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Editor's Forum

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The papers presented in this issue of *Health Ethics Today* reflect a range of ethical issues and approaches. While some papers are more argumentative, others are more reflective. Some turn to health law, others turn to empirical literature, and still others to philosophy and literature. What unifies them is that none present a solitary perspective. Instead, the authors reflect in a nuanced manner on these contemporary issues.

Our first paper by Jared Bly discusses the ethics of disaster triage, orienting us to the nature of disasters where resource allocation frameworks are needed. Here, he introduces utilitarianism, and then goes further to show that while utilitarianism provides a grounding for disaster medicine, it is insufficient to guide the ethical conduct of health care providers. Compassion, caring, and other qualities are ultimately still needed.

Next, we have a paper by Nikita-Kiran Singh which unfolds the ethics of cross-cultural communication. She offers the reader a multifold way to think about culture, including how othering of cultures may perpetuate dominant perspectives, risking discrimination. Thinking about cross-cultural communication should occur at the bedside and at institutional levels to ensure care is fair and equitable.

Our third paper is by C. Dalrymple-Fraser. They address the topic of suicide prevention, specifically "means restriction efforts" that prevent individuals from accessing lethal means to die by suicide. Here, they discuss limitations affecting the study of suicide, including the failure of researchers to account for disabling nonfatal outcomes, which are of moral and practical relevance to individuals and society.

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Lisa Spiegel, in our next paper, reviews health law pertaining to social media and health professionals. She shows how, despite differences in statutory frameworks, the protection of the public remains a core principle reflected in case law. This principle extends not only to health providers who spread misinformation, but also to those whose conduct may undermine public confidence in the health professions. This does not mean that health professionals lack rights, but rather that their rights are subject to reasonable limits connected to their professional status.



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Finally, we have a paper by Malene Beck reflecting on the ethics of hospital environments. She shows how a place is not simply a location, but rather a place which may or may not carry the possibility for dwelling. Here, dwelling has existential significance as a possibility for finding oneself situated somewhere “to be” while receiving care. What a hospital place may need to accommodate may differ for a child compared to an adult. And it may differ among children and among adults. And, it may vary by medical condition, acuity, illness trajectory, family support, culture, or all manner of other aspects. So, in a way, perhaps when we design hospital spaces, we need to support a degree of flexibility whereby the hospital becomes a place that accommodates a patient “to be” where they need to be. These are critical considerations that must not be forgotten as hospitals simply struggle to find spaces for patient care.

I hope you enjoy reading this issue of Health Ethics Today, as a source for reflection and perhaps guidance.

Ethics for Disaster Triage

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You are on your way home, after finishing your hospital shift, when you hear a loud explosion from across the street. Smoke billows out from the building, and rubble litters the sidewalk. There is crying, yelling, and screaming. It is a horrible scene; many have been injured. You see four people near the building’s entrance who need help. How do you decide who to help? Who is given priority? What actions do you take?

Most health providers will fortunately never have to experience navigating the ethics of a disaster. Instead, their experiences will be limited to simulations and/or the reading of protocols. And yet, we should

appreciate the philosophical thought that guides such decision-making, particularly as our healthcare system experiences crises and resource constraints. Many disaster triage protocols exist (JUMP, JUMPSTART, SALT, Careflight, MASS, etc.) (Baziar et al., 2019). Overwhelmingly, these protocols cite utilitarianism as the underlying ethical framework. “Greatest good for the greatest number” is the common refrain, urging us along a utilitarian path (Moskop & Iserson, 2007, p. 284). In this paper, I will trace utilitarianism from its roots to show how while it is useful, it ultimately is insufficient as a sole guide for ethical practice in disaster situations.

Utilitarianism at its Roots

Utilitarianism is a form of consequentialism, a moral theory whereby the rightness or wrongness of an act is determined by its consequences. There are many different forms and variations of utilitarianism, but at its root, it understands society as a cooperative venture whereby overall happiness or well-being is what matters most.

Some specific principles supporting this goal are:

1. Consequentialist. Only the results of actions matter (rather than intent, tradition, rules, perceived benefit, etc.).
2. Hedonistic. Not in the modern application, as in debauchery, but this refers to pleasure minus pain as the composite endpoint of interest. Modern versions expand this to happiness or well-being.
3. Egalitarian. All people matter in and of themselves, each as a sentient being counting for one and only one, regardless of race, occupation, status, gender, etc.
4. Aggregational. The sum of happiness (or survival, health, or whatever outcome is used) can be derived.

Using these principles as a foundation, many disaster medicine resources cite utilitarianism as the underlying framework guiding disaster triage. Triage applies when a scarcity of resources exists. And the scarcity is even more apparent in a large-scale disaster than in the routine crises of emergency medical care, where triage was born. Therefore, “distribution of resources is undertaken to achieve one of the main concepts of triage — to do the greatest good for the greatest number” (Ranse & Zeitz, 2010, p. 60). Utilitarianism thus reduces complex ethical decisions to calculations of well-being for every individual, summed up for the population. That seems reasonable, even necessary. But is this accurate in theory and practice?

The typical thought experiment used to demonstrate or challenge utilitarian thinking is the trolley problem (Andrade, 2019). In this scenario, there is a trolley

speeding towards five people tied to the tracks. You are at a lever which, if pulled, will divert the trolley to another track where one person is tied up. All kinds of conditions are imposed (you have no time to call for help, you have no other choices available to you, the trolley cannot stop, etc.) such that there is one and only one possible decision—pull the lever or not. And you cannot claim innocence by inaction; consequentialists will insist that allowing something to happen confers the same moral culpability as acting



Problems with Utilitarianism

What initially seemed quite acceptable, doing the most good for the most people, now feels very uncomfortable. Killing one person to save five? A similar thought experiment proposes that a physician has five patients in good health except that each has a different failing organ. A sixth patient has all these organs in perfect condition, available for transplantation. Of course, harvesting all these organs from one patient would lead to this individual's death. Utilitarianism might suggest that sacrificing the sixth to save five others is acceptable, even obligatory. Few find this satisfactory or remotely acceptable.

The problem with such scenarios is that they are not real. Elizabeth Anscombe (2020), friend and classmate of Philippa Foot, who gave us the trolley problem, suggests that you cannot compare the moral quality of reality with nonexistent hypothetical alternatives. Anscombe, Williams (Chappell & Smyth, 2006), and others criticize consequentialism for relying on imaginary situations and future outcomes in order to determine right actions in real situations in real time.

So it may be argued that thinking along such lines misplaces responsibility, offers false certainty, sets up false dilemmas, and ignores other important issues.

Falsely binary, and falsely certain. You can pull the lever or not. Five people die, or one person dies. There is no one to help, no other options. Oh, except a fat man. This is the other main variation. The philosophers will allow you to be on a bridge, and only one track below with people tied to it. Beside you on the bridge is a fat man large enough to stop the trolley if you push him over. The dilemma is outlined with all the caveats—if you decide to push him, you will succeed; if he falls, he will die; he will certainly land on the track, and in dying, will stop the trolley, thus saving the five who are tied to the tracks. What is set up as a purely binary decision, in my mind, leaves so many questions. Ethical dilemmas, in actuality, are similarly loaded with questions, approaches, and possibilities.



Thinking in this way misplaces responsibility. Who put me solely in charge of operating complicated and dangerous public transit? Never mind who tied these people to the tracks! Lindsay Thomas has written extensively on disaster preparedness, criticizing the common substitution of response for responsibility. A plan to move to high ground when the flood hits our flood-prone neighborhood is a plan to respond, not preparedness. A plan to roll out vaccines when the next pandemic is in full force is a plan to respond, not prevent. "Preparedness, document after document implies, is just about disaster response, not prevention, not quality of life, not social welfare, not justice" (Thomas, 2021, p. 18)

Responsibility is not equally felt. Other criticisms of utilitarianism are extensions of what may initially seem attractive with this approach. Equality rings true to most of us. But what if your own children are involved? Utilitarianism says that your children are as valuable, and no more, than a stranger's children. We may accept equality of worth, but there are undeniable aspects of human psychology that motivate us to favour our own offspring (most days). And some undeniable advantages. It is a *Brave New World* (that is not so appealing) where parents have no attachment to their children (Huxley, 1932).

Consequences. Utilitarianism says that what matters is the final result. But consequences are not always in our control. Consider a typical medical interaction, a patient diagnosed with pneumonia, for example. Treatment decisions (which antibiotic, hospital admission decisions, adjunctive therapies, etc.) proceed along guidelines and standards of care. Is a bad outcome possible? Of course. And we expect, and hope, that the practitioner would be judged by their actions, their adherence to accepted and expected practice, rather than the actual outcome.

Hedonism. Even if we substitute a more currently acceptable word—well-being, for instance—it is difficult to measure values of and in lives. Initial versions of utilitarianism didn't account for relationships, beauty, and knowledge. Attempts have been made to capture these important concepts and still retain a utilitarian approach. The difficulty is including all values, making all values equal for all people, and making values comparable and calculable. How do we compare and calculate beauty with pain, resilience with uncertainty, knowledge with cardiac output? Can you conceivably identify, compare, and calculate all that gives life value?

Emotions. Authoritative sources suggest that emotions can interfere with our rational judgement: "...emotional responses...can interfere with the effective triage of children..." (Ranse & Zeitz, 2010, p. 69). This sounds logical, but also cold. And, actually, inappropriate in ignoring the moral and cognitive importance of emotions in crisis

Hume, no less, considered emotion to be a key to morality. Morality is not strictly a matter of external facts; also important are internal motivations, including emotions. Not only morality, but decision-making, is facilitated by our emotions. Gardiner (2003) suggests that it's unwise

...to strip this process of affect or attitude and focus on reason alone. Humans are sophisticated creatures with an ability to reason that is tempered by our emotional reactions. These reactions are an integral part of how we perceive and assess the world around us. (p. 297)

Emotions are also an important consideration in mental health. To ignore emotions in making a difficult decision sets the stage for moral injury (Norman & Maguen, n.d.). This overlaps with the importance of rights. In these discussions, rights usually only refer to the rights of patients. These are not to be ignored, of course. But they are, if we are strictly utilitarian, Utilitarianism risks ruling by the 'tyranny of the majority', whereby individual rights, relationships, and other values are sacrificed to the public interest (see Puyol (2025) for further criticism of utilitarianism in public health). And increasingly, authors are advocating the need to recognize the rights of health care providers, suggesting that health care workers have a right to emotional safety. Emotional trauma comes with difficult situations, but external factors, such as institutional constraints may conflict with deeply held values (Čartolovni, et al., 2021; Keric, et al., 2026). This suggests that emotional safety needs to be built into disaster planning and preparation, and is compromised when difficult decisions are left until the response is needed.

Alternatives

Modern medical ethics is based on principles that blend duties and virtues. Beneficence, nonmaleficence, respect for autonomy, and justice are foundational to modern medical ethics (Varkey, 2021). Are we less committed to these principles in a crisis? Beneficence, some suggest, changes from do the best for the patient to population-level considerations. Nonmaleficence is difficult to

maintain if it is suggested that it may sometimes be right to withdraw medical interventions afforded to one patient in order to prioritize another with greater survivability. Autonomy, too, is not upheld when individual choice is sacrificed to utilitarian goals. And justice, by utilitarian standards, could only be justified on a population level. Equal distribution of resources to all may be forgotten in the diversion of scarce resources to a few by the principle of the 'greater good'. Interestingly, John Stuart Mill holds autonomy to be supreme. This key architect of utilitarian theory would not approve of allowing one to come to harm for the benefit of others. Preventing harm to others would be the only possibly acceptable reason to overlook respecting an individual's autonomy.

So, it would seem, despite the dogma, utilitarianism is not widely accepted in practice of disaster response (O'Sullivan et al., 2022). It may be more accurate, and I would argue that it is clearly more efficacious, responsible, and ethical to maintain ethical values especially in difficult circumstances. As Koenig (2012) suggests, care does not change in extreme situations, though the application might. And some suggest that the fundamental values hold even more sway in difficult dilemmas. The duty to help others in need, for example, may be the primary purpose of health care in a disaster response (Kalokairinou, 2018).



Virtue Ethics

Responding to suffering. Part of disaster management is about avoiding suffering, but once we get to disaster triage, we are past prevention and preparation, and into response. And disaster

response, like philosophy, is not about “how to avoid suffering but how to relate to it” (Löfquist, 2017, p. 207).

Flexibility. One of the problems with disaster planning is that you cannot plan for everything. Disasters by definition call for resources beyond what is available, and thus for plans that are not in place. Where utilitarianism focuses on the outcome of an event (it is agent-neutral), virtue ethics is all about the agent. The variety of specific disaster events one would have to prepare for is incalculable. Preparing oneself by encouraging virtuous responses to whatever situation, is more conceivable.

Virtue ethics recognizes that all endings will not be tidy, and leaves room for humanity even in the aftermath of the worst trolley incident you can imagine. “Virtue ethicists recognize that tragic dilemmas can rarely be resolved to the complete satisfaction of all parties and that any conclusion is likely to leave some remainder of pain and regret” (Gardiner, 2003, p. 301). It is not reasonable to expect the perfect answer where there will be no loss. The calculation that leaves no room for pain will be missing inevitable input. Responding and relating to the pain are necessary.



Concluding Thoughts

While utilitarianism is appropriate moral grounding for disaster planning and prevention, it alone is insufficient and benefits from the inclusion of other philosophical grounding. We should also appreciate that a utilitarian approach to disaster management would recognize ethical obligations to invest in disaster prevention and mitigation, as these are much more efficient than investment in response.

And the effect per dollar spent in prevention, is, proportionately larger (\$7 to \$13 larger) than the effect of a dollar in response (US Chamber of Commerce, 2024). Unfortunately, it is politically unattractive to spend public funds on events that have not yet occurred (Etkin, 2014, p. 282). Naomi Zack (2009) corrects the typical utilitarian catchphrase “save all you can...” to “save all who can be saved with adequate preparation” (p. 55). This suggests population-level approaches in preparation. Response, including disaster triage, must still be guided by a commitment to duties, rights, and virtues.

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Cross-Cultural Communication During Critical Illness: A Matter of Bioethical Relevance

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In an increasingly diverse and globalized world, healthcare communication frequently occurs between clinicians and patients with different cultural backgrounds. This phenomenon, known as cross-cultural communication, implies differing ethical and social norms exist between cultures, which can present ethical quandaries and impact medical decision-making (Chattopadhyay & De Vries, 2013). In this article, I argue that cross-cultural communication is a matter of bioethical relevance as it underscores barriers to care that threaten health equity and justice. I also present strategies for mitigating these risks and fostering cultural safety, including in the critical care environment.

What is Culture?

Culture refers to shared beliefs, values, and practices of a particular social group (Hruschka & Hadley, 2008). The scope of culture is multifold, ranging from healthcare teams (e.g., the culture of a particular medical unit) to broader social groups (e.g., culture based on shared language and/or regional identity). While cultural considerations are ubiquitous in healthcare, ranging from an individual patient’s cultural traditions to workplace culture, they are often only made salient to in the context of conflict or differences. This tendency to think of culture primarily in relation to others rather than in reference

to one's own culture can perpetuate the othering of minority groups and reinforce dominant perspectives as the "default" or "standard" (Chattopadhyay & De Vries, 2013). So, culture shapes the experiences of all healthcare team members and patients, not solely the ones with backgrounds different from the dominant culture.

Of note, while culture frequently intersects with other axes of identity, not all terms are interchangeable. For example, culture refers to shared beliefs and practices while race is primarily a social construct, in part based on shared physical attributes (Ioannidis et al., 2021). In comparison, cultural discrimination involves injustices targeting individuals or groups based on their cultural identity such as traditions. Racism involves the systemic subjugation of social groups based on race, ranging from individual biases to structural disadvantage (Williams et al., 2019). Conversations of culture discrimination often overlap with racism because social groups with shared race also often share culture; therefore, it is important to consider how the historical and ongoing experiences of a social group may impact their interactions within the healthcare system. In Canada, this phenomenon is of particular importance for Indigenous patients, whose experiences surviving attempts at genocide include both racism and attempts to erase culture (Matthews, 2019).

Culture and Critical Illness

There is a growing recognition of how death has become increasingly medicalized over the last century, shifting from a primarily spiritual to medical event (Hannig, 2024). The advent of intensive care interventions has led to life-sustaining therapies that can prolong life, shaping cultural expectations around what is possible. During critical illness and periods of heightened acuity, conversations about goals of care often need to unfold quickly depending on the patient's severity of illness. This communication can significantly impact trust among patients and families, especially those with a history of marginalization. Acknowledging cultural context, by asking patients and families about their cultural values and grounding goals of care conversations in these values,

can foster trust-building, particularly when time is of the essence.

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Why is Cross-Cultural Communication a Bioethical Matter?

Cross-cultural communication often highlights underlying forms of structural disadvantage (e.g., racism, migration status, and language discordance) that are known to impact health outcomes. Canadian literature confirms that Indigenous patients are at higher risk for many health issues, including increased infectious disease burden, substance use disorders in the context of trauma, and decreased life expectancy (Gracey & King, 2007). In comparison, immigrants are more likely to die with higher intensity of care at end-of-life and less likely to access palliative care resources (Dookie & Martin, 2025; Yarnell et al., 2017). Patients experiencing language discordance, meaning their preferred language differs from their clinicians' language, are at higher risk for adverse events, including restraint use, reported delirium, and miscommunication around medical decision-making (Gershengorn et al., 2023; Seo et al., 2025). Collectively, these examples highlight how cross-cultural contexts can coincide with structural barriers to care. Even in cases where cross-cultural communication does not underscore structural disadvantage, variations in cultural context can impact the dialogue and understanding between clinicians, patients, and families. Examples include differing expectations around disclosure of illness,

varying familial approaches to medical decision-making, and perceptions of an unfamiliar system that can impact trust-building.



Ultimately, differential health outcomes arising from barriers to care perpetuate health inequities, which in turn compromise justice. While there are different conceptions of justice, when conceived of as the “fair, equitable, and appropriate treatment in light of what is due or owed to affected individuals and groups” (pp. 267-268), it is important to consider what precisely is owed to patients and families experiencing cross-cultural communication (Beauchamp & Childress, 2019). The concept of “the right to narrate” highlights how language, race, and migration status can perpetuate inequities in communication (Rawal, 2022, pp. 2849-2850). For example, as a consequence of English colonization, English is considered the default language in many parts of the world; therefore, language discordance is not simply a technical problem, but rather, a reflection of dominant culture. The right to narrate refers to empowering communication among patients whose linguistic needs differ from the dominant culture by dismantling the barriers that may impede communication rather than viewing language discordance as an individual failing. To address these inequities requires utilizing resources to explicitly address these challenges (e.g., interpretation services using patients’ preferred languages, cultural navigators if accessible) and fostering cultural safety.

What is Cultural Safety?

Cultural safety refers to healthcare interactions in which the “patient feels respected and empowered, and that their culture has been acknowledged” (Donovon et al., 2008). The term cultural competence has fallen out of favor, given it is simply not possible to gain full competence in patients’ cultural beliefs and values (Salhi et al., 2020). Instead, cultural humility acknowledges that the ongoing process of self-reflection to mitigate power inequities is crucial. To create and sustain cultural safety requires eliciting and centering the patient’s values, acknowledging relevant histories that may have led to medical mistrust, and demonstrating an earnest commitment to addressing these challenges through action. It is important to consider that even if historical context feels far removed from an individual clinical encounter, from the patient’s perspective, the clinical environment can be inextricably tied to past injustices or traumatic experiences.



Narrative Ethics for Cross-Cultural Communication

Narrative ethics refers to the idea that the morally salient features of an ethical situation arise in understanding the patient’s story and its components (e.g., voice, characters, plot, Montello, 2014). In contrast to principlism, which starts with basic universal principles to guide ethical decision-making,

narrative ethics places greater importance on the priority of the particular. Utilizing case-specific context to understand the ethical issues at hand allows for grounding the patient's medical decision-making in their unique personal history and values, while simultaneously avoiding the pitfall of stereotyping. Well-intended clinicians may inadvertently perpetuate stereotypes by assuming people of a particular culture share the same preferences or values. Utilizing a narrative framework allows for centering the patient's individual nuances within the context of their cultural beliefs and values.



What can we do next?

As it relates to end-of-life conversations, interviews with Black patients who've experienced critical illness have highlighted that recommendations to de-escalate care can be perceived as an extension of unjust institutions (Brown et al., 2023). Furthermore, patients were more likely to trust physicians recommending a procedure over those who did not. For critically ill patients experiencing cross-cultural communication, these findings highlight the importance of prioritizing trust-building first before

advancing goals of care conversations to discontinue medical interventions. Furthermore, framing changes in goals of care as introducing interventions to address the patient's medical needs rather than using language about "withdrawing care" can impact how medical recommendations are received. While time constraints are very real in critical care, this initial point of contact can powerfully shape future conversations. Otherwise, proposed de-escalations in intensity of care can be perceived as a perpetuation of ongoing injustices. Healthcare professionals have a responsibility to interrogate themselves to understand how medical decisions and recommendations can be affected by unconscious biases. Framing conversations in a strengths-based way (e.g., highlighting the role of a patient's community) can also help foster dialogue when compared with a deficits-based approach.

Furthermore, the social history of consultations is a prime opportunity to incorporate cultural considerations for patients' care. Rather than solely asking about cultural considerations for patients whose backgrounds differ from our own, consistently asking about these considerations for all patients provides an opportunity to provide value-concordant care without inadvertently stereotyping. In addition to providing patients and their families an opportunity to express culturally meaningful values, these conversations can also help healthcare professionals shape medical recommendations with a stronger understanding of the patient as a person. A deeper exploration of these considerations can also foster improved and quicker access to culturally relevant resources.

Conclusion

While cross-cultural communication may be associated with barriers to care, it also presents powerful opportunities to create resonance with patients and families, particularly during the stressful time of critical illness. Utilizing strategies for trust-building, fostering cultural safety, and existing resources for cultural care can enhance communication between clinicians and patients, ultimately leading to decision-making that is concordant with patients' values. These strategies are crucial in addressing the underlying health inequities

that cross-cultural communication can highlight, thereby advancing a collective effort towards health justice.

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Behind the *Veil*: Disabling Nonfatal Outcomes for Suicide Bridge Barriers

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Near where I live there's a viaduct
Where people jump when they're out of luck
Raining down on the cars and trucks below
They've put a net there to catch their fall
Like it'll stop anyone at all
What they don't know is when nature calls, you go
—Barenaked Ladies (2003) “War on Drugs”

Introduction: The *Luminous Veil*

In 2003, Toronto completed initial construction on the *Luminous Veil*. The multimillion-dollar project consists of thousands of LED-illuminated stainless-steel rods installed along the Bloor Viaduct. While now a recognizable part of the cityscape, the *Veil* was developed as a public health measure. Prior to 2003, nearly 500 people died by jumping from the 40-metre tall Viaduct, with the bridge ranking second in jumping deaths only to the Golden Gate Bridge (Sinyor et al., 2017). Following the *Veil*'s installation, Sinyor et al. reported only one death at the Viaduct across nearly two decades. This suggests the *Veil* was an effective intervention, consistent with research on other “means restriction” barriers (Okolie et al., 2020). Similar interventions have been proposed for other suicide hotspots, and aim to prevent deaths either by providing more time for suicidal intentions to pass, or by redirecting people toward less lethal means of suicide (O'Carroll et al., 1994; Shin et al., 2025; Yip et al., 2012).

This article complicates the effectiveness of bridge barriers by introducing a modified substitution challenge. If bridge barriers lead people to choose less lethal methods of attempting suicide, this may

result in substituting fatal outcomes with disabling nonfatal outcomes. These outcomes cannot be discounted by existing research on bridge barrier effects on fatality rates. This argument is primarily concerned with gaps in how we understand and research suicide, and has consequences for moral and practical arguments concerning the appropriateness of suicide interventions. Ultimately, I argue that a more comprehensive understanding of the effectiveness and appropriateness of bridge barriers requires attending to disabling nonfatal outcomes.

The Substitution Challenge

A longstanding objection to bridge barriers is that they “do not prevent suicides; substitutes would be found” (O'Carroll et al., 1994, p. 89; Glasgow, 2011; Sinyor et al., 2017). People deterred from dying at the Viaduct may simply displace their attempt to a different bridge or replace jumping with methods like hanging or self-poisoning. Indeed, at least one person reportedly drove to a nearby bridge to die after finding the *Veil* under construction (Ross, 2010). Furthermore, the comparative inaccessibility of bridges to other household suicide methods may indicate that attempts to die in these locations are less impulsive and more resilient to means restriction efforts (Glasgow, 2011). While studies of jump survivors at the Golden Gate Bridge suggest that bridge barriers would have averted their attempts entirely (Rosen, 1975), those survivors reflect a small portion of those who jump and there may be qualitative differences between those survivors and those who would attempt at the Viaduct (Glasgow, 2011; Sinyor & Levitt, 2010). Studies suggest that people prefer jumps into open water rather than onto land (Lindqvist et al., 2004), and that the Golden Gate

Bridge is selected for its cultural iconography (Rosen, 1975). The Golden Gate Bridge is also the only major bridge in the San Francisco Bay Area with pedestrian access (Glasgow, 2011). By contrast, the Bloor Viaduct spans over several lanes of highway, has limited cultural relevance, and is proximate to several other bridges with pedestrian access (Sinyor & Levitt, 2010). Accordingly, those attempting to die at the Viaduct may be differently impacted by means restriction efforts. Determining the effectiveness of the *Veil* requires we attend to this substitution challenge.

An initial study of the *Veil* found a decrease in Viaduct fatalities over a 4-year period, but a roughly commensurate increase in jumping fatalities at other bridges (Sinyor & Levitt, 2010). These findings may suggest the *Veil* resulted in mere displacement of deaths: increased mortality at other bridges may reflect people diverted from the Viaduct. However, a subsequent study found these increases to be short lived, possibly attributable to media reports on the *Veil*'s construction (Sinyor et al., 2017). Over an 11-year period, suicide deaths by jumping at bridges declined significantly, and these findings suggest that the *Veil* did not result in sustained substitution by displacement (Sinyor et al., 2017).



Replacement by other means is more difficult to assess. Viaduct suicide deaths comprise a small portion of Toronto's total suicide deaths, and many uncontrolled variables can influence suicide rates by other means over time (O'Carroll et al., 1994; Sinyor et al., 2017). Neither study of the *Veil* was able to discount impacts of other suicide prevention initiatives, socio-economic trends, or changing population demographics (Sinyor & Levitt, 2010; Sinyor et al., 2017). This makes it difficult to attribute any changes in fatality rates to the site-specific intervention with statistical significance. Nonetheless, the available data does not suggest an increase in rates by other means, and the remainder of this article will assume that the *Veil* was associated with a reduction in fatality rates despite concerns about substitution. I turn now to argue that substitution may produce other effects obscured by this emphasis on fatal outcomes.

A Modified Challenge: Disabling Nonfatal Outcomes

I argue that the primary focus on death data in bridge barrier research obscures other possible effects associated with the substitution challenge. Bridge barrier studies primarily address effectiveness in terms of declining fatality rates (e.g., Okolie et al., 2020; Sinyor & Levitt, 2010; Shin et al., 2025; Shin et al., 2026). This includes responses to substitution challenges, as indicated in the previous section. As Yip et al. (2012) offer, "from the perspective of public health and injury prevention, the choice of a method that is less lethal than are others can be advantageous if the attempt proves to be non-fatal" (p. 2393). But nonfatal outcomes are not merely reducible to the bare absence of death. Nonfatal jumps can result in chronic pain, traumatic brain injuries, compromised organ function, paralysis, and other acquired disabilities with severe impacts on day-to-day living. Substituting for less lethal means may substitute death outcomes with disabling outcomes. These possible disabling outcomes are obscured through aggregation as merely nonfatal outcomes, and raise challenges for measurement norms.

To make this point explicit, consider a morbid hypothetical. Imagine all those who would have died

at the Viaduct are displaced by the *Veil* and jump from a less lethal height. Each survives, acquiring quadriplegia and chronic neuropathic pain. This outcome is consistent with existing evidence: it reflects a net reduction in deaths at the intervention site and substitution sites. But it would be plainly inappropriate to suggest that this is a desirable intervention outcome that should be duplicated. In practice, it may be that all attempts are prevented or are nonfatally substituted with no disability consequences. The primary concern is that death data alone cannot distinguish between these scenarios, and therefore provides an incomplete picture of the intervention's effects and effectiveness. These concerns are not unique to the *Veil*. A 2020 systematic review of means restriction for jumping found that "none of the included studies reported data on change in hospital admission rates for [nonfatal] attempted suicide" (Okolie et al, 2020, p. 15). More recent studies reflect similar emphases on jumping fatality outcomes (Kim & Jeon, 2025; Shin et al., 2025).

While this argument is primarily epistemological in nature—concerning how we understand and research suicide—it also has consequences for ethical debates on suicide prevention. As Joseph Fins reminds, "good facts make for good ethics" (2021, p. 222) and incomplete facts can make for incomplete arguments about suicide prevention. My argument does not by itself entail that bridge barriers or means restriction interventions are inappropriate, net harmful, or an unjustifiable response to suicide. Rather, it suggests that arguing these points requires critical consideration of what effects are reflected in appeals to effectiveness and which effects are disvalued or obscured.



Further implications

This argument contributes to recent challenges to suicide scholarship. For example, Saartje Tack (2019) argues that suicide research uncritically assumes the desire to live is a natural and unquestionable facet of human life; death prevention is therefore considered the natural response to suicide rather than just one possible orientation toward suicide. Others note that prevention is not a culturally or historically universal norm (Marsh, 2010). These arguments suggest that emphases on death prevention warrant more explicit justification. While much more modest in scope, the present argument identifies a further limitation of framing suicide research in terms of preventing deaths and may provide further resources for alternative normative frameworks, such as harm-reduction approaches (Baril, 2023).

Alexandre Baril (2023) argues further that the default emphasis on prevention is not uniformly applied even where it is a norm. For example, disabled people are framed as deserving help in their desires to die—such as through medical assistance in dying programs, or endorsed in ableist refrains like "You're so brave; if I were you, I'd kill myself" —while non-disabled people's suicides are considered tragedies needing intervention. Studies affirm that disabled people's suicides are perceived as more acceptable than non-disabled people's (Lund et al., 2016). This may contribute to the limited research on disability and suicide (Khazem, 2018; Lund et al., 2016). The present argument motivates exploring the association between disability and suicide further. Even those who believe that disability status impacts the moral appropriateness of suicide should be concerned that prevention efforts may result in disabilities. On such an account, substitution effects might convert someone targeted for suicide prevention to a candidate for suicide support.

Lastly, people staunchly "pro-life" with respect to suicide—who believe that suicide deaths should be prevented at all costs—benefit from better understanding those costs. Another common objection is that bridge barriers are not cost-effective and funds could be better allocated to different intervention efforts (O'Carroll et al., 1994; Sinyor et

al., 2017; Whitmer & Woods, 2013). Research on cost-effectiveness of bridge barriers is limited (Okolie et al., 2020), but existing studies do not consider personal or social costs associated with disabling nonfatal outcomes such as increased healthcare utilisation, accessibility accommodations, or loss of employment (Whitmer & Woods, 2013). These analyses may overestimate cost-effectiveness and underestimate the need to integrate disability supports in intervention designs. Attending to disabling nonfatal outcomes may also enrich debates over resource allocation and distributive justice, given existing scarcities in healthcare and social supports.

Bridging the Gap

Setting aside preventionist norms in suicide research (Baril, 2023; Marsh et al., 2021; Tack, 2019), these research gaps may also reflect trends in data availability and standardization (Douglas, 1967). Fatal outcomes from public bridges are more readily identified and recorded as suicides in coronial records. Records of disabling outcomes may be decentralized across health institutions and may lack standardization. While the WHO (2014, 2016) has provided guidance on developing registries for nonfatal suicide outcomes, few such registries exist to date.

More comprehensive research will engage suicide survivor experiences, such as through co-produced research and ethnographies. Suicide research is predominantly quantitative, and there have been regular calls to better integrate suicidal perspectives to address unidentified gaps and biases in research (Baril, 2023; Douglas, 1967; Hjelmeland, 2016). However, people experiencing suicidality often deliberately mask their attempts and intentions (Baril, 2023; Costanza et al., 2026). After all, being documented as suicidal carries material risks of losing access to insurance, housing, employment, social and religious supports, quality healthcare, and freedom of movement (Baril, 2023; Marsh, 2010). Accordingly, people may decline to participate in studies or withhold meaningful information as a means of self-protection. Where such research is vital to a fuller understanding of suicide, we might side with Karl Marx's (1999) observation that addressing suicide requires nothing short of "a

total reform of the organization of our current society" (p. 50).



In addition to WHO (2014, 2016) resources on nonfatal registry development, other researchers have offered outlines for supportive harm-reduction approaches to suicide that may help mitigate structural sources of silencing in clinical practice and research (Baril, 2023). Ethnographic research from online "pro-choice" forums offers another direction when co-produced research is less viable (Marsh et al., 2021). Most minimally, we ought to attend to these gaps as possible limitations to our understandings of suicide and suicide prevention.

Conclusion

This article argued that we should attend critically to disabling nonfatal outcomes of suicide interventions. While I have focused on the *Luminous Veil* for scope, these conclusions may generalize to interventions on methods with similar accessibility and lethality. These arguments do not entail that bridge barriers are not effective or justifiable. Rather, they call attention to the effects prioritized in measures of effectiveness and to gaps in our understanding of suicide and prevention. These gaps can impede more comprehensive ethical arguments on practical responses to suicide. Attending to disabling nonfatal outcomes invites us to think more critically and creatively about our orientations toward suicide and suicide prevention research.

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Regulated Health Professionals in the Age of Social Media: Understanding the Evolving Landscape of Health Law in Canada

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Social media has fundamentally reshaped how information is created, shared, and consumed. For regulated professionals, this evolution has raised questions about professional obligations, freedom of expression, and the boundaries between personal and professional communication. Across Canada, regulators and courts have sought to address the appropriate limits of online speech for regulated professionals.

This article explores the mandates of health professional regulatory bodies, leading cases, and emerging risk-management considerations that define today's health-law landscape.

The Mandate of Health Professional Regulators

Each province has its own statutory framework governing regulated health professionals. For example, in Ontario, the *Regulated Health Professions Act 1991* establishes the overall framework for the regulation of health professionals and their regulatory Colleges, with parallel profession-specific Acts established for each profession. In Alberta, the *Health Professions Act* establishes a consolidated framework with both general and profession-specific regulations.

Despite differences in statutory frameworks, a core principle applies across Canada: the purpose of health-profession legislation is the protection of the public. The Supreme Court of Canada confirmed this principle long ago in *Pharmascience Inc. v. Binet*, 2006 SCC 48, emphasizing that regulatory bodies exist not to advocate for members but in the interests of the public.

This public interest mandate has been applied as it pertains to the conduct of regulated health professionals, including their conduct on social media (and podcasts). As social media can blur personal and professional boundaries, regulators must determine when and in what context a sufficient professional nexus justifies intervention.



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How Courts Have Responded: Key Case Law Across Canada

The following cases are examples of decisions released by the courts and tribunals across Canada from 2020 to 2025:

1. *Strom v. Saskatchewan Registered Nurses' Association*, 2020 SKCA 112

In this landmark Saskatchewan decision, a nurse criticized her grandfather's palliative care on Facebook and was subsequently disciplined by her regulatory

body for professional misconduct. The Saskatchewan Court of Appeal overturned the decision, finding that:

- The Discipline Committee failed to conduct a proper contextual analysis relating to the social media posts.
 - Her Charter right to freedom of expression was insufficiently considered.
 - There was no evidence that her comments harmed public confidence in the profession.
2. *Pitter v. College of Nurses of Ontario*, 2022 ONSC 5513 misconduct.

In this case, Ontario's Divisional Court upheld a remedial order made by a regulatory body's screening committee applicable to a nurse practitioner who posted false and misleading COVID-19 misinformation while using her professional designation. The Divisional Court held that:

- The nurse's statements spread dangerous misinformation
- The College's caution and remedial program minimally impaired her rights.
- Public protection justified the regulatory response.

The case reaffirmed that speech which results in misinformation about health issues, especially during a public-health crisis, falls squarely within the regulatory authority's jurisdiction.

3. *Peterson v. College of Psychologists of Ontario*, 2023 ONSC 4685

Jordan Peterson, a psychologist, author, and public figure with a significant social-media presence, was ordered by the College of Psychologists of Ontario to complete a social-media coaching program after considering complaints pertaining to some of his statements. Although he was no longer engaged in clinical practice, he continued to publicly identify himself as a psychologist. The Divisional Court upheld the College's decision, emphasizing that while regulated professionals retain expressive rights under the Charter, those rights are subject to reasonable

limits connected to the privileges and responsibilities of professional status. Because Peterson's statements were closely tied to his professional identity, the regulator's intervention was found to be reasonable, proportionate, and within its mandate.

4. *College of Physicians and Surgeons of Ontario v. Trozzi*, 2023 ONPSDT 22; *Trozzi v. CPSO*, 2024 ONSC 6096

Dr. Trozzi was alleged to have promoted COVID-19 misinformation online, describing the pandemic as a global conspiracy and presenting himself as a medical expert. This matter proceeded to the College's discipline tribunal, which found his behaviour disgraceful, dishonourable, or unprofessional. The tribunal revoked Dr. Trozzi's certificate of registration. The Divisional Court upheld the tribunal's decision, finding that the harm caused by such statements outweighed his right to freedom of expression.

5. *British Columbia College of Nurses and Midwives v. Hamm*, 2025 BCCNM 1 (Canlii)

A nurse was alleged to have made discriminatory statements about transgender individuals across podcasts, videos, and social media. These allegations were raised before the nurse's regulatory College's Discipline Tribunal, which concluded that "off-duty" conduct may constitute professional misconduct when a sufficient nexus exists between the conduct and the profession. Factors included:

- The nature and seriousness of the statements.
- Their repeated and public nature.
- The link between her statements and her status as a nurse.

Recently Introduced Legislation in Alberta

Late last year, Alberta passed the *Regulated Professions Neutrality Act* (formerly Bill 13), which has been informally referred to as the "Peterson Law". While passed, this Act is not yet operative as it is awaiting proclamation. Upon proclamation, this Act will apply to over 100 regulated professions in Alberta, including health professionals, and establishes

paramountcy over other Alberta legislation governing regulated professionals.

Upon becoming operative, this legislation could reshape how professional regulatory bodies respond to off-duty expression, since the Act seeks to prohibit disciplinary action for expressive off-duty conduct except in narrowly defined statutory categories. Permitted grounds for disciplining regulated professionals for off-duty conduct include threats of violence, improper sexualized communication, and expression resulting in criminal convictions.

Risk-Management Considerations

Given the evolving legal landscape, regulated health professionals should critically evaluate their online presence and conduct. When posting or re-posting content on social media, health professionals ought to consider:

- Whether the author of the speech/content identifies themselves as a regulated professional.

- Whether statements are evidence-based.
- The size and nature of the audience.
- Whether comments may undermine public confidence in the profession.
- Whether language could be considered degrading, discriminatory, or inflammatory.

Conclusion

Canadian case law makes clear that regulatory oversight may extend into online spaces whenever a professional's expression affects public trust, safety, or the integrity of the profession. While Charter rights apply, they must be balanced against professional obligations. As social media becomes more embedded in communication, regulated health professionals must exercise judgment, professionalism, and caution in their online engagement.

"Where are we supposed to hang out?" Hospital Space as an Ethical Question

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I recently accompanied my son to a newly built hospital. We walked through long, bright corridors while the sound of our footsteps echoed against the white walls. Everything felt strangely still. The smell of fresh paint and disinfectant hung in the air. A nurse led us into the room where we would stay. When we stepped inside, it was completely empty. No bed. No chairs. No furniture. Only the light from the large window and the polished floor. The nurse smiled

gently and explained that a bed would arrive soon. She spoke softly and tried to make my son feel at ease. We stood there for a while waiting for the bed, and then my son looked at me and asked, "*Where are we supposed to hang out?*"

The question has stayed with me. It was a practical question, like one of those ordinary questions children ask when they find themselves waiting somewhere unfamiliar. Not unlike "*Are we there yet?*", it seemed to express an impatience of having to wait for an uncertain amount of time while others decide what will happen next. Yet, over time, I have come to hear

something more in the question. Perhaps because it points toward something that is often overlooked in discussions about healthcare environments.



Heidegger's (1971) reflections on dwelling offer a way of understanding what may have been at stake in that moment. In *Building Dwelling Thinking*, he suggests that spaces receive their essence from places rather than the other way around. This idea invites us to think differently about what a place is. A place is not simply a location. It is somewhere life gathers. Somewhere human beings are able to dwell. For Heidegger, dwelling is not simply a matter of housing or shelter. Rather, dwelling points toward a way of being in the world, of finding oneself situated somewhere, able to remain, and able to belong.

Seen in this light, my son was not simply asking where the bed would be placed. The space was there, but the place was missing. The experience does not reflect a lack of care. My son was met with kindness and professional attentiveness throughout his admission. Yet his question points toward something that may be overlooked when healthcare environments are discussed primarily in terms of architecture, design, or physical infrastructure. What allows a hospital room to become a place rather than merely a space? What allows patients and relatives not simply to be located somewhere, but to dwell there?

Similar questions emerged in an empirical study of neurological patients' experiences of hospital environments we completed, entitled *Becoming a Nomad* (Beck et al., 2020). Although patients had rooms and beds, experiences repeatedly returned to questions of place. The question seemed less

concerned with where patients were located than with where they could be. Here, one patient described sitting near a basement exit because cool air entered whenever someone opened the door. Another person repeatedly walked to the parking lot simply to watch the movement of trees in the wind. Others sought out quiet corridors, staircases, or small corners where they could briefly withdraw from the sensory intensity of the ward. On the surface, such descriptions may be considered incidental. However, these places were rarely described in terms of comfort, beauty, or design. Rather, they were described as places where patients could breathe more freely, gather their thoughts, or feel more like themselves. Patients often returned to them when speaking about everyday life in the hospital.

The Norwegian phenomenologist Christian Norberg-Schulz (1980) describes placelessness as a loss of existential foothold. Human beings need places that allow them to orient themselves in the world. Places do not merely locate us geographically; they help us find ourselves existentially. They offer continuity, recognition, and belonging. Perhaps this perspective helps illuminate what several patients seemed to be describing. Many spoke about particular places within and around the hospital. Rarely were these places remarkable in any architectural sense. Yet they appeared to matter.

Another patient, who I will call Eric, helped me understand this more clearly. As we walked through the department together, Eric pointed out rooms, corridors, and everyday spaces. Yet what gradually emerged from our conversation was not simply a description of the ward itself. It was a description of something absent. Eric was not showing me a room. He was showing me the absence of a room. At first, this sounds paradoxical. The ward contained many rooms. Yet what appeared absent was not physical space itself, but a place where he could gather himself for a while. A place where he could withdraw from observation, close a door, and simply remain. Perhaps what Eric revealed was not primarily a problem of architecture. Rather, he revealed how difficult it can be to find a place when one is surrounded by spaces.

A place becomes a place when it allows us to be someone, not just somewhere (Norberg-Schulz, 1980).

The title of our research, *Becoming a Nomad*, emerged from our growing awareness that some patients seemed to move continuously through the hospital in search of places where they could momentarily come to rest. Not because they wished to leave treatment behind, but because remaining in one place had become difficult. Perhaps the notion of “becoming a nomad” captures something important about illness itself? Serious illness may unsettle the ordinary ways in which we inhabit the world. What once felt familiar may suddenly become strange. Places that previously supported everyday life may no longer do so in the same way. The patients in our study rarely described this directly. Instead, it appeared indirectly through their movements. They walked corridors, sought out staircases, sat near exits, or returned repeatedly to particular corners of the hospital. What seemed to matter was not the places themselves, but the possibilities they offered for pausing, withdrawing, orienting oneself, or simply remaining for a while.

The philosopher Otto Friedrich Bollnow (2011) offers a language for understanding this distinction. For Bollnow, space is never neutral. It is not an empty container in which life unfolds. Rather, it is always experienced through moods, memories, expectations, and possibilities as a lived space. Some places seem to shelter us, while others leave us exposed. Some invite us to remain, while others subtly move us onward. Although such experiences are often difficult to articulate, they reflect how we find ourselves in the world.

Perhaps we recognize this immediately in everyday life. We enter a room and sense something before we think about it. We feel welcomed, uneasy, relaxed, exposed, or unsettled. Such experiences are rarely reducible to physical design alone. Instead, atmosphere seems to emerge somewhere between ourselves and our surroundings. It belongs neither entirely to the person nor entirely to the room. It arises in the relation between them. This became especially clear in another encounter from our research. A woman described entering her husband’s hospital

room and discovering that his bed was gone. For a moment, she thought he had died. He had only been taken for an MRI scan, but nobody had informed her. What remained striking was not the misunderstanding itself, but how the experience continued to inhabit the room afterwards. Even when her husband returned safely, she explained that she still noticed the absence before anything else whenever she entered. The room was no longer encountered as before. Maybe this is why certain hospital rooms remain vivid in memory long after discharge? It is not simply because particular events took place there, but because experiences of waiting, uncertainty, or loss gradually became woven into the place itself. What is remembered is often not only what happened there, but how the room came to be experienced. In Bollnow’s (2011) terms, lived space is never merely geometric or physical. Experiences remain attached to places, and places continue to carry traces of the experiences lived within them.

Phenomenological thinkers such as Casey (1993), Malpas (1999), and Seamon (2018) have also argued that places are never simply physical surroundings. Experiences become sedimented within them. Over time, places gather meanings that exceed their architectural form and become intertwined with the lives that unfold within them. This perspective invites us to think differently about what is at stake in hospital environments. The question may not only concern how places are experienced, but also what follows when places become part of how illness, care, and everyday life are lived. At this point, we may wonder if questions of place begin to overlap with questions of care? If places matter for how people gather themselves, remain with others, or find moments of respite during illness, then their significance may extend beyond architecture and design alone.

The Danish philosopher Knud Ejler Løgstrup offers another way of considering questions of space and place (1984, 1997). In his work, he shows how human life does not unfold independently of the world around us: we are always already situated within situations, relationships, and surroundings that affect how we find ourselves in the world. Løgstrup draws attention to the ways in which our surroundings

continually make an impression upon us. Before we think about a place, we are already affected by its atmosphere, its sounds, its rhythms, its openness or enclosure. The world comes toward us through the sensuous qualities of our surroundings. This is not merely an aesthetic observation. For Løgstrup, human life is always lived in relation to others. The ways in which the world comes toward us, therefore, also shape the situations in which we encounter one another. Questions of atmosphere and environment cannot be entirely separated from questions of human coexistence. They belong, in different ways, to the conditions under which our lives with one another unfold.

For this reason, the examples described throughout this article may invite us to hesitate before reducing hospital space to architecture alone. What appears significant in these accounts is not primarily walls, furniture, or design features, but the ways places become woven into experiences of illness. This raises a further question. If such experiences are always lived somewhere, what significance might this have for how we understand care? The question is not whether hospitals should resemble homes. Nor is it whether architecture can resolve the difficulties that often accompany illness. Rather, the examples discussed throughout this article seem to draw attention to something more fundamental. Illness never occurs nowhere. It enters particular rooms. It unfolds along particular corridors. It is lived within waiting areas, entrances, thresholds, and bedside spaces that gradually become part of the experience itself.

Perhaps this is why questions of place continue to reappear throughout the accounts explored here. Not because places stand apart from experiences of illness, but because they become intertwined with them. Waiting takes place somewhere. Relief takes place somewhere. Uncertainty, worry, hope, and loss take place somewhere. The places in which these experiences unfold may, therefore, matter in ways that are easily overlooked. Not simply because they surround us, but because they become part of how situations are encountered, endured, remembered, and shared with others. If this is so, then the ethical

question may not only concern what healthcare professionals do. It may also concern the worlds within which patients, relatives, and professionals meet one another. Perhaps this is where the ethical question ultimately resides: What kind of human encounter do these places make possible?

These reflections do not lead to straightforward design prescriptions. Rather, they invite healthcare professionals, managers, and planners to become attentive to how places participate in experiences of illness and care. Such attentiveness may encourage questions about where patients and relatives are invited to wait, rest, gather themselves, or simply be together during difficult moments. Perhaps ethical reflection in healthcare must sometimes begin not only with what we do for one another, but also with the places in which we meet.

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