006 New Jersey will get its first Needle Exchange Program. The state also decided whether it will let pharmacies sell limited numbers of syringes without prescriptions.¹¹

This turn of events may have been brought on by the 2003 reports citing the economic burden. The report stated that “lifetime AIDS care costs approximately $227,000, and that if new HIV infection rates continue at present levels, New Jersey could expect public health costs to increase by $400 million annually. In contrast, a clean needle costs ten cents.”¹⁰

A BMC Public Health article from 2003 found similar data. This article summarized costs as a direct comparison that the lifetime cost of one HIV infection is $195,000 and that same amount of money could buy over 2 million sterile syringes.¹²

What About Hepatitis C Infection?

According to the CDC, about 60% of new hepatitis C cases occur in IDUs.¹⁶ A major reason for this is that the major route of transmission for this virus is contaminated blood. Hepatitis C infection can turn into a chronic infection of the liver. The CDC estimates direct medical costs to treat the complications of hepatitis C (including cirrhosis, liver failure, and liver cancer) to cost between 6.5 and 13.6 billion dollars.¹⁶ Additionally, there is currently no vaccine to protect against hepatitis C unlike other forms of hepatitis viruses, leading to an even greater risk of infection.

I feel like this is important to point out because most of the literature focuses to a greater extent on the HIV infections. Although most articles do mention the risk of hepatitis C and almost all organizations running or supporting a SEP mention hepatitis C as a major concern, it seems to be secondary to HIV/AIDS. I speculate that this could be that HIV has a broader means of transmission and therefore has a farther-reaching scope within society.

Abstinence versus Harm Reduction

Within the last 10 years the idea of “harm reduction” has arisen. Harm reduction does not stop drug use, but rather provides services that can lead to safer drug use, such as those provided at the Grand Rapids needle exchange. The hopes of harm reduction is to decrease the spread of blood borne illness (especially HIV and hepatitis C) while encouraging IDU to seek help and get education. This idea looks at IV drug use as a problem that we know exists, and it is better to try to help make the problem better any way we can rather than ignore the problem and let disease spread. One author describes harm reduction in the following manner:

The harm reduction paradigm is simple and approaches addictive behavior on the basis of three fundamental principles. First, excessive behaviors occur along a continuum of risk ranging from minimal to extreme. Addictive behavior is not an all-or-nothing phenomenon. Second, changing addictive behavior is a stepwise process, with
complete abstinence as the final step. Those who embrace the harm reduction model

believe that any movement in the direction of reduced harm, no matter how small, is positive. Third, sobriety simply isn’t for everyone. This principle requires acceptance of the fact that many people live under horrible conditions.\textsuperscript{13}

A 1995 report by The US National Academy of Sciences and Institute of Medicine concluded that there was a reduction in HIV transmission without increased drug use when SEPs were in place.\textsuperscript{8} This report gets to the heart of the debate over SEPs and other access to sterile syringes to IDUs. The Drug Free America Foundation has called the idea of harm reduction “harm promotion.” It says that providing services such as SEPs condones drug use and sends a message that using illegal drugs is acceptable as long as it is done safely.\textsuperscript{14}

The idea behind harm reduction is also that getting a drug user in contact with a health care provider or professional, even if it is to buy syringes, can be a positive interaction for the drug user. By offering services that show that you are concerned about the health and welfare of the patient, the patient may be more receptive of your offers to help them become abstinent or more likely to accept education. The Drug Free America Foundation states on their website “these strategies give the message that society has given up on the addict.”\textsuperscript{13} Harm reduction actually intends to send the opposite message. The message is not that society has given up, but rather that society cares enough about their well being that they will make any effort possible to ensure safety for the IDUs. One article even goes as far as to say that access to sterile syringes via SEPs will make the drug user more likely to enter a drug treatment program.\textsuperscript{12}

Results of the Multistate Trial

In an article published in 2004 in The Journal of Urban Health: Bulletin of the New York Academy of Medicine, the authors undertook an experiment to examine ease of purchase of syringes from pharmacies. The purpose was to look at some of the barriers to syringe sales. The trial was conducted in 4 states: Colorado, Connecticut, Kentucky, and Missouri. It also looked at differences in urban settings versus rural settings. Overall the trial conducted 1600 purchase attempts in the 4 states. Kentucky and Missouri had higher rates of refusal than Colorado and Connecticut. Urban setting had a higher rate of refusal that the urban settings. The overall refusal rate was 35%.\textsuperscript{15}

This is concerning because as the authors state “purchase of syringes form pharmacies has the potential advantage of widespread availability based on the broad distribution of pharmacies throughout most areas of the United States, many of which are open for extended hours of operation.”\textsuperscript{15}

The previous statement raises a very good point. Taking Michigan for example, there are a total of 3 exchange programs in the entire state. The following map of the state shows the prevalence of HIV/AIDS by county.\textsuperscript{3} The three red dots added in represent the three areas where syringe exchange programs are operated.

Even though not all of those infected with HIV will use drugs, and not all of those who use drugs will contract HIV, it should be of significant concern that due to the widespread nature of the disease, greater access to exchange programs could benefit the whole state.
A similar and smaller trial was performed in Denver, Colorado. This smaller study looked at 26 pharmacies in the Denver area and had a total of 206 purchase attempts. This trial was conducted in 2002 and found only about 54% of their purchase attempts to be successful. Some of the pharmacies in this study reported being out of stock, some sold to all, and others only sold on certain attempts.\textsuperscript{17}

Both of these trials demonstrate that availability through pharmacies, although probably the most convenient, is certainly not consistent. The consistency was lacking state-to-state and also within each state depending on the setting.

Neither trial however found that there were any consistent findings showing that refusal was based on race or gender.
2006 Profile of HIV/AIDS in Michigan

Distribution of HIV/AIDS Prevalence by Local Health Jurisdiction

Data from HIV/AIDS Reporting System (HARS)

Figure 2: Michigan Prevalence of HIV Disease (Including AIDS) per 100,000 population, by Local Health Department, January 2006
Public Opinion: a Reflection of Governmental Opinion?

In 1999, when asked about allowing better access to sterile syringes to injection drug users, a well know TV personality, Judge Judy, responded “Give them all dirty needles and let them die.” It is this kind of attitude that reflects why there is such an epidemic of HIV among injection drug users. This attitude is quite extreme, as most who oppose SEPs oppose them based on the notion that providing a sterile syringe will encourage drug use. This attitude goes a step further and implies that those who use illegal injectable drugs deserve death if that is what comes of their drug use.

The federal government has firmly said that it will not provide federal funds for SEPs. The government has a fear that supporting SEPs will make them appear “soft on drugs” as one article puts it. In fact, the federal government imposed a ban on funding for SEPs that has been in place since 1988.²

Is it nonmaleficence or beneficence?

Because there is a risk of harm that can be associated with lack of sterile syringe availability (for example contracting HIV or hepatitis C) it is fair to make the argument that by denying an IDU access to a sterile syringe, you are in fact violating the principle of beneficence. Beyond the harm that could befall the drug user who has been denied access to a sterile needle and reuses a dirty needle and gets infected, that person could go on to infect others such as sexual partners. It is therefore clearly beneficent to supply IDUs with sterile syringes as not doing so (an act of omission) could potentially cause harm.

Some may argue that you will harm the patient by selling them a syringe as this will “encourage” them to use drugs. By doing this you are violating the principle of nonmaleficence or the idea of doing no harm. Having a clean needle will only encourage a person to practice safer and more responsible drug use. They are already planning on using, whether they have a clean needle or not. Therefore, by refusing the purchase of a clean syringe, you are probably doing more harm than good.

Michigan law does not prohibit the sales of syringes without a prescription. Because of this, the decision to sell or not is in the pharmacists hands. It is important to respect the autonomy of the IDU when they come to purchase syringes in the community pharmacy. They are in fact individuals. Individuals that may have a problem and it may be a problem that you don’t understand. However, it has become their choice to abuse their bodies with drugs, and that’s not something you can stop by simply refusing them a sterile syringe. It would be better to think to yourself that at least they are being responsible with their body and trying not to spread diseases.

One day, maybe they will seek treatment and at that point they will be healthier and possibly be able to become a productive part of society once they are clean because they aren’t sick and can lead a full life.

A Former Addict’s take on Availability

The 2002 JAPhA supplement that addresses the issue here and supports the sale of sterile syringes via pharmacies also Contains an interview with Harry L. Simpson, who is a Detroit resident who runs a Detroit SEP, supports harm reduction, and is a former injection drug addict. In this interview, he confirms what the support has said all along- sterile needle or not, people will use. He addresses the availability of nonsterile needles:
If not from pharmacies, where else do drug users get syringes? They rent them from “shooting galleries” where many users go to inject drugs. They get them from drug houses when they purchase drugs. They get them from illegal, unlicensed stores in homes located near known drug-selling areas. These stores sell syringes, pipes for smoking crack, stems, and other drug paraphernalia. Drug users may purchase them from “street sellers,” often users themselves, who are able to obtain large quantities of syringes. There’s no guarantee that these rented or purchased syringes are new; in fact, they have likely been used.18

This statement is one of outreach. Someone who has been there calling on a whole profession, our profession, to help. Telling us that we are a part of the solution to a problem if only we are beneficent enough to make the decision that the wellbeing of a person, who may happen to be a drug user, is important enough that we will put personal beliefs aside and make this decision based on not only scientific evidence, but also on the fact that it is ethical to sell sterile syringes even if you know that the purpose will be to use them for illegal drug use.

References

1. Jones TS. Preventing blood-borne infections through pharmacy syringe sales and safe community syringe disposal. <i>JAPhA</i>. 2002; 42:6 supp2: S1-S9


10. New study released by New Jersey economics finds lack of sterile syringe access costs taxpayers millions in avoidable medical costs. Accessed via www.drugpolicy.org


