

COMMENTARIES

A Case for Needle Exchange Programs: Not Letting Perfection be the Enemy of the Good

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Introduction

Injection drug use, like most issues in the world, is complicated, inconsistent, and gray. It is full of nuances and very unique to the individual experiencing it. Like many other complicated issues, working to treat and heal persons who inject drugs (PWIDs) is not a straightforward process and requires a multidisciplinary approach. Medical professionals play an instrumental role in this healing process, and ethical and moral frameworks must be applied to this relationship to achieve the greatest level of good for the patient. Pellegrino has advocated for the internal morality of clinical medicine, a morality that is inherent and intrinsic to the practice of medicine itself. In increasing levels of importance, he identified 4 components of the good of the patient: the medical good, the patient's perception of the good, the good for humans, and the spiritual good. He also called on all 4 "goods" to be served in any patient-physician relationship.¹ Despite an imperfect outcome, needle exchange programs (NEPs) satisfy these 4 levels of good because their focus is on healing rather than health.

Injection drug use contributes to overdose deaths as well as infectious disease transmission, namely, hepatitis and HIV.²⁻⁵ Syringe services programs (SSPs), or NEPs, are community-oriented organizations that provide sterile syringes, disposal of used injection equipment, vaccines, and infectious disease and sexually transmitted infection testing, as well as connect individuals to treatment for substance use and infectious disease care.^{2,6,7} Research has shown that not only do SSPs not increase drug use, but they also decrease infectious disease transmission (50% reduction in HIV and hepatitis C virus infection).^{2,7,8} Furthermore, SSPs connect PWIDs to treatment facilities for substance use and people who use SSPs are upwards of 5 times more likely to receive treatment for their substance use and upwards of 3 times more likely to reduce or stop injecting drugs.^{2,9-11} Criticisms and potential negative outcomes of NEPs include that they may lead to increased poor disposal of used needles, they condone and even encourage drug use, and that by making it safer, more people will be inclined to start injecting drugs because of access to these types of programs.¹² In this article, the case for NEPs/SSPs is made

by demonstrating that these organizations satisfy each of the 4 levels of good as defined by Pellegrino, exemplifying that they also contribute to the internal morality of medicine.

Discussion

Pellegrino argued for the internal morality of medicine, meaning that “the ethics of these professions has its source in the nature of these professions, in what is distinctive about them and the good at which they aim.”¹ The morality of medicine is internal because the “standard of excellence” of healing is a good that is intrinsic to the practice of medicine.¹ The universality of the experience of seeking care, being healed, and being sick is what makes the good intrinsic to the practice of medicine—for its inherent nature of healing is defined by the practice of medicine itself.¹ But how do we define this inherent morality? Pellegrino argued for 4 levels of “good” that exemplifies the healing of the whole person—the medical good, the patient’s perception of the good, the good for humans, and the spiritual good.

The Medical Good

Pellegrino defined the medical good as “that which relates most directly to the aim of the art of medicine, that part which is based in the knowledge, science and technique of medicine.”¹ As long as the medically good aligns with the patient’s perceived good, then this good is satisfied. The medical good is based in the physiological effectiveness of a treatment, returning the mind and body to their proper function, and the relief of suffering. Surely, SSPs/NEPs that diminish the transmission of infectious disease, connect individuals to treatment facilities, provide sexually transmitted infection and infectious disease testing, and refer out for proper treatment satisfy this good. Though some may argue that this good is incompletely satisfied because a person may continue injecting drugs, the crucial component of this good is that it must be in alignment with the patient’s perception of the good to be satisfied. Therefore, with forced treatment and medical management of someone injecting drugs that is contrary to their wishes, though it may successfully improve an individual’s health and bodily function, this good would not be satisfied. Thus, the only way to satisfy this good is to accept the incompleteness of this treatment, acknowledging that while someone may continue injecting drugs or induce bodily harm, SSPs and NEPs still satisfy the medical good because they meet people where their wishes are and serve as a physiological benefit to the patient.

Patient’s Perception of the Good

A patient’s perception of the good is “concerned with the patient’s personal preferences, choices, and values, and the kind of life he wants to live, the balance he strikes between the benefit and burdens of the proposed intervention.”¹ Uniquely, this good pertains solely to the opinions and beliefs as defined by the patient. This good focuses on the belief systems, cultural backgrounds, and uniqueness to each individual seeking care, acknowledging

that each person has a completely unique set of values and preferences about an existing medical intervention and the implications that it may have on their life. There is no universal good here, but rather individual goods as defined by each person. As previously stated, this opens the door to permit a PWID to continue injecting drugs if that is the life they choose and want to live, and yet this good continues to be satisfied under that circumstance. The beauty of SSPs and NEPs is that any good provided to a PWID, so long as it is voluntary and chosen, has satisfied this good, precisely because it has been deemed wanted and good by the patient. Because the patient's autonomy and choices are maintained at SSPs and NEPs, this good is automatically satisfied.

The Good for Humans

The good for humans is defined by Pellegrino by the “good particular to humans, like preservation of dignity of the human person, respect for his rationality as a creature who is an end in himself and not a mere means, whose value is inherent and not determined by wealth, education, position in life etc.”¹ It is this good that the familiar pillars of medical ethics are found: autonomy, beneficence, nonmaleficence, and justice. This good acknowledges the inherent dignity and value in each person and Pellegrino called on physicians to protect this good at every clinical encounter. As it pertains to PWIDs and SSPs/NEPs, this good is satisfied because NEPs/SSPs are serving a vulnerable patient population, meeting the patients where they are in life, and using evidence-based practices to connect PWIDs to resources and reduce infectious transmission.² This good also has more to do with the specific physician who is treating the patient and the way they interact with the patient. In every clinical encounter, Pellegrino noted that the medical good and the personal good must be in alignment with the good for humans, for it is only through returning the physiological function of the human body that is in alignment with the patient's wishes that the good for humans is possible to be satisfied.

The Spiritual Good

The spiritual good is the highest level of good and each of the aforementioned goods must support the spiritual well-being of an individual in a clinical encounter. This good “acknowledges some end to life beyond material well-being”¹ and may be uniquely defined by the individual in question. As it pertains to NEPs/SSPs, it requires that there be some acknowledgment of spirituality or religion in the clinical setting and that the spirituality of the patient be explored and respected in order for this good to be satisfied. For example, as noted by Pellegrino, although it would satisfy the medical good, administering a blood transfusion to a person who observes the Jehovah's Witness faith would completely contradict their spiritual good.¹ Therefore, despite satisfying one of the goods, if it does not also support the spiritual good then it is not considered a “healing act.”¹ In the example of a PWID, both the patient and physician would have to agree and acknowledge that the act of

exchanging needles is in fact a spiritual act of harm reduction and true healing for the person in question. This might involve a more in-depth conversation about what the patient perceives “healing” to mean to them physically as well as spiritually. It may involve acknowledging how one’s spirit is being nurtured by this act of bodily healing, acknowledging the interconnectedness between body, mind, and spirit, and how they affect one another. Needle exchange satisfies this good because, when performed in a safe and supportive environment where patients feel empowered over their body, health, and decision-making abilities, there is an intrinsic impact on one’s spiritual health.

Challenges to NEPs/SSPs

Despite their proven effectiveness and benefits, NEPs/SSPs face many challenges in their implementation and success.¹³ Legal, political, and financial barriers as well as the rapidly evolving drug epidemic all serve as challenges to both new and existing NEPs/SSPs.¹³ The pervasive negative stigma that still surrounds drug addiction and NEPs/SSPs as well as the overt illegality of their implementation in some states are examples of these barriers.¹³ Notably, a federal funding ban is a symbolic and actual barrier to the success of NEPs/SSPs that essentially states that while federal funds can be used to support NEPs/SSPs, the money cannot be directly used on syringes.¹³ This is a notable symbolic opposition to NEPs/SSPs because it does not give complete support to these organizations by restricting funding to be not used on the very core piece of these organizations. Furthermore, the growth in the number of PWIDs and those who seek services at NEPs/SSPs is a challenge to these organizations because they are struggling to keep up with the demand.¹³ SSPs/NEPs are constantly identifying strategies to overcome these barriers and oppositions, such as advocating in the political realm, finding new funding sources, and broadening the scope of existing NEPs/SSPs.¹³

Opposition to NEPs/SSPs

Opposing arguments to NEPs/SSPs include that they may lead to increased poor disposal of used needles, they condone and even encourage drug use, and that by making it safer, more people will be inclined to start injecting drugs because of access to these types of programs.¹² Regarding an increase in improperly discarded needles, a study compared the frequency of improperly discarded syringes in a city with NEPs/SSPs (San Francisco, California) vs a city without NEPs/SSPs (Miami, Florida) and found fewer improperly disposed syringes in San Francisco (44/1000 blocks) vs Miami (371/1000 blocks).¹⁴ Furthermore, 95% of PWIDs in Miami self-reported improperly disposing of syringes in the last 30 days when compared with only 13% of PWIDs in San Francisco, where there was access to NEPs/SSPs.¹⁴ These data clearly demonstrated that access to NEPs/SSPs actually provides places for proper disposal of needles and that PWIDs use these services effectively. Regarding the arguments that SSPs/NEPs condone or encourage drug use and that they could lead to an increase in PWIDs because of access to these

organizations, there are some important points to make. To acknowledge, care for, and provide services to PWIDs is not the equivalent to condoning or encouraging their behavior. On the contrary, NEPs/SSPs frequently connect people to rehabilitation services and as previously mentioned, people who use NEPs/SSPs are upwards of 5 times more likely to receive treatment for their substance use and upwards of 3 times more likely to reduce or stop injecting drugs.^{2,9-11} Rather than encourage drug use, these organizations are actually more effective at helping people stop their use of drugs. One study even found that PWIDs who used NEPs/SSPs were more likely to reduce injection, halt injecting drugs completely, and participate in drug treatment programs.⁹ Most importantly, these arguments against NEPs/SSPs miss a major point regarding the benefits of these programs: they are not a perfect solution to the problem and they do not offer a perfect outcome. These programs are not single-handedly eliminating drug use, and there is always a risk that there may be imperfect outcomes from these programs. However, on applying Pellegrino's framework to these programs, it becomes clear that the benefits outweigh the costs, and the satisfaction of the 4 levels of good makes it a net positive outcome, despite the risk of it being an imperfect outcome.

Conclusions

This article makes the case that NEPs/SSPs satisfy all 4 levels of good defined by Pellegrino. He described the moment that the health care system converges: "that moment when some human being in distress seeks help from a physician within the context of a system of care."¹ In that moment, when a PWID finds it within themselves to seek care at an NEP/SSP, it should be viewed no differently than when someone with hypertension seeks care at their primary care clinic. In both scenarios, the universality of someone in need seeking help at a medical institution is present. As long as the care provided to someone at an NEP/SSP is serving to improve their bodily health, is voluntarily chosen by the patient, is administered with respect and compassion, and serves for the spiritual well-being of the patient, then these 4 goods are satisfied. The crux of the satisfaction of these goods is that medical care can be an act of healing without completely turning the patient "whole" again. Pellegrino indirectly acknowledged the value of harm reduction in his article by realizing that a medical intervention does not need to be perfect for it to be good. In an ideal world, PWIDs and any other sick individual heals complete, returning their body, mind, and spirit back to whole physiologic and spiritual health; however, this is unrealistic. Pellegrino's work teaches us that in most cases, complete healing is unattainable or impossible, but that there is still room for healing in these cases. Strategies such as NEPs/SSPs are some of the medical interventions that reduce harm and bring some level of healing to many PWIDs. Despite an imperfect outcome, these organizations bring true acts of healing by satisfying each level of good.

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Disclosures/Conflicts of Interest

None reported.

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