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HARM REDUCTION IN THE HEALTH CARE SYSTEM: THE LEGALITY OF PRESCRIBING AND DISPENSING SYRINGES TO DRUG USERS

Scott Burris†
Peter Lurie‡‡
Mitzi Ng‡‡‡

I. INTRODUCTION

THE CRIMINAL JUSTICE APPROACH to drug use and syringe availability has profoundly affected the health of injection drug users, particularly with regard to infectious disease transmission. Today, more new cases of HIV are expected among injection drug users (IDUs) than among any other risk group in the United States. It has been credibly estimated that as many as half of all new HIV infections are caused by the sharing of needles and syringes contaminated with HIV, either directly due to injection drug use, through sexual contact with

† Professor, Temple University School of Law. B.A. 1980, Washington University; J.D. 1987, Yale Law School. This research was funded by a grant from the Substance Abuse Policy Research Program of the Robert Wood Johnson Foundation. The authors thank Temple Law School students Salli Ortiz, Ryan Silverman, and Ron Webster for invaluable research work on this project. They also thank the members of the project’s expert advisory committee: Terje Anderson, Arthur Caplan, T. Stephen Jones, Frank McClellan, Jane Silver, Sharon Stancliff, Robert Swenson, and Donald Williams.

‡‡ Deputy Director, Public Citizen’s Health Research Group, M.D. 1987, Albert Einstein College of Medicine; M.P.H. 1991, University of California at Berkeley. Dr. Lurie’s work on this project was supported in part by grant DA09712 from the National Institute of Drug Abuse.

‡‡‡ B.A. 1996, Stanford University; M.P.H. 1999, Boston University; J.D. candidate, Temple University School of Law.

drug injectors, or by birth to a mother who acquired HIV infection through one of these means.\(^2\) In fact, the sharing of syringes by IDUs is the leading source of HIV infection among women and children.\(^3\) There is now evidence of a massive epidemic of both hepatitis B (HBV) and C (HCV) among injection drug users.\(^4\) Prevalence of HCV among IDUs in the U.S. and abroad ranges from 65% to 80%.\(^5\) The reuse of syringes is also a known risk factor for acute bacterial endocarditis, subcutaneous abscess, and cellulitis. While earlier ethnographic work ascribed the sharing of syringes to an IDU culture, research now shows that sharing is largely the product of the scarcity of sy-


rings. Thus, addressing the sharing and reuse of syringes by IDUs, and the scarcity of syringes that encourages it, is a major public health priority.

The scarcity of syringes is the direct result of law and law-enforcement practices. Recent research has found a significant correlation between HIV prevalence and legal restrictions on syringe access. A web of state syringe prescription, drug paraphernalia, and pharmacy practice rules restrict the sale and possession of injection equipment and, in effect, make physicians and pharmacists the gatekeepers to syringe access. Thirteen states have rules requiring a prescription for a syringe under at least some circumstances. Other states require the buyer to demonstrate to the pharmacist a legitimate medical purpose for the purchase, which makes a prescription useful if not indispensable. Most states have paraphernalia laws that apply to syringes under at least some circumstances, and which may deter pharmacists from selling syringes to people they suspect of injecting illegal drugs.

Extensive research shows that providing safe injection equipment to IDUs prevents HIV and other blood-borne infections and does not increase drug abuse. A recent cost-benefit analysis indicates that a policy of funding syringe exchange programs, pharmacy sales, and syringe disposal to cover all illicit drug injections would cost an estimated $34,278 per HIV infection averted, a figure well below the estimated lifetime cost.

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of medical care for a person with HIV infection. There is now strong consensus among public health and medical authorities that IDUs should use sterile equipment for every injection. The leading federal public health agencies addressing drug use prepared a set of consensus guidelines for physicians caring for drug users that explicitly recommended that drug users be counseled to "use a new, sterile syringe to prepare and inject drugs." In light of the research evidence and these clinical guidelines, we have previously argued that physicians treating IDU patients should strongly consider protecting their patients from blood-borne diseases by prescribing sterile injection equipment when appropriate.

In the past, physicians who wished to prescribe syringes have been deterred by the widespread perception that it would violate state and federal laws aimed at combating drug abuse. Today, the medical evidence compels a reassessment of the legality of providing injection equipment by prescription, because many of the laws governing prescription and dispensing of injection equipment employ, explicitly or implicitly, a standard of medical necessity. Now that even previously hesitant federal

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10 See HELENE D. GAYLE ET AL., HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILICIT DRUGS (U.S. Dep't of Health & Hum. Serv., May 9, 1997); GUIDE TO CLINICAL PREVENTIVE SERVICES: REPORT OF THE U.S. PREVENTIVE SERVICES TASK FORCE (Carolyn DiGuiseppi et al. eds., 2d ed. 1996); see also San Francisco AIDS Found., Statements/Resolutions/Policies on Increased Access to Clean Needles and Syringes (last modified Nov. 9, 1997) <http://www.sfaf.org/prevention/needleexchange/statements.html> (collecting statements from ten national organizations supporting the use of needle exchange programs and/or the use of sterile injection equipment).


public health agencies are advising that access to sterile injection equipment is medically necessary to prevent serious disease,\(^\text{14}\) prescribing and dispensing such equipment in the course of caring for IDU patients may reasonably be said to be legal in many states and under federal law. Where legality is in doubt, physicians and pharmacists have both the opportunity and a responsibility to their IDU patients to advocate for the elimination of legal barriers to safe injection.

The public health problem of unsterile injection is not simply a matter of the ability to purchase a syringe. Law enforcement practices that target individual drug users—relying both on drug paraphernalia and drug possession laws—create an environment in which drug use is furtive and hidden.\(^\text{15}\) People who feel subject to search by the police are often reluctant to carry syringes, even when they possess them, and so may not have a clean syringe at the moment when drugs are available. The underground quality of drug use leads some users to shooting galleries or other concealed venues where clean water and other hygienic amenities are lacking, which can contribute to the transmission of infections.\(^\text{16}\) The problem is probably worse for people who are homeless, or lack a private, clean place for drug use.\(^\text{17}\) Urban black drug users, though a minority of drug users, are most likely to be arrested, and so their willingness to carry syringes may be disproportionately affected.\(^\text{18}\) Physicians and pharmacists—indeed, all health care providers—can play an important role in the ongoing reexamination of U.S. drug control policy, by advocating for drug users as people with medical needs.

This article presents the results of a study of the laws governing physician prescription and pharmacy sale of syringes to

\(^{14}\) See infra notes 48-51 and accompanying text.

\(^{15}\) See Koester, supra note 6, at 290; Ricky N. Bluthenthal et al., Collateral Damage in the War on Drugs: HIV Risk Behaviors Among Injection Drug Users, 10 Int'l J. of Drug Pol'y 25 (1999) (indicating that the “war on drugs” has increased needle sharing rather than decreasing it).

\(^{16}\) See Koester, supra note 6, at 292; see also Michael Marmor et al., Risk Factors for Infection with Human Immunodeficiency Virus Among Intravenous Drug Abusers in New York City, 1 AIDS 39, 43 (1987); Bourgois, supra note 6, at 2336.


\(^{18}\) See Ricky N. Bluthenthal et al., Drug Paraphernalia Laws and Injection-Related Infectious Disease Risk Among Drug Injectors, 29 J. Drug Issues 1, 6, 9 (1999) (indicating that fear of arrest may increase needle sharing).
injection drug users, covering all fifty states, Puerto Rico, and the District of Columbia. It finds that, contrary to conventional wisdom, the prescription of syringes to IDUs is clearly legal in 48 states and territories. It is clearly legal for pharmacists to fill these prescriptions in 26 states and territories, and there is a reasonable claim to legality in 22 more. We found only four jurisdictions in which prescribing or dispensing were clearly illegal.

Part II of the article reviews the medical and public health evidence on the value of syringe prescription and dispensing. This section presents the epidemiologic and scientific evidence linking unsafe injection practices to the transmission of highly infectious blood-borne disease. Part III presents the results of our legal analysis in summary form. In Part IV, we examine the legality of prescribing a syringe under the laws of 52 states and territories. Part V also investigates the regulatory scheme and laws, this time with regard to dispensing injection equipment in a pharmacy. Here, a careful examination of the legislative history of syringe regulation indicates that these regulatory provisions were never intended to curtail legitimate medical care to injection drug users. In a majority of states, the inapplicability of paraphernalia laws to pharmacy sales of syringes by prescription is so patent that we conclude that the practice is clearly legal.

In Part VI, our analysis concludes with a discussion of how laws might be changed or clarified to promote greater access to injection equipment for IDUs through the health care system. While physicians and pharmacists cannot stem the epidemic of needle-borne infections on their own, prescription-based distribution of injection equipment can contribute, not only to better syringe access, but also to the public recognition of drug addiction as a health problem that can be effectively addressed by the health care system.

II. FURTIVE INJECTION, SYRINGE SCARCITY, AND THE LAW: RESEARCH EVIDENCE

The immediate mechanism through which IDUs are infected with HIV and hepatitis is not in dispute: blood containing virus from an infected user in drug injection equipment is transmitted to the next user of the equipment. This can happen under several circumstances, including: (1) needle sharing, in which a needle is used by two or more people serially; (2) re-use, in which a previously used, unsterile needle is used later by
another person, who may have found or purchased the needle and may or may not believe that it was sterilized or even new; and (3) unsterile drug preparation, which comprises behavior including use of unsterile water, contact with another's blood, and use of an unsterile needle to measure out shared drugs. The biological rationale for removing contaminated injection equipment from circulation is supported by laboratory data that indicate the durability of HIV in the syringe. Recent findings show that the virus can survive in a syringe for periods in excess of four weeks. Individuals who reuse contaminated syringes are therefore susceptible to infection during this period. Indeed, use of an unsterile needle is well-documented as a means of bacterial infection, whose unpleasant, sometimes fatal, and often expensive consequences include abscesses, necrotizing faciitis, and even damage to the heart.

A somewhat more disputed question, at least early in the epidemic, was the reason for unsterile injection, particularly needle sharing. Some early investigations attributed this largely to social reasons, suggesting that needle sharing was a bonding ritual. Although it may often have social functions, more thorough ethnographic and ecological studies have led to the conclusion that sharing is largely the result of the unavailability of needles at the time of injection.

Needles are very inexpensive, commonly costing between ten cents and a quarter per needle, depending upon the quantity purchased. They are manufactured each year in billions, and, in the United States, move through an effective marketing and distribution system. In the U.S., the main impediment to needle access for drug users is law. As we discuss below, needles are subject to considerable regulation as to their purchase; just as important, under drug paraphernalia and needle prescription laws, possession of a syringe can be the basis of arrest or at

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19 See Koester, supra note 6, at 293; see also Bourgois, supra note 6.
22 See Koester, supra note 6, at 287.
23 See id.
least the pretext for a stop and frisk. Drug users report being unwilling to carry needles for fear that it will mark them for harassment or arrest.\textsuperscript{24} As a result, even people who possess needles may not always carry them when purchasing drugs, and may not have them on hand at the time of injection.\textsuperscript{25}

The public health value of providing sterile injection equipment is well-supported. Providing needles, through needle exchanges and pharmacies, has been shown to be an effective means of preventing blood-borne diseases. Since the mid-1980s, IDUs have had ready legal access to clean needles in Australia and much of Western Europe.\textsuperscript{26} Legal access to sterile injection equipment, whether through over the counter sales, syringe exchange programs, or both, has become a standard public health strategy for preventing further spread of HIV among IDUs in nearly all other developed countries.\textsuperscript{27} In the United States, syringe exchange programs (SEPs) have become especially common. These programs reduce the transmission of HIV and other blood-borne infections associated with drug injection by providing sterile syringes and other "works," in exchange for used and potentially contaminated needles.\textsuperscript{28} In an official report to Congress, Health and Human Services Secretary Donna Shalala concluded that SEPs are "an effective component of a comprehensive strategy to prevent HIV and other blood borne infec-

\textsuperscript{24} See Bluthenthal et al., supra note 15, at 33.

\textsuperscript{25} For a review on how drug and needle access laws act as "structural factors" that broadly influence IDU vulnerability to disease, see Don C. Des Jarlais, Structural Interventions to Reduce HIV Transmission Among Injecting Drug Users, 14 AIDS S41, S45-46 (Supp. I 2000). See also Jennifer A. Taussig et al., Syringe Laws and Pharmacy Regulations Are Structural Constraints on HIV Prevention in the US, 14 AIDS S47, S48 (Supp. I 2000) (arguing that criminalizing possession of drug paraphernalia contributes to syringe sharing among IDUs who prefer not to carry syringes for fear of arrest).


tious diseases.\textsuperscript{29} The National Institutes of Health convened a panel of medical experts who agreed that, "[t]here is no longer doubt that these programs work."\textsuperscript{30} Most recently, the Surgeon General reviewed the research data since 1998 and concluded that "there is conclusive scientific evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs."\textsuperscript{31} Numerous medical and scientific organizations also validate the public health effects of syringe exchange.\textsuperscript{32}

Researchers studying SEPs have focused on reported changes in behavior capable of transmitting HIV among SEP clients. The epidemiologic data indicate that participants in SEPs are less likely to share injection equipment and more likely to use a new, sterile syringe for each injection as recommended by public health officials.\textsuperscript{33} Research findings also


\textsuperscript{31} Evidence-Based Findings on the Efficacy of Syringe Exchange Programs, supra note 2.

\textsuperscript{32} Organizations supporting access to sterile syringes include the: American Bar Association, American Medical Association, American Public Health Association, Association of State and Territorial Health Officers, Centers for Disease Control and Prevention, National Academy of Sciences, National Association of State AIDS Directors, National Institutes of Health Consensus Panel, Office of Technology Assessment of the U.S. Congress, President Bush's and President Clinton's AIDS Advisory Commissions.

show a reduced risk of HIV infection among SEP participants. In one such study, IDU HIV rates were compared for cities with and without SEPs. On average, seroprevalence increased by 5.9% per year in the 52 cities without SEPs, and decreased by 5.8% per year in the 29 cities with SEPs. The average annual change in seroprevalence was 11% lower in cities with SEPs.

A second study estimated that between 4,394 and 9,666 new cases of HIV could have been prevented between 1987 and 1995 had syringe exchange programs been implemented in the United States during the early stages of the AIDS epidemic.

Currently, 31 states and territories have SEPs in operation, including 10 with statutes explicitly authorizing such programs. These programs typically offer an array of services for IDUs. Of 87 programs surveyed in 1996, 97% provided referral to substance abuse treatment, 80% provided education to reduce the risk of STDs, while many others provided primary health care,
tuberculosis screening, and HIV counseling and testing.\textsuperscript{37} Although lowering HIV rates is the primary goal of needle exchange, other outcomes have been found. These include reduced drug use, lower rates of criminal activity for profit, and greater entry and retention in drug treatment programs.\textsuperscript{38}

Syringe exchange programs are not a panacea for the AIDS epidemic.\textsuperscript{39} If the availability of clean syringes fails to meet the needs of the IDU population in a given community, redistribution of used equipment can occur and subsequently affect HIV incidence. Unfortunately, the existing network of some 134 SEPs cannot on its own satisfy the needs of IDUs in the U.S. Estimates of the annual number of syringes required to meet the Health and Human Service’s single-use recommendation run in the range of one billion.\textsuperscript{40} The most recent estimate of the num-


\textsuperscript{38} See Robert Brooner et al., Drug Abuse Treatment Success Among Needle Exchange Participants, 113 PUB. HEALTH REP. 129, 138 (Supp. I 1998); see also Hagan et al., Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-Exchange Participation in Seattle Drug Injectors, supra note 32, at 248-50 (finding that one-third of IDUs reported substantially fewer injections after the needle-exchange program ended); Hagan et al., An Interview Study of Participants in the Tacoma, Washington, Syringe Exchange, supra note 32, at 1694-95 (concluding that participation in syringe exchange program was associated with significant decline in high-risk injection practices).

\textsuperscript{39} See Julie Bruneau et al., High Rates of HIV Infection Among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study, 146 AM. J. EPIDEMIOLOGY 994, 1001 (1997) (suggesting that NEPs are only successful in reducing the spread of HIV if distribution meets the needs of the drug population); Julie Bruneau et al., Assessing Harm Reduction Strategies: The Dilemma of Observational Studies, 146 AM. J. EPIDEMIOLOGY 1007, 1010 (1997). Although the Montreal study is sometimes cited as evidence that SEP does not work, the authors of the study themselves took the unusual step of disclaiming that interpretation of their data. See Julie Bruneau & Martin T. Schechter, The Politics of Needles and AIDS, N.Y. TIMES, Apr. 9, 1998, at A27 (arguing insufficient Canadian syringe volume explains author’s study reporting the inability of needle exchange programs to reduce the spread of blood-borne disease). Subsequent data from the Montreal cohort indicate that there was no correlation between HIV seroconversion and NEP use. See J. Bruneau et al., Changes in HIV Seroconversion Rates of IDUs Attending Needle Exchange Programs (NEP) in Montreal: The Saint-Luc Cohort, 10 CAN. J. INFECTIOUS DISEASE 45B (Supp. B 1999).

ber of syringes distributed by SEPs in the United States, however, was only 17.5 million in 1997.\(^{41}\)

Many policies, including those governing access to drug treatment, the sale of needles by pharmacies, and the arrest of IDUs for possessing needles, influence the spread of HIV.\(^{42}\) There is no doubt, however, that physician prescription of sterile needles and syringes is an important and effective tool in harm reduction to minimize HIV transmission among IDUs, their partners, and their children. While pharmacy provision of sterile syringes has increasingly been advocated as a method to supply sterile syringes, many pharmacists do not sell syringes to suspected IDUs,\(^{43}\) and may demand a prescription even in states without prescription laws.\(^{44}\) Furthermore, there is evidence that some pharmacists are less willing to sell syringes to African-American prospective buyers.\(^{45}\) A prescription, even if not required, could persuade a pharmacist to exercise his or her discretion to sell syringes in a particular case. The preferences of IDUs themselves are also an important factor. Some may prefer the ready access to ancillary services offered at a SEP, others the anonymity of a pharmacy, and still others the access to medical care offered by a physician prescribing syringes. All these preferences may vary as times and needs change for the individual, and so the goal of sterile injection is served by providing a variety of access options.


\(^{43}\) See Patricia Case et al., Access to Sterile Syringes in Maine: Pharmacy Practice After the 1993 Repeal of the Syringe Prescription Law, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. & HUM. RETROVIROLOGY S94 (Supp. I 1998) (finding that even when the sale of syringes without a prescription is legal, many pharmacists still choose not to sell syringes to suspected drug users).

\(^{44}\) See Wilson M. Compton III et al., Legal Needle Buying in St. Louis, 82 AM. J. PUB. HEALTH 595, 596 (1992); Taussig et al., supra note 25, at S50 (explaining that in Maine, pharmacists were still hesitant about selling syringes to suspected IDUs despite that legislature removing the prescription requirement for syringes sales); Alice A. Gleghorn et al., Pharmacists’ Attitudes About Pharmacy Sale of Needles/Syringes and Needle Exchange Programs in a City Without Needle/Syringe Prescription Laws, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. & HUM. RETROVIROLOGY S89, S92 (Supp. I 1998); F. Stephen Bridges et al., Sale of Nonprescription Syringes to Men and Women - Florida, 1994-1995, 10 FLA. J. PUB. HEALTH 12, 15 (1998).

\(^{45}\) See Compton et al., supra note 44, at 596 (stating that African-Americans were denied syringes possibly due to racial bias).
Approximately two-thirds of individuals with addiction will see a primary care or urgent care physician every six months, and many others are regularly examined by other medical specialists. This means that physicians can play an important role in addressing substance abuse and its devastating health consequences. Physician prescription of injection equipment has the potential to make a difference in a number of ways:

1. It affords access to needles and ensures that they can be legally carried.

2. It entails access to a health care provider who may be able to help the patient enter and complete drug treatment.

3. It provides an incentive for injection drug users to seek medical treatment.

4. It creates an opportunity for other harm reduction measures (e.g., counseling on drug overdose and prescription of naloxone).

A recent HIV/AIDS Prevention Bulletin from the U.S. Department of Health and Human Services essentially establishes a standard of care for IDU patients (See Table I). In the document, the federal agencies responsible for drug-related public health issues—the Centers for Disease Control and Prevention (CDC), the National Institute on Drug Abuse, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration—suggest that health care workers counsel IDUs who continue to inject to "use a new sterile syringe to prepare and inject drugs." This approach has also been endorsed by medical and public health organizations including the U.S. Preventive Services Task Force, the American College of Physicians, and the American Academy of Family Physicians.

47 Drug users are a medically underserved population. Economic and cultural barriers combine to reduce their willingness to access care and their satisfaction with the care they do receive. Physicians have increasingly recognized a need to find new ways to reach IDUs in medical need. See Nathaniel Gunn et al., Primary Care as Harm Reduction for Injection Drug Users, 280 JAMA 1191 (1998).
49 See GUIDE TO CLINICAL PREVENTIVE SERVICES, supra note 10.
can Medical Association, and the Association of State and Territorial Health Officials. In June 2000, the American Medical Association approved a resolution asking that “our [AMA] strongly support the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases.”

**Table I.** U.S. Department of Health and Human Services Provisional Recommendations to Drug Users Who Continue to Inject

<table>
<thead>
<tr>
<th>Recommendations</th>
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<tbody>
<tr>
<td>Stop using and injecting drugs</td>
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<tr>
<td>Enter and complete substance abuse treatment, including relapse prevention</td>
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<tr>
<td>Take the following steps to reduce personal and public health risks, if injection drug use persists:</td>
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<tr>
<td><em>Never reuse</em> or “share” syringes, water, or drug preparation equipment</td>
</tr>
<tr>
<td>Use only syringes obtained from a reliable source (e.g., pharmacy)</td>
</tr>
<tr>
<td>Use a new, sterile syringe to prepare and inject drugs</td>
</tr>
<tr>
<td>If possible, use sterile water to prepare drugs; otherwise, use clean water from a reliable source (such as fresh tap water)</td>
</tr>
<tr>
<td>Use a new or disinfected contained (“cooker”) and a new filter \ (“cotton”) to prepare drugs</td>
</tr>
<tr>
<td>Clean the injection site before injection with a new alcohol swab</td>
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<tr>
<td>Safely dispose of syringes after one use</td>
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</table>

Physician prescription and pharmacy sales of sterile injection equipment to IDUs makes sense from both a public health and clinical health care standpoint. Yet because it involves drug use and injection equipment that are subject to at least some regulation in most states, the practice’s legality must be considered along with its possible benefits. This article reports the results of detailed legal research on the question, and provides an overview of the legal issues presented.

III. RESULTS IN SUMMARY: THE LEGALITY OF PHYSICIAN PRESCRIPTION AND PHARMACY SALES

To determine the legality of prescribing and dispensing syringes to known IDU patients, we collected statutes, regulations and case law governing medical and pharmacy practice, and syringe access, for all fifty states, Puerto Rico, and the District of Columbia. A separate analytic memorandum was prepared for each state and territory.\(^{52}\)

Table II. The Legality of Prescribing and Dispensing Sterile Injection Equipment to IDUs to Prevent Disease Transmission\(^{53}\)

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<tr>
<td>AK</td>
<td>X</td>
<td>X</td>
<td>Local drug paraphernalia ordinances in several cities</td>
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<td>X</td>
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<td>AR</td>
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<td>X</td>
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\(^{52}\) The memoranda are available on the Internet. See Temple University of the Commonwealth System of Higher Education, Beasley School of Law, Project on Harm Reduction in the Health Care System (Nov. 10, 1999) <http:llwww.temple.edu/lawschoollaidspolicyldefault.htm> [hereinafter Project on Harm Reduction].

\(^{53}\) A web of state syringe prescription, drug paraphernalia, and pharmacy practice rules restrict the sale and possession of syringes and needles:

Syringe prescription laws (denoted Pres. law in table) require a prescription for the sale or possession of injection equipment. These laws were enacted to remedy the abuse of prescribing opiates like morphine during the late nineteenth and early twentieth centuries. Physician prescription practices, however, no longer contribute to illicit drug use since the medical profession is now subject to strict regulation.

Paraphernalia laws (denoted Para. law in table) were primarily enacted in the 1960s and 1970s to regulate the growth of the drug paraphernalia industry. These laws restricted the manufacture, sale, distribution, and possession of items like rolling papers, bongs, pipes, freebasing kits, and in some states, needles. In 1979, the Justice Department's Drug Enforcement Administration (DEA) promulgated the Model Drug Paraphernalia Act (see U.S. DRUG ENFORCEMENT ADMIN., U.S. DEP'T OF JUSTICE, DRUG ENFORCEMENT 29 (Mar. 1980).
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<td>Y ? N Y ? N</td>
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<tr>
<td>CO</td>
<td>X</td>
<td>X</td>
<td>Paraphernalia law does not mention syringes; pharmacy law provides immunity to pharmacists filling valid prescriptions.</td>
<td>X</td>
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<tr>
<td>CT</td>
<td>X</td>
<td>X</td>
<td>Paraphernalia law excludes &lt; 31 syringes; prescription law excludes &lt; 11</td>
<td>X</td>
<td>X</td>
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<tr>
<td>DE</td>
<td>X</td>
<td>X</td>
<td>Prescription law limits syringe possession to those for whom it is &quot;necessary for the treatment of an injury, deformity or disease then suffered.&quot;</td>
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<td>DC</td>
<td>X</td>
<td></td>
<td>If authorized by commissioner of health under needle exchange law.</td>
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<tr>
<td>FL</td>
<td>X</td>
<td>X</td>
<td>Prescription required for sale to minors.</td>
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<td>GA</td>
<td>X</td>
<td></td>
<td>Syringe sales require legitimate medical purpose but prescription not required.</td>
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<td>HI</td>
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<td>IN</td>
<td>X</td>
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<td>Paraphernalia law exempts sellers of items &quot;historically and customarily used in connection with the ... injecting ... of ... lawful substance[s].&quot;</td>
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<td>IA</td>
<td>X</td>
<td>X</td>
<td>Paraphernalia law excludes syringes distributed for a &quot;lawful purpose.&quot;</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>KS</td>
<td>X</td>
<td>X</td>
<td>Case law narrowly interprets &quot;legitimate medical purpose.&quot;</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>KY</td>
<td>X</td>
<td>X</td>
<td>Syringe sale law places detailed restrictions on sales.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>LA</td>
<td>X</td>
<td>X</td>
<td>Paraphernalia law explicitly excludes items distributed for medical use.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ME</td>
<td>X</td>
<td>X</td>
<td>Sale of &lt; 11 syringes unrestricted</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MD</td>
<td>X</td>
<td>X</td>
<td>Board of Pharmacy has implied pharmacist discretion, extends to dispensing syringes to prevent disease.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MA</td>
<td>X</td>
<td>X</td>
<td>Dispensing legal if authorized for disease prevention purposes by any state or local agency.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MN</td>
<td>X</td>
<td>X</td>
<td>Prescription or sale of &lt; 11 syringes only</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MS</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MO</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MT</td>
<td>X</td>
<td></td>
<td>Paraphernalia law exempts physicians and pharmacists.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NE</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NV</td>
<td>X</td>
<td>X</td>
<td>Prescription required except for insulin, asthma, and other specified uses.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
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<td>-------------------</td>
</tr>
<tr>
<td>NH</td>
<td>X</td>
<td>X</td>
<td>Effective 1/1/2001, prescription law excludes &lt; 11 syringes for adults and paraphernalia law no longer applies to injection equipment.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NJ</td>
<td>X</td>
<td>X</td>
<td>Department of Health could approve prescription/pharmacy based harm reduction program.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NY</td>
<td>X</td>
<td>X</td>
<td>Prescription law excludes &lt; 11 syringes and paraphernalia law exempts syringes sold pursuant to the prescription law (as of 1/1/2001). Commissioner of Health also has authority to authorize dispensing by prescription or otherwise.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NC</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ND</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OH</td>
<td>X</td>
<td></td>
<td>Specific syringe possession and distribution statute controls; physicians and pharmacists exempt from paraphernalia law.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OK</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>OR</td>
<td>X</td>
<td></td>
<td>Paraphernalia law excludes syringes.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PA</td>
<td>X</td>
<td>X</td>
<td>Prescription required for sale by pharmacy regulation.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PR</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>RI</td>
<td>X</td>
<td></td>
<td>Director of Health, and medical and pharmacy boards have approved a program of physician prescription and pharmacy sales. As of 9/1/2000, prescription law will be repealed and paraphernalia law will exclude injection equipment.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>SC</td>
<td>X</td>
<td></td>
<td>Syringes separately regulated; paraphernalia law does not include “injection” or syringes, and does not apply to heroin use.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>SD</td>
<td>X</td>
<td></td>
<td>Paraphernalia law exempts physicians and pharmacists; buyer must show “medical need.”</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>TN</td>
<td>X</td>
<td></td>
<td>Paraphernalia law exempts physicians and pharmacists; buyer must show “medical need.”</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>TX</td>
<td>X</td>
<td></td>
<td>Paraphernalia law exempts physicians and pharmacists; buyer must show “medical need.”</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>UT</td>
<td>X</td>
<td></td>
<td>Paraphernalia law exempts physicians and pharmacists; buyer must show “medical need.”</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>VT</td>
<td>X</td>
<td></td>
<td>Paraphernalia law exempts physicians and pharmacists; buyer must show “medical need.”</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>VA</td>
<td>X</td>
<td>X</td>
<td>Syringe law governs medical distribution and requires prescription for children under 16.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>WA</td>
<td>X</td>
<td></td>
<td>Pharmacy regulation to clarify legality of unrestricted sales pending.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>WV</td>
<td>X</td>
<td></td>
<td>Paraphernalia law allows sale by licensees such as pharmacists.</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
The question of the legality of prescribing and dispensing syringes brings the analyst into territory that is at once highly developed and quite obscure. The legality of needle exchange has been the subject of legal analysis and litigation. Yet even the issue of needle exchange program legality continues to involve dispute. Providing syringes by physician prescription and pharmacy sales requires a quite different analysis than needle provision by unlicensed lay people. Unlike the lay exchanger, the physician has considerable authority to prescribe drugs and devices, and pharmacists are usually required to fill valid prescriptions. In the following sections, we explain the reasoning we used to reach the conclusions summarized in Table II.

For each state and territory assessed, we asked three specific questions:

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55 See Commonwealth v. Leno, 616 N.E.2d 453 (Mass. 1993) (holding that defendants were not entitled to necessity defense after violating statutes restricting possession and distribution of syringes during operation of needle-exchange program); State v. McCague, 714 A.2d 937 (N.J. Super. Ct. App. Div. 1998) (rejecting the defenses of medical necessity and “de minimus infractions” in upholding convictions for furnishing or giving hypodermic needles as part of an exchange program); People v. Bordowitz, 588 N.Y.S.2d 507 (N.Y. Crim. Ct. 1991) (upholding necessity defense in charge under the state hypodermic needle possession statute where defendants were distributing clean needles in an exchange program); Spokane County Health Dist. v. Brockett, 839 P.2d 324 (Wash. 1992) (holding needle exchange program legal based on the broad powers of local health boards to institute efforts to prevent the spread of HIV).
1) May a physician legally prescribe sterile injection equipment to an IDU patient?

2) May a pharmacist legally fill such a prescription?

3) How might state law be changed or clarified to promote access to sterile injection equipment for IDUs through the health care system?

IV. MAY A PHYSICIAN LEGALLY PRESCRIBE STERILE INJECTION EQUIPMENT TO AN IDU PATIENT?

Answering this question required a two-step analysis. We determined first whether prescription of sterile injection equipment was consistent with the general law governing medical practice in each state. If so, we then asked whether any other law, such as a drug paraphernalia provision, prohibited prescription of syringes to an IDU patient. We begin with an overview of the regulatory environment.

A. The Regulatory Scheme

1. Medical Licensure Law

All states regulate the practice of medicine. The common regulatory structure includes a statute setting out basic requirements for licensure and standards of professional practice. These statutes are administered by medical boards, which normally have the authority to issue further regulations and the responsibility to enforce practice rules through disciplinary ac-


57 See, e.g., ALASKA STAT. § 08.64.100 (Michie 1998); COLO. REV. STAT. § 12-36-104(1)(a) (1999); DEL. CODE ANN. tit. 24, §§ 1720–39 (1997); FLA. STAT. ANN. § 458.309 (West 2000); KAN. ADMIN. REGS. 100-6-1–100-16-4.
In a few states, professional discipline is under the jurisdiction of a separate board or agency with responsibility for multiple regulated professions. Physicians who fail to maintain the required standards are subject to discipline up to and including revocation of their license.

Medical licensure law almost never explicitly addresses the physician’s general authority to write prescriptions for or dispense drugs and devices. It appears that the physician’s authority to prescribe medically necessary drugs and devices in the course of providing care is so inherent and accepted a part of medical practice that no explicit authorization is required. Leaving aside any limitations imposed by other laws, a physician is free to prescribe any drug or device she believes will benefit the patient and the prescription of which is consistent with the accepted standard of care.

Medical practice laws set out basic standards of professional practice, usually in the form of a list of acts that constitute “unprofessional conduct.” These lists identify specific illegal practices. Oklahoma’s list is illustrative:

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60 See, e.g., Evers v. Board of Med. Exam’rs, 516 So.2d 650 (Ala. Civ. App. 1987) (refusing to issue an injunction restricting Alabama’s State Medical Licensure Commission from investigating physician’s “herbal tumor removal” system); Storrs v. State Med. Bd., 664 P.2d 547 (Alaska 1983) (affirming medical board’s decision to revoke physician’s license on grounds of professional incompetency); Ghani v. Department of Health, 714 So.2d 1113 (Fla. Dist. Ct. App. 1998) (holding on appeal that physician’s conduct did not fall below the standard of care and, therefore, the disciplinary actions of the Board of Medicine were not warranted); Hasbun v. Department of Health, 701 So.2d 1235 (Fla. Dist. Ct. App. 1997) (holding that while testimony failed to support the imposition of disciplinary measures for violating the standard of care, a physician may nevertheless be subject to discipline for exploiting his or her patient for personal financial gain); Pennsylvania Med. Soc’y v. State Bd. of Med., 546 A.2d 720 (Pa. Commw. Ct. 1988) (addressing provisions regarding the regulatory authority of the State Board of Osteopathic Medicine).

61 For an exception, see KAN. STAT. ANN. § 65-2837b (Supp. 1999) (limiting the physician’s general authority to write prescriptions for or dispense drugs within its designation of “unprofessional conduct”). See also 35 PA. CONS. STAT. ANN. § 780-111(d) (West Supp. 2000) (authorizing prescription of drugs and devices).
(1) Indiscriminate or excessive prescribing, dispensing or administering of Controlled or Narcotic drugs....

(6) Dispensing, prescribing or administering a Controlled substance or Narcotic drug without medical need....

(10) [C]onviction of a felony or any offense involving moral turpitude whether or not related to the practice of medicine and surgery.

(11) Conduct likely to deceive, defraud, or harm the public....

(15) Gross or repeated negligence in the practice of medicine and surgery....

(25) Except as otherwise permitted by law, prescribing, selling, administering, distributing, ordering, or giving to a habitue or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug.62

These standards tend to explicitly turn on the medical justification for the care provided, and so whether a practitioner has violated these standards requires reference to general professional standards. Often, compliance with general medical standards is itself an explicit requirement for practice. Pennsylvania’s Medical Practice Act, for example, states:

A practitioner departs from, or fails to conform to, a quality standard of the profession when the practitioner provides a medical service at a level beneath the accepted standard of care. The board may promulgate regulations which define the accepted standard of care. In the event the board has not promulgated an applicable regulation, the accepted standard of care for a practitioner is that which would be normally exercised by the average professional of the same kind in this Common-

wealth under the circumstances, including locality and whether the practitioner is or purports to be a specialist in the area.63

A court will assess a practice alleged to be unprofessional and beneath the standard of acceptable care "[b]y considering what the practitioner has done in the particular circumstances, and by comparing his conduct with what a 'responsible segment of the medical profession' would say should have been done."64 Conviction of a felony violation under state or federal controlled substances laws is a separate ground for discipline in virtually every state,65 and often stands as the basis for automatic suspension of a practitioner's medical license.66

2. Controlled Substances Law Generally

All states have in place detailed regulations governing drugs that are regarded as always or potentially subject to abuse.67 These generally follow the format of the Federal Con-

64 Commonwealth v. Stoffan, 323 A.2d 318, 328 (Pa. Super. Ct. 1974) (referring to a practitioner's choice of either physically/visually examining a person or foregoing such an exam if he is convinced by evidence that the person is not drug-dependent when making a decision to prescribe a controlled substance); accord State Bd. of Med. Educ. & Licensure v. Ferry, 94 A.2d 121, 123 (Pa. Super. Ct. 1953). "Generally speaking, apart from, or in the absence of, statutory definitions, what constitutes unprofessional conduct ... must be determined by those standards which are commonly accepted by those practicing the same profession in the same territory. In determining what constitutes dishonorable conduct every case must be determined on its own particular facts." Id.
66 See, e.g., ALA. CODE § 34-24-360(6) (1997 & Supp. 1999) (authorizing Medical Licensure Commission to suspend any license to practice medicine whenever the licensee is found guilty of violating state or federal laws pertaining to controlled substances); ARIZ. REV. STAT. ANN. § 13-3414 (West 1989) (stating that if a person is convicted of a drug offense, the court has the discretion to suspend or revoke licensure or registration); FLA. STAT. ANN. § 893.11 (West 2000); PA. STAT. ANN. tit. 63, § 422.40(b) (West 1996).
trolled Substances Act. Drugs deemed to have the potential for abuse are placed by statute or regulation on one of five schedules. All scheduled drugs are subject to more or less strict limitations on prescription, dispensing, and use. As we will discuss further below, either by statute or by case law or both, controlled substances in nearly every state can only be prescribed for a legitimate medical purpose by a physician acting in good faith in the normal course of professional practice. Although the term “controlled substance” is never defined to include syringes or other medical devices, these statutes are highly relevant to our analysis because they, and the case law under them, provide the only explicit legal standard under state law for assessing the validity of a prescription.

A minority of states’ controlled substances laws include an explicit prohibition of physicians prescribing controlled substances to drug dependent persons, unless the physician is legally authorized to provide drug treatment services (in the case, for example, of methadone) or the drug is prescribed for some

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Many states place their drug paraphernalia or syringe laws within the title of their statutes covering controlled substances. We found only one state, however, whose rules on prescribing controlled substances included explicit coverage of devices. Pennsylvania’s Controlled Substance, Drug, Device and Cosmetic Act includes the following unique provision:

A practitioner may prescribe, administer, or dispense a controlled substance or other drug or device only (i) in good faith in the course of his professional practice, (ii) within the scope of the patient relationship, and (iii) in accordance with treatment principles accepted by a responsible segment of the medical profession.

malady other than drug abuse. Like controlled substances prescription regulations, they do not apply to syringes, but could be read as evidence of a public policy limiting physician discretion in matters of drug abuse.

3. Drug Paraphernalia Law

Forty-nine states and the District of Columbia have paraphernalia laws. Most of these statutes are based on, and often virtually identical to, a model drug paraphernalia act drafted by the U.S. Department of Justice in the late 1970s. The typical statute defines drug paraphernalia generally as all equipment, products, and materials of any kind which are used, intended for use, or designed for use, "to manufacture, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of" the state’s controlled substances laws.

71 See, e.g., ALA. CODE § 20-2-54(a)(5) (1997) (allowing physician to prescribe controlled substances in certain enumerated instances but not recognizing drug addiction as an illness); CAL. HEALTH & SAFETY CODE § 11153(a)(2) (West Supp. 2000) (stating that a valid legal prescription may be written for an addict or habitual controlled substance user as part of an authorized narcotic treatment program); CONN. GEN. STAT. ANN. § 21a-252(a) (West 1994 & Supp. 2000) (restricting the dispensing of controlled substances for drug dependence, but allowing the dispensing of take-home doses of methadone under certain circumstances); HAW. REV. STAT. § 329-38(e)(3) (Supp. 1999); KAN. ADMIN. REGS. § 68-20-18(b)(3); MASS. GEN. LAWS ANN. ch. 94C, § 19(c) (West 1997); MONT. CODE ANN. § 37-7-401 (1999) (indicating that a prescription may not be used for the dispensing of narcotic drugs listed in any schedule for "detoxification" or "maintenance treatment"); NEV. ADMIN. CODE ch. 453, § 430 (2000); N.Y. COMP. CODES R. & REGS. tit. 10, § 80.65 (1999) (excluding specifically prescriptions written for a controlled substance to an addict for their customary use from the statutory meaning of a prescription); 35 PA. CONS. STAT. ANN. § 780-113(a)(13) (West 2000); S.C. CODE ANN. § 44-53-360(h) (Law. Co-op. 1985) (restricting prescriptions of controlled substances to legitimate medical purposes).

72 See Gostin & Lazzarini, supra note 54, at 615. Alaska is the exception among the states. The territory of Puerto Rico also lacks a paraphernalia law. The Virgin Islands, not covered in our study, has a drug paraphernalia and a syringe prescription law. See id.


74 See NEB. REV. STAT. § 28-441 (1995); accord ARIZ. REV. STAT. ANN. § 13-3415(F)(2)(k-l) (West 1989); COLO. REV. STAT. § 18-18-426(1)(g) (1999); D.C. CODE ANN. § 33-601(3) (1998); GA. CODE ANN. § 16-13-32.1(a) (1996); OHIO REV. CODE ANN. § 2925.14(A) (Banks-Baldwin Supp. 2000). But see IND. CODE ANN. § 35-48-4-8.5(d)(2) (West 1998) (exempting from the paraphernalia law sellers of items "historically and customarily used in connection with the... injecting... of...
It then provides a list of a dozen or more particular items that could be drug paraphernalia by way of example. In the majority of states, this list includes "[h]ypodermic syringes, needles, and other objects used, intended for use, and designed for use in parenterally injecting controlled substances into the human body."\(^{75}\) It is important to note, however, that by this definition, the status of any item as paraphernalia depends not just on the characteristics of the item itself, but also the intention or acts of the defendant. A small glass vial used to store saffron in a spice store is not drug paraphernalia. The same vial, sold with knowledge to a crack dealer and used in packaging his product, would be paraphernalia.

The model paraphernalia law was written in broad terms, to encompass almost any type of item that might be used for drug abuse. Because of this, both legislators and courts were concerned that they could be construed to apply to innocent transactions, people, or equipment.\(^{76}\) To guide the finder of fact, paraphernalia statutes often include a list of factors to be taken into consideration when determining whether an item is drug paraphernalia or not. The list typically includes:

(a) Statements by an owner or person in control of the object concerning its use.

(b) Prior convictions, if any, of an owner or person in control of the object, under any state or federal law relating to any controlled substance.

(c) The proximity of the object, in time and space, to a direct violation of the uniform controlled substances act.

(d) The proximity of the object to controlled substances.

(e) The existence of any residue of controlled substances on the object.

\(^{75}\) See Ferguson et al., \textit{supra} note 54, at 48-53 (reviewing legislative history of Pennsylvania's paraphernalia law).
(f) Direct or circumstantial evidence of the intent of an owner or person in control of the object, to deliver it to a person the owner or person in control of the object knows, or should reasonably know, intends to use the object to facilitate a violation of the uniform controlled substances act. The innocence of an owner or person in control of the object as to a direct violation of the uniform controlled substances act shall not prevent a finding that the object is intended for use as drug paraphernalia.

(g) Oral or written instructions provided with the object concerning its use.

(h) Descriptive materials accompanying the object which explain or depict its use.

(i) National and local advertising concerning the object’s use.

(j) The manner in which the object is displayed for sale.

(k) Whether the owner or person in control of the object is a legitimate supplier of similar or related items to the community, such as a distributor or dealer of tobacco products.

(l) Direct or circumstantial evidence of the ratio of sales of the object or objects to the total sales of the business enterprise.

(m) The existence and scope of legitimate uses for the object in the community.

(n) Expert testimony concerning the object’s use.\footnote{KAN. STAT. ANN. § 65-4151 (1992); accord CAL. HEALTH & SAFETY CODE § 11014.5(c) (West 1991); FLA. STAT. ANN. § 893.146 (West 2000); 720 ILL. COMP. STAT. ANN. 600/4 (West Supp. 2000); MONT. CODE ANN. § 45-10-102 (1999); VT. STAT. ANN. tit. 18, § 4475(b) (Supp. 1999).}

Paraphernalia laws usually create two basic offenses: manufacturing or distributing, and possessing. The former is phrased
in terms that tend to repeat the scienter element built into the
definition, and make it a crime to:

deliver, possess with intent to deliver, or manufacture
with intent to deliver, drug paraphernalia, knowing, or
under circumstances where one reasonably should
know, that it will be used to... inject, ... or otherwise
introduce into the human body a controlled substance or
marijuana in violation of [state controlled substances
laws].

The enforcement of paraphernalia possession laws is often
regarded as an important contributing cause to unsterile injec-
tion.

It is typically unlawful, in the words of the model statute:

[T]o use, or to possess with intent to use, drug para-
phernalia to ... introduce into the human body a con-
trolled substance in violation of this Act[;] ... deliver,
possess with intent to deliver, or manufacture with in-
tent to deliver, drug paraphernalia, knowing, or under
circumstances where one reasonably should know, that
it will be used to ... introduce into the human body a
controlled substance ... .

The severity of the offense varies. In most states, it is a
misdemeanor, but in a few it is a felony. Anecdotal evidence

78 S.D. CODIFIED LAWS § 22-42A-4 (Michie 1998); accord KY. REV. STAT.
ANN. § 218A.300(3) (Banks-Baldwin 1999); MASS. GEN. LAWS ANN. ch. 94C, §
32I(a) (West 1997); N.C. GEN. STAT. § 90-113.23 (1999); N.M. STAT. ANN. § 30-31-
25.1(B) (Michie 1997); WYO. STAT. ANN. § 35-7-1056 (Michie 1999).
79 See Bluthenthal et al., supra note 18, at 12; Lawrence O. Gostin et al., Prevent-
ion of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users:
A National Survey on the Regulation of Syringes and Needles, 277 JAMA 53 (1997)
(concluding that the strict enforcement of drug paraphernalia laws has greatly con-
tributed to the spread of HIV/AIDS); see also Gostin & Lazzarini, supra note 54, at
648 (noting that restricting access to syringes may contribute to blood-borne infection
in IDUs, their sexual and needle-sharing partners, and their children).
80 Annotation, Validity, Under Federal Constitution of So-Called "Head
Shop" Ordinances, supra note 73, at 21.
81 See, e.g., ALA. CODE § 13A-12-260(d)(1) (1994); CAL. HEALTH & SAFETY
CODE § 11374 (West 1991); IND. CODE ANN. § 35-50-3-2 (West 1993); KAN. STAT.
82 See, e.g., ARIZ. REV. STAT. ANN. § 13-3415 (West Supp. 1999); HAW. REV.
STAT. § 329-43.5 (1993); IDAHO CODE § 37-2734B (1994); MO. ANN. STAT. §
195.235 (West 1996); NEV. REV. STAT. ANN. § 453.560 (Michie 1996); S.D.
and some research suggests that these laws are often enforced, at least in some states.\textsuperscript{83}

While 49 states have some form of paraphernalia law, they can differ in small ways that can have significant impact on the analysis of syringe access by prescription. Nine states' paraphernalia laws exclude syringes categorically\textsuperscript{84} or when sold in designated amounts.\textsuperscript{85} Six more states provide some kind of immunity to pharmacists that would cover the filling of a valid syringe prescription.\textsuperscript{86} South Carolina's paraphernalia law omits any reference to syringes or injection, and does not apply to items used in the consumption of opiates.

4. Syringe Prescription Law

Thirteen states have a law or regulation that requires a prescription to purchase a syringe under at least some circumstances.\textsuperscript{87} These laws may be divided for present purposes into two groups: those that pervasively regulate the sale and possession of needles and constitute a major barrier to IDU access, and those that do not. The latter group includes three states

\begin{itemize}
  \item Rhode Island has repealed its syringe prescription law as of September 1, 2000.
\end{itemize}
whose laws apply in only limited circumstances (Florida, Nevada, and Virginia) as well as four states that have “deregulated” sales of ten syringes and fewer (these states — Connecticut, New Hampshire, New York, and Maine — are discussed below.) This leaves six states (California, Delaware, Illinois, Massachusetts, New Jersey, Pennsylvania) whose syringe prescription rules remain an impediment to syringe access.

Most of the general prescription laws on the books today limit who may legally possess a syringe, require a prescription for sale to non-medical or other unauthorized personnel, and set out more or less onerous record-keeping requirements. For example, Massachusetts’ law states:

(a) No person, not being a physician, . . . registered under the laws of this commonwealth, or of the state where he resides, or a registered embalmer, manufacturer of or dealer in embalming supplies, pharmacist, wholesale druggist, manufacturing pharmacist, manufacturer of or dealer in surgical supplies, . . . or a person who has received a prescription issued under subsection (c), . . . shall have in his possession a hypodermic syringe, hypodermic needle, or any instrument adapted for the administration of controlled substances by injection.

(b) No such syringe, needle or instrument shall be delivered or sold to, or exchanged with, any person except a pharmacist, . . . physician, . . . or a person who has received a written prescription issued under subsection (c) . . .


87 Nevada’s prescription law allows syringes to be sold without a prescription, including:
(a) For the use in the treatment of persons having asthma or diabetes.
(b) For use in injecting intramuscular or subcutaneous medications prescribed by a practitioner for the treatment of human beings.
NeV. Rev. Stat. Ann. § 454.480(2) (Michie 1996). The effect of these exceptions has been to allow routine pharmacy sales.

(c) A physician may issue to a patient under his immediate charge a written prescription to purchase, or may issue an oral prescription to a pharmacist on behalf of said patient to purchase, from a pharmacist only, any of the instruments specified in subsection (a). Such prescription shall contain the name and address of the patient, the description of the instrument prescribed and the number of instruments prescribed. The pharmacist filling the prescription shall record upon the face of said prescription, over the signature of the pharmacist making the sale, the date of such sale. Such prescription may be renewed or refilled for one year unless the physician indicates otherwise on the prescription, and each refilling shall be noted upon the prescription. No prescription for such instruments shall be refilled after one year from date of issue. The pharmacist filling the prescription shall dispense any such instrument in a sanitary container which shall completely enclose such instrument, and shall affix to said container a label bearing (1) the name and address of the pharmacy, and if said pharmacy is in a hospital, the name and address of said hospital, (2) the name and address of the patient, (3) the file number of the prescription, and (4) the name of the physician prescribing the same. The person to whom the prescription is issued shall keep such instrument in said container at all times, except when such instrument is in actual use or is in the process of being cleaned.

(d) A record shall be kept by the person selling such syringes, needles or instruments, which shall give the date of the sale, the name and address of the purchaser and a description of the instrument. This record shall be open to inspection pursuant to a judicial warrant or to the provisions of section thirty [administrative inspection of controlled premises].

(e) No person except ... a pharmacist or wholesale druggist, which pharmacist or wholesale druggist is licensed under the provisions of chapter one hun-
dred and twelve [Registration of Certain Professions and Occupations], shall sell, offer for sale, deliver, or have in possession with intent to sell hypodermic syringes, hypodermic needles or any instrument adapted for the administration of controlled substances by injection, unless licensed so to do by the department . . . . No person except a person listed in subsections (b) or (c) shall obtain, receive or purchase a hypodermic syringe, hypodermic needle or any instrument adapted for the administration of controlled substances by injection, unless licensed so to do by the department, or by a local board of health.\footnote{Mass. Gen. Laws Ann. ch. 94C, § 27(a)-(e) (West 1997); accord Nev. Rev. Stat. Ann. § 454.480(1) (Michie 1996).}

These statutes are strict in the sense that they limit the ability of individuals to acquire, and pharmacists to sell, syringes. For present purposes, however, it is to be noted that most state prescription laws do not purport to set any substantive standard by way of limiting the physician’s discretion to write the syringe prescription. This can be seen in the one state whose rule proves the exception. Delaware’s law requires that the prescription certify that the “possession of such instrument is necessary for the treatment of an injury, deformity or disease then suffered by the person possessing the same.”\footnote{Del. Code Ann. tit. 16, § 4757(c) (1995). Based on this provision alone, we concluded that a Delaware physician may not legally write a prescription for syringes to an IDU with no other qualifying medical condition.}

5. “Deregulation States”

Eight states and territories may be said to have deregulated the sale or possession of syringes; i.e., more or less completely eliminated legal restrictions on the sale and possession of at least some number of syringes.\footnote{For a detailed analysis on syringe deregulation, see ABA AIDS Coordinating Comm., Deregulation of Hypodermic Needles and Syringes as a Public Health Measure: A Report on Emerging Policy and Law in the United States (forthcoming 2001).} Three states (Oregon, Rhode Island, and Wisconsin) have explicitly excluded syringes from the definition of “drug paraphernalia” and do not require a prescription or other evidence of medical need to purchase a syringe. Five states (Connecticut, Maine, Minnesota, New Hamp-
shire, and New York) have changed paraphernalia and/or syringe prescription laws to remove restrictions on purchase or possession of ten and fewer needles. Alaska and Puerto Rico never had statewide paraphernalia or prescription laws, though Alaska does have ordinances in some cities that restrict syringe access.

6. The Impact of Needle Exchange Laws

A number of states have passed legislation authorizing needle exchange programs. Generally, such legislation is not directly relevant to physician prescription and pharmacy sale of prescribed syringes, both because the statutes specifically authorize exchange and because exchange is usually carried out by people who cannot prescribe because they are not licensed. However, there are exceptions. We found some cases in which the passage of a needle exchange law was relevant to interpreting the intended coverage of the paraphernalia or prescription laws, and in at least three states, we concluded that a program of physician prescription might qualify as a needle exchange program as defined in those states' law.

These include: California, Connecticut, District of Columbia, Hawaii, Maine, Maryland, Massachusetts, New Mexico, Rhode Island, and Vermont.

California, District of Columbia, and Vermont. See Cal. Health & Safety Code § 11364.7 (West Supp. 2000) (stating that "[n]o public entity, its agents, or employees shall be subject to criminal prosecution for distribution of hypodermic needles or syringes to participants in clean needle and syringe exchange projects authorized by the public entity pursuant to a declaration of a local emergency due to the existence of a critical local public health crisis"); D.C. Code Ann. § 33-603.1 (1998); Vt. Stat. Ann. tit. 18, § 4475(a)(1) (Supp. 1999); see also Project on Harm Reduction, supra note 52 (referencing syringe and prescription laws for all states).

In Vermont, for example, a licensed health care provider may apply to the commissioner of health for authorization to operate a needle exchange program. A physician and pharmacist could design a program of prescription-based distribution and submit it for approval under the terms of the state's needle exchange rules, which would require that the program provide needles free of charge, and offer various referral services. See Vermont Dept. of Health, Operating Guidelines for Organized Community-Based Needle Exchange Programs (Sept. 1999) (on file with author).
B. Analysis of the Physician’s Ability to Write a Syringe Prescription

1. Authority to Prescribe

The first question is whether any laws directly addressing syringe prescription or the prescription of devices are applicable, as these would be expected to control. In fact, in nearly all the prescription law states, the prescription law itself did not set any substantive standard for the prescribing physician, but rather simply set a prescription as the sine qua non for dispensing or possession. The two exceptions were Delaware, see supra note 92, and Ohio. In Ohio, the syringe prescription law, in relevant part, limits provision and possession of syringes to individuals who have "legal . . . medicinal purposes," Ohio Rev. Code Ann. § 3719.172(A)(5) (West 1998 & Supp. 2000). The syringe law on its face repeatedly conditions legal possession on a proper purpose or legitimate reason for possession, making clear that illegal or improper uses will not be tolerated. Allowing a disease prevention purpose to justify syringe possession that would otherwise be illegal departs from a maximally stringent interpretation of drug control laws. One could reasonably read the syringe law to exclude possession in all instances in which an illegal purpose is present.

This statutory scheme was, however, in place before the medical necessity for sterile injection equipment arose, so it cannot be said that the legislature intended to prohibit therapeutic and preventive uses of needles by drug abusers. Unlike most other states, Ohio's scheme has long carved out a protected zone of discretion for physicians and other health care providers, and has placed a steep burden on the state to prove that this discretion was being abused. See State v. Pawlyszyn, 619 N.E.2d 1255, 1258 (Ohio C.P., Cuyahoga County 1993) (finding no clear and convincing evidence that physician's conduct fell below acceptable standards of medical practice). In so doing, the legislature recognized that actions that might be illegal when performed by lay people for non-medical reasons could fall within the proper and legal exercise of medicine. Just as a physician may sometimes prescribe narcotics to an actual or possible abuser when the physician believes the drug is medically necessary for purposes other than continuing the patient's addiction, see generally Christopher Vaeth, Annotation, State Law Criminal Liability of Licensed Physician for Prescribing or Dispensing Drug or Similar Controlled Substance, 13 A.L.R.5th 1, 20 (1993) (controlled substances laws "almost universally . . . contain exceptions in favor of physicians who, in good faith and in the regular and legitimate practice of their profession . . . prescribe . . . narcotics to their patients or to addicts for purposes of treatment"), so the legislative scheme for injection equipment can reasonably be read to give physicians the discretion to prescribe needles as a disease prevention measure even when the patient has other, illegal purposes as well. The 1998 amendment of § 3719.172 to eliminate the requirement that "the pharmacist . . . shall require positive identification of each person to whom hypodermics are furnished, and shall keep a written record of each transaction" indicates a legislative intention to ease access to syringes. Ohio Rev. Code Ann. § 3719.172 (West 1998), amended by Ohio Rev. Code Ann. § 3719.172 (West Supp. 2000).
a standard for the prescription of devices generally, which would presumably include syringes.

In most syringe prescription and non-prescription states, then, we were left without explicit guidance on the authority of physicians to prescribe syringes. We did not conclude, however, that there were no standards. Rather, we examined state law for the most analogous and sensible standard, which we found almost uniformly in controlled substances laws and less clearly, but still frequently, in general professional standards. We found the standard there, for the simple reason that the only case law on prescribing arose out of allegations that the broad, inherent power to prescribe had been in some way abused. The most common type of abuse was the prescription of controlled substances without proper justification or in an improper manner. A few cases involved allegations, often related to controlled substance law violations, that prescriptions had been unprofessional. Under the laws of all the states, we expect a court or medical licensing board would accept a prescription as valid if it is written in good faith, for a legitimate medical purpose, in the normal course of professional practice.\textsuperscript{7} The case law does not always treat these three prongs separately, and there can fairly be said to be considerable overlap among them.

In normal usage, "good faith" entails a genuine concern for the well-being of the patient and others who might be infected through sharing injection equipment with the patient, and conduct devoid of malice or deception: "[a] doctor who prescribes a potentially dangerous drug without first making some attempt to determine the physical condition or health needs of the person for whom he writes the prescription is not acting in good faith and in the usual course of his practice."\(^9\) A physician who is providing syringes to a patient who the physician has determined cannot or will not enter drug treatment, and whose injection drug use places him at high risk of contracting or spreading a communicable disease, should have no difficulty satisfying the "good faith" prong of the prescription standard.

In determining whether a prescription arises out of the usual course of professional practice, a court will consider whether a bona fide doctor-patient relationship existed, whether other care was provided, whether proper records were kept of the encounter, and whether the prescription was based on a proper history or individualized assessment of the patient’s risk factors, efforts to provide other harm reducing services, follow up and so on. "The phrases ‘usual course of business or practice’ of such persons as physicians and surgeons ... are in such common use that any reasonable man can determine their meaning. Surely, one licensed as a physician knows when he is acting in the usual course of his practice of medicine."\(^9\) In the leading case, *United States v. Moore*, the court wrote:

The evidence presented at trial was sufficient for the jury to find that respondent's conduct exceeded the bounds of "professional practice." ... \(^9\) He gave inadequate physical examinations or none at all. He ignored the results of the tests he did make .... He did not regulate the dosage at all, prescribing as much and as frequently as the patient demanded. He did not charge for medical services rendered, but graduated his fee ac-

\(^9\) See also People v. Lonergan, 267 Cal. Rptr. 887, 892 (Cal. Ct. App. 1990) (describing good faith as "that state of mind denoting honesty of purpose, freedom from intention to defraud, and, generally speaking, means being faithful to one's duty or obligation") (quoting People v. Nunn, 46 Cal.2d 460, 468 (1956)); Vaccaro, 361 A.2d at 50. "A physician who is honest and ethical, and dispenses the prohibited drugs in a good faith effort to treat and cure patients, has no fear of the criminal sanctions of the statute." \(^9\) Id.

\(^9\) State v. Bridges, 398 S.W.2d 1, 4 (Mo. 1966).
cording to the number of tablets desired. In practical ef-
fct, he acted as a large-scale “pusher” — not as a physi-
cian.100

A physician prescribing syringes to bona fide patients in his
regular office or in a clinic, keeping records, and providing
other treatment services, would not be at risk of failing this
prong of the test.

Few decisions have clarified the meaning of a “legitimate
medical purpose.” Such case law as there is suggests a standard
looking to whether or not other physicians would regard the
practice as legitimate.101 A practice is not illegitimate simply
because some physicians disagree with the practice at issue, but
only where no responsible segment of the medical profession
accepts the appellant’s methods.102 Expert testimony and at-
tending circumstances will then help the fact-finder determine
the legitimacy of the physician’s actions.103

100 423 U.S. 122, 142-43 (1975).
 Ct. 1979) (recognizing physician’s ability to choose between available options
of treatment based on medical judgment); Commonwealth v. Salameh, 617 A.2d 1314,
practitioner to be convicted, it must be shown that no other segment of the medical
profession would have approved the practitioner’s choice of treatment).

102 See Glover v. Board of Med. Quality Assurance, 282 Cal. Rptr. 137, 140
(Cal. Ct. App. 1991). “As long as the differences of opinion are legitimate, we have
no dispute with the notion that different methods of treatment can all be considered
acceptable medical practice.” Id.; accord Lonergan, 267 Cal.Rptr. at 893. “The fact
that a Physician might have . . . acted in a fashion different from that of other practi-
tioners is immaterial if the Physician acted in good faith.” Id.

It is often the burden of the physician to prove a legitimate medical purpose.
See Kane, 586 S.W.2d at 814 (holding that physician has the burden of bringing him-
self within the exceptions to a controlled substance statute); accord State v. West,
929 S.W.2d 239 (Mo. Ct. App. 1996). “Generally, where an exception is part of the
section which defines the offense, the burden is on the State to plead and prove that
the defendant is not within the exception. However, where the exception is found in a
separate clause or part of the statute disconnected from the definition of the offense,
the exception is not for the prosecution to negate, but for the defendant to claim as a
matter of affirmative defense.” Id. at 242.; see also MO. ANN. STAT. § 195.180 (West
1996) (indicating that a physician may have burden to prove legitimate reason for
prescribing controlled substance).

103 Significantly, a physician is not limited to only presenting expert medical
witnesses to support the legitimacy of prescribing syringes to IDUs to prevent the
spread of HIV. Missouri courts have shown a willingness to consider the testimony of
any witness whose area of expertise is relevant to the issue at hand. Therefore, a phy-
sician would be able to offer testimony from researchers, syringe exchange programs
Medical evidence and public health guidelines, combined with the support of major professional organizations, make a compelling case for the practitioner prescribing injection equipment to IDUs. Not all physicians will agree that prescriptive participants, and others familiar with the beneficial aspects of this practice. See St. Luke's Hosp. v. May, 588 S.W.2d 217, 222 (Mo. Ct. App. 1979).


In two states, however, the leading cases leave some room for doubt as to the proper interpretation of the third prong of the standard. The controlled substances law in Kansas requires only a “medical purpose,” and does not use the common modifier “legitimate.” In State v. Vakas, the trial court had dismissed an indictment against a doctor because the prosecutors had added “legitimate” to the charge. 744 P.2d 812 (Kan. 1987). The Kansas Supreme Court reversed, on the ground that “[i]t would indeed be a strained construction of the statute to say that the legislature intended the prescription of a controlled substance for an illegitimate purpose to be lawful and within the statutory exception. Such a determination of legislative intent and construction of the statute would be ridiculous.” Id. at 815. The court also addressed the meaning of “legitimate”: “The word 'legitimate' when used as a descriptive term is a word of common usage and understanding. Legitimate, when used as it was here, has been defined as '[r]eal, valid or genuine.' It is also defined as 'lawful, legal, recognized by law, or according to law.' BLACK'S LAW DICTIONARY 811 (5th ed. 1979).” Id. In this passage, the court may be understood as departing from the usual view that the legitimacy of the purpose is to be judged exclusively in medical terms. On this view, a prescription would only be legitimate if its purpose was both medically valid as judged by scientific evidence and professional standards, and legally valid (i.e., not in violation of other law). Given the existence of a paraphernalia law in Kansas, this is a potentially important distinction.

The most cautious view is that Kansas’ paraphernalia statute applies to syringes prescribed for disease prevention purposes when they will be used to inject illegal drugs. General medical practice law, on this reading, allows a physician to write a prescription with a valid medical purpose and, in the course of medical practice, except when the practitioner knows or should have known the patient intends to use the item for drug use, when the drug paraphernalia provision makes the purpose illegitimate. This reading is consistent with the plain meaning of the Kansas paraphernalia statute, which prohibits any person, without exception for health care providers, from delivering or causing to be delivered drug paraphernalia to someone knowing it will be used to ingest illegal drugs. Under this interpretation of “legitimate medical purpose,” a physician in Kansas probably cannot legally prescribe injection equipment to an IDU patient even as a means of preventing the transmission of serious blood-borne disease.

Unlike most states, Oklahoma has a definition of “medical purpose” in its controlled substances law. This definition embraces the use of a controlled substance for “physical or mental treatment, for diagnosis, or for the prevention of a disease condition not in violation of any state or federal law and not for the purpose of satisfying physiological or psychological dependence or other abuse.” OKLA. STAT. ANN. tit. 63, § 2-101(24) (Supp. 2000). Inartfully drafted, this provision presents some difficulty in interpretation. As applied to controlled substances, it appears simply to
scribing injection equipment is within the bounds of good medical practice, but only the support of a responsible segment of medical opinion is required.\footnote{See Glover, 282 Cal. Rptr. at 140; see also Stephen E. Stone, The Investigation and Prosecution of Professional Practice Cases Under the Controlled Substances Act: Introduction to Professional Practice Case Law and Investigations, 10 Drug Enforcement 21, 23-26 (1983).}

Despite the widespread perception to the contrary, courts are quite reluctant to interfere with physician discretion in the practice of medicine.\footnote{See Marshall B. Kapp, Treating Medical Charts Near the End of Life: How Legal Anxieties Inhibit Good Patient Deaths, 28 U. Tol. L. Rev. 521 (1997) (describing the interaction between physicians, law, policy, and the courts).} Courts have consistently held that prescribing statutes were not meant to "invade the legitimate doctor-patient relationship when the doctor may dispense or prescribe... for medical reasons."\footnote{United States v. Collier, 478 F.2d 268, 274 (5th Cir. 1973). See also United States v. Lindler, 268 U.S. 5, 15, 18 (1925) (holding that the meaning of legitimate medical practice depends on the facts and circumstances of each case).} Providing injection equipment to drug-injecting patients out of a sincere desire to prevent disease transmission, without pecuniary motive, clearly satisfies the prescription standard. Given this medical evidence, it would also be difficult to argue that providing sterile injection equipment falls beneath the minimal standards of professional practice set forth in the laws governing the practice of medicine.

2. Limits on Physician Prescribing Authority

We turn now to the second question: Do any other laws prohibit physicians from prescribing sterile injection equipment to IDU patients? We generally identified two main possibilities.

Some states have provisions that explicitly prohibit a physician from prescribing controlled substances to a known drug dependent person for the purpose of maintaining their addic-
Such statutes could be the basis of an argument that providing sterile injection equipment must also be illegal. Per this argument, providing syringes enables drug users to maintain their drug use, and is therefore inconsistent with the basic purposes of the law.

This argument has a common-sense appeal, but should fail on at least two grounds. First, the plain language of the prohibition does not embrace syringes, and it is a cardinal rule of statutory construction in most states that criminal laws are to be strictly construed against the state. Under this rule, a court should not read a criminal statute as prohibiting conduct it does not explicitly prohibit. Second, even if we accept the analogy between providing controlled substances and providing sterile equipment for injecting them, the provisions themselves not uncommonly make an exception for prescriptions necessary to treat some other malady. Preventing the spread of infectious disease, while not literally curing or treating a disease, is a plainly acceptable medical intervention, and so would seem to fall well within a broad interpretation of the provision.

Drug paraphernalia laws were a more serious possibility, which we addressed in a narrow, technical fashion. The ultimate issue presented by this mode of needle distribution is whether the prescription is sufficient basis for the legal sale of the syringe by the pharmacist. This issue nearly always turned on the proper interpretation of the scope and application of a paraphernalia law. For physicians, however, a plain-text reading of the paraphernalia laws has generally led along a narrower path to the non-applicability of paraphernalia laws.

Nearly all paraphernalia laws characterize the criminal act as to "deliver, possess with intent to deliver or manufacture with the intent to deliver drug paraphernalia with knowledge, or under circumstances where one reasonably should know, that it

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108 See, e.g., CAL. HEALTH & SAFETY CODE § 11156 (West 1991) (stating that "[n]o person shall prescribe for or administer, or dispose a controlled substance to an addict or habitual user, or to any person representing himself as such, except as permitted by this division").


110 See, e.g., MO. ANN. STAT. § 334.106(4) (West Supp. 2000) (stating that a physician is not liable for or accountable to the board for prescribing addictive or potentially addictive medications or treatments).
will be used to ... inject, ... or otherwise introduce into the human body a controlled substance” in violation of the act.\footnote{111}

The definition of “delivery” usually comes from the definitions section of the state controlled substances act, and takes this form: “the actual, constructive, or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship.”\footnote{112} A physician who writes a prescription for an item is not actually transferring possession of that item to the patient, but merely providing the patient with instructions and authorization for the pharmacist who will transfer possession by dispensing the prescription.

Nor does the concept of a constructive delivery embrace the writing of a prescription. Constructive delivery requires, at a minimum, prior constructive possession of the item. One constructively possesses a controlled substance “when one knows of the nature or character of the substance and of its presence and has dominion or control over it.”\footnote{113} The authority to write a prescription for a syringe does not give the physician the ability to exercise dominion over it; like the patient, he would have to go to the pharmacy and purchase the syringe in order to possess it, and so cannot be said to constructively possess it.\footnote{114} Since the

\footnote{111} N.M. STAT. ANN. § 30-31-25.1(B) (Michie 1997) (emphasis added); accord A.L.A. CODE § 13A-12-260(d)(1) (1994).


\footnote{113} State v. DeGroat, 508 N.W.2d 861, 865 (Neb. 1993) (citations omitted).

\footnote{114} It should be noted that courts interpreting controlled substances laws have sometimes interpreted terms like “sell,” “dispense,” “furnish” or “distribute” to embrace the writing of a prescription for a controlled substance. See, e.g., Jin Fuey Moy v. United States, 254 U.S. 189, 192-94 (1920) (affirming defendant’s conviction for unlawfully issuing a prescription in violation of the Anti-Narcotic Act); United States v. Thompson, 624 F.2d 740 (5th Cir. 1980) (affirming conviction of physician for unlawfully dispensing a controlled substance); Commonwealth v. Comins, 356 N.E.2d 241, 244 (Mass. 1976), cert. denied, 430 U.S. 946 (1977); State v. Moody, 393 So.2d 1212, 1214-15 (La. 1981) (detailing requirements to convict a physician for unlawful distribution of a prescription drug). See generally Vaeth, supra note 96, at 20 (enumerating and clarifying elements of possession). In our state-by-state analyses of case law, however, we did not generally find these interpretations of controlled substances acts to be applicable to the rather different terminology used in
physician does not have any level of possession of the syringe, he can not logically be capable of delivering it.

Our legal analysis revealed that only a handful of state laws set out explicit criteria to govern a physician’s prescription of injection equipment. We found that prescribing injection equipment in good faith, in the course of a physician’s normal professional practice, and for a legitimate medical purpose, like disease prevention, was legal in 48 states and territories. Writing a prescription for a syringe probably violates laws in Delaware and Kansas, and presents a reasonable claim to legality in Ohio and Oklahoma.

V. MAY A PHARMACIST LEGALLY FILL SUCH A PRESCRIPTION?

Writing the prescription is only an effective health intervention if the patient can then purchase the syringes at a pharmacy. Our research found that pharmacists were clearly or arguably subject to more restrictions than physicians, leading to the finding that filling a valid syringe prescription for a known IDU is clearly legal in 26 states, with a reasonable claim to legality in 22 more. (See Table II.)

A. The Regulatory Environment

1. Pharmacy Licensure Law

All states regulate the practice of pharmacy. The regulatory structure typically includes a statute setting out basic re-
requirements for licensure and standards of professional practice. These requirements are administered by state pharmacy boards, which have authority to promulgate further regulations and the responsibility to enforce practice rules through disciplinary action. Pharmacists who fail to maintain the required standards are subject to discipline up to and including revocation of their license. Syringe prescription and record-keeping laws or regulations, discussed below, are often codified within pharmacy law.

Pharmacy practice laws set out basic standards of professional practice, usually in the form of a list of acts that constitute "unprofessional conduct." These lists identify specific illegal practices. The disciplinary provisions of Arkansas' Pharmacy Act provide one example:

The Arkansas State Board of Pharmacy may revoke an existing license of a licensed pharmacist or may suspend the license or may refuse to issue a license if the holder or applicant, as the case may be, has committed or is found guilty by the board of any of the following acts or offenses set forth: . . .

(3) That the person has been found guilty or pleaded guilty or nolo contendere in a criminal proceeding, regardless of whether or not the adjudication of guilt or sentence is withheld, by a court of this state, another state, or the federal government for:

(A) Any felony;


119 *See, e.g.,* CAL. BUS. & PROF. CODE §§ 4141–42 (West 2000) (prohibiting the furnishing of syringes without a board license and the selling of syringes without a prescription).
(B) Any act involving moral turpitude, gross immorality, or which is related to the qualifications, functions, and duties of a licensee; or

(C) Any violation of the pharmacy or drug laws of this state or rules and regulations pertaining thereto, or of the pharmacy or drug statutes, rules, and regulations of any other state or of the federal government; . . .

(7) That the person has been guilty of gross unprofessional or dishonorable conduct;

(8) That the person has willfully violated any of the provisions of the pharmacy laws of the State of Arkansas;120

A pharmacist is generally authorized to dispense medications ordered by a valid prescription, and is ordinarily expected to do so in the absence of a good reason to refuse.121 At the same time, a pharmacist is not required to blindly follow a practitioner's orders. New Jersey's pharmacy regulations state that:

The pharmacist shall have the right to refuse to fill a prescription if, in his or her professional judgment, the prescription is outside the scope of practice of the prescriber; or if the pharmacist has sufficient reason to question the validity of the prescription; or to protect the health and welfare of the patient.122

120 ARK. CODE ANN. § 17-92-311(a)(1-8) (Michie 1995). See also D.C. CODE ANN. § 2-2010 (1994) (stating conditions under which the mayor can withhold, suspend, or withdraw a pharmacist's license); see also LA. REV. STAT. ANN. § 37:1225 (West 1988) (determining that the standards of pharmacy arise under the disciplinary provisions of the pharmacy act within a section on the code of ethics).


122 N.J. ADMIN. CODE tit. 13, § 13:39-6.1(a) (2000). The regulations for the controlled substance law in most states make clear that a pharmacist has an independent responsibility to ensure that controlled substances are properly prescribed. See also Askin v. Commonwealth Dep’t of Pub. Welfare, 423 A.2d 1371, 1373-74
A "right" and perhaps a common-law duty to exercise some discretion is, in a few states, stated as a positive requirement. For example, Colorado's licensure law prohibits the filling of prescriptions in the absence of medical need:

Medical need: No licensee or registrant shall compound, dispense, deliver or distribute any drug to any person in such quantity or in any situation where the licensee or registrant knows or reasonably should know said drug has no recognized medical utility or application. Violation of this rule shall constitute prima facie proof of violation of CRS 12-22-125.\(^\text{123}\)

2. Syringe Specific Laws

Pharmacy law nationally includes four basic types of controls over syringe sales: the requirement of a prescription,\(^\text{124}\) which often most directly applies to pharmacists; "sub-prescription" requirements, such as requiring the buyer to demonstrate a legitimate medical or legal purpose for the syringe purpose;\(^\text{125}\) record-keeping and display laws;\(^\text{126}\) and, finally, a

\(^\text{123}\) See discussion supra Part IV.A(4).


\(^\text{125}\) The Pharmacy Act in Indiana, for example, sets forth identification and record-keeping requirements that limit the sale of syringes and needles:

(a) A . . . device known as a hypodermic syringe and/or needle for human use may be dispensed by a pharmacist without a prescription to a purchaser at retail, provided that: . . .

(4) the pharmacist requires every purchaser of a . . . device . . . not known to the pharmacist to furnish suitable identification (including proof of age where appropriate); and

(5) separate bound record books for dispensing of . . . devices under this section . . . are maintained by the pharmacist. These books shall contain the name and address of the purchaser, the name and quantity of . . . devices purchased, the date of each purchase, and the name or initials of the pharmacist who dispensed the substance or devices to the purchaser these books shall be
variety of informational and disposal rules that are found primarily in states that have liberalized or deregulated syringe purchase limits.127

3. Controlled Substances and Drug Paraphernalia Laws

The controlled substances and paraphernalia laws discussed earlier in connection with prescribing128 are also applicable to analyzing the legality of filling syringe prescriptions for IDU patients.

B. Analysis of the Pharmacist's Ability to Dispense a Syringe

We have concluded above that a physician's prescription for sterile injection equipment, written under the factual conditions assumed for purposes of this analysis, is valid under law in 48 jurisdictions. Ordinarily, the pharmacist is required to fill a valid prescription.129 In the several states that do not have paraphernalia laws, syringe prescription statutes or syringe-related pharmacy regulations, this is the end of the analysis.130 In the five states allowing the sale of syringes in amounts of ten and under, a pharmacist may likewise dispense up to ten syringes without a prescription.131 In the remaining states, the

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127 See, e.g., MINN. STAT. ANN. § 151.40 (West 1998) (requiring a pharmacist to properly dispose of used hypodermic needles and syringes).
128 See discussion supra Part IV.A.2 & Part IV.A.3.
129 A pharmacist presumably could refuse to fill a syringe prescription if he believed that the prescription was unlawful, potentially harmful to ultimate user, or was not for a legitimate medical reason. See, e.g., ALA. ADMIN. CODE r. 680-X-2-21(2) (2000); 3 COLO. CODE REGS. §§ 719-3.00.20; 719-3.00.50 (1999); N.Y. COMP. CODES R. & REGS. tit. 10, § 80.65 (holding pharmacist ultimately responsible for filling a prescription of a controlled substance for an addict to support his/her habit).
130 These states include Alaska and Puerto Rico, which have no paraphernalia statutes, and Oregon, Wisconsin, and Rhode Island, which have deregulated syringe sales for disease prevention purposes.
question is whether filling the prescription would be prohibited under any other provision of law. Our state-by-state research found that the paraphernalia law was the key factor proscribing the dispensing of a syringe.

There are four states in which some specific element of law makes dispensing clearly illegal, including the two states in which prescribing is clearly illegal in the first place. In Kansas, case law narrowly interprets "medical purpose" to mean both a medically valid and legally valid purpose. Similarly, dispensing in Georgia is clearly illegal because of its pharmacy regulations, which require syringes to be sold only for a "lawful" purpose. Delaware limits syringe sale and possession to the "treatment of a . . . disease then suffered," and Hawaii law makes clear that syringes distributed for disease prevention are one of the enumerated items covered by the paraphernalia law.

The remaining states can be divided into three groups: (1) states with a paraphernalia law that clearly does not limit syringe access; (2) states with both a paraphernalia and a prescription law, the interaction of which determines legality; and (3) the remaining states, where the legality of dispensing a prescribed syringe turns on whether the paraphernalia law was intended to reach the sale of syringes, by prescription, for a legitimate medical reason. An analysis of each of these categories follows.

1. Paraphernalia Laws Not Applicable

Leaving aside the states that have deliberately deregulated syringe access for health purposes, there are seven states whose paraphernalia laws, for one reason or another, do not apply to either pharmacists or syringes. (See Table II.) The paraphernalia statutes in Indiana and South Carolina omit needles and "injecting" from the list of uses that make an item drug paraphernalia. Four other states (Colorado, Montana, Tennessee and West Virginia) have pharmacy and paraphernalia laws that provide immunity or exemption for pharmacists who fill valid pre-

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133 See supra Table II.
scriptions. Louisiana also carves out an exemption in its paraphernalia law for bona fide medical use:

It shall be an affirmative defense that the person to whom the drug related object or advertisement or notice was distributed had a prescription from a licensed medical practitioner or psychiatrist for marijuana or the controlled substance for which the object is primarily intended to be used.134

In Ohio and Iowa, state paraphernalia laws may reasonably be interpreted to exclude from liability a pharmacist who dispenses medications ordered by a valid prescription. Ohio exempts pharmacists and physicians from paraphernalia law, but restricts syringe distribution via its specific syringe prescription law. Iowa excludes syringes distributed for a "lawful purpose" from its paraphernalia statute.135

It is also important to note that virtually all paraphernalia laws are triggered by the seller's knowledge of the illegal use. Our analysis and categorizations in Table II assume the pharmacist knows or has reason to know that the syringe will be used for illicit drug use. In fact, however, it is very likely that in a significant proportion of cases, the pharmacist will not know the purchaser's intent to inject illegal drugs. Moreover, these laws impose no affirmative obligation to inquire. In all such cases, filling the prescription for the IDU does not violate the paraphernalia law.

2. Prescription Law States

In eight states (New Jersey, California, Delaware,136 Illinois, Massachusetts, Nevada, Pennsylvania, Virginia), our

135 For a detailed analysis of the Iowa paraphernalia statute, see Project on Harm Reduction, supra note 52.
136 As mentioned above, Delaware's prescription law limits syringe possession to those for whom it is "necessary for the treatment of an injury, deformity or disease then suffered." Del. Code Ann. tit. 16, § 4757(c) (1995). The purpose of prescribing a syringe is to prevent disease transmission or acquisition. It does not "treat" the disease in the common sense of the word. However, it could be argued that syringe prescription "treats" the disease of drug addiction by reducing the harm caused by the condition. See Project on Harm Reduction, supra note 52, Delaware Memorandum.
analysis found that the specific prescription laws applied more readily to syringe dispensing than the broadly phrased paraphernalia statutes. The prescription laws generally require a prescription, but do not set out substantive criteria for when a prescription is valid (see discussion above.) In most of the prescription law states, the prescription and paraphernalia laws do not refer to each other, but exist side by side in a way that would create inconsistent results if they were read to apply to pharmacists filling valid prescriptions. In these states, we read the syringe prescription laws to supersede and displace paraphernalia laws.

Generally, when two statutes overlap to create apparently inconsistent requirements, the more specific statute controls.\textsuperscript{137} The hypodermic possession and sale laws are the more specific provisions. These provisions focus exclusively upon hypodermic syringes and needles, while the paraphernalia laws usually address the full range of items that might be used in connection with drug consumption, preparation or sale. Massachusetts' paraphernalia law, for example, applies to "any person" and covers:

\begin{quote}
[A]ll equipment, products, devices and materials of any kind which are primarily intended or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, re-packaging, storing, containing, concealing, injecting, ingesting, inhaling or otherwise introducing into the human body a controlled substance in violation of this chapter.\textsuperscript{138}
\end{quote}

\textsuperscript{137} See CAL. CIV. PRO. CODE § 1859 (West 2000): "In the construction of a statute the intention of the Legislature . . . is to be pursued, if possible; and when a general and [a] particular provision are inconsistent, the latter is paramount to the former. So a particular intent will control a general one that is inconsistent with it." \textit{See generally} 2B NORMAN J. SINGER, STATUTES AND STATUTORY CONSTRUCTION (SUTHERLAND STATUTORY CONSTRUCTION) § 46.06 (6th ed. 2000) (discussing that each word of a statute is to be given effect).

\textsuperscript{138} MASS. GEN. LAWS ANN. ch. 94C, § 1(d) (West Supp. 2000). Application of the paraphernalia law to "any person" appears in MASS. GEN. LAWS ANN. ch. 94C, § 32I (West 1997).
In contrast, Massachusetts' syringe prescription law focuses on regulating sale, control/possession, and prescription of hypodermic syringes by pharmacists, physicians and patients:

(a) No person, not being a physician, ... registered under the laws of this commonwealth, or of the state where he resides, or a registered embalmer, manufacturer of or dealer in embalming supplies, pharmacist, wholesale druggist, manufacturing pharmacist, manufacturer of or dealer in surgical supplies, ... or a person who has received a prescription issued under subsection (c), ... shall have in his possession a hypodermic syringe, hypodermic needle, or any instrument adapted for the administration of controlled substances by injection ... .

(c) A physician may issue to a patient under his immediate charge a written prescription to purchase ... from a pharmacist only, any of the instruments specified in subsection (a) .... The pharmacist filling the prescription shall record upon the face of said prescription, over the signature of the pharmacist making the sale, the date of such sale. Such prescription may be renewed or refilled for one year unless the physician indicates otherwise on the prescription, and each refilling shall be noted upon the prescription. No prescription for such instruments shall be refilled after one year from date of issue ....

California, Illinois, Nevada, Pennsylvania, and Virginia also have syringe-specific laws allowing pharmacists to dispense injection equipment for legitimate purposes. The syringe law in these states focuses on health care providers and others with legitimate professional uses for syringes, within the context of regulating users and suppliers of controlled substances and related devices. In contrast, the paraphernalia law applies to all individuals without any exception for physicians and pharmacists. Under the traditional canons of statutory construction, the

140 See Project on Harm Reduction, supra note 52 (containing syringe and paraphernalia law analysis for all states).
narrower and more specific syringe statute would apply to pharmacists, rather than the broadly phrased paraphernalia law.

In one state, New Jersey, it is quite clear that the legislature intended to distinguish between syringes and other types of paraphernalia, and to give physicians and pharmacists a special role in their distribution and sale. New Jersey’s general paraphernalia statute, N.J. Stat. Ann. §§ 2C:36-1 to -7, makes a systematic distinction between drug paraphernalia generally and syringes:

- Section 2C:36-1\textsuperscript{141} is the familiar broad, intent-driven definition of drug paraphernalia. Notably, however, it excludes the word “inject” and does not include syringes in the illustrative list of items that may be drug paraphernalia under some circumstances.
- Sections 2C:36-2\textsuperscript{142} and 2C:36-3\textsuperscript{143} prohibit, respectively, possession and distribution of drug paraphernalia.

\textsuperscript{141} As used in this act, “drug paraphernalia” means all equipment, products and materials of any kind which are used or intended for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, ingesting, inhaling, or otherwise introducing into the human body a controlled dangerous substance or controlled substance analog in violation of the provisions of chapter 35 of this title.


\textsuperscript{142} It shall be unlawful for any person to use, or to possess with intent to use, drug paraphernalia to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, ingest, inhale, or otherwise introduce into the human body a controlled dangerous substance or controlled substance analog in violation of the provisions of chapter 35 of this title. Any person who violates this section is guilty of a disorderly persons offense.


\textsuperscript{143} It shall be unlawful for any person to distribute or dispense, or possess with intent to distribute or dispense, or manufacture with intent to distribute or dispense, drug paraphernalia, knowing that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, ingest, inhale or otherwise introduce into the human body a controlled dangerous substance or controlled substance analog in violation of the provisions of chapter 35 of this title. Any person who violates this section commits a crime of the fourth degree.

• Section 2C:36-4\(^{144}\) prohibits advertising of paraphernalia. Section 2C:36-5\(^{145}\) raises the penalty for those who distribute to minors.
• Section 2C:36-6\(^{146}\) prohibits possession or distribution of syringes unless otherwise authorized by law.
• Section 2C:36-7 authorizes forfeiture of "[a]ny drug paraphernalia, hypodermic syringe or needle seized in violation of this chapter."\(^{147}\)

The plain text of New Jersey's paraphernalia statute evinces and accomplishes the intent to regulate syringes separately from other items that can be used with illicit drugs, and not to include syringes in any substantive provision of the statute other than those in which they are explicitly named. In three separate sections of the paraphernalia statute, the legislature carefully excised references to syringes and injection from the model act it was adopting. In a fourth section, it added specific prohibitions applicable only to syringes, more stringent than those applied to drug paraphernalia generally. In a fifth section, it referred to syringes and needles disjunctively from drug paraphernalia.\(^{148}\)

\(^{144}\) It shall be unlawful for any person to place in any newspaper, magazine, handbill, or other publication any advertisement, knowing that the purpose of the advertisement in whole or in part, is to promote the sale of objects intended for use as drug paraphernalia. Any person who violates this section commits a crime of the fourth degree.


\(^{145}\) Any person 18 years of age or over who violates N.J.S. 2C:36-3 by delivering drug paraphernalia to a person under 18 years of age commits a crime of the third degree.


\(^{146}\) Except as otherwise authorized by law, it shall be unlawful for a person to have under his control or possess with intent to use a hypodermic syringe, hypodermic needle or any other instrument adapted for the use of a controlled dangerous substance or a controlled substance analog as defined in chapter 35 of this title or to sell, furnish or give to any person such syringe, needle or instrument. Any person who violates this section is guilty of a disorderly persons offense.

N.J. STAT. ANN. § 2C:36-6 (West Supp. 2000).

\(^{147}\) N.J. STAT. ANN. § 2C:36-7 (West Supp. 2000).

\(^{148}\) This interpretation also adheres to the general rule that "when there is a conflict between general and specific provisions of a statute, the specific provisions will control." Wilson v. Unsatisfied Claim & Judgment Fund Bd., 536 A.2d 752, 756 (N.J. 1988). In this instance, sections 2C:36-2 and -3 conflict with section -6 not only in the state of mind required for a violation but on the very question at issue here: the syringe-specific provision allows any sale of a syringe on valid prescription, even if
Prosecutions of needle exchange staff for syringe distribution in prescription law states support the contention that syringe and paraphernalia statutes operate distinctly from each other. An established usage in regard to the meaning and effect of a statute is a relevant and persuasive guide to its authoritative interpretation. The drug paraphernalia and syringe prosecutions brought by New Jersey’s Attorney General have arguably given rise to an “established usage” of these statutes. Both of New Jersey’s major needle exchange prosecutions were brought under section six, the syringe-specific provision, and not under the general drug paraphernalia prohibition of section three. Moreover, no pharmacist or pharmacy had been charged with any sort of paraphernalia violation in the state. This is also true of prosecutions in Massachusetts and New York.

the seller knows it will be used for illicit injection. Such a sale would be prohibited under the general paraphernalia provision.

Interpretation of the paraphernalia act begins with the federal Model Drug Paraphernalia Act, upon which the New Jersey law was based. A comparison of the two statutes’ definitions of drug paraphernalia provides unmistakable evidence that the New Jersey legislature intended to exclude syringes from the general category of drug paraphernalia as defined in the statute. Although the New Jersey Act is virtually identical to the Model Act, both references to injection equipment in the Model Act were omitted by the New Jersey legislators who drafted the state provision. The legislature deliberately diverged from the model act in this respect, a decision that makes perfect sense given a decision to exclude syringes from the general drug paraphernalia provisions, and which makes no sense if we assume that the legislature intended to include syringes within the general definition of drug paraphernalia. It is an accepted canon of statutory interpretation in New Jersey that “where the Legislature has carefully employed a term in one place and excluded it in another, it should not be implied where excluded.” GE Solid State, Inc. v. Director, Div. of Taxation, 625 A.2d 468, 473 (N.J. 1993); see also SINGER, supra note 137, at § 47:24 (applying the maxim of expressio unius to determine the effect of statutory language).

See SINGER, supra note 137, at § 49.06.


In fact, there have been no cases in which a pharmacist or pharmacy had been charged with any paraphernalia violation in any of the 52 jurisdictions.

3. Paraphernalia Law Only States

The 22 states where syringe dispensing by prescription is arguably, but not indisputably, legal, generally share in common the existence of a paraphernalia law and a lack of any law that explicitly authorizes syringe sales in a pharmacy or that otherwise renders that paraphernalia law inapplicable. In cases where a pharmacist dispenses a syringe to an IDU, the pharmacist is undoubtedly transferring the syringe. Thus, if a syringe is classified as drug paraphernalia and the pharmacist is aware of the syringe’s intended use, then the transfer is illegal. We thus come to the fundamental question of whether the sale of a syringe dispensed by a valid prescription, for legitimate medical reasons, is prohibited by paraphernalia law.¹⁵⁵

The most cautious view is that dispensing under these circumstances would violate state paraphernalia law. The paraphernalia statutes may be read as a limitation on the practitioner’s authority to dispense. General professional practice law, on this reading, allows a pharmacist to fill a prescription written with a valid medical purpose and in the course of medical practice, except when the pharmacist knows or should know the patient intends to use the item for drug use, when a drug paraphernalia provision interposes its prohibition. This reading is consistent with the terms of paraphernalia statutes, which prohibit any person, without exception for health care providers, from providing drug paraphernalia to someone knowing it will be used to ingest illegal drugs.

It does not follow, however, that this cautious reading is the correct reading. It may reasonably be argued that drug paraphernalia laws do not and were not intended to regulate health care professionals acting within the scope of their professional practice, and that both the syringe prescription provisions and the interpretive guidance included in the statutes provide a clear basis for excluding syringes sold by prescription for disease prevention purposes.

¹⁵⁵ In many cases, whether something is drug paraphernalia depends, in narrowest terms, upon whether the seller knows or has reason to know that it will be used for illegal drug use. As stated above, however, a pharmacist who does not know or have reason to know that the patient intends to use the syringe to inject illegally, does not violate the paraphernalia law, even if in fact the item will be used for drug abuse.
In all states, the object of interpretation and construction of laws is to ascertain and effectuate the intent of the legislature. In Illinois, for example, determining what the framers of legislation intended entails first looking "to the words of the statute, and it is only where the words are inadequate that the court may turn to legislative history and interpretative aids to discover the legislative intent." New Jersey case law further provides that, "[o]ur duty is to apply the legislative intent as expressed in the statute's language, and we are not to presume that the Legislature intended something other than what it expressed by its plain language." Thus, a faithful effort to determine legislative intent should be guided by both the language of the statute and the expressed purposes of the lawmakers who wrote it, to avoid absurd results.

There is considerable evidence in the text and background of typical state paraphernalia law to indicate that it was never intended to regulate the distribution of medical devices in the health care system. As a class, paraphernalia laws were never aimed at physicians and pharmacists. States began passing paraphernalia laws in the late 1970s, as part of a national trend led by the federal government, to eliminate what had become an enormous retail trade in the equipment necessary to use illegal drugs. By 1976, between 15,000 and 30,000 "head shops" did an annual three billion dollar business in such items as rolling papers, bongs, and freebasing kits. The statutes apparently have significantly reduced the number of head shops. There is no indication in the history of either the model act or any statute to suggest, however, that it was intended to interfere with good medical care or public health interventions to prevent disease.

In the only case on point, the court concluded that paraphernalia laws do not prohibit legitimate public health measures to increase access to needles. In Spokane County Health District

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158 See Gostin & Lazzarini, supra note 54, at 611-12 (reviewing Congressional investigation of the paraphernalia problem).
v. Brockett,\textsuperscript{159} the Supreme Court of Washington was faced with the question of whether needle exchange programs operated by health authorities under their general powers were prohibited by the Washington drug paraphernalia statute. The Court wrote:

It is undisputed the needles at issue in this case are "drug paraphernalia". Those distributing the needles know they will be used to inject controlled substances unlawfully. Nevertheless, plaintiffs argue, the needle exchange program is authorized under the Washington Constitution, statutes granting broad powers to local health officials, and the omnibus AIDS act. Therefore, they conclude, the drug paraphernalia act, which is aimed at criminal conduct, simply does not apply to their actions. We agree, finding the [Spokane County Health Department's] needle exchange program permissible under the constitution and statutes of this state.\textsuperscript{160}

Physicians' and pharmacists' decisions about prescribing or dispensing medication are controlled by the professional practice and controlled substances laws, not a paraphernalia law aimed at commercial drug businesses. Indeed, were the drug paraphernalia law to apply to legitimate disease prevention activities, it would be illegal to even provide IDUs with bleach for sterilizing needles or alcohol pads for disinfecting an injection site.\textsuperscript{161} Yet, these are universally accepted measures, which have never been subject to prosecution. Prosecutions and convictions under paraphernalia law have been consistent with this latter interpretation: all the reported cases under the law involve head shops or individuals also convicted of possession and/or distribution of controlled substances.\textsuperscript{162}

The foregoing analysis makes clear that a pervasive web of laws, administrative regulations, and practice guidelines define the circumstances under which injection equipment may be sold

\textsuperscript{159} 839 P.2d 324 (Wash. 1992).
\textsuperscript{160} Brockett, 839 P.2d at 328.
\textsuperscript{161} See id. at 328-29.
\textsuperscript{162} See, e.g., Florida Businessmen for Free Enter. v. City of Hollywood, 673 F.2d 1213 (11th Cir. 1982) (upholding constitutionality of headshop laws restricting advertisements); Subuh v. State, 732 So.2d 40 (Fla. Dist. Ct. App. 1999) (finding prosecution failed to prove defendant's knowledge that glass pipes are used to ingest illegal drugs).
or dispensed. Syringe-specific laws do not usually pose a barrier to pharmacy dispensing of syringes. Most prescription law states require just that—a prescription—and no more. While paraphernalia laws are inapplicable to pharmacists and syringes in a number of states, drug paraphernalia statutes remain the greatest source of uncertainty for the 22 states categorized as having a “reasonable claim to legality.”

VI. HOW MIGHT LAWS BE CHANGED OR CLARIFIED TO PROMOTE ACCESS TO STERILE INJECTION EQUIPMENT FOR IDUS THROUGH THE HEALTH CARE SYSTEM?

In the first thorough analysis of the legality of prescribing and dispensing syringes through the health care system, we found that both prescribing and dispensing sterile injection equipment is legal in most states. Public health, medical, and legal organizations have all supported increased access to sterile syringes in order to combat the infectious disease epidemic among IDUs. However, to adequately increase syringe availability to IDUs, immediate action must be taken by both state governments and health care practitioners.

It is not possible to optimally facilitate safe injecting without removing the legal barriers that have limited it. Where applicable, state legislatures should therefore repeal prescription and paraphernalia laws to legalize the over-the-counter sale of injection equipment under all circumstances. Syringe possession should also be decriminalized to permit IDUs to obtain syringes from reliable sources like physicians, pharmacists, public health officials, and registered syringe exchange programs. All the available evidence suggests that these steps would reduce disease without increasing drug use.

In the absence of deregulation, state medical and pharmacy boards can facilitate syringe prescription under current law. These boards have the power to and should issue regulations explicitly stating that providing sterile injection equipment to IDU patients in order to prevent transmission of serious communicable disease is an acceptable medical/pharmacy practice. The Pharmacy Board in Washington has taken such action by interpreting the term “legal purpose” to include disease preven-
tion. Medical and pharmacy boards could also require training in the theory and practice of harm reduction as part of mandated continuing education. Instructing health care professionals about infectious disease and the unique needs of IDUs would enable them to make informed decisions about the prescription and sale of syringes.

Physicians and pharmacists can play a critical role to increase access to sterile injection equipment. Where legality is clear, physicians and pharmacists should strongly consider prescription distribution of syringes as a legitimate clinical intervention to prevent infectious disease transmission. In cases where legality is less clear, professionals faced with uncertainty about the applicable law may be unwilling to run the legal risk. This need not lead to inaction, however. Avenues exist for clarifying the law and minimizing the risks of criminal liability or professional sanction. Discussions with public health agencies, professional boards, and colleagues will be useful in testing the local acceptance of the medical necessity of providing sterile syringes and needles to injection drug users. Contact with law enforcement officials can do a great deal to clarify both the interpretation of the law and the willingness of authorities to prosecute. Physicians and pharmacists may be able to seek fur-

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163 The board’s draft resolution, which has been approved in principle by the medical board, states:

Whereas: Recent studies by the Centers for Disease Control and Prevention (CDC) and by various states have found that a large number of new cases of HIV/AIDS, hepatitis and other sexually transmitted diseases are found in persons who either are injection drug users [(IDU’s)] or who have had sexual relationships with IDU’s. A recent meeting cosponsored by CDC, National Association of Boards of Pharmacy, and the American Pharmaceutical Association demonstrated that revisions in state laws [and] rules to permit the unrestricted sale or distribution of sterile syringes and needles to injection drug users. Contact with law enforcement officials can do a great deal to clarify both the interpretation of the law and the willingness of authorities to prosecute. Physicians and pharmacists may be able to seek fur-

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164 See Burris et al., supra note 54, at 1164-65.
ther guidance in the form of an opinion from the state attorney general,\textsuperscript{165} or go to court for a declaratory judgment.\textsuperscript{166}

It is within the power and the obligation of state governments and the medical profession to help insure that the law does not prohibit care that is medically legitimate. In the few states where paraphernalia laws or pharmacy regulations appear to categorically prohibit the dispensing of syringes, physicians and pharmacists may add their considerable professional weight to efforts to change these rules. It is clear that only a thorough revision of drug policy will adequately address the health care needs of injection drug users. However, physicians and pharmacists can offer a new approach to disease prevention among IDUs—one that can begin with one prescription.

\textsuperscript{165} In most states, state agencies and/or individual practitioners may request an opinion of the attorney general on the proper interpretation of a statute. \textit{See e.g.}, \textit{Conn. Gen. Stat. Ann.} \textsection{} 4-176 (West 1998); \textit{N.H. Rev. Stat. Ann.} \textsection{} 7:7 (1988); \textit{N.J. Stat. Ann.} \textsection{} 52:17A-4 (West 1986 & Supp. 2000). However, as a general rule, Attorney General opinions are considered persuasive authority, and are not binding.

\textsuperscript{166} Declaratory judgments are available to individuals whose contemplated conduct could subject them to criminal prosecution. A brief review of case law indicates that physicians or health care organizations that wish to prescribe injection equipment to IDU patients would have standing, along with dispensing pharmacists, to sue a county prosecutor charged with the duty of enforcing the criminal law. \textit{See e.g.}, \textit{Lucky Calendar Co. v. Cohen}, 117 A.2d 487, 492 (N.J. 1955); \textit{Keuper v. Wilson}, 268 A.2d 760, 762 (N.J. Super. Ct. Ch. Div. 1970); \textit{see also Griffith v. Board of Med. Exam'rs}, 454 So.2d 683 (Fla. Dist. Ct. App. 1984) (allowing practitioners to seek declaratory statement by their respective agencies).