

Exploring the concept of vulnerability in health care

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The *Oxford English Dictionary* defines “vulnerability” as “the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally.”¹ In one sense, vulnerability is characteristic of the human condition; however, definitions and applications of this concept in health care are diverse.^{2,3} As *CMAJ* launches its focus on vulnerable populations, we discuss different conceptualizations of vulnerability and considerations surrounding use of this term within Canadian health care contexts.

In North America, four principles of bioethics — autonomy, beneficence, nonmaleficence and justice — are commonly applied in health care.⁴ These principles are rooted in the US Department of Health and Human Services’ 1979 Belmont Report, which addressed concerns about the treatment of human research participants.⁵ In the report, vulnerability is presented as a special consideration, concerning those most vulnerable to harm in health research.⁵ The application of vulnerability has been expanded from research ethics to the broader realms of health care and health technologies, and beyond individual contexts; families, groups, communities, populations and countries may be described as vulnerable.³ Contrasting definitions have emerged that frame vulnerability in terms of the (in)ability to protect one’s own best interests, susceptibility to harm and social determinants of health.^{6,7}

The early positioning of particular groups as vulnerable in research ethics guidelines (e.g., those who are sick or impoverished, or belong to a minority group) signalled that vulnerability could be considered a product of both internal factors (e.g., limited capacity to consent) and external factors (e.g., subordinate position).³ In Canadian health care contexts, many groups have been classified as vulnerable based on health outcomes and experience of adverse social determinants of health. For example, efforts to address the needs of vulnerable populations and to reduce health inequities were documented in a recent report in which Indigenous groups, individuals with low income and education, those in rural and remote communities, and immigrants to Canada were identified as groups particularly vulnerable to health inequities.⁷

It is important to consider the function of identifying vulnerability in health care. According to Brown, “ideas about vulnerabil-

KEY POINTS

- “Vulnerability” is a term commonly used — but not consistently defined — in health care.
- The concept of vulnerability may be used to justify access to resources and help define our moral and ethical obligations, yet it may lead to stigmatization.
- The term “vulnerable” should be used carefully, with attention given to potential implications of this language for those served by health care systems.

ity shape the ways in which we manage and classify people, justify state intervention in citizens’ lives, allocate resources in society and define our social obligations.”⁸ Thomasma argues that “[i]n human relations generally, if there are inequities of power, knowledge, or material means, the obligation is upon the stronger to respect and protect the vulnerability of the other, and not to exploit the less advantaged.”⁹ International policy documents suggest that health care providers, researchers and policy-makers have ethical obligations in terms of human rights both to protect from harm and to respond to the needs of those who are vulnerable.^{3,7} These ideals are reflected in Canada’s health care system, which, while continuously evolving, characterizes health care as a public good and is rooted in the principles of equity and solidarity, with the goal of providing universal access to medically necessary health care based on need rather than ability to pay.¹⁰

However, we must also consider the effects of discourses about vulnerability on the well-being of those determined to be in need of protection. Drawing on the social sciences, Brown presents three main critiques of the concept of vulnerability: it can be paternalistic and oppressive; it can serve to widen social control; and labelling groups as vulnerable can result in exclusion and stigmatization.⁸ Another critique is centred around disempowerment from attention placed on deficits, dependency and passivity, rather than challenges, opportunities, autonomy and self-determination.¹¹ Lastly, some commentators have rightly cautioned against embarking on a “vulnerability

reducing agenda, which aims to eliminate all vulnerability, i.e., suffering, abnormality, deafness and disability, in order to create perfect human beings.”² Being sensitive to the consequences of generalizations, and ensuring that we are attuned to the rich diversity within populations, will support success when striving to understand and address health care needs.¹²

Although it may be paternalistic to label a particular group or individual as vulnerable, and this labelling may occur without consent in ways that may increase stigma, some argue that careful application of this concept can serve to highlight our moral obligations to work toward social justice and to justify access to resources.⁸ Yet vulnerability should be used with careful consideration of the potential implications, and reflection given to whether other terminology may be more accurate. For example, Piggott explores semantic differences among the terms “vulnerable,” “marginalized” and “underserved” in relation to populations with relatively lower health status.¹² Notably, whereas the word “vulnerable” situates problems internally, the term “underserved” calls attention to systemic issues that result in unmet needs.¹² Use of language that locates challenges outside of an individual or group may appropriately call attention to external factors, and create opportunities to develop strategies that mitigate effects of the root causes of health inequities. Failure to appreciate nuances regarding the language of vulnerability has implications for how we understand, analyze and address challenges in health care.

Finally, we reiterate Rendtorff’s caution against striving to eliminate vulnerability to create flawless human beings.² Although it is frequently painted as such, vulnerability need not be considered a negative attribute. To be human is to be vulnerable. This does not relieve us of an obligation to address vulnerability, but instead mandates an ethical duty to create just and

equitable health care systems that promote autonomy, foster engagement, enhance cultural safety and support the well-being of all.

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