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The Future of Health Care Must Be Harm Reductionist—To Bring It About, We Need Moral Philosophy

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THE FUTURE OF HEALTH CARE MUST BE HARM REDUCTIONIST—TO BRING IT ABOUT, WE NEED MORAL PHILOSOPHY

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ABSTRACT

In the United States, more than 100,000 people now die each year from drug overdose, but nearly all of these deaths are preventable. The purpose of this Article is to show that harm reduction interventions could go a long way towards saving these lives, but we don't adopt many of these interventions, or fail to adopt them at the scale needed. Although it is often suggested by opponents of harm reduction that the interventions are unlikely to actually reduce harm, this Article argues that the empirical debate is largely over—decades of data demonstrate that harm reduction saves lives, promotes health, saves money, and even improves public order. Rather, this Article suggests opposition to harm reduction is actually often moral, stemming from the implicit moral philosophies that we all carry around. For this reason, this Article takes seriously some of the most powerful ethical arguments against harm reduction, and shows that the richest philosophy of harm reduction undermines these arguments by recognizing the value neutrality of drug use. This Article concludes that harm reduction is justified on a wide variety of moral philosophical grounds.

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I. INTRODUCTION

In 2021, the United States passed a grim milestone. More than 100,000 people now die from drug overdose each year—the vast majority of them involving opioids, particularly illicit fentanyl and its chemical analogs.[1] These drugs are incredibly potent—ranging from *100* to *10,000 times* more potent than morphine[2]—and their presence in the illicit market has led to a toxic, unreliable supply.[3] Although fentanyl was originally found primarily in other opioids like heroin, to cheaply increase potency, it can now be found in other drugs as well, such as stimulants like cocaine and pressed tablets like counterfeit Xanax.[4] Thus far, efforts to curb the drug overdose crisis have failed to make much headway, as overdose deaths continue to increase month after month.[5]

In the investigation that follows, this Article begins by highlighting the striking, distressing fact that the U.S. knows how to prevent these deaths, but is simply choosing not to. That fact cries out for explanation and justification. In short, implementing a philosophy of harm reduction in the U.S. health care system could prevent drug overdose deaths. Why does the U.S. not do it, then? Although both scholarly and political discussions may make it seem as though what is at issue is whether harm reduction *works*, this Article argues that the empirical question is largely settled. Rather, Americans often oppose harm reduction on *moral grounds*. The moral philosophical grounding of their objection is not unreasonable, but it is ultimately wrong. Thus, the second half of this Article argues that a proper understanding of the philosophy of harm reduction (as opposed to a mere strategy of harm reduction) helps clarify why it should be accepted, and thus why it must be incorporated into the future of health care.

II. THE STRIKING CLAIM

In the midst of a drug overdose crisis, it is common to think of drugs as dangerous, or even *deadly*. Ingesting illicit drugs seems like a terribly risky thing to do, not only because the drug itself is dangerous, but because it must be bought on the street. These illicit drugs are often laced with unknown quantities of fentanyl and other contaminants, such as the central nervous system depressant xylazine (indeed, depending on where one purchases it, there may be no heroin

1. *Drug Overdose Deaths in the U.S. Top 100,000 Annually*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 17, 2021), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

2. *Fentanyl Facts*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 23, 2022), https://www.cdc.gov/stopoverdose/fentanyl/index.html.

3. *Id.*

4. *Id.*

5. *Vital Statistics Rapid Release Provisional Overdose Death Counts*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 15, 2023), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

at all in any "heroin" procured).[6] Given this sense of risk, it may be surprising to consider the following claim: *no one has to die from their drug use*. Virtually every one of the more than 107,000 overdose deaths in the United States in 2021 was preventable.[7]

There are many reasons to believe this is true. First, treating an overdose victim with immediate health care is life-saving.[8] If someone experiences respiratory depression, they need oxygen;[9] if their heart stops beating, they need chest compressions or defibrillation.[10] This health care is often delayed during an overdose either because the person is alone, or those around are afraid to call for help because an emergency call brings the police.[11]

More importantly, the vast majority of drug overdose deaths (nearly 81,000 in 2021) involve an opioid.[12] Whether by itself, or in combination with other drugs like alcohol or benzodiazepines, opioids cause respiratory depression.[13] However, there is a positive aspect to opioids being the leading killer in drug overdoses: we have an antidote. Naloxone (brand name Narcan) can reverse an overdose in progress by ejecting the opioids out of the brain's receptors.[14] What this means is that if someone is overdosing, it is likely that opioids are involved, and that naloxone will therefore reverse the overdose.[15] Thus, naloxone can reverse the vast majority of overdoses, and rescue breathing or supplemental oxygen can prevent brain damage while the naloxone is taking effect.[16] Of course, as previously mentioned: someone must be nearby to witness the

6. Sarah G. Mars et al., *Sold as Heroin: Perceptions and Use of an Evolving Drug in Baltimore, MD*, 50 J. PSYCHOACTIVE DRUGS 167, 169, 172 (2017).

7. *U.S. Overdose Deaths in 2021 Increased Half as Much as in 2020 – But Are Still Up 15%*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 11, 2022), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

8. *Lifesaving Naloxone*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 25, 2023), https://www.cdc.gov/stopoverdose/naloxone/index.html.

9. *Opioid Overdose Basics: Responding to Opioid Overdose*, NAT'L HARM REDUCTION COAL., https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/responding-to-opioid-overdose/ (last modified Sept. 1, 2020).

10. *Chest Compressions and Rescue Breathing when Administering Naloxone in Opioid Overdose*, ONT. HIV TREATMENT NETWORK, https://www.ohtn.on.ca/rapid-response-chest-compressions-and-rescue-breathing-when-administering-naloxone-in-opioid-overdose/ (last visited Feb. 13, 2023).

11. Melissa Tracy et al., *Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention*, 79 DRUG & ALCOHOL DEPENDENCE 181, 186 (2005).

12. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 7.

13. *Benzodiazepines and Opioids*, NAT'L INST. ON DRUG ABUSE (Nov. 7, 2022), https://nida.nih.gov/research-topics/opioids/benzodiazepines-opioids.

14. *Naloxone DrugFacts*, NAT'L INST. ON DRUG ABUSE (Jan. 2022), https://nida.nih.gov/download/23417/naloxone-drugfacts.pdf.

15. *Id.*

16. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., OPIOID OVERDOSE PREVENTION TOOLKIT 7, 12 (2018).

overdose, and be able and willing to administer the naloxone in order for it to work.[17]

The idea that simple practices like not using drugs while alone, being able and willing to access medical help immediately, and having naloxone on hand can prevent all, or nearly all, overdose deaths is not mere speculation. There is a large, informal public health experiment going on around the world in the form of safe consumption spaces (previously called safe injection sites, and sometimes rebranded as overdose prevention sites).[18] These spaces are brick and mortar locations where people who use drugs can access sterile supplies and use their drug(s) in the presence of health care professionals (who are armed with naloxone).[19] In the fall of 2021, the first two sites opened in the U.S.—both in New York City[20]—but safe consumption spaces are well-established elsewhere in the world.[21] The first space opened in Switzerland in 1986,[22] and as of 2022, there are nearly 200 sites in fourteen countries around the world.[23] In the decades since these spaces have been in practice, tens of millions of people have used drugs in them, and thousands of overdoses have been reversed.[24] In all that time, there has not been a single recorded death in a safe consumption space from drug overdose.[25]

Decades of drug use.[26] Millions of injections.[27] Thousands of overdoses.[28] And not a single death.[29] Using illicit drugs need not be fatal.

Safe consumption spaces also distribute sterile supplies for cooking and injecting drugs, which further reduces the morbidity and mortality from drug use.[30] Sterile syringes prevent needle-sharing, which reduces the incidence of

17. Tracy et al., *supra* note 11, at 189.

18. Elana Gordon, *What's the Evidence that Supervised Drug Injection Sites Save Lives?*, NPR (Sept. 7, 2018, 2:40 PM), https://www.npr.org/sections/health-shots/2018/09/07/645609248/whats-the-evidence-that-supervised-drug-injection-sites-save-lives.

19. *Id.*

20. Brian Mann & Caroline Lewis, *New York City Allows the Nation's 1st Supervised Consumption Sites for Illegal Drugs*, NPR (Nov. 30, 2021, 3:54 PM) https://www.npr.org/2021/11/30/1054921116/illegal-drug-injection-sites-nyc.

21. Gordon, *supra* note 18.

22. M.J. Wright & Charlotte N.E. Tomkins, *Supervised Injecting Centers*, 328 BUS. J. MED. 100, 101 (2004).

23. *Overdose Prevention Centers*, DRUG POL'Y ALL., https://drugpolicy.org/issues/supervised-consumption-services (last visited Feb. 13, 2023).

24. NAT'L INSTS. OF HEALTH, U.S. DEP'T OF HEALTH & HUM. SERVS., OVERDOSE PREVENTION CENTERS, 5 (2021).

25. ERIC ARMBRECHT ET AL., SUPERVISED INJECTION FACILITIES AND OTHER SUPERVISED CONSUMPTION SITES: EFFECTIVENESS AND VALUE 87 (2021).

26. NAT'L INSTS. OF HEALTH, *supra* note 24, at 5–6.

27. *Id.*

28. *Id.*

29. *Id.*

30. ARMBRECHT ET AL., *supra* note 25, at 15.

blood-borne diseases like human immunodeficiency virus ("HIV") and Hepatitis C.[31] Sterile cookers, cotton, and water prevent bacterial infections which cause endocarditis and serious injection site wounds.[32] Simple interventions, such as distributing sterile equipment, can prevent the additional death toll that can come from untreated illness or infection, as well as the suffering that goes along with those conditions.[33]

The majority of drug use harms, then, are not necessary features of that activity; rather, they are incidental to it. Endocarditis is not a necessary result of injecting heroin; it is the result of unsafe injection practices, which are incentivized by laws and policies that make it difficult to acquire sterile equipment.[34] Injecting heroin does not guarantee that one will eventually die from an overdose; the likelihood of a fatal overdose depends on whether there is someone nearby with naloxone should their breathing become too depressed, but our laws and policies incentivize using alone and not calling for help.[35] Thus, these harms, which are not essential to drug use, can be mitigated by policy changes, without requiring people to stop using drugs.

That is where harm reduction comes in. Harm reduction is variously defined by different sources.[36] It is both a description of a class of interventions and a rich philosophy,[37] and as this Article will describe, different people identify harm reduction with more or fewer of several properties.[38] However, the essential core of harm reduction is a practice and philosophy that meets people where they are by attempting to reduce the harms of a behavior without requiring abstinence from it.[39] It is also common to hear harm reduction referred to as

31. Esther J. Aspinall et al., *Are Needle and Syringe Programmes Associated with a Reduction in HIV Transmission Among People Who Inject Drugs: A Systematic Review and Meta-Analysis*, 43 INT'L J. EPIDEMIOLOGY 235, 245 (2014).

32. Kinna Thakarar et al., *Harm Reduction Services to Prevent and Treat Infectious Diseases in People Who Use Drugs*, 34 INFECTIOUS DISEASE CLINICS N. AM. 605, 607, 609 (2020).

33. *Id.* at 610.

34. Jessica Cohen, *Supervised Injection Facilities Face Obstacles, but That Shouldn't Stop Them*, HEALTH AFFS. (Nov. 29, 2018), https://www.healthaffairs.org/do/10.1377/forefront.20181127.121405/full/.

35. *Id.*

36. Thakarar et al., *supra* note 32, at 605; *see also Harm Reduction*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/find-help/harm-reduction (last updated Aug. 16, 2022) ("Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services.").

37. Thakarar et al., *supra* note 32, at 605.

38. *Principles of Harm Reduction*, NAT'L HARM REDUCTION COAL., https://harmreduction.org/about-us/principles-of-harm-reduction/ (last visited Feb. 17, 2023).

39. *Id.* The Harm Reduction Coalition goes further in separating out aspects of harm reduction, noting that it is a practical strategy, a set of ideas (similar to what I'm calling a philosophy), and a movement for social justice. They further articulate eight distinct foundational principles to harm

"non-judgmental" and "value-neutral",[40] though these aspects are associated with the richer *philosophy* of harm reduction, as you can absolutely distribute sterile syringes to people who use drugs while judging them for their life choices. However, this would be engaging in the practice of harm reduction without embracing the full philosophy of harm reduction. Safe consumption spaces, distribution of naloxone, sterile syringe exchange, and Good Samaritan laws that provide protection from prosecution for people who call for medical help during an overdose[41] are all instances of harm reduction. When Americans use drugs, they die at a catastrophic rate.[42] But when people use drugs in safe consumption sites, no one dies.[43]

What that means is that many of the harms associated with drug use are the direct result of policies that society has implemented, often in an effort to decrease drug use. Drug paraphernalia laws criminalize the distribution of needles, leading to unsafe practices.[44] The criminalization of drug use makes it legally difficult to open safe consumption spaces, or to observe and help people using drugs.[45] Stigma and the criminal law lead people who use drugs to hide[46] where they cannot be seen or helped. When people die from endocarditis or bacterial infections stemming from unsafe injection practices, it is not a death resulting only from drug use. When people die from overdose, while using drugs alone, because they are afraid to use where anyone can see them, the deaths are not solely from drug use. All these deaths are partially the result of punitive drug laws and policies that attempt to address drug use by disincentivizing it. These deaths are avoidable.

reduction. National Harm Reduction Coalition. n.d. *Principles of Harm Reduction.* Accessed December 1, 2022. *Id.*

40. Laura Vearrier, *The Value of Harm Reduction for Injection Drug Use: A Clinical and Public Health Ethics Analysis*, 65 DISEASE-A-MONTH 119 (2019).

41. *Overdose Prevention*, CNTY. OF L.A. PUB. HEALTH, http://publichealth.lacounty.gov/sapc/public/overdose-prevention.htm (last visited Feb. 17, 2023); Amy Lieberman & Corey Davis, *Harm Reduction Laws in the United States*, NETWORK FOR PUB. HEALTH L. (Dec. 2, 2020), https://www.networkforphl.org/resources/harm-reduction-laws-in-the-united-states/.

42. Michael Howard, *5 Facts About Drug Overdose and Death*, WEBMD, https://www.webmd.com/connect-to-care/addiction-treatment-recovery/facts-about-drug-overdose-and-death (last visited Feb. 17, 2023).

43. *Safe Consumption Sites: Study Identifies Policy Change Strategies and Challenges*, JOHNS HOPKINS BLOOMBERG SCH. OF PUB. HEALTH (Feb. 13, 2019), https://publichealth.jhu.edu/2019/safe-consumption-sites-study-identifies-policy-change-strategies-and-challenges.

44. *Needs-Based Syringe Distribution and Disposal at Syringe Services Programs*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 2020), https://www.cdc.gov/ssp/docs/CDCSSP-FAQ_508.pdf.

45. *Against Drug Prohibition*, ACLU, https://www.aclu.org/other/against-drug-prohibition (last visited Feb. 17, 2023).

46. Louise Gaille, *16 Decriminalization of Drugs Pros and Cons*, VITTANA (Jan. 30, 2018), https://vittana.org/16-decriminalization-of-drugs-pros-and-cons.

This is why harm reductionists often say, "every overdose death is a policy failure."[47]

III. THE PUZZLE

This Article thus far has argued that, despite North America's tragic overdose crisis, drug use need not kill anyone. So why do we prevent so few deaths? Given that our drug policies are harm-expanding rather than harm-reducing, why do we stick with them?

Public health scientists and advocates sometimes act as though the reason that Americans resist harm reduction is a lack of familiarity with the evidence in favor of it.[48] So, scientists continue to run more studies demonstrating that syringe exchange programs reduce the prevalence of HIV and Hepatitis C, while simultaneously improving public order by discouraging discarded syringes.[49] Scientists continue to analyze existing safe consumption sites,[50] and model new ones,[51] to demonstrate that they save lives,[52] save money,[53] improve public order,[54] and increase the number of people entering recovery.[55] When opponents suggest that such interventions would "enable" or "incentivize" drug use, advocates point to the data that shows this is not true: harm reduction reduces harm without increasing drug use.[56]

47. Taylor Sabol & Annie Benjamin, *International Overdose Awareness Day*, AIDS UNITED (Aug. 31, 2022), https://aidsunited.org/international-overdose-awareness-day-2022/.

48. Katie Stone, *The Overwhelming Evidence in Favor of Harm Reduction*, OPEN SOC'Y FOUNDS. (Dec. 14, 2018), https://www.opensocietyfoundations.org/voices/overwhelming-evidence-favor-harm-reduction.

49. *Syringe Services Programs*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 1, 2023), https://www.cdc.gov/hiv/effective-interventions/prevent/syringe-services-programs/index.html.

50. Jorge Finke & Jie Chan, *The Case for Supervised Injection Sites in the United States*, 105 AM. FAM. PHYSICIAN 454, 454 (2022).

51. *See* Amos Irwin et al., *Mitigating the Heroin Crisis in Baltimore, MD, USA: A Cost-Benefit Analysis of a Hypothetical Supervised Injection Facility*, HARM REDUCTION J., May 2017, at 2, PMID 28532488.

52. Finke & Chan, *supra* note 50; Irwin et al., *supra* note 51, at 8.

53. Finke & Chan, *supra* note 50; Irwin et al., *supra* note 51, at 8.

54. Chloe Potier et al., *Supervised Injection Reviews: What Has Been Demonstrated? A Systematic Literature Review*, 145 DRUG & ALCOHOL DEPENDENCE 48, 65 (2014).

55. Jessica Cohen, *Supervised Injection Facilities Face Obstacles, But That Shouldn't Stop Them*, HEALTH AFFS. (Nov. 29, 2018), https://www.healthaffairs.org/do/10.1377/forefront.20181127.121405/full/ (citing numerous studies which show that safe injection sites increase addiction treatment uptake).

56. Timothy W. Levengood et al., *Supervised Injection Facilities as Harm Reduction: A Systematic Review*, 61 AM. J. OF PREVENTATIVE MED. 738, 742 (2021).

This belief that the disagreement must be about the state of the evidence sometimes comes directly from policymakers.[57] When California Governor Gavin Newsom recently reversed course after promising that he would support supervised consumption sites in his state, he suggested that more research was needed to prevent unintended consequences.[58] Taking them at their word, scientists produce data, yet public figures still claim that more data is needed.[59] This appeal to the need for more study allows politicians to avoid taking controversial action without seeming unreasonable. After all, more data sounds like a good thing.

At this point, it really is not a debate about the empirical evidence. Public health scientists have been collecting data on harm reduction interventions, like syringe exchanges and safe consumption sites, for decades,[60] and the evidence always tells the same story: harm reduction reduces harm.[61] Yet, no amount of evidence ever seems fully convincing, which is good reason to suspect that opposition to harm reduction is, most fundamentally, a moral position rather than an empirical one.

To see this clearly, consider a quick thought experiment (which you can run as an actual experiment the next time you have the opportunity to discuss harm reduction with someone who opposes it). Imagine that you are proposing a harm reduction intervention to a policymaker, colleague, friend, or acquaintance who is deeply antagonistic to your idea. At first, they argue that giving people who use drugs sterile equipment and a safe place to do drugs will make more people want to do drugs and thus increase harm. You then produce the decades of empirical data that disproves this claim. Do you imagine your interlocutor changing their position? Probably not. Rather, they would likely step back and say that, even if that is true, it is *wrong* to help people do drugs. It is enabling. It is disrespectful to them, as it amounts to giving up on them. And it is a bad use of health care resources since those people will keep using drugs and die anyway.

The point here is that the appeal to a need for empirical evidence is—at least often—insincere. Objectors to harm reduction oppose such interventions on

57. *See* Bente Birkeland & John Daley, *Political Pressure, Legal Threats Stall Hope for Denver's Safe Injection Site*, CPR NEWS (Feb. 19, 2019, 4:50 PM), https://www.cpr.org/2019/02/19/political-pressure-legal-threats-stall-hopes-for-denvers-safe-injection-site/.

58. Letter from Gavin Newsom, Gov. of Cal., to Members of Cal. State Senate, Re: Senate Bill 57 (Aug. 22, 2022), https://www.gov.ca.gov/wp-content/uploads/2022/08/SB-57-veto-msg-August-22-2022.pdf.

59. *See id.*

60. *See* Finke & Chan, *supra* note 50 (describing studies of safe injection sites dating back between the 1990s).

61. *See* Levengood et al., *supra* note 56, at 742 (citing various studies which found safe injection sites created safer injection behaviors and reduced infection rates).

moral grounds.[62] Even if these interventions reduce harm, we ought not to implement them. If the thought experiment above was not sufficient to convince you that this is often underlying such opposition, we can introduce yet more radical harm reduction interventions. Another effective way to reduce overdose mortality among people who use drugs is to give them pure, regulated versions of their drug of choice so that they do not accidentally overdose from contaminated drugs.[63] So, we could provide people who use heroin with pharmaceutical grade diacetylmorphine. Even if we can produce rock solid evidence that such an intervention saves lives—and the evidence is strong here too,[64] though less robust than for other harm reduction interventions[65]—do you imagine your interlocutor being swayed? No, because they likely believe it is wrong to give drugs to someone who is addicted to them. It makes society complicit in their bad behavior. Indeed, in the United States, a rule against this sort of complicity is actually built into health law, as a provision of the 1914 Harrison Narcotics Tax Act has been interpreted to prohibit clinicians from prescribing maintenance doses of opioids (excepting methadone and buprenorphine) to patients with a use disorder.[66]

If the foregoing is broadly on target, then the resistance to harm reduction is not primarily about the strength of evidence. Opposition to harm reduction is grounded in a moral philosophy that sees something wrong with "helping" people to engage in behavior that one takes to be bad or wrong. Moving the conversation forward must go beyond the evidence. If the debate over harm reduction is grounded in moral philosophical commitments, then society must do some moral philosophy.

IV. COMPETING (IMPLICIT) MORAL PHILOSOPHIES

Most of us carry around something like a moral philosophy. Not necessarily explicitly, and certainly not always coherently. But people, in general, have a moral point of view on the world and a framework through which they interpret ways of life and make moral judgments. Since these are not often worked out carefully, they can be considered "implicit moral philosophies."

62. Phillip Boffey, *The Debate Over Safe Injection Sites*, DANA FOUND. (Apr. 15, 2022), https://dana.org/article/the-debate-over-safe-injection-sites/.

63. Paul Moakley, *The 'Safe Supply' Movement Aims to Curb Drug Deaths Linked to the Opioid Crisis*, TIME (Oct. 25, 2021, 7:00 AM), https://time.com/6108812/drug-deaths-safe-supply-opioids/.

64. Mark Tyndall, *An Emergency Response to the Opioid Overdose Crisis in Canada: A Regulated Opioid Distribution Program*, 190 CANADIAN MED. ASS'N J. E35, E36 (Jan. 15, 2018).

65. *Id.*

66. Kelly K. Dineen & James M. Dubois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction*?, 42 AM J.L. & MED. 1, 27 (2016).

To see how these become operationalized, take safe consumption sites as the paradigmatic harm reduction intervention. These sites are easily and obviously justified for those who have an implicit consequentialist moral philosophy. Remembering that most of our philosophies are not perfectly coherent, we can say somewhat vaguely that those with more consequentialist sympathies *tend* to judge actions and policies as right, or as justified, when they produce more good than harm. This sort of reasoning comes second nature to those accustomed to thinking in economic terms (as a moral analog to cost-benefit analysis), but also, crucially, to those in public health. Public health, after all, is the field charged with promoting the health of entire populations,[67] so the effectiveness of interventions is a key measure of its success.[68] Consider the motto for the Johns Hopkins School of Public Health: "Protecting Health, Saving Lives—*Millions at a Time*."[69] An intervention is justified when, and because, it does a lot of good.

Of course, many of us who are concerned with public health value more than the good that interventions can produce; we are also often concerned with *social justice*, which limits the ways in which harms and benefits may permissibly be distributed.[70] Thus, even if an intervention promotes the most good in terms of health, if any benefit is mostly enjoyed by the most well-off and any burden is borne by the least well-off, many in public health will object on social justice grounds.[71] This sort of concern for the distribution of benefits and burdens also seems to easily support safe consumption sites, as they benefit some of the most marginalized members of the community.[72]

What is important to note is that both consequentialist theories and theories of social justice, which direct us to focus our efforts on the most marginalized, are *forward-looking* moral philosophies.[73] They take no account of the past, but instead aim to accomplish some particular distribution of good and bad[74]—they generate what Robert Nozick calls "end-state principles of justice," as they

67. *What is Public Health?*, AM. PUB. HEALTH ASS'N, https://www.apha.org/what-is-public-health (last visited Feb. 17, 2023).

68. Elizabeth Samuels et al, *Overdose Prevention Centers: An Essential Strategy to Address the Overdose Crisis*, JAMA, July 15, 2022, at 2, Art. No. e2222153.

69. *Johns Hopkins Bloomberg School of Public Health*, PULITZER CTR., https://pulitzercenter.org/campus-consortium/johns-hopkins-bloomberg-school-public-health (last visited Feb. 17, 2023).

70. MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY 81 (2006).

71. *Id.* at 88.

72. Carolyn Greene et al., *Supervised Consumption Sites Reduce Drug Overdoses and Disease Transmission — and Deserve Government Support*, THE CONVERSATION (Jan. 16, 2023, 2:45 PM), https://theconversation.com/supervised-consumption-sites-reduce-drug-overdoses-and-disease-transmission-and-deserve-government-support-197593.

73. Derk Pereboom, *Undivided Forward-Looking Moral Responsibility*, 104 MONIST 484, 485–86, 495 (2021).

74. ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA 154 (1974).

instruct us to promote some particular pattern or structure.[75] Opposed to such views are what Nozick calls "historical principles"—which he prefers—and which hold that what one is entitled to depends on what one has done in the past.[76] What this sort of framing makes clear is that questions about the justification of political or collective interventions are questions about what individuals are *owed*, or what they are *entitled to*. For someone who finds historical views appealing, we do not owe the same thing to a victim of wrongdoing as we do to someone who is at risk because they made bad choices.

One reason to object to consequentialist or social justice reasoning, then, is to hold that what people deserve (also discussed as "desert" below) depends on their past actions. This is a particular instance of a broader point, which is simply that many of us, as part of our implicit moral philosophies, have the idea that more than consequences matter in determining whether an action is justifiable. Some actions are simply wrong, *regardless of their consequences*, or promoting good consequences is not sufficient for making an act right or obligatory. Which is to say: many of us have broadly *deontological* views about what makes certain actions wrong.

In addition to historical concepts like desert, considerations of complicity come into play as well. Moral worries about keeping one's hands clean are paradigmatically non-consequentialist concerns. If what matters is that some good or bad happens, it does not matter much how the good or bad happens. But as the British philosopher Bernard Williams powerfully illustrates in his exploration of integrity, most moral agents seem to think it important whether some consequence *comes from me*.[77] This general way of thinking about morality supports the idea that by helping someone do something bad or wrong, you yourself have done something bad or wrong.[78] You become complicit in their behavior. In the context of drugs, society worries about this so much that people use a special, morally-marked word for it—*enabling*. Some people worry about giving money to those asking for help on the street corner, worrying that they will "just use it to buy drugs"; parents worry about not kicking their addicted children out of the house, afraid that by providing for them, they are promoting their bad behavior; friends worry about failing to use "tough love" when someone they care about spirals into chaotic drug use. In all of these cases, the language of "enabling" is used and assumed to be bad. Crucially, this is so, even if one's actions in each case did not cause any harm, or even if it might prevent harm. If giving someone money to buy drugs meant they would both get their drugs *and* get to eat that night (rather than use all their money for drugs), this is harm-reducing, and yet still may be deemed enabling behavior.

75. *Id.* at 153, 155.
76. *Id.* at 155.
77. J.J.C. SMART & BERNARD WILLIAMS, UTILITARIANISM: FOR AND AGAINST 108 (1973).
78. *Id.* at 96.

Backwards-looking views that focus on non-consequential concepts like desert, complicity, and enabling, help us to understand why there is so much disagreement about harm reduction, despite the empirical evidence in its favor. Safe consumption sites are the societal analogue to providing resources to your loved one who has an addiction: they are spending resources on people who will use those resources to pursue their drug use.[79] According to some views, this is unjustified because people who use drugs do not deserve this help.[80] But, according to other views, the case is actually worse than that, not merely because we are *not* obligated to rescue people from the bad choices—but because it is wrong to become part of their bad choices. If we get our hands dirty by giving people the tools and the spaces to use drugs, then we become implicated in their outcomes and lifestyles.[81]

Finally, we should note that even quite progressive political philosophies can have a hard time dealing with the case of drug use.[82] The literature around luck egalitarianism has made rigorous and theoretical the implicit moral philosophical idea many of us have: that individuals should not be made worse off by circumstances that they cannot control.[83] Thus, the egalitarian commitment in luck egalitarianism is to ensure that people do not lose equal access to goods or opportunities through no fault of their own.[84] This raises the question, however: what if the inequality *is* through some fault of their own? The intuitive focus on not allowing bad luck to derail someone's life does not tell us what to do when bad choices derail someone's life. This has led to a discussion in the luck egalitarian literature about whether there is an obligation to "rescue the imprudent."[85] Even amongst egalitarians, then, it is not obvious whether there is a duty to prevent harms that come from an individual's free choice.[86]

79. Finke & Chan, *supra* note 50.

80. Lindsey Brooke Porter, *Harm Reduction and Moral Desert in the Context of Drug Policy*, 28 HEALTH CARE ANALYSIS 362, 363 (2020).

81. Timothy Kirschenheiter & John Corvino, *Complicity in Harm Reduction*, 28 HEALTH CARE ANALYSIS 352, 355 (2020).

82. Mark A.R. Kleiman, *Drugs and Drug Policy: The Case for a Slow Fix*, 15 ISSUES SCI. & TECH. 45, 45 (1998).

83. This idea became a preoccupation of mainstream political philosophy with Rawls, but has received sustained attention in the work of many other thinkers, including, notably, Nagel, Dworkin, and Cohen. JOHN RAWLS, A THEORY OF JUSTICE 12, 14–15 (1971); THOMAS NAGEL, MORTAL QUESTIONS 28 (1979); RONALD DWORKIN, SOVEREIGN VIRTUE: THE THEORY AND PRACTICE OF EQUALITY 128, 130 (2000); G.A. COHEN, IF YOU'RE AN EGALITARIAN, HOW COME YOU'RE SO RICH? 120 (2000).

84. Anca Gheaus, *Hikers in Flip-Flops: Luck-Egalitarianism, Democratic Equality and the* Distribuenda *of Justice*, 35 J. APPLIED PHIL. 54, 54 (2018).

85. *Id.* at 57.

86. *Id.* at 59.

The above ways in which people's implicit moral philosophies lead them to object to harm reduction are worth taking seriously because these philosophies are not strange or idiosyncratic views—they are reasonable, often compelling moral theoretic positions that many people find intuitive at least some of the time in some circumstances. Most people do think that what you deserve depends on what you have done in the past; that complicity in bad behavior is generally to be avoided, and that whether I played a role in producing some outcome matters morally; and that it is more important to prevent harms that resulted through no fault of one's own than it is to prevent harms that came about due to bad choices. Certainly, one can disagree with each of these views, but these views are not uninformed or unreasonable, and so they should be engaged with.

If we take these views seriously, though, they show that a prominent harm reduction strategy is unlikely to work. Advocates of harm reduction often argue for *compassion* for people who use drugs, which is understandable.[87] It seems like getting people to care about others and see their lives as worth saving is what matters. But, if harm reduction is taken by opponents to be unjust and enabling,[88] then it is not compassionate to engage in it; it is bad and wrong. On such views, people who freely chose to do drugs are responsible for their choices and may even deserve the outcome. Not only would it be unjust for society to invest in them, but it would make all of us complicit in their behaviors. For the sorts of backwards-looking and deontological views of harm reduction articulated above, safe consumption sites and similar interventions amount to enabling bad behavior.

An argument for harm reduction, thus, needs much more than evidence. It needs to explain why the implicit moral philosophies of so many people are getting this one wrong. This Article turns to that task now.

V. THE MORAL PHILOSOPHICAL ARGUMENT(S) FOR HARM REDUCTION

As supporters of harm reduction will have already been thinking by this point, there are many possible responses to the sorts of non-consequentialist positions laid out above.[89] However, this section of the Article argues that they may be weaker than they appear at first glance.

The first important assumption that this section makes is that it is not particularly helpful to simply argue for some form of consequentialism at this point in the dialectic. Although it is true that consequentialism can justify the sorts of harm reduction interventions previously discussed (as they save lives,[90]

87. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 36.

88. Rachel Martin & Brian Mann, *Controversial Harm Reduction Strategies Appear to Slow Drug Deaths*, NPR (Sept. 15, 2022, 5:08 AM), https://www.npr.org/2022/09/15/1123108839/controversial-harm-reduction-strategies-appear-to-slow-drug-deaths.

89. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 36.

90. *Id.*

reduce morbidity,[91] save money,[92] and so on), the very disagreement is based in the fact that many people seem to have deontological intuitions. Thus, even for those who hold consequentialist intuitions, simply asserting consequentialism would not be helpful at moving the debate forward, and this is a crucially *practical* problem, with real stakes. It would be much better to show that harm reduction could be justified on nonpartisan (philosophically speaking) grounds.

In addition, there is reason to think that harm reduction as a rich philosophy is not simply an extension of consequentialism. As noted above, harm reduction can refer either to just interventions or to a philosophy,[93] and different people define the concept differently.[94] One powerful description of harm reduction is grounded in a recognition of other peoples' dignity, and recognizing their autonomy to make choices that one disagrees with.[95] This sort of justification for moral concern is deeply Kantian, and goes beyond simply doing what will produce the best outcome.[96] Thus, not only is it unhelpful to rest justification for harm reduction on the truth of consequentialism (since that limits the audience that will take the argument seriously), but it does not seem fully accurate. There are both consequentialist and deontological reasons for promoting harm reduction.

If we accept the need for a nonpartisan argument for harm reduction, there are two candidate maneuvers that seem most immediately attractive: rejecting a punitive notion of 'desert' and rejecting the idea that the choice to take drugs is truly free. The following paragraphs will address each in turn.

At the most basic level, we might argue that accepting a historical view does not require us to endorse a strong view of desert, and that we should not. The basic move here would make the case that certain forms of assistance should not be available only to those who deserve them. And health care, in particular, is one of these. Many people end up needing health care because they made questionable decisions.[97] Professional athletes, downhills skiers, motorcycle riders—all of these people face the charge that they perhaps "should have known better" when they end up in the trauma bay or with brain injuries. But, we do not deny them care. The fact that they need help as a result of their risky choices does not seem to justify not caring for them. Life-saving care is not the sort of thing that you should have to earn.

91. *Id.*

92. *Id.*

93. Shaul Lev-Ran et al., *Examining the Ethical Boundaries of Harm Reduction: From Addictions to General Psychiatry*, 51 ISR. J. PSYCHIATRY & RELATED SCI. 175, 175 (2014).

94. Nicholas B. King, *Harm Reduction: A Misnomer*, 28 HEALTH CARE ANALYSIS 324, 325 (2020).

95. Sarah Hoffman, *Kantian Harm Reduction*, 28 HEALTH CARE ANALYSIS 335, 340–41 (2020).

96. *Id.* at 341.

97. *Id.* at 337.

In addition, even if you are convinced that we should generally reward good behavior, and that people should live with the consequences of their bad behavior, it is hard to believe that the costs borne by people who use drugs is really an appropriate "punishment" for their choice. Death is a steep penalty for trying to feel good.

Although this argument is compelling, it may struggle in the American context, where we do not have a socialized medical system.[98] The basic premise of the argument above is that health care is not something you should have to earn, with the implicit underlying claim being that health care is a right of all people. But we do not treat health care as a right in the United States,[99] with many people having suboptimal or basically no access to health care.[100] So, using the right to life-saving health care in the context of people who use drugs may feel *ad hoc* in a setting where many others also lack access to life-saving care. Returning to the practical goal of wanting to make real progress in the harm reduction debate, basing one's argument on a right to health care seems not so much better than basing it on consequentialism, as both are major assumptions that many people involved in the debate do not share.

The second argument that seems obvious in response to harm reduction's opponents is that their account has an unrealistic view of how autonomous the choice to use drugs really is. In short: the opponents of harm reduction object to rescuing people who use drugs, because they are *choosing* to engage in risky behavior.[101] Using the language introduced above: even if we have a duty to rescue those who suffer as a result of bad luck, it may not seem that we have a duty to rescue the imprudent.[102] This idea implies that people being harmed by, and dying from, drug use made a choice at all, whereas many of them presumably suffer from an addiction.[103] And addiction, famously, undermines

98. *What is Socialized Medicine?*, HEALTHINSURANCE.ORG, https://www.healthinsurance.org/glossary/socialized-medicine/ (last visited Feb. 17, 2023).

99. Mary Gerisch, *Health Care as a Human Right*, AM. BAR ASS'N (Nov. 19, 2018), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/health-care-as-a-human-right/.

100. Sara R. Collins et al., *The State of U.S. Health Insurance in 2022*, COMMONWEALTH FUND (Sept. 29, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey.

101. April Boykin, *The Psychology Behind Medical Care Avoidance*, NASHVILLE MED. NEWS (Mar. 7, 2022, 9:30 AM), https://www.nashvillemedicalnews.com/article/4590/the-psychology-behind-medical-care-avoidance.

102. Gheaus, *supra* note 85, at 57.

103. Tom Hill, *Is Addiction a Choice?*, MENTAL HEALTH FIRST AID (Mar. 25, 2019), https://www.mentalhealthfirstaid.org/external/2019/03/is-addiction-a-choice/.

one's will.[104] Further, because addiction is a health condition,[105] with a recognized genetic component,[106] whether one develops an addiction seems substantially a matter of luck.[107] So, the people at risk of suffering and dying are not the imprudent, they are the unlucky. They are entitled to our help on a luck egalitarian framework, and certainly do not deserve their plight on any framework.

Although this argument, too, raises important points, we should not rest too much on it. For one, it treats addiction as if it were a condition that literally robs someone of their free will—and that is the way that many people think of it. But it is not a good model. As neuroscientists[108] and philosophers of addiction[109] have made clear, addiction—however much it may *undermine* autonomy to various degrees—does not turn one into a zombie or a robot. People living with addiction are still capable of making free choices.[110] Indeed, harm reduction works by explicitly leveraging the ability of people who use drugs to make choices: they can choose to use safer injection practices, choose to use with other people, choose to test their drugs for contaminants, and so on. It is also why we celebrate those in recovery, congratulating them on milestones reached—because those people *chose* to stop using drugs, even though the choice was hard. This sort of argument makes allies of people who use drugs feel uncomfortable, because it threatens to hold them fully responsible for their actions. However, there is no tension between recognizing that addiction makes certain choices incredibly difficult and yet does not render someone with an addiction completely unfree.[111]

104. The orthodox, neurobiological disease model of addiction notes that compulsive desires to use drugs are a core part of addiction, which explains why someone suffering from addiction continues to use despite negative consequences. Nora Volkow et al., *Neurobiological Advances from the Brain Disease Model of Addiction*, 374 NEW ENG. J. MED. 363, 364 (2016). Pathological brain structures render them unable to stop using—their will is undermined by compulsions. *Id.* at 367.

105. *Id.* at 364.

106. *Id.* at 369.

107. *Understanding Drug Use and Addiction DrugFacts*, NAT'L INST. ON DRUG ABUSE (June 2018), https://www.drugabuse.gov/publications/drugfacts/understanding-drug-use-addiction.

108. *See, e.g.*, MARC LEWIS, THE BIOLOGY OF DESIRE: WHY ADDICTION IS NOT A DISEASE 2 (2015); CARL HART, HIGH PRICE: A NEUROSCIENTIST'S JOURNEY OF SELF-DISCOVERY THAT CHALLENGES EVERYTHING YOU KNOW ABOUT DRUGS AND SOCIETY xi, 267, 269 (2013).

109. *See* Hannah Pickard, *The Puzzle of Addiction*, *in* THE ROUTLEDGE HANDBOOK OF PHILOSOPHY AND SCIENCE OF ADDICTION 9, 11 (2019).

110. *Free Will and Addiction: Is It a Choice?*, ARIZ. ADDICTION CTR. (Sept. 13, 2019), https://arizonaaddictioncenter.org/free-will-and-addiction-is-it-a-choice/.

111. *See* TRAVIS RIEDER, IN PAIN: A BIOETHICIST'S PERSONAL STRUGGLE WITH OPIOIDS 118, 120–21, 224 (2019) (providing a more in-depth discussion of this topic).

Furthermore, not everyone who uses drugs has an addiction.[112] Some people use drugs because they are fun.[113] If that sounds implausible to you, stop to think whether everyone who drinks alcohol has an alcohol use disorder. The answer is: of course not. Many drugs can be used recreationally without leading to an addiction.[114] And, if your drug of choice happens to be illegal, then you have no choice but to get it from a dangerous, contaminated black market.[115] Thus, some of the people who die each year from drug overdose likely do not have an addiction.[116] Harm reduction holds that we ought to save them too, even if their autonomy was not in any way undermined by addiction.

Thus, the proper response to deontological opposition to harm reduction is a sort of nuclear option. While there are insights to be had above that tinker around the edges of the argument for harm reduction, we must go to the core of it. Notions of desert, justice, and complicity do not count against harm reduction because *drugs are not bad* and *drug use is not wrong*.[117] Much of the debate above examines the "fact" that drug-induced morbidity and mortality is a result of bad behavior, and then explores whether the implication is really that we should not thereby help, or whether it's really "behavior" in the sense of freely-chosen action.[118] But the analysis must go even deeper. Even if we hold strong desert views, and even if drug use is autonomous behavior,[119] it is not bad behavior. It is the very foundational value theory that the discussion so far has gotten wrong.

The idea that drugs are not bad sounds strange to many who have not thought much about it before. Drugs *must be* bad. They are dangerous, and they do terrible things to us. Recall Nancy Reagan's admonition from the 1980's to "just say no,"[120] or the omnipresent public service announcement comparing a healthy

112. William Nicholls-Allison, *Going Upstream to End the Opioid Emergency*, WILL TO BE (Sept. 2, 2022), https://www.willtobe.org/post/going-upstream-to-end-the-opioid-emergency.

113. *Drugs for Fun: Why Do We Feel So Bad About Feeling Good?*, CBC RADIO (Aug. 14, 2017), https://www.cbc.ca/radio/ondrugs/drugs-for-fun-why-do-we-feel-so-bad-about-feeling-good-1.4240366.

114. *See Recreational Drug Use vs. Addiction*, ASPENRIDGE RECOVERY (Aug. 9, 2021), https://www.aspenridgerecoverycenters.com/recreational-drug-use-vs-addiction/.

115. *See* DRUG ENF'T ADMIN., 2020 NATIONAL DRUG THREAT ASSESSMENT 83, 85 (Mar. 2021) (describing the existence of a continued illicit black market for the drug trade and making comments related to the contamination of the black-market supply).

116. *See generally* CTRS. FOR DISEASE CONTROL & PREVENTION, OVERDOSE DEATHS AND THE INVOLVEMENT OF ILLICIT DRUGS (Jan. 23, 2023), https://www.cdc.gov/drugoverdose/featured-topics/VS-overdose-deaths-illicit-drugs.html (showing that 20% of people who died from an opioid overdose had been previously treated for substance use disorder).

117. Travis N. Rieder, *Solving the Opioid Crisis Isn't Just a Public Health Challenge—It's a Bioethics Challenge*, HASTINGS CTR. REP., July–Aug. 2020, at 24, 29, 31.

118. *Id.* at 30.

119. *Id.* at 29.

120. Nancy Reagan, *"Just say no."*, SCHOOL SAFETY, Spring 1986, at 5, https://www.ojp.gov/pdffiles1/Digitization/118410NCJRS.pdf.

brain with a fresh egg, showing an egg being cracked into a skillet, warning, "This is your brain on drugs. Any questions?"[121] Not to mention the very fact that justifies this paper's existence, which is that drugs are killing hundreds of thousands of people a year.[122] Obviously drugs are bad, right?

The uncomfortable fact that clouds this judgment is that most of us have a significant appreciation of drugs. It seems many people might not think alcohol is inherently, morally bad, nor do they think it is wrong for autonomous adults to drink alcohol. Some alcohol even has societal clout attached.[123] You can achieve social standing by being a wine or whiskey connoisseur, or by mixing great cocktails.[124]

Of course, some people think alcohol is bad for our health and that we should not drink it,[125] but we can show that they are often big fans of other drugs—namely, when used in medicine. Recreational drugs largely exist because they were developed for use in medicine where they have important roles.[126] Cocaine was long used in dentistry as an anesthetic (alongside other '-caines' such as lidocaine).[127] Opioids such as oxycodone (which helped spark today's drug overdose crisis) are crucial pain medications for people in severe pain.[128] And benzodiazepines are used in all sorts of medical contexts, from mental health to critical care.[129] Drugs that feel good recreationally also feel good when we feel bad. They exist because we developed them to solve problems. No one wants to experience, say, post-surgical pain, without opioids.[130]

To this line of reasoning, questions arise as to whether or not it is really true that *no drugs* are simply bad; the most common drug offered to me as an example of a "bad drug" is heroin. But heroin is not special. It is also an opioid, and it,

121. *Frying Pan* (Partnership for a Drug-Free America advertisement 1987).

122. *Drug Overdose Death Rates*, NAT'L INST. ON DRUG ABUSE (Feb. 9, 2023), https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates.

123. *See* Peter Dean, *Marc Almert on What Life is Like as the World's Best Sommelier*, THE BUYER (Aug. 1, 2022) interviewing one of the best wine sommeliers, discussing his business and international engagements, https://www.the-buyer.net/people/on-trade/marc-almert-best-sommelier-world/.

124. *Id.*

125. Jamie Ducharme, *A New Study Says Any Amount of Drinking is Bad for You. Here's What Experts Say*, TIME (Aug. 24, 2018, 2:25 PM), https://time.com/5376552/how-much-alcohol-to-drink-study/.

126. *A Social History of America's Most Popular Drugs*, PBS, https://www.pbs.org/wgbh/pages/frontline/shows/drugs/buyers/socialhistory.html (last visited Feb. 17, 2023).

127. Howard Markel, *Your Trip to the Dentist Wouldn't Include Anesthesia Without This Doctor*, PBS (Mar. 21, 2018, 4:23 PM), https://www.pbs.org/newshour/health/your-trip-to-the-dentist-wouldnt-include-anesthesia-without-this-doctor.

128. *Talk to Your Doctor About Managing Your Pain*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 16, 2020), https://www.cdc.gov/injury/features/manage-your-pain/index.html.

129. Connor Bounds & Vivian Nelson, *Benzodiazepines*, NAT'L LIBR. OF MED. (Nov. 21, 2022), https://www.ncbi.nlm.nih.gov/books/NBK470159/.

130. RIEDER, *supra* note 112, at 32, 35.

too, was developed as a pharmaceutical (by the company Bayer, in fact—just before they patented Aspirin).[131] Heroin is a fine opioid: it is moderately potent (about 1.5 times as strong as morphine, or approximately equivalent to oxycodone), and provides both analgesic and euphoric effects like other μ-receptor opioid agonists.[132] Heroin is illegal in the U.S., mostly because of the historical role it played leading to addiction and overdose in the early twentieth century, which caused lawmakers to tightly regulate and ultimately ban it.[133] But, there is no scientific reason that it should not be used in medicine.[134] Even fentanyl, the modern-day bogeyman in North America, is an important drug.[135] In the medical context, fentanyl is used for post-surgical and other severe pains (such as cancer pain or for pain at the end of life).[136] The illegal version is not magic; it is just unregulated.[137] Used in a controlled, medical context, the benefits of fentanyl, oxycodone, cocaine, or even heroin (if it were legal for medical purposes) can outweigh the risks.[138] But in unknown quantities, contaminated by other drugs, the risks can outweigh the benefits and, ultimately, be lethal.[139]

So, no—drugs are not bad. Drugs have side-effects, some of them deadly. Yet, many behaviors are risky, like, for instance, urban commuting by bicycle. Having associated risks is not sufficient for rendering a substance inherently bad or a behavior inherently wrong. Which means that those who think drug use is morally problematic must hold that the *way* in which some people take drugs is wrong. In particular: *recreational drug use* is what is wrong.

This, too, is difficult to defend, though. For those who believe that it can be permissible to enjoy alcohol (or even less risky drugs, like caffeine), recreational drug use is not inherently impermissible. The lines are even more blurred now

131. *Id.* at 47.

132. Jana Sawynok, *The Therapeutic Use of Heroin: A Review of Pharmacological Literature*, 64 CANADIAN J. PHYSIOLOGY & PHARMACOLOGY 1, 1, 5 (1986); Armaan Dhaliwal & Mohit Gupta, *Physiology, Opioid Receptor*, NAT'L LIBR. OF MED. (July 25, 2022), https://www.ncbi.nlm.nih.gov/books/NBK546642/.

133. Sonia Moghe, *Opioid History: From 'Wonder Drug' to Abuse Epidemic*, CNN (Oct. 14, 2016, 6:41 AM), https://www.cnn.com/2016/05/12/health/opioid-addiction-history/index.html.

134. *Id.*

135. *Fentanyl*, NAT'L INST. ON DRUG ABUSE, https://nida.nih.gov/publications/drugfacts/fentanyl (last visited Feb. 17, 2023).

136. *Id.*

137. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 2.

138. *Opioids*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/opioids (last visited Feb. 17, 2023); *Drugs and Supplements Cocaine (Topical Route)*, MAYO CLINIC, https://www.mayoclinic.org/drugs-supplements/cocaine-topical-route/description/drg-20063139 (last modified Feb. 1, 2023).

139. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 2.

with the legalization of cannabis in many states,[140] and the associated belief by many that recreational use of cannabis is clearly permissible.[141] So, it seems that, when a drug is legal, we often tend to think its recreational use is permissible. As we have already seen in the case of heroin, our drug laws do not clearly mark out "good" vs. "bad" drugs. Indeed, as has been clearly shown by Michelle Alexander and others, drug policy has historically been weaponized as a racist tool of social control, criminalizing behavior by Black people and other minorities, while legitimizing behaviors by white people.[142] So, the law is no guide to whether a drug is good or bad. Rather, the law tends to track political motivations, many of them bad.

As a result, there is no reason to think that drugs, as a category of substance, are bad, or that their use is wrong. Instead, drugs are tools of medicine and society with various associated risks and benefits, and our regulation of these tools does not map neatly onto these risks and benefits. But that means that we cannot read off from the fact that someone uses drugs, or that they developed an addiction, that they are doing something wrong. What we know when someone chooses to use drugs is that they are seeking the benefits of those substances, but are also at risk from the unintended effects. This is like many other human behaviors, and tells us nothing about the value of the action.

For this reason, drug taking is value neutral in itself. Objections to harm reduction based on deontological implicit moral philosophies fail because they all assume that the person taking drugs has done something wrong, which is why they may not deserve our resources, or why helping them may make us complicit in their wrongdoing. However, since taking drugs is not wrong, all of these objections crumble from the foundation. There is no grounding for the very moral judgment that would legitimize treating people who take drugs differently from anyone else who needs help.

If we return to the different components of the practice and philosophy of harm reduction, we can see that the philosophy of harm reduction is sometimes said to involve value neutrality.[143] At the least, this is part of the spirit of meeting people where they are by recognizing people who use drugs as autonomous agents with dignity, worthy of respect regardless of their decision, and not judging them for those decisions. But this Article has argued that a rich philosophy of harm reduction that most powerfully justifies the practice of harm

140. Emily Laurence, *Your Guide to Cannabis Legalization by State*, FORBES (Jan. 19, 2023, 12:44 PM), https://www.forbes.com/health/body/cannabis-legalization-by-state/.

141. Ted Van Green, *Americans Overwhelmingly Say Marijuana Should Be Legal for Medical or Recreational Use*, PEW RSCH. CTR. (Nov. 22, 2022), https://www.pewresearch.org/fact-tank/2022/11/22/americans-overwhelmingly-say-marijuana-should-be-legal-for-medical-or-recreational-use/.

142. MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS 112 (New Press 10th Anniversary ed. 2020).

143. NAT'L HARM REDUCTION COAL., *supra* note 38.

reduction cannot see value neutrality as an optional component: value neutrality is essential to a philosophy that explains the permissibility (and goodness!) of harm reduction interventions. When society really embraces the idea that drugs are not inherently bad, and that drug use is just a choice based in subjective valuation like any other, then we cannot help but recognize seemingly-radical interventions, like safe consumption spaces, as forces of powerful good, promoting health and reducing harm with no moral downside.

VI. CONCLUSION

There is a yet more radical definition of the philosophy of harm reduction than those considered here. According to some in the movement, harm reduction is not simply a practice, and it goes beyond even compassion or the recognition of dignity. Harm reduction is *care*; or, more powerfully, harm reduction is *love*. The goal of practicing harm reduction is not simply to hand out clean syringes or naloxone, but to actually care about and for people who use drugs. If someone is in the midst of chaotic drug use and living on the street, many of their interactions with others may involve law enforcement, judgment, and stigma. Adopting the philosophy of harm reduction instructs one to not only help such a person, but to treat them like anyone else, relate to them with mutual concern, regardless of the choices they make or the way they live their lives.

This model makes clear that the role of harm reduction in people's lives can go far deeper than simply reducing the risk of disease and death. A syringe exchange worker could pass out sterile injection kits without warmth, and while clearly judging those who come to use the service. This would still amount to a practice of harm reduction (getting sterile syringes into the community), but it would not be an embrace of a rich philosophy of harm reduction. And while one could show care and love to people who use drugs without embracing value neutrality, the recognition that drug use is not wrong can be part of what justifies this much richer way of engaging in harm reduction practices. Meeting people where they are and acting non-judgmentally can be done while maintaining the personal, moral belief that the people you are serving are engaging in bad behavior; but it comes much more naturally (and authentically) if you recognize that their choices are genuinely not bad. Harm reduction does not require us to "love the sinner"; it requires us to recognize that people who use drugs are not (by that action) sinners in the first place.

This Article began by showing how incredibly bad the U.S. has been at reducing preventable harms in the midst of a catastrophic drug overdose epidemic.[144] The future of health care, if we are to turn the tide against this

144. DRUG POL'Y ALL., OPIOID OVERDOSE: ADDRESSING THE GROWING PROBLEM OF PREVENTABLE DEATHS 1 (2015), https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Opioid_Overdose-Addressing_a_National_Problem_June2015.pdf.

tragedy, must be harm reductionist. But, in a polarized society of people holding very different implicit moral philosophies, making progress toward this goal requires reasoning with people about our deepest normative beliefs concerning drugs, and the people who use them. This means that the practice of harm reduction does not float free from a deeper philosophy of harm reduction—commitments to value neutrality, and the connection to judgment and attitudes are not incidental or optional components of harm reduction. Although those with forward-looking implicit moral philosophies believe that harm reduction interventions are right simply due to the fact that they prevent harm, many others hold the implicit view that only some ways of preventing or reducing harms are morally right. The value neutrality of drug use explains why even these people should endorse harm reduction in the drug policy space.