Ethics of Providing Sterile Syringes to Injection Drug Users

By: Keivan Rehward

In most states, no specific laws prohibit pharmacy sale of syringes without a prescription. Pharmacists, however, may refuse to sell syringes to suspected drug users or place restrictions on syringe sale by requiring bulk purchases.

Surveys and an in-depth study published in a supplemental article of the Journal of American Pharmacist Association divided pharmacists and pharmacy students’ attitude about selling syringes without a prescription to Injection Drug Users (IDUs) 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), structural issues (e.g., regulations that limit syringe sales or pharmacy policies) and their approach to help reduce drug use by IDUs. ¹

As pharmacists or pharmacist interns we are still uncertain 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 us to consider if we are unaware of the laws and regulations surrounding the issue. To me, it is frustrating not to have a universal federal law about syringe sale in order to unify all the pharmacists in their position about this issue.

The American Pharmacists Association (APhA) as the major professional organization has made their position on the subject clear. Why do I even mention this? Of course, just to
prove my point, it is important to note that the APhA is in support of access to sterile syringes by IDUs.

Here, I am intending to provide an overview of some barriers including laws and other regulations regarding providing access to sterile syringes to injection drug users. I will then discuss the HIV epidemiology and some other diseases that are prevalent in this population. I will also discuss some thoughts and programs that led to the development of programs that create safer and preventive approaches to this issue. Finally, I will wrap it all up with the ethical issues that need to be taken into consideration.

**Legal Issues Affecting Syringe Sales**

By law, each state has the authority to standardize the sales of syringes. However in the majority of their regulations there is no distinct line for pharmacists to utilize in their practice. Some have talked about the issue clearly while others have been complicated. Sterile syringes may be obtained legally by 3 methods although their availability varies considerably from state to state. They can be purchased over the counter, prescribed by a practitioner, or obtained at a Syringe Exchange Programs (SEPs) or by other authorized agencies. Many states do not require prescriptions for syringes and since the beginning of the HIV epidemic, twelve states, Connecticut, Hawaii, Illinois, Maine, Minnesota, New Hampshire, New Mexico, New York, Oregon, Rhode Island, Washington, and Wisconsin have changed their syringe access laws making it possible to obtain syringes over the counter. In many states, syringes can be legally prescribed by healthcare professionals for drug injection by IDUs.
As of 1998, at least 131 SEPs were operating in 31 states. Not all of these have a clear legal basis. Twelve states and the District of Columbia have affirmatively authorized SEPs. Ten jurisdictions have passed statutes establishing programs (Connecticut, District of Columbia, Hawaii, Maine, Maryland, New Mexico, Rhode Island and Vermont) or authorizing local governments to do so (California and Massachusetts). In New York, syringe exchange programs are authorized by the Commissioner of Health, exercising power granted in the paraphernalia law to waive its application. In the state of Washington, local health officials secured a declaratory judgment from the state Supreme Court holding that the paraphernalia law did not prohibit them from authorizing SEPs, a ruling that was later codified by the legislature. Each of these options has its own strengths and limitations; different groups of IDUs are more likely to use pharmacies while others are more likely to use syringe exchange programs. The availability of all options is the most effective way to provide maximum access for injection drug users. This article describes and discusses the various options for legal syringe access for injection drug users.

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 from 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>
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<tr>
<td></td>
<td></td>
<td>Paraphernalia law</td>
<td>Allowed possession of 10 or fewer syringes without a prescription (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 (during two-year experiment)</td>
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<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>
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<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 &quot;for the purpose of reducing the transmission of bloodborne diseases&quot;</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 interest is the 2002 Washington law, which specifically states that the reason pharmacy sale is allowed, is to reduce spread of diseases.

**IDU Associated Epidemic**
The CDC reports that more than 33% of all AIDS cases are among injection drug users, their partners and children, and the numbers continue to climb. Over 63% of AIDS cases among women are related to injection drug use and over 50% of AIDS cases among children are attributable to injection drug use by their parents, according to the CDC. Injection drug users become infected and transmit the viruses to others through sharing contaminated syringes and other drug injection equipment and through high-risk sexual behaviors. Women who become infected with HIV through sharing needles or having sex with an infected IDU can also transmit the virus to their babies before or during birth or through breastfeeding.

According to the CDC, about 60% of new hepatitis C cases occur in IDUs. 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 be between 6.5 and 13.6 billion dollars. 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.

Although most articles do mention the risk of hepatitis C and almost all organizations mention hepatitis C as a major concern, it seems to be secondary to HIV/AIDS. I speculate that this could be due to the fact that HIV has a broader means of transmission and therefore has a farther-reaching scope within society.
Sterile Syringe Access

It is estimated that an individual IDU injects about 1,000 times a year. This adds up to millions of injections, creating an enormous need for reliable sources of sterile syringes. Syringe Exchange Programs allow people to trade used syringes for sterile syringes. Numerous scientific studies as well as government-sponsored reports have shown that syringe exchange programs reduce the spread of blood-borne diseases. Although many states and municipalities in the United States have taken steps to improve access to sterile syringes, the possession, distribution, and sale of syringes remain criminal offenses in much of the country. The federal government, though one of the largest funders of AIDS prevention in the world, refuses to fund syringe exchange programs. This forces many programs offering these crucial services to operate largely underground. There are currently 185 syringe exchange programs operating in 36 states as well as Washington D.C., Puerto Rico, and Native American lands. However, the legality of the programs often depends on a county-by-county certification of a State of Emergency that must be regularly renewed.

Pharmacy Sale of Syringes

Non-prescription, over-the-counter sale of syringes has recently expanded to include almost all of the United States. Only four states (Delaware, Massachusetts, Pennsylvania, and New Jersey) still require prescriptions to purchase syringes. States have taken several different approaches to revising their policies so that syringes can be sold without a prescription, including exempting syringes from paraphernalia laws and broadening language in laws related to medical need.
Physician Prescription of Syringes

Another means of increasing access to sterile syringes is permitting doctors to prescribe syringes to their patients. This would appear to be uncontroversial given the role of doctors in preventing disease transmission, but few states currently allow the practice. Drug Policy Alliance has taken a lead role in providing the legal analysis to support efforts to increase the ability of doctors to prescribe syringes nationwide. Physician prescription of syringes, much like syringe exchange programs, can provide a vehicle through which injection drug users can access healthcare services and referrals to drug treatment programs.7

The Evidence of HIV/AIDS reduction

Three recent journal articles provided data from studies of syringe exchange programs and policies in the U.S.

Study 1

In the first study, reported in the February 6, 2007 online edition of Addiction, researchers sought to determine whether dispensation policies are associated with adequate syringe coverage among syringe exchange program clients. The authors studied 24 syringe exchange programs in California, which collectively served 1576 injection drug-using clients. Participants were classified as having adequate syringe coverage if they received at least as many syringes as the number of self-reported injections during the past 30 days.
Results:

Adequacy of syringe coverage by dispensation policy was as follows: unlimited need-based distribution: 61%; unlimited 1-for-1 exchange plus a few additional syringes: 50%; limited (up to a set number per visit) 1-for-1 exchange plus a few extras: 41%; unlimited 1-for-1 exchange with no extras: 42%; limited 1-for-1 exchange with no extras: 26%.

In a multivariate analysis, adequate syringe coverage was significantly higher for all other dispensation policies compared to a limited 1-for-1 exchange with no extras. Programs that provided additional syringes beyond the 1-for-1 exchange generally resulted in more clients having adequate coverage compared with strict 1-for-1 exchange programs (50% vs 38%; P = 0.009). Similarly, programs that allowed for unlimited syringe exchange or distribution resulted in better coverage than programs with per-visit numerical limits (42% vs 27%; P = 0.05). "Providing less restrictive syringe dispensation is associated with increased prevalence of adequate syringe coverage among clients," the authors concluded. "Syringe exchange programs should adopt syringe dispensation policies that provide IDUs sufficient syringes to attain adequate syringe coverage."8

Study 2

In the second study, which appeared in the February 3, 2007 online edition of Drug and Alcohol Dependence, researchers assessed whether adequate syringe coverage “enough to allow for 1 injection per syringe” is associated with changes in injection-related risk behaviors and syringe disposal. This study looked at the same population of IDUs from 24 California syringe exchange programs described above. Individual syringe coverage was calculated as a proportion of syringes retained from program site visits to the total number of reported injections during the
past 30 days. Participants were divided into 4 groups based on extent of syringe coverage: less than 50%; 50%-99%; 100%-149%; 150% or more.

Results:

Compared to clients with adequate syringe coverage (100%-149%), those with less than 50% syringe coverage were significantly more likely to report receptive syringe sharing (using a syringe after someone else) during the past 30 days (adjusted OR 2.3; 95% CI 1.4-3.6). Clients with 150% or better syringe coverage were less likely to report receptive syringe sharing (adjusted OR 0.5; 95% CI 0.3-0.8). Similar associations were observed for other measures of distributive syringe sharing and syringe re-use. No differences in safe syringe disposal were observed based on extent of syringe coverage. “Individual syringe coverage is strongly associated with safer injection behaviors without impacting syringe disposal among syringe exchange program clients," the researchers concluded. "Syringe coverage is a useful measure for determining if IDUs are obtaining sufficient syringes to lower HIV risk." These results should help allay concerns that providing extra syringes beyond a strict 1-for-1 exchange might encourage clients to unsafely dispose of used syringes rather than bringing them back to the distribution site.

Study

Finally, the third study, reported in the January 31, 2007 online edition of the American Journal of Public Health, explored why syringe exchange programs are available in some cities but not others. "Community activism can be important in shaping public health policies," the authors wrote as background. "For example, political pressure and direct action from grassroots activists have been central to the formation of syringe exchange programs in the United States."
They hypothesized that such programs are unevenly distributed across geographic areas as a result of political, socioeconomic, and organizational characteristics of localities, including needs, resources, and local opposition.

Results:

Looking at different U.S. metropolitan statistical areas in the year 2000, they found that the following characteristics predicted the presence of a syringe exchange program: percentage of the population with a college education; existence of a local chapter of the activist group AIDS Coalition to Unleash Power (ACT UP); and the percentage of men who have sex with men in the population. However, they found that need -- such as number of at-risk IDUs -- was not a predictor of whether a locality had a syringe exchange program. These results suggest that activist pressure has played a key role in the establishment of harm reduction measures such as syringe exchange programs.

Abstinence versus Harm Reduction

What is “Harm Reduction”? Regardless of what position pharmacists take regarding sterile syringe sale to a potential IDU, their rationale always refer to “Harm Reduction.” However their definition of Harm Reduction is specific to them considering their belief. Harm reduction does not stop drug use, no matter what you call harm reduction. But rather “My Harm Reduction” provides services that can lead to safer drug use. In the same approach, abstinence (cutting or limiting the access to sterile syringes) does not stop drug use. The hope of harm reduction is to minimize the spread of blood borne illness while encouraging IDUs to seek assistance and get education. Although this approach considers injection drug use as a problem but it is healthier to try to help resolving this issue in a more efficient way. We all agree on the
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.13

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.8 The main focus of this report is the debate over SEPs and other access to sterile syringes to IDUs.

Another benefit of harm reduction is that getting a drug user in contact with a healthcare 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 make the patient more likely to accept education. It is all about having the opportunity as a healthcare
professional to build a relationship with an IDU that may lead to him or her seeking help. This in fact sends a message that we care enough about their well being and we are working hard to ensure their safety while helping them to find an efficient method to quit. Studies show that offering easier access to sterile syringes does not increase the number of IDUs.

**Non-maleficence or Beneficence?**

Let’s look at the whole issue from an ethical point of view and discuss the issue with well known terminologies. By denying IDUs access to sterile syringes you are putting them at risk. There is risk of harm associated with lack of sterile syringe availability. Beyond the harm that could happen to drug users who have been denied, you are indirectly guiding them to reuse a dirty needle because they are determined to use the drug, especially for long time addicts (as you know it is quite difficult to distinguish who is a long time addict). It is appropriate to make the argument that blocking the access to sterile syringes violates the principle of beneficence. In addition to 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.

Non-maleficence violation is the main argument of some groups that are claiming by selling a sterile syringe to IDUs you are basically encouraging them to use drugs. In their response, I want to go back to my previous discussion that it is extremely hard to find out who is a long time addict and who is drug-naïve. Having a clean needle will only encourage a person to practice safer and more responsible drug use. If they are already planning on using, they will
pursue their plan whether they have a clean needle or not (especially in addicts). Therefore, by refusing the purchase of a clean syringe, you are probably doing more harm than good. You may hope that you are discouraging them to use drugs while not considering that many of them are so determined to do their practice. One thing that we all should know as professionals that will face this issue is that making a decision to use drugs is not an instant action. Many factors come together that make a person addicted to injection use (like cocaine), although they may have thought about some of the consequences of their practice. Some of the reasons a person may become addicted are: *Personality* – The personality of a person plays a huge role in why they choose to take drugs in the first place. If someone is a people pleaser, a risk taker or always follows the crowd, they are far more likely to take drugs; *Biological Makeup* – Someone’s biological makeup personally affects how addictive they may be to a substance. Also, someone with a drug addict in their close family has a much higher risk for addiction; *Social Environment* – The social environment of a person determines a person’s accessibility to drugs, as well as affects their personal opinion about them. If a person grows up in a home with parents who constantly inject drugs and drink, that person has a much higher chance of doing the same. Also, if a person chooses to make friends with people who constantly buy drugs and party, they are likely to join in, increasing their chances of drug abuse. While these circumstances are not certain to make someone a drug addict, they do greatly increase his or her chances; *Psychological Disorders* – Specific psychological disorders put someone at a greater risk for addiction. Also, a person suffering from anxiety, loneliness, constant rage or a great deal of stress has a higher chance of becoming a cocaine addict; *Addictive Nature of Drugs* – Lastly, the addictive nature of drugs is probably the primary reason addiction is so common. People take cocaine to receive its euphoric effects. After frequent use, these effects become less intense
unless more of the drug is taken, creating a compulsive habit. Such repeated use of cocaine alters chemical levels of dopamine in the brain. This chemical controls the brain’s movement and pleasure mechanisms which gives the user his or her desired sense of euphoria.

Michigan law does not prohibit the sales of syringes without a prescription. Because of this, the decision to sell or not is in the pharmacist hands. I strongly recommend to respect the autonomy of the IDU and not to be judgmental 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 we do not fully understand. However, with everyone’s effort to prevent them from doing so, it has become their choice to heal their bodies, pains or problems with drugs, and that is not something we can stop by simply refusing them from accessing a sterile syringe. It would be better to be grateful that at least they are being responsible with their body and trying not to spread diseases. There is hope that one day they may become drug-free and possibly be able to become a productive part of society and can lead a full life. But for right now, I just do not want to worsen the problem by not looking at the picture as a whole.
References


