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CATHOLIC PARTICIPATION IN NEEDLE- AND SYRINGE-EXCHANGE PROGRAMS FOR INJECTION-DRUG USERS: AN ETHICAL ANALYSIS

DANIEL P. SULMASY, O.F.M.

Needle- and syringe-exchange programs aim to decrease infections among those who are dependent on injection drugs. Some have questioned whether church sponsorship of such programs constitutes illicit cooperation in the evil of drug abuse. This article examines the question under classical formulations of cooperation and in light of current empirical evidence and concludes that this is not the case. Questions are also raised about whether, if substance dependence is a disease and not a moral failing, an analysis based on cooperation is actually the appropriate category of analysis.

A RECENT ANNOUNCEMENT that a needle-exchange program would be sponsored by Catholic Charities of the Diocese of Albany led to vociferous moral objections from a few Catholic bloggers and from a series of sound-bite defenses by several Catholic scholars.[1] While there is some existing theological literature on this topic,[2] most of it is more than a decade old and was never very formal or focused regarding the specific case of needle exchange. This lack points to the need for a new, in-depth analysis of this issue.

DANIEL P. SULMASY, O.F.M., received his PhD in philosophy from Georgetown University and his MD from Cornell University. He is the Kilbride-Clinton Professor of Medicine and Ethics in the Department of Medicine and Divinity School, as well as the Associate Director of the MacLean Center for Clinical Medical Ethics at the University of Chicago. Specializing in medical ethics, philosophy of medicine, and spirituality and medicine, he has recently published *Methods and Medical Ethics*, 2nd ed. (2010), and is working on a monograph on spirituality and medicine.

[1] Daniel Burke, "Drug Abuse, AIDS and the Lesser Evil: Albany, N.Y., Diocese Defends Needle-Exchange, but Some Catholic Scholars Take Exception," *Washington Post*, February 13, 2010, B2; and Matthew Hanley, "Should Catholic Charities Settle for Harm-Reduction?" *On the Square: Daily Columns from First Things' Top Writers*, March 24, 2010, http://www.firstthings.com/onthesquare/2010/03/should-catholic-charities-settle-for-harm-reduction (this and all other URLs cited herein were accessed on February 5, 2012).

[2] See Jon Fuller, "Needle-Exchange: Saving Lives," *America* 179.2 (July 18, 1998) 8–11; and James F. Keenan, S.J., "Applying the Seventeenth-Century Casuistry of Accommodation to HIV Prevention," *Theological Studies* 60 (1999) 492–512.

Needle- and syringe-exchange programs aim to help prevent the spread of infectious diseases, most notably the human immunodeficiency virus (HIV) but also various forms of viral hepatitis and bacterial and fungal infections of the skin, heart valves, lungs, and brain, diseases common among injection-drug users due to their propensity for sharing and reusing contaminated needles and syringes. Such public health practices are known as "harm-reduction" programs, noting in this case that persons who are addicted to injectable drugs such as heroin and/or cocaine are, tragically, unlikely to cease using these substances in a harmful way, but that the total harm of the addictive disorder can be reduced if at least the burden of these associated infections can be mitigated.[3] It is important to note that preventive measures for infectious diseases not only prevent the individual addicted persons themselves from succumbing to these infections, but also that an addict infected with HIV or hepatitis B can infect other addicts and even non-drug-users such as spouses or sexual partners. Moreover, persons living with HIV are more susceptible to other infections of public health concern (such as tuberculosis) even before they develop full-blown Acquired Immunodeficiency Syndrome (AIDS) and become susceptible to infection by organisms that do not infect people with normal immune systems. Since injection-drug users frequent shelters and prisons, where tuberculosis and multidrug-resistant tuberculosis infection rates are high, HIV infection in this population serves to perpetuate tuberculosis not only in prisons and shelters but also among the innocent persons with whom infected users have contact in their communities. Thus, prevention of an infectious disease redounds to the common good more robustly than prevention of a heart attack. Lowering one person's cholesterol may prevent one person's death from heart disease. Preventing one case of HIV infection may prevent ten deaths.

Understanding these programs also requires an awareness of the epidemiological nexus of poverty, race, injection-drug use, and HIV.[4] Relatively wealthy and educated gay white men have been more likely to change their practices and to slow the spread of the disease in the gay community. New cases of HIV in the United States are disproportionately high among persons of color, and the number of black and Latina women who contract the disease from sexual partners who use injectable drugs represents the fastest-growing segment of the population of persons with newly acquired HIV infection.

[3] G. Alan Marlatt and Katie Witkiewitz, "Update on Harm-Reduction Policy and Intervention Research," *Annual Review of Clinical Psychology* 6 (2010) 591–606.

[4] Victoria A. Cargill and Valerie E. Stone, "HIV/AIDS: A Minority Health Issue," *Medical Clinics of North America* 89 (2005) 895–912; and Vivian T. Shayne and Barbara J. Kaplan, "Double Victims: Poor Women and AIDS," *Women and Health* 17 (1991) 21–37.

The stakes are thus very high, and Catholic teaching regarding the common good, the preferential option for the poor, and Christian charity must figure heavily in any serious moral analysis of such programs.

Nonetheless, evil may not be done so that good may come of it (see Rom 3:8). Addictive disorders are themselves a scourge that plagues Western nations. Alcoholism, prescription drug abuse, marijuana abuse, and addiction to injection drugs such as heroin and cocaine have become major problems. Abuse and addiction to these drugs ruin the lives of those suffering from substance disorders as well as the lives of those around them—families, friends, and coworkers. Not only do abuse and addiction to these substances interfere with the psychological well-being of those so afflicted, but these disorders are accompanied by biomedical problems as well. Some of these problems are caused directly by the drugs themselves (in the case of heroin, e.g.: overdose, aspiration pneumonia, and impotence); many are caused by infections associated with "dirty needles" (e.g., HIV, hepatitis, and endocarditis [bacterial infection of the heart valves]). Injectable drugs in particular, since they are expensive and illegal, lead to a web of crime and destructive behavior, including violence. These are all great social evils, and the social mission of the church includes an obligation to try to mitigate these evils as well.

These two significant moral imperatives can come into tension. Many observers have expressed a fear that if efforts at harm reduction were to exacerbate the problems of drug abuse and addiction, this would be wrong. Likewise, although less frequently admitted by critics of harm-reduction programs, efforts at eliminating drug abuse can lead to greater social harms. Making drug use illegal, for example, drives the practice underground and might increase the practice of needle sharing. Criminalizing drug use might also increase crime and gang-related violence, and might even increase the total number of addicts if police efforts were to lead to the incarceration of large numbers of addicts who would in turn lead other prisoners to addiction. There is no simple solution to these problems.

Other issues underlying questions about harm reduction for those addicted to injectable drugs are the nature of addiction and its effect on free will, whether addiction is a disease or a sin, the definition of disease, the causes of addiction, and the nature of responsibility. These issues are really fundamental to the ethical questions and must also be addressed.

COOPERATION

The central moral concern that has been raised regarding the ethics of needle-exchange programs is whether the sponsorship of such programs by Catholic organizations constitutes immoral cooperation by the church in

the sin of drug abuse. Cooperation is a general framework with a number of variations and differences of opinion regarding its application.[5] The basic framework, however, enjoys a centuries-old, commonly shared, and widely accepted set of principles. I am not certain (for reasons that I will explain below) that cooperation actually fully applies to the issue of a needle-exchange program for persons addicted to injection drugs.[6] I will, however, begin my analysis based on the assumption that the principle of cooperation is applicable, because this is the assumption of the critics.

Intrinsic Evil?

First, the free distribution of needles and syringes is not intrinsically evil. The same needles and syringes employed by injection-drug users are also used by diabetics to self-administer insulin, and wherever there is government insurance these types of needles and syringes are distributed free of charge. While the precise act of a Catholic organization would be limited to the distribution of these needles and syringes, it must also be observed that the use to which they are being put—the intravenous injection of opioid drugs—is not intrinsically evil either. When used properly, these are extremely useful and effective drugs for treating pain and other symptoms. They can even be used (with care) to treat pain and other symptoms in

[5] US Conference of Catholic Bishops (hereafter USCCB), *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (2009), http://www.ncbcenter.org/document.doc?id=147; Joseph M. Boyle Jr. "Principles of Cooperating with Evil," in *Conscience, Cooperation, and Complicity*, ed. Kenneth D. Whitehead (Chicago: University of Scranton, 2009) 1–20; Benedict M. Ashley, O.P., Jean deBlois, and Kevin D. O'Rourke, O.P., *Health Care Ethics: A Catholic Theological Analysis* (Washington: Georgetown University, 2006) 55–57; Helen Watt, ed., *Cooperation, Complicity, and Conscience: Problems in Healthcare Science, Law, and Public Policy* (London: Linacre Center, 2005); Peter J. Cataldo and John M. Haas, "Institutional Cooperation: The ERDs; This Principle of Cooperation Can Guide Collaboration with Other-than-Catholic Partners," *Health Progress* 83.6 (November–December 2002) 49–57, 60; Germain Grisez, *Difficult Moral Questions* (Quincy, IL: Franciscan Herald, 1998) 871–97; James F. Keenan, S.J., and Thomas R. Kopfensteiner, "The Principle of Cooperation: Theologians Explain Material and Formal Cooperation," *Health Progress* 76.3 (April 1995) 23–27; and Bernard C. Häring, *The Law of Christ: Moral Theology for Priests and Laity*, 3 vols. (Westminster, MD: Newman, 1961) 2:495–519.

[6] Questions can also be raised about the fundamental bases of the theory of cooperation; I am grateful to an anonymous reviewer for pointing this out. It is intriguing to consider, for instance, whether mitigation is a completely separate category of moral analysis. Such considerations, however, are beyond the scope of this article. My argument can be taken as conditional. That is, to the extent that cooperation is the proper category for moral analysis of needle-exchange programs, then the considerations that follow in my text are applicable.

individuals who have a history of abusing them,[7] or to treat addicts' symptoms of withdrawal. Sirach 38:6–8 supports this position: "He endows men with the knowledge to glory in his mighty works, through which the doctor eases pain and the druggist prepares his medicines; thus God's creative work continues without cease in its efficacy on the surface of the earth."

Formal Cooperation?

Second, harm-reduction efforts are not formal cooperation. Formal cooperation requires that the cooperator share in the actor's sinful intention to do evil. Presumably, no Catholic organization would explicitly intend that anyone should abuse or become addicted to injectable drugs. Still, it has recently been argued that there is a category of implicit formal cooperation. While not accepted by all theologians or explicitly adopted by the magisterium,[8] this argument suggests that some actions are so close to the evil act that even if the alleged cooperator denies sharing the intent, they constitute formal cooperation. Even if there were such a category, however, harm-reduction efforts could not reasonably be considered to constitute implicit formal cooperation. This is because harm-reduction efforts typically begin with an explicit repudiation of the evil act. The general case of the structure of a harm-reduction effort can be put thus: "I do not approve of your doing X, but I cannot stop you. So, if you do X, please also do Y, so that Z may not occur and compound the harm." Understood in the general case, such efforts are common in the ordinary moral life of good, faithful Christians and of the church itself. For example, a parent may say, "I do not approve of your riding a motorcycle, but you are over 18 years old, and I cannot stop you, so, if you do, please promise me that you will wear a helmet. In fact, I have just bought you one. Please use it." In such a case can anyone reasonably say that such a parent implicitly shares in the intention of the son or daughter to ride a motorcycle? I think not.

As another example of how harm-reduction efforts cannot automatically be considered implicit formal cooperation, consider a case in which the church may warn a nation not to invade another, arguing that just-war criteria have not been fulfilled. If, despite such warnings, the attack seems imminent, and a cardinal in the Vatican says, "We do not approve of this

[7] Steven D. Passik and Kenneth L. Kirsh, "Opioid Therapy in Patients with a History of Substance Abuse," *CNS Drugs* 18 (2004) 13–25; and Steven D. Passik and Kenneth L. Kirsh, "Managing Pain in Patients with Aberrant Drug-Taking Behaviors," *Journal of Supportive Oncology* 3 (2005) 83–86.

[8] Boyle, "Principles of Cooperating"; Ashley, deBlois, and O'Rourke, *Health Care Ethics*; Cataldo and Haas, "Institutional Cooperation"; Grisez, *Difficult Moral Questions*; Keenan and Kopfensteiner, "Principle of Cooperation"; and Häring, *Law of Christ* 2:495–519.

war, but we are powerless to stop you. If you do insist on this invasion, however, please be sure that, although you have defied the *jus-ad-bellum* criteria, you abide by the *jus-in-bello* criteria in the invasion's conduct. We would even be prepared to send theological advisors to instruct you in criteria for avoiding civilian deaths, justly treating prisoners, etc." Does anyone think, under such circumstances, that the church has contradicted itself, or is being duplicitous, implicitly sharing in the intent to prosecute a war that it has explicitly condemned as unjust? I think not.

Recall that formal cooperation involves a sharing in the evil intention. One simple test of whether an event lies outside the scope of the intention of the act is a counterfactual question regarding the conditions of fulfillment of an agent's intention-in-acting: what would be the attitude and actions of the agent were the event alleged to be outside the scope of the agent's intention not to occur? Would the agent sense failure or frustration of the intention? Would the agent engage in other actions to be sure that the allegedly unintended event would take place? If not, then the event could properly be considered outside the scope of the agent's intention.[9] For an event to be declared implicitly intended, as might be averred in the case of a harm-reduction strategy, it would have to be the case that no reasonable person could construe the evil event as falling outside the agent's intention. By the counterfactual test, it would thus need to be the case that no reasonable person could believe anything other than that, were the evil event to fail to take place, the agent would be frustrated and/or sense failure and begin to take alternative actions to make the allegedly unintended evil event take place. Thus, to allege implicit formal cooperation of the church in the example of the admonition regarding an unjust war, it would need to be the case that no reasonable person could believe anything other than that church officials would be frustrated and sense failure, were the unjust war not to take place, and that the church would then go about finding alternative ways to make the war happen. That would seem absurd. Just the opposite seems to be the case.

Similarly, in the case of needle exchange, were there to be implicit formal cooperation, it would need to be the case that no reasonable person could believe anything other than that, were all the injection-drug users in the local community to enter drug-free treatment programs rather than continue to inject drugs, the Catholic sponsors of the program would be frustrated and sense failure and go about trying to find ways to induce as many local citizens as possible to use injection drugs. This also seems patently false. Any reasonable person would suppose that the church would be delighted were all the injection-drug users to enter drug-free

[9] Daniel P. Sulmasy, "Killing and Allowing to Die: Another Look," *Journal of Law Medicine and Ethics* 26 (1998) 55–64.

treatment programs. Thus, harm-reduction efforts do not constitute either explicit or implicit formal cooperation.

Material, but Mediate, Contingent, and Remote?

Third, such harm-reduction efforts constitute mediate, contingent material cooperation. While not formal, the cooperation is material in that some addicts will undoubtedly use the supplied needles and syringes to inject drugs for the purpose of obscuring consciousness. Such cooperation is mediate rather than immediate, in that the cooperation of the Catholic organization would not be necessary for the illicit injection of the drugs. The needles can (and generally are) supplied by means or organizations other than the sponsoring Catholic organization.

Further, the act of supplying needles and syringes constitutes a form of *remote*, mediate material cooperation. Supplying needles and syringes is distant in space and time from injecting drugs for nonmedical purposes.[10] This is perhaps a noteworthy difference between proposing to establish an injecting room for drug use and proposing to establish a needle-exchange program, a point to which I will return later.

Thus, a needle-exchange program would represent remote, contingent, mediate material cooperation.[11]

JUSTIFIABLE COOPERATION

These judgments, however, are not sufficient to render the cooperation morally licit. There must be sufficient justificatory grounds for undertaking the action in addition to separation in space, time, and intention. Thus one must ask further prudential questions such as whether there is any important element of duress, whether there is a proportionately grave reason for the cooperation, and whether there is a significant danger of scandal.

Duress does not seem to be a typical consideration in the case of needle-exchange. Catholic organizations are not being forced to undertake these actions as a matter of law. To the best of my knowledge, government

[10] As an interesting aside, while it has been thought that "*immediate material cooperation* is always *proximate*" (Pontifical Academy for Life, "Moral Reflections on Vaccines Prepared from Cells Derived from Aborted Human Foetuses," *National Catholic Bioethics Quarterly* 6 [2006] 541–50, at 545, emphasis original), new technologies might now provide the possibility of remote but immediate material cooperation, such as the use of telemedicine to direct the conduct of an abortion thousands of miles away. Such cooperation would be illicit.

[11] Fuller, "Needle-exchange"; and Jorge J. Ferrer, "Needle-Exchange in San Juan, Puerto Rico: A Traditional Roman Catholic Casuistic Approach," in *Catholic Ethicists on HIV/AIDS Prevention*, ed. James F. Keenan, S.J., with Jon D. Fuller, S.J., MD, Lisa Sowle Cahill, and Kevin Kelly (New York: Continuum, 2000) 177–91.

funding for other charitable works of greater significance has not been made contingent upon Catholic organizations' undertaking these actions. Some might argue that there could be duress, if there were no other social agency other than a Catholic organization to implement a needle-exchange program—e.g., if the only hospital in a city's drug district were Catholic. This, however, is not a standard construal of duress, which must classically involve coercion or threat to the cooperator. Thus, duress would not seem to supply justificatory grounds for the cooperation.

Determining whether proportionate grounds exist for acting depends on the balance of harms and goods that might be accomplished through a harm-reduction program. In part, this is an empirical question that depends on assessments of the effectiveness of such programs. Good ethics depends on solid facts. The grounds for stating that there is a proportionately grave reason for undertaking such programs are greater if they have been proven effective.

The best and most recent evidence suggests that needle-exchange programs are effective in reducing infectious complications of injection-drug use.[12] While the evidence is not unassailable,[13] even strong critics of these studies accept that needle-exchange programs are at least modestly effective in reducing the rate of HIV infection.[14] And all reviewers agree that there is very good evidence that these programs have been proven effective in reducing behaviors that predispose to HIV infection. Thus, given the importance of the problem and the preponderance of evidence for benefit

[12] Franklin N. Laufer, "Cost-Effectiveness of Syringe-Exchange as an HIV Prevention Strategy," *Journal of the Acquired Immune Deficiency Syndrome* 28 (2001) 273–78; Katy M. Turner et al., "The Impact of Needle and Syringe Provision and Opiate Substitution Therapy on the Incidence of Hepatitis C Virus in Injecting Drug Users: Pooling of UK Evidence," *Addiction* 106 (2011) 1978–88; Marlatt and Witkiewitz, "Update on Harm-Reduction"; Alex Wodak and Leah McLeod, "The Role of Harm Reduction in Controlling HIV among Injecting Drug Users," *AIDS* 22 (2008) Suppl 2:S81–92; Alex Wodak and Annie Cooney, "Do Needle Syringe Programs Reduce HIV Infection among Injecting Drug Users? A Comprehensive Review of the International Evidence," *Substance Use and Misuse* 41 (2006) 777–813; Don C. Des Jarlais et al., "HIV Incidence among Injecting Drug Users in New York City Syringe-Exchange Programmes," *Lancet* 348 (1996) 987–91.

[13] Kerstin Käll et al., "The Effectiveness of Needle-Exchange Programmes for HIV Prevention," *Journal of Global Health Policy and Practice* 1.3 (2007), http://www.globaldrugpolicy.org/1/3/1.php.

[14] Norah Palmateer et al., "Evidence for the Effectiveness of Sterile Injecting Equipment Provision in Preventing Hepatitis C and Human Immunodeficiency Virus Transmission among Injecting Drug Users: A Review of Reviews," *Addiction* 105 (2010) 844–59.

to the common good, there appear, prima facie, to be proportionate reasons for acting.

There are also good data to show that programs offering abstinence alone are ineffective in reducing HIV risk behaviors, largely because these programs are not very effective in treating the underlying addiction—very few patients successfully achieve long-term drug-free remissions.[15] The best available evidence suggests that combined programs that offer the alternative of drug treatment in addition to needle exchange are even more effective than needle-exchange programs alone.[16] Most drug treatment consists of methadone maintenance, an alternative form of harm reduction that substitutes addiction to one substance for addiction to another.[17] A relatively new form of treatment for opioid addiction called buprenorphine is also an opioid substitution therapy, but one that may prove more successful as a pharmacological bridge to long-term drug-free recovery and HIV prevention.[18] So, any program operating under Catholic auspices would have a moral obligation to ensure that it is offering drug addicts state-of-the-art, multifaceted drug treatment with a full range of treatment options.

The remaining issue with respect to the principle of cooperation in the moral evaluation of a needle-exchange program is the question of scandal.

[15] Giuseppe Salamina et al., "Effectiveness of Therapies for Heroin Addiction in Retaining Patients in Treatment: Results from the VEdeTTE Study," *Substance Use and Misuse* 45 (2010) 2076–92; Karen L. Sees et al, "Methadone Maintenance vs 180-day Psychosocially Enriched Detoxification for Treatment of Opioid Dependence: A Randomized Controlled Trial," *Journal of the American Medical Association* 283 (2000) 1303–10; and Richard P. Mattick et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," *Cochrane Database of Systematic Reviews* 3 (July 8, 2009), art. no. CD002209.pub2, DOI: 10.1002/14651858.

[16] Marlatt and Witkiewitz, "Update on Harm-Reduction"; Palmateer et al., "Sterile Injecting Equipment Provision"; Käll et al., "Needle-Exchange Programmes"; and Charlotte van den Berg et al., "Full Participation in Harm Reduction Programmes is Associated with Decreased Risk for Human Immunodeficiency Virus and Hepatitis C Virus: Evidence from the Amsterdam Cohort Studies among Drug Users," *Addiction* 102 (2007) 1454–62.

[17] M. Connock et al., "Methadone and Buprenorphine for the Management of Opioid Dependence: A Systematic Review and Economic Evaluation," *Health Technology Assessment* 11.9 (March 2007) 1–171; Mattick et al., "Methadone Maintenance Therapy versus No Opioid Replacement Therapy"; and Sees et al., "Methadone Maintenance vs 180-Day Psychosocially Enriched Detoxification."

[18] Connock et al., "Methadone and Buprenorphine;" David S. Metzger, George E. Woody, and Charles P. O'Brien, "Drug Treatment as HIV Prevention: A Research Update," *Journal of the Acquired Immune Deficiency Syndrome* 55 (2010), Suppl 1:32–36.

The possibility of significant scandal is the principal reason for the worries aired about whether Catholic participation in such programs is licit.

However, it is critically important to understand the precise meaning of scandal as it is employed in theological discussions of cooperation. The *Catechism of the Catholic Church* defines scandal as "an attitude or behavior which leads another to do evil."[19] This is not the ordinary linguistic use of the term "scandal" upon which some critics seem to rely. It may very well be that confusion could arise among the faithful about such a program, but the fact that some persons are confused or even astonished does not constitute scandal as the term is understood in the technical, theological sense used in assessing the moral permissiveness of an act of remote material cooperation. Nor is it sufficient to say that an action constitutes scandal in the required technical theological meaning of the term if certain culturally conservative attitudes, mores, or practices are disturbed by the action of the church. Political and cultural conservatism is neither the deposit of faith nor the *sensus fidelium*. A culturally and politically conservative Catholic might be dismayed by the church's stances on issues of economic justice, international affairs, or issues such as the death penalty. This would not be scandal. The mere fact that such persons might be disturbed by the participation of official Catholic organizations in needle-exchange programs is not scandal.

"Scandal" means that some person or persons, on observing the behavior of the faithful and/or of church authorities, are led to believe that the church does not seriously hold what it claims to hold and are thereby led to commit sins related to the observed laxity. Thus, scandal, in a technical sense, might be given by church leaders if priests were not to observe chastity, and if persons were led by this public sinfulness to believe that the church's sexual ethics is not taken seriously by its own leadership, and this belief then leads them to sexual promiscuity. Scandal would be given by church leaders if church-associated banks were to have laundered money, and if this were to lead someone to say that if the church can launder money, I can cheat on my taxes.

Harm-reduction programs, however, are not in themselves sinful—thus they stand outside these classical examples of scandal. The scandal at issue in remote, material cooperation is always more indirect, since the evil is morally distant from the agent. In all cases of scandal, however, including considerations regarding remote, material cooperation, the subtle flavor of hypocrisy must arise. For example, were the church to permit Catholic hospitals to use an embryonic stem-cell treatment based on fresh supplies of nascently created and destroyed human embryos, on the proviso that the

[19] *Catechism of the Catholic Church* (Liguori, MO: Liguori, 1994) no. 2284.

embryos were created and killed elsewhere, this would be remote, material cooperation, but one could credibly claim that it would be scandalous, because it would seem that the church really did not hold what it says it does regarding stem-cell research, and this could lead to the proliferation of such programs and to greater participation in embryo destruction even by the Catholic faithful. For the church to give scandal by participating in a needle-exchange program, however, it would be necessary to believe that people will thereby be led to think that what the church *really* believes is that drug abuse is not a serious moral wrong, and that this would lead them to start using injectable drugs to escape life's pressures or to create a false sense of happiness. On the face of it, this seems an extremely farfetched premise.

In my medical practice, I have treated hundreds of persons dependent on injectable heroin or cocaine, and I do not recall one for whom the opinions or actions of the Roman Catholic Church about anything had the slightest impact on their drug use. The prevalence of injection-drug use is highest among poor persons of color growing up in conditions in which drug abuse dominates their local cultures.[20] Many of these abusers are the children of addicts.[21] Most are high school dropouts. Many begin using drugs at young ages through the influence of older siblings and friends. Their lives are often caught up in and dominated by the world of drugs and the crime associated with drugs before they have had genuine opportunities to escape. And persons addicted to these substances generally die very young. The aim of a needle-exchange program is to help addicts live longer and reduce the harm they do to themselves and their communities, and to give them time to recover from their addictions and not harm anyone else. Thus, such programs are truly respectful of their human dignity, and aim to treat them as whole, integrated persons.

Beyond its apparent implausibility, however, empirical evidence shows that worries about needle-exchange programs leading to increased drug use are misplaced. The best evidence suggests that needle-exchange programs do not lead to increased drug abuse in the community, but rather are associated with more sustained drug *abstinence* even by the participating

[20] Hannah L. F. Cooper et al., "Estimating the Prevalence of Injection Drug Use among Black and White Adults in Large U.S. Metropolitan Areas over Time (1992–2002): Estimation Methods and Prevalence Trends," *Journal of Urban Health* 85 (2008) 826–56; and Carl A. Latkin et al., "Neighborhood Social Disorder as a Determinant of Drug Injection Behaviors: A Structural Equation Modeling Approach," *Health Psychology* 24 (2005) 96–100.

[21] Joseph Biederman et al., "Patterns of Alcohol and Drug Use in Adolescents Can Be Predicted by Parental Substance Use Disorders," *Pediatrics* 106 (2000) 792–97.

addicts.[22] If needle-exchange programs lead to less rather than more addiction, then worries about scandal are diminished.

IS COOPERATION THE PROPER CATEGORY OF ANALYSIS?

The underlying assumption of the foregoing analysis according to the principle of cooperation is that addiction to intravenous heroin and cocaine and similar drugs is a sin rather than a disease. This assumption needs to be challenged.

First, one needs to distinguish between drug abuse and drug addiction. Those being treated in a needle-exchange program are overwhelmingly suffering from drug addiction, not abusing drugs. This distinction is critical in conducting a moral analysis of the degree of free will, culpability, responsibility, and sinfulness of drug use. To illustrate this difference: a college student who binges on alcohol once or twice a semester and becomes insulting to others and has illicit sexual relations while intoxicated has abused alcohol; whereas a 25-year-old woman who injects heroin several times per day and prostitutes herself to buy enough heroin to keep her from experiencing withdrawal symptoms is an addict.

Since the time of Thomas Aquinas individuals who abuse a drug like alcohol have been considered to have diminished free will while intoxicated, and this observation has, to some extent, been understood to mitigate their culpability, at least in part.[23] Still, such individuals have not been considered to have impaired will while not intoxicated and thus have been held morally responsible for having become intoxicated in the first place, and therefore morally culpable for the acts they committed while intoxicated. In other words, such persons have sinned. The church has consistently preached against such abuse of alcohol and other drugs and must perpetually continue to do so.

Drug *addiction*, by contrast, is almost universally considered by modern medicine to be a disease, and one that dramatically impairs the will of the addict, whether actively intoxicated or not. The current *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV-TR) includes tolerance, withdrawal, and the inability to quit among the criteria for the diagnosis of substance dependence (addiction).[24]

[22] Don C. des Jarlais et al., "Syringe-Exchange, Injecting and Intranasal Drug Use," *Addiction* 105 (2010) 155–58; and Dezheng Huo, Susan L. Bailey, and Lawrence J. Ouellet, "Cessation of Injection Drug Use and Change in Injection Frequency: The Chicago Needle-Exchange Evaluation Study," *Addiction* 101 (2006) 1606–13.

[23] Thomas Aquinas, *Summa theologiae* 2–2, q. 150, aa. 1–4.

[24] *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR* (Washington: American Psychiatric Association, 2000).

Persons toward whom the needle-exchange programs are directed suffer from a diagnosis of substance dependence—dependence on extremely addictive substances such as heroin and cocaine. The inability to stop using the substance despite both knowing its untoward effects and desiring to quit are characteristic of the disorder. Attempting to stop using these substances has profoundly negative physical consequences for the addict. Keeping an adequate blood level of the substance is needed just to feel "normal." Genetic studies consistently point to some component of hereditary predisposition in substance-dependence disorders.

All this constitutes prima facie evidence of a diseased state characterized by impaired will and physical dependence. It has taken great effort over a long period to dampen, even partially, the popular opinion that persons suffering from substance dependence are sinners who are exhibiting defects of character. This approach has paved the way for more effective treatment, including abstinence approaches such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) that repudiate the notion that addicts are sinners. AA bluntly states, "Alcoholism isn't a sin, it's a disease."[25] Preconciliar Catholic manuals hold this view. As John Ford and Gerard Kelly put it, "Subjectively, it seems that not many alcoholics are morally guilty as far as the addiction itself is concerned."[26] The church's *Charter for Health Care Workers* (1995) incorporates this view: "To say that drugs are illicit is not to condemn the drug-user. That person experiences his condition as 'a heavy slavery' from which he needs to be freed. The way to recovery cannot be that of ethical culpability or repressive law, but it must be by way of rehabilitation."[27]

AA considers substance abuse to be a very serious disease:

> An illness of this sort—and we have come to believe it an illness—involves those about us in a way no other human sickness can. If a person has cancer all are sorry for him and no one is angry or hurt. But not so with the alcoholic illness, for with it there goes annihilation of all the things worth while in life. It engulfs all whose lives touch the sufferer's. It brings misunderstanding, fierce resentment, financial insecurity, disgusted friends and employers, warped lives of blameless children, sad wives and parents—anyone can increase the list.[28]

[25] Bill W., *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*, 4th ed. (New York: AA World Services, 2002) 344.

[26] John C. Ford, S.J., and Gerald Kelly, S.J., *Contemporary Moral Theology*, vol. 1, *Questions in Fundamental Moral Theology* (Westminster, MD: Newman, 1960) 290.

[27] Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* (Vatican City: Vatican, 1995) no. 94.

[28] Bill W., *Alcoholics Anonymous: The Story* 18.

Pope Benedict XVI recently visited a drug rehabilitation center in Brazil, and in his address there he condemned as sinners not the drug addicts but the drug pushers and explicitly endorsed AA and NA, stating:

> My thoughts turn now to those many other institutions throughout the world which work to rebuild and renew the lives of these brothers and sisters of ours present in our midst, whom God loves with a preferential love. I am thinking of groups such as Alcoholics Anonymous and Narcotics Anonymous as well as the sobriety associations working generously in many communities so as to build up the lives of others.[29]

Indeed, priests, sisters, and religious who are sent for treatment for addictive disorders are considered to be sick persons, not sinners in need of a retreat or fraternal correction. Such an understanding has been an advance for the life of the church.

If substance dependence is not a sin, then any analysis of needle-exchange programs that is based on the notion that such programs are scandalous and lead others to sin falls apart.

It is true that not everyone in society accepts this view of addictive disorders. Many socially conservative people view acceptance of the "disease model" of substance dependence as the first step toward widespread social acceptance of the view that no one has free will and that all behavior is socially, genetically, biochemically determined. As demonstrated, however, the church does not appear to share this view of addiction. Moreover, such a global view of the end of the concept of free will is not logically entailed by accepting the disease model of substance-dependence disorders. It is true that the church has an interest in combating the potentially distorted ways in which the whole notion of disease is now being deconstructed, and in fighting the crude attempts of neuroethicists to undermine the notion of free will.[30] Nonetheless, the idea that substance dependence is a disease and that it at least partially impairs free will is reasonable, even obvious, and it would not seem necessary to argue against the disease concept of addiction in order to defend the general concepts of free will and responsibility.

[29] Benedict XVI, "Greeting of His Holiness Benedict XVI" (Meeting with the Community Living in the Fazenda, Fazenda da Esperança, Guaratinguetá, Saturday, May 12, 2007), http://www.vatican.va/holy_father/benedict_xvi/speeches/2007/may/documents/hf_ben-xvi_spe_20070512_fazenda-brazil_en.html.

[30] On this debate about the definition of disease, see my "Diseases and Natural Kinds," *Theoretical Medicine and Bioethics* 26 (2005) 487–513; and my "Medicine without Limits," a review of Andrew Stark, *The Limits of Medicine* (2006), *New Atlantis* 18 (2006) 89–93. For a critique of the claims of neuroethics about free will, see Tom Buller, "Rationality, Responsibility, and Brain Function," *Cambridge Quarterly of Healthcare Ethics* 19 (2010) 196–204.

It is true, however, that typically the first use of any drug is an act of free will, for which the individual is morally responsible, even if one were to argue that the individual's culpability for initiating drug abuse can be mitigated by social circumstances. Abuse necessarily precedes dependence, and individual persons can be held morally responsible for abuse. So, the critics' worry might not really be the "scandal" of "helping drug addicts inject their next dose," but that church sponsorship of a needle-exchange program might lead persons who have never tried drugs to start experimenting with drugs. One could argue that the initial use could be considered sinful, so that it would be legitimate to invoke the idea of scandal after all. The substances at issue in this program, however, heroin and cocaine, are among the most highly addictive substances known to humankind. It is rare that they are abused occasionally and recreationally as alcohol might be. And again, as argued above, it is almost impossible to imagine that, given the social circumstances that accompany the initial use of these drugs, potential addicts would think that the sponsorship of a needle-exchange program by a Catholic organization must mean that the church is really not seriously opposed to substance abuse and therefore conclude that it is not so bad if they take their first "hit."

It is also true that successful drug-free living is possible for addicts. If so, it might be argued, addicts must have free will and must therefore be responsible for their addictions and be sinners. However, as demonstrated above, twelve-step programs such as those promoted by AA and NA (endorsed by the pope) do not consider addiction to be a sin or a moral defect. Rather, the theory behind these programs is that the substance-dependent person must accept that he or she has lost his or her will with respect to the substance and that only by turning his or her life over to a "higher power" can recovery begin. This theory actually represents sound theology—that it is by the grace of God alone and not by any act of will on the part of the addict that the opportunity for renewed life begins.

Thus, a double bind results from the claim that needle-exchange programs involve scandal. By invoking the issue of scandal, critics imply that substance dependence is a sin, not a disease. Yet the premise that substance dependence is a sin undermines the very structure of the abstinence programs (such as NA) that critics advocate as the only acceptable means of treating substance dependence. Such a logical contradiction is not compatible with the highest theological aspirations of a church committed to the conjunction of both *fides* and *ratio*.

Lastly, one must consider the logical implications of the conclusion that church sponsorship of harm-reduction programs for injection-drug users constitutes immoral complicity in the sin of drug abuse and that only abstinence-based rehabilitation programs are morally acceptable. Needle sharing is not the only form of harm-reduction strategy. As noted above, a

much more common and long-standing harm-reduction program is methadone maintenance. Methadone maintenance does not cure addiction; it merely substitutes addiction to an oral opioid drug for addiction to an injectable opioid drug. The purpose of methadone maintenance is harm-reduction—it is more difficult to overdose on methadone, and since it is an oral drug, methadone, like needle exchange, mitigates the infectious problems associated with needle use. It should be obvious, then, that if needle exchange is illicit cooperation in the evil of drug abuse, then, a fortiori, methadone maintenance is illicit cooperation in the evil of drug abuse. On the strength of the arguments given against needle exchange, then, no Catholic institution should be permitted to give methadone to patients suffering from addiction to heroin or other opioids. Distributing the drug itself to someone who suffers from a substance-abuse disorder is much more materially proximate than distributing clean paraphernalia. Only an irrational aversion to the idea of the church's distributing needles would seem to separate these acts. Must we shut down all methadone-maintenance programs sponsored by any and all Catholic organizations? I can only hope this is viewed as a reductio-ad-absurdum argument for why we should not deem Catholic sponsorship of a needle-exchange program to be an act of illicit material cooperation in the evil of drug abuse.

IS DOUBLE EFFECT THE PROPER CATEGORY FOR ANALYSIS?

Peter Clark offers an alternative analysis based on the rule of double effect.[31] He argues that the good intended by a needle-exchange program is the prevention of infection, and that the foreseen but unintended harm is the possibility of increased drug use. Since the evil of increased drug use would not be the cause of the good of decreased infections, and the good effect outweighs the bad effect, Clark argues that the program would be permissible under double effect.

This line of reasoning, however, represents just a different form of category mistake. Not everything in Catholic ethics that has a proportionality condition is an application of the rule of double effect. Double effect applies only to situations in which the good and the bad effects flow directly from the agent's act. To apply the rule of double effect, the bad effect cannot be one that requires an intervening agent.[32] Since the evil

[31] Peter A. Clark, "Heroin Addiction: An Ethical Evaluation of New York City's Heroin Manual," *Internet Journal of Health* 12.1 (2011), http://www.ispub.com/journal/the_internet_journal_of_health/volume_12_number_1_11/article/heroin-addiction-an-ethical-evaluation-of-new-york-city-s-heroin-manual.html.

[32] Daniel P. Sulmasy, "'Re-inventing' the Rule of Double Effect," in *The Oxford Handbook of Bioethics*, ed. Bonnie Steinbock (New York: Oxford University, 2007) 114–49.

that one claims to foresee but not intend (drug use) requires the action of an intervening agent (i.e., the drug user), then the proper category of analysis would be cooperation, not double effect. The use of proportionate reason does not automatically imply that the rule of double effect is being invoked. Thus, just as I have argued that cooperation ought not to be invoked to prohibit needle exchange, so double effect ought not to be invoked to justify it.

PROPORTIONALITY RE-VISITED

Perhaps, however, one might yet make a case against church sponsorship of a needle-exchange program by using the word "scandal" in its ordinary linguistic sense, such that confusion and dismay among the faithful would not figure into an analysis of scandal in a theological sense, but would be counted among the bad effects to be weighed according to the principle of proportionality. The possible confusion and dismay caused by church sponsorship of a needle-exchange program might be considered such a serious and likely anticipated harm that one would deem it disproportionate for the church to sponsor this program and therefore judge the cooperation illicit. For this argument to work, however, one would need to establish that the degree of confusion and dismay among the faithful caused by such a program would be so likely and of such magnitude as to swamp the good effects of preventing HIV and other infections among drug users, and so inevitable that it could not be stopped. In this regard, one should note that negative reaction to such programs has only been provoked by impassioned Internet bloggers. Everyone, but especially the church, needs to be very careful about interpreting public opinion based on the ability of a few individuals to use the Internet to create and manipulate opinion. The best scientific evidence suggests that community opinion regarding needle-exchange programs, when effectively educated about the matter, has actually been quite positive, especially as communities observe that none of the sometimes hysterical tales told by those who are opposed to these programs actually come to pass.[33]

Thus, to allay fear and prejudice toward those addicted to heroin, cocaine, and other drugs, and at least to promote a spirit of charity toward those so afflicted, the truly proportionate response of the church should be

[33] Kristi L. Allgood et al., "HIV Testing Practices and Attitudes on Prevention Efforts in Six Diverse Chicago Communities," *Journal of Community Health* 34 (2009) 514–22; Carla Treloar and Suzanne Fraser, "Public Opinion on Needle and Syringe Programmes: Avoiding Assumptions for Policy and Practice," *Drug and Alcohol Review* 26 (2007) 355–61; and Holly Villarreal and Catherine Fogg, "Syringe-Exchange Programs and HIV Prevention: If They're Effective, What's the Controversy?" *American Journal of Nursing* 106.5 (2006) 58–63.

to educate the laity about the true meaning of scandal and the moral permissibility of certain forms of remote, material cooperation, if not to demand our special care for them according to the principle of the preferential option for the poor.[34] The public health implications of preventing infections that could harm many others would also argue for educating the laity about the moral goodness of public health measures that are not intrinsically wrong but actually redound to the common good.[35]

Even in the absence of such educational efforts, however, fears of widespread dismay and confusion among the faithful seem disproportionately exaggerated. It therefore seems that there is little reason to accept an argument that cooperation by a church organization in a needle-exchange program is illicit on the grounds that the harm it does in fomenting widespread confusion and dismay is disproportionate to the harm it prevents. Such an argument fails on the basis of the best empirical evidence and accepts the dubious premise that the ignorance of the faithful about these matters is, in principle, invincible.

ECCLESIASTICAL PRECEDENTS

Not all harm-reduction programs are the same. One must be careful not to paint with a broad brush and reject all forms of harm reduction without a careful analysis of each type.[36]

Some observers have stated that the 1999 precedent case of the proposed participation of St. Vincent's Hospital, Sydney, Australia, in the establishment of an injecting room for substance-dependent persons provides definitive grounds for the church in 2012 to repudiate needle-exchange programs. This conclusion, however, is hasty and unwarranted. Upon reading the sensible and dispassionate report by Gerald Gleeson on this incident,[37] one realizes quickly that the differences between the two cases are morally significant.

[34] Mary Jo Iozzio, "Needle Exchange: The Moral Framework for a Global Problem," *Health Progress* 92.6 (2011) 64–67.

[35] Nuala P. Kenny, S.C., "Cure vs. Prevention: Catholic Perspectives," in *Prevention vs. Treatment: What's the Right Balance*, ed. Halley S. Faust and Paul T. Menzel (New York: Oxford University, 2011) 291–311.

[36] Unfortunately, a broad-brush rejection was implied (perhaps inadvertently) in a recent intervention by the Holy See Mission to the United Nations. See Francis A. Chulikatt, "Statement by Archbishop Francis Assisi Chulikatt, Permanent Observer of the Holy See to the United Nations," High-Level Plenary on HIV/AIDS (New York, June 8–10, 2011) 30 Years after the Discovery of the Virus, http://www.vatican.va/roman_curia/secretariat_state/2011/documents/rc_seg-st_20110610_aids_en.html.

[37] Gerald Gleeson, "St. Vincent's Withdraws from Supervised Injecting Room," *Bioethics Outlook* 10.4 (1999) 1–6, http://www.acu.edu.au/__data/assets/pdf_file/0018/216306/Vol_10,_No_4._December_1999.pdf.

The first and most obvious difference is that an injecting room is not a needle-exchange program. Injecting rooms bring the Catholic institution "closer" to the act of drug use, are not as common as needle-exchange programs, and to this day few data support their efficacy.

Second, while the letter of the Congregation for the Doctrine of the Faith to Cardinal Edward Clancy of Sydney was never made public, the congregation apparently did not engage in a formal theological analysis of whether the program constituted illicit cooperation but suggested that, as a practical matter, given the unproven benefit of such programs, the risk of public misunderstanding seemed too great to recommend proceeding with the program.[38]

Third, needle-exchange programs, as documented above, are different from injecting rooms in that there are now scientific data to support the thesis that such programs reduce behaviors that transmit infections, can reduce HIV and hepatitis rates, and can actually lead addicts into sustained abstinence. These data were not available at the time of the Sydney injecting-room discussion.

Moreover, one should note that needle-exchange programs were already in place at St. Vincent's Hospital, Sydney, at the time of the injecting-room controversy, and that needle exchange continues throughout Australia without any controversy or any questioning by the local church. In fact, one of the leading investigators in the field (who performed several of the analyses of the effectiveness of needle-exchange programs), Dr. Alex Wodak, is the long-standing director of drug and alcohol services at St. Vincent's Hospital. He opened the first needle-exchange program there in 1989.[39] Active needle-exchange programs have also operated quietly under Catholic auspices and without controversy in Dublin,[40] Rochester, NY,[41] San Francisco,[42] and Springfield, IL.[43] Widespread confusion and negative public reaction have not occurred.

[38] The contents of the CDF's letter are partially described in Gleeson, "St. Vincents Withdraws."

[39] Australian Broadcasting Company, "Needle-Exchange Program Marks 20 years," *ABC News*, November 13, 2006, http://www.abc.net.au/news/2006-11-13/needle-exchange-program-marks-20-years/1308546.

[40] Kieran Cronin, "Harm Reduction and Drug Abuse," *Furrow* 52 (2001) 154–63.

[41] Diana Hayes, "Come Ye Disconsolate: American Black Catholics, Their Church, and HIV/AIDS," in *Catholic Ethicists on HIV/AIDS Prevention* 96–107.

[42] The Catholic Worker Movement, http://www.catholicworker.org/communities/commlistall.cfm; and St. Francis Memorial Hospital, "Meet Our Providers: Bradley W. Maring, MD," www.saintfrancismemorial.org/Medical_Services/195509.

[43] Franciscan Sisters at Springfield, "Share Our Story: Story of the Month," November 2010, http://www.hospitalsisters.org/StFrancisScripts/Story.asp?StoryID=121.

Thus, there are ample reasons to distinguish the case of the injecting room in Sydney in 1999 from a needle-exchange program in 2012.

CONCLUSIONS

Rational analysis and a review of the empirical evidence support the conclusion that even if drug addiction were sinful and cooperation were the proper category for analysis and therefore sponsorship of a needle-exchange program by a Catholic organization would constitute remote, mediate material cooperation, there would be proportionate grounds for acting, and there would be no genuine risk of scandal, given a proper theological understanding of the term. Such cooperation can be judged licit.

A more enlightened understanding would recognize that, while the act of injecting drugs with the explicit intention of obscuring consciousness and escaping life's suffering is always objectively wrong, substance dependence sufficiently interferes with the free will of the addicted person that he or she is not morally culpable for the act of injecting and therefore is not sinning. Such an understanding would suggest that cooperation is not the proper category of analysis, and that a Christian approach based on charity (if not the preferential option for the poor) toward persons afflicted with substance dependence and on commitment to building up the common good independently justify such programs.

The best available data suggest that offering multiple options works better than offering either rehabilitation or needle exchange alone. This is apparently because some substance-dependent persons are initially attracted by the idea of rehabilitation, but "fall off the wagon," and then migrate into needle-exchange, while for others, needle-exchange serves as the first step in a path that leads to rehabilitation.[44] Thus, any Catholic organization that would sponsor a needle-exchange program in 2012 ought to implement an integrated program of harm reduction and rehabilitation and make it prominently known that they offer such multidimensional care for persons dependent on injection drugs.

[44] James Peterson et al., "Getting Clean and Harm Reduction: Adversarial or Complementary Issues for Injection Drug Users," *Cadernos de Saude Publica* 22 (2006) 733–40.