

Episode: *Author Interview: “What Would Equitable Harm Reduction Look Like?”*

Guest: Oluwole Jegede, MD, MPH

Host: Tim Hoff

Transcript: Cheryl Green

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[bright theme music]

[00:00:03] TIM HOFF: Welcome to another episode of the Author Interview series from the *American Medical Association Journal of Ethics*. I’m your host, Tim Hoff. This series provides an alternative way to access the interesting and important work being done by Journal contributors each month. Joining me on this episode is Dr Oluwole Jegede, an assistant professor of psychiatry at the Yale School of Medicine in New Haven, Connecticut, with a joint clinical appointment as a community addiction psychiatrist and the director of the Medication for Addiction Treatment Clinic at the Connecticut Mental Health Center. He’s here to discuss his article, coauthored with Drs Julio C. Nunes, Terence Tumenta, Carmen Black, and Joao P. DeAquino, “*What Would Equitable Harm Reduction Look Like?*,” in the July 2024 issue of the Journal, [Harm Reduction and Opioid Use Disorder](#). Dr Jegede, thank you so much for being on the podcast. [music fades]

DR OLUWOLE JEGEDE: Thank you for having me, Tim. Great to be here.

[00:00:58] HOFF: So, what’s the main ethics point that you and your co-authors are making in your article?

JEGEDE: Thank you for that great question. In this article, our core of the article is on equity, which, as you know, is a very important and core ethical issue in medicine. The absence of equity makes our health care system outcomes subpar. It means health care system basically has a two- or multi-tier system working for some and not others. In this article, we made a case that harm reduction programming must be grounded in social justice—which it is, in fact, its foundation—and must center social determinants of health. And social determinants of health, to put that in perspective, conditions where people with substance use disorders are born, live, learn, work, play, worship, and age. So, our first ethical point of this article was equity.

Another one is that harm reduction programming cannot function optimally in race-neutral frameworks. By this, what we’re trying to say is we must always consider racism and the many forms and formats of it in designing harm reduction programs. In this article, we also highlighted racial inequities in the treatments of substance use disorders. We made a point for buprenorphine, which is not often prescribed to racially minoritized people for a variety of reasons. And also, the disparity and the inequities that we now see in the distribution of naloxone. Naloxone is the opioid antagonist and the antidote for opioid overdose. Finally, we made an ethical point in the measurement

of social determinants of health, which must be consistent, equitable, reproducible, and sustainable.

[00:03:06] HOFF: And so, what do you see as the most important thing for health professions students and trainees specifically to take from your article?

JEGEDE: One of the many things we think trainees should take from our article is really the difference between inequity and inequality. This is very important because it goes into how we communicate, with research, how policy is made. That difference is very important also clinically. Any difference in outcomes between minoritized and non-minoritized groups in general is referred to as inequality, regardless of the difference. But when we go to the granular level, which is where we really want to be, is when this difference is due to avoidable, unjust policies or practices, it is more accurate for us to refer to those as inequities and not just inequality.

Also would have trainees understand that the biological causation of disease is only half of the equation. Many chronic diseases, including substance use disorders, indeed have a social causation. And we want our trainees to always think about a pre-existing structural context when they conceptualize and formulate disease.

[00:04:36] HOFF: And finally, if you could add a point to your article that you didn't have the time or space to fully explore, what would that be?

JEGEDE: That's quite an interesting point. I think if we had more space, we will expand more on systemic and structural racism. The impact it has had on health care, which almost feels like it's health care system is almost intentionally designed to get the outcomes that we have. In other words, we have to think about social intention in the design of our systems. Think about the stigma of people who use drugs and the prevalent moral framework of our institutions. If for any one chronic disease that kills over 100,000 people per year, as we have found drug-related mortality in the wake of the COVID-19 pandemic since 2000, 2001, killing almost 100,000 people every year, it would be an outrage. But because of the way our system has been set up structurally with racism and the structural inequities and the fact that we have almost a moral failure framework within our institutions, our society looks the other way because it's people with substance use disorders. So if we had more time and more space in our article, we would expand more on systemic racism, structural racism, and just the way that the inequities that is inherent from the way our health care system is set up. [theme music returns]

[00:06:17] HOFF: Dr Jegede, thank you so much for your time on the podcast, and thanks to you and your co-authors for your contribution to the Journal this month.

JEGEDE: Thank you, Tim.

HOFF: To read the full article, as well as the rest of this month's issue for free, visit our site, journalofethics.org. We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics*.