VULNERABILITY ANIMATION TRANSCRIPT

Vulnerability is a term we've all likely become familiar with over the course of the Covid-19 pandemic. Older people, and those with underlying health conditions have been considered vulnerable to the severe effects of the virus, as have minoritised and racialised groups in majority white countries. Health and social care workers, as well as other essential workers are also in particularly vulnerable positions, given their roles. Yet all these groups are vulnerable to Covid-19 and its impacts in different ways –healthcare professionals and victims of domestic abuse, for example, face not only different kinds of vulnerabilities, but also face the impacts of such vulnerabilities in different ways. So, vulnerability is a complex term, but it is also one that seems to push us to action (into 'doing something' about it, into taking care of those among us who are considered additionally vulnerable). So, in this video, let's unpack what we might mean by 'vulnerability' and how it applies to different groups during the Covid-19 pandemic.

Although we all seem to have an intuitive understanding of the term 'vulnerability', it has been a widely discussed term in the bioethical literature. It has, for example, been criticised for being both too broad – we're *all* vulnerable to Covid-19 - *and* too narrow –if we list particular groups in terms of being vulnerable, we are bound to miss out on others, who are also at greater risk of harm. Over the last few years, as well as during the pandemic, there has been renewed interest in the term, its various meanings, who it applies to, and when. And, importantly in terms of ethics, what kinds of obligations or responsibility it gives rise to.

Several scholars have put forward influential and nuanced accounts of the concept of vulnerability in bioethics, and it's their work that we are drawing on. Samia Hurst, for example, defines being vulnerable as being at greater risk of being harmed or wrong when compared to a given baseline. Florencia Luna, on the other hand, asks as to think about vulnerability in terms of dynamic layers that add up and reinforce each other – the more layers an individual has, the more vulnerable they are. In their influential taxonomy of vulnerability, Mackenzie, Rodgers, and Dodds differentiate between different *sources* of vulnerability. We are all, for example, inherently vulnerable to death and disease by virtue of being human. We are situationally vulnerable, however, depending on the context we live in – a person with poor health may be more vulnerable to get the flu than a healthy person, for example.

Let's now take a look at how 'vulnerability' in the Covid-19 context.

First, and early on in the pandemic, it became apparent that older people, or those with underlying health conditions, are particularly vulnerable to Covid-19. Here, we're talking about a biological, or health-based source of vulnerability. Due to their weakened immune systems, some people will be more susceptible to the diseases and its more serious symptoms.

When the first lockdown was imposed in the UK in 2020, various women's groups alerted us to the fact that those at risk of domestic and family violence and abuse would be made more vulnerable if required to isolate with their abusers for an extended period. This might be characterised as an example of 'pathogenic vulnerability', a vulnerability that paradoxically arises out of measures that we take to *reduce* that or another type of vulnerability. In this case, lockdown measures were introduced to limit the spread of Covid-19 and everyone's susceptibility to being infected by the virus. But it also meant that those at risk of violence – generally women and children – would be confined to a shared space with their abusers, be more isolated from potential support structures and resources, and therefore be at a heightened risk of violence and abuse.

Over the next few months, it became clear that the shortage of adequate personal protective equipment (PPE), as well as the nature of their work made many healthcare professionals and frontline workers disproportionately vulnerable to Covid-19. These groups – the people facing the public and ill patients – became *situationally* vulnerable. They were not inherently or biologically at greater risk of catching the disease than any other member of the public. Instead, it was the situation and context in which they worked – one where they were interacting with potentially infected patients and members of the public without adequate PPE – that increased their vulnerability to the virus.

Over the following months, data started to show that minoritised and racialised individuals and communities were disproportionately vulnerable to Covid-19 and its effects. They faced higher infection and death rates, for example, in the UK and USA. This is an example of *structural vulnerability*, arising from structural and systemic forms of racism, both historical and ongoing. Here, society and institutions have evolved, and operate in such a way as to make some groups systematically more vulnerable to health and social inequalities, and therefore make them additionally vulnerable in the context of health crises. Minoritized people, for example, are more likely to be front-line workers and less likely to have jobs that allow them to work from home. It is important to notice that in the last example, two types or lines of

vulnerability overlap: the vulnerability that healthcare professionals face in the context of PPE shortages adds to the heightened vulnerability due to overrepresentation in essential work as well as in health and social care work.

As these examples show, vulnerability is an important, if complicated concept. When used in the context of public health, and public health crises, it requires a careful and nuanced approach. In thinking about our ethical obligations and responsibilities, we need to engage with the various ways in which people can be made vulnerable to ill health and inequality.