

Research statement

My research rests at the intersections of bioethics, philosophy of disability, social epistemology, and public health research. I am primarily interested in the ways our concepts, theories, policies, and measurements in healthcare—in short, our ways of knowing—can impact our ability to ask better questions and make better decisions.

My dissertation identified ways that marginalized communities can be silenced and excluded in bioethics and healthcare, and which can impact the quality of healthcare they receive. For example, ignoring or discounting women’s pain reports is a form of silencing that can often delay endometriosis diagnoses, an issue compounded for transgender patients who are not considered legible or eligible for a “woman’s” disorder. I identified sources of silencing and exclusion that are themselves often overlooked in bioethics—including silencing by epistemic injustices, policy, research design, and even physically inaccessible hospitals and cities.

My current research moves from *identifying* sources of silencing and exclusion to strategies for *addressing* them. To this end, I am currently developing two main projects. The first addresses issues with evidence in **suicide bioethics**, and the second addresses issues in **public health architecture**. These projects build on testimony from suicidal communities and disabled communities to raise challenges to existing norms in bioethics.

1. Suicide bioethics.

Bioethics has paid relatively little attention to suicide in recent decades, except perhaps when discussing medical assistance in dying (MAID). Many suicide issues are considered straightforwardly settled, with general agreement that we should support suicide prevention strategies. However, recent changes in medicine, technology, and research strategies raise important ethical and epistemological challenges, and emerging scholarship in critical suicidology, queer studies, and disability studies have put new pressure on existing suicide norms. Adding to these conversations, I will explore how the ways we conceptualize and research suicide can obscure the harms and limitations of existing suicide strategies. I argue that the experiences and testimonies of suicidal communities reveal important problems with the ways we approach suicide prevention. I currently have outlines for three papers.

- (1) **“Are suicide prevention nets and barriers successful? Examining the data” (In progress)**. The Golden Gate Bridge is currently being fitted with a “Suicide Deterrent Net” that aims to prevent deaths from jumps and falls. Similar nets and barriers have been constructed around the world, and available data suggests that they do reduce suicide deaths. I argue that this data is not enough to show these interventions are “successful,” except on a very limited view of suicide prevention. Even if we take for granted the available data, a reduction in suicide *deaths* does not entail a reduction in suicide *attempts*, nor does it address the *underlying causes* of suicide. To say whether these barriers are successful more broadly, we need to examine data on injury and hospitalization, and not merely death rates. But this data is often unavailable, absent from existing research on bridge barriers, and will ultimately require setting up new

health reporting mechanisms. I argue that the Golden Gate Bridge project offers an important opportunity to correct these gaps.

(2) “Sodium nitrite restrictions: Neglected arguments from suicide communities”

(Planned). In response to increases in suicide deaths by sodium nitrite (SN), many organizations have called for increased restrictions on SN sales. This paper raises neglected counterarguments against SN restriction by drawing from online suicide support communities. Suicide community narratives suggest that restricting SN may not necessarily lead to reductions in the *quantity* of suicide deaths, but rather a reduction in *quality* of suicide deaths. Importantly, these arguments suggest that SN restriction may frustrate, rather than advance, broader goals in suicide prevention.

(3) “Reconceptualizing suicide: not an intentional, self-caused death” **(Planned).**

Philosophers, sociologists, and medical professionals have argued against understanding suicide primarily as an intentional, self-caused death, because it is very difficult to (a) determine people’s actual *intentions*, and to (b) determine what counts as a relevant *cause*. I argue that we should also interrogate whether suicide should be considered a type of *death*. For example, many medical determinations of suicide are subject to circumstantial luck: someone who attempts to die by suicide may survive that attempt just because an ambulance happened to drive by to administer care; someone else may die in a similar case just because no ambulance was nearby. And as the previous projects argue, measuring prevention in terms of reductions in fatalities can obscure important nonfatal outcomes. These observations put pressure on whether and how death is essential to our practical inquiries into suicide, and to our concepts of suicide. Drawing from work in sociology and critical suicidology, I argue toward a broader conceptualization suicide for research purposes, and demonstrate how this impacts existing public health research and policies.

2. Disability and public health architecture.

An increasingly popular approach to public health is to focus on the “active design” or “healthy design” of cities and buildings. A common goal of this research is to shape the material environment in ways that nudge people toward desired, healthier behaviours. However, much of this research excludes disabled people, despite disabled people making up an increasingly large part of the population. For example, a lot of healthy design research focuses on increasing stair use, reducing public benches or replacing them with leaning bars, or rerouting public transportation to create pedestrian-only zones. Meanwhile, most health geography and urban planning research measures health outcomes in terms of “walkability” and “accessibility” scores, but rarely considers physical accessibility of the routes they measure. As a result, many of these projects focus on public health only for a very particular subset of the public.

I will draw from architecture and disability design to show how public health architecture projects exclude disabled communities. While some philosophers of disability and bioethicists have focused on disability exclusions in healthcare generally, they primarily focus on public policies, epistemic vices, and stigmatized care. But even if we wrote new policies,

addressed our biases, and developed better disability-centric care, none of this by itself will tear down a wall or build a ramp. Attending to disability and public health architecture calls for different kinds of interventions than addressed to date. I am currently planning three papers.

- (1) **“Accessible cities could have mitigated COVID-19”** (Planned). This paper argues that disabled expertise and accessible design can support public health, focusing on the recent COVID-19 pandemic. Consider two illustrations. Many city sidewalks are too narrow for wheelchair users and people who use sign language, and do not meet accessibility laws and guidelines. Implementing these guidelines would have made social distancing easier and safer during COVID-19, where many pedestrians ended up walking in roads and gutters. Meanwhile, better use of automated entrances would reduce viral spread through high-contact surfaces. Drawing from public health data, disability design, and disability history, I will argue that accessible cities are important to public health, and that public health ethics thus provides further support for stricter accessibility legislation.
- (2) **“Disability exclusions in healthy design research: A critical literature review”** (Planned). To date, there is no systematic literature review on disability in healthy design research. By conducting a critical literature review, I aim to (a) demonstrate the scope of disability exclusions, (b) outline the possible consequences of these exclusions, both for disabled communities and for external research validity, and to (c) recommend concrete strategies for more inclusive public health research and planning.
- (3) **“Material epistemic exclusions in healthcare access”** (Planned). I argue that epistemic oppression can become “cemented” in buildings and objects through design practices—a vicious version of what Aimi Hamraie calls knowing-making or material-epistemic practices. Importantly, I argue that these material sources of epistemic exclusion can be resilient to change: virtuous listening habits will not turn a staircase into a ramp. This paper will map material epistemic exclusions in public health architecture, and argue that these exclusions impact not only health outcomes but also epistemic justice in healthcare.

In addition to these two primary projects, I have continued interests in queering and disabling bioethics and philosophy. I am workshopping projects on neurodiverse approaches active noise reduction technologies, on uses of disabled testimonies in MAID argumentation, on queer representations of grief and mourning in fiction, on the rhetorics of forgiveness interventions in psychology, and on disability epistemology in horror cinema. Outside of these focuses, I have begun collaborating with Tim Mt. Pleasant on MAID’s impacts on the Six Nations First Nation. Each of these projects seeks to identify processes of exclusion and omission in dominant knowing practices, and how these processes and practices can be mitigated by engaging with existing marginalized narratives, archives, and knowledges.