Theor Med Bioeth (2016) 37:1–7
DOI 10.1007/s11017-016-9357-9

Human vulnerability in medical contexts

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Published online: 12 March 2016
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Conceptions of the moral relevance of vulnerability in human life have assumed a deserved prominence in contemporary work in both moral philosophy and political analysis. In the mid-1980s, two important books emerged which had, and continue to have, significant influence within moral and political philosophy and beyond. Those books were Martha Nussbaum's *The Fragility of Goodness* [1] and Robert Goodin's *Protecting the Vulnerable: a Reanalysis of our Social Responsibilities* [2]. More recently, Catriona Mackenzie, Wendy Rogers, and Susan Dodds edited a collection of essays on this topic in *Vulnerability: New Essays in Ethics and Feminist Philosophy* [3]. The essays in this special issue of *Theoretical Medicine and Bioethics* are given context by these important contributions, and can be situated in helpful ways by considering the frameworks set up by them.

A key idea in Nussbaum is that it is a condition of the moral life itself, and of being good, that human subjects are vulnerable to having their trust in people, and in things in the world, shattered. Like a plant tended by a gardener, our reliance on another leaves us vulnerable, yet it is the willingness to expose ourselves in this way which allows us to enter into morally important relationships. Indeed, according to this way of thinking, a condition of moral goodness is to be in that state of a permanent possibility of loss. Good people are open and trusting, and must bear up

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under conditions of uncertainty. They must, then, at least in some circumstances, show forbearance in the face of threats to choice and control, when it is clear that something or someone else is a potential threat insofar as their vulnerability allows it. It is this willingness to be exposed to the tragedies of life—this precariousness in life—that provides the constitutive grounds for what counts genuinely as good, as excellent and as beautiful.

In later writings, Nussbaum was keen to contrast a Kantian conception of human persons, as beings with a capacity for freedom and reason, with beings who deserve respect based on being human animals in the world, needy creatures whose embodied condition is the very thing which generates a view of us as possessed of dignity. Human rational animals are mortal; they are dependent, and they rely on limited resources. They must make their way in the world in spite of having to endure its unreliable surface. Doing so is the thing that makes human goodness good, and doing one's best within that realm is the thing that gives us dignity. Respectfulness comes into play here just because of our animal nature, not in spite of it.

Relations of dependence—even between those of equal power—by their very nature render those within such relationships as susceptible to loss, to intrusions of various sorts, even to violation and abuse of a trust. These points are all too familiar in relations between the nearest and dearest, and the exposure from such intimacy brings with it a range of obligations not to undo the moral work that went into establishing moral closeness in the first instance. For example, the secrets and private information shared in friendship can be part of what constitutes that relation and of what raises the moral stakes within it. So, indeed, there are special obligations raised where our vulnerability can be read off from the particulars of those intimate relationships. Yet does the story stop there? Robert Goodin argued that it does not, and that the range of people affected by our actions and choices goes beyond those with whom we share our intimate lives. There is a wider network of human social connectivity, and so a wider sphere in which the vulnerable can be made worse off by what all of us do, not merely in our local relations, but as citizens of our cities, states, and indeed, of the wider international community. Given this recognition, and noting the importance of the way policy and law can bring about suffering and harm, it is a short step to making the connection between responsibility and vulnerability. On this conception, policy and law must be informed by the ways in which the vulnerable are made worse off when those policies wrong them, in particular by exploiting them. On this view, then, we have a responsibility to protect the vulnerable.

The more recent theorising on vulnerability by Mackenzie et al. [3] helpfully unpacks a three-way distinction between three different sources of vulnerability. It may originate, first, from some *inherent* features of our status within human social environments. This makes vulnerability an unavoidable state because it comes to us in virtue of *being* a certain way, viz., embodied individuals with needs and emotional dependencies, beings who are dependent at the core because of features of our constitution given the biological and social nature of our humanness. These things are grounded in what we are; it is a vulnerability that is inescapable. Second, it can emerge out of specific features of the context. Societies vary in the conditions

that facilitate how we may get on. This is a *situational* vulnerability because our different environments vary in the harms and benefits affecting the degrees to which human fragility is expressed or revealed. Finally, the two vulnerabilities already mentioned can be made worse particularly when others intervene or institutional policies fail. In contexts of abuse, prejudice, oppression, or persecution, already vulnerable individuals can suffer further losses by attacks on their autonomy or remaining power, harms to their wellbeing, and the undermining of their sense of being a narrative agent. Ironically, these interventions could also include practices designed to alleviate the harms and suffering of the vulnerable persons they were designed to protect. If a policy prevents or excludes vulnerable persons from participating in an activity, ostensibly for their own good, problems are usually not far away. This last source of vulnerability they call *pathogenic* vulnerability.

The fact of ontological vulnerability, that unavoidable state of dependence, raises important questions about whether an attempt to avoid the fragilities of life or enhance our humanness is a good or rational pursuit. Perhaps the right way to think of vulnerability is that it leaves room for the thought that something of value resides in maintaining our openness to social attachments. For example, we are vulnerable to grief not atypically, but just because of this. Yet, in grief we may be prescribed anti-depressant medications to dampen the effects of an unpleasant experience. And what if we could "enhance" ourselves to remove altogether the grief experience? It seems on the face of it to be undesirable to eliminate a vulnerable trait such as this because doing so would undermine something fragile about us we regard as important to human personhood.

To put it another way, echoing Nussbaum, it is an important general question in bioethics to consider the extent to which we ought to elevate human self-sufficiency away from the reach of bad luck. If fragility is an inherently unavoidable (and arguably in many cases desirable) aspect of our humanity, to what extent should we regard fragility or dependence as pervading the human condition such that it ought not count as an obstacle, or even pathology, to be removed? And in consequence, to what extent does this compromise (if at all) the bioethical project of applying the instruments of reason, theory, policy, or law to address human vulnerabilities in this area?

This Special Issue is devoted to some applications of these conceptions of vulnerability particularly as they are played out in the medical sphere, conceived broadly. Our authors offer a mixture of both theoretical and practical accounts of vulnerability and of the various ways in which that concept gets traction generally and within specific contexts. Beginning at a general level, John Quilter [4] and Doug McConnell [5] show that human agency and self-formation unavoidably must build from social connectedness and dependence. Quilter identifies three aspects of vulnerability. First, we must overcome obstacles, for instance, ill health and sickness. Second, we must acknowledge that losses to vulnerability might threaten, at least to some extent, identity; it is not unintelligible, he says, to see that some groups traditionally seen as vulnerable—for instance the deaf or the lame—might resist moves to alleviate the condition that motivates this view of them. And third, in trusting relationships, such as friendship, there is a clear sense in which we trust the other with our vulnerabilities, and this trust is what structures the relationship. With

these types of case in mind, Quilter considers the question of human enhancement, arguing that we put too much faith in the prospects of making moral progress by applying moral theories to particular or imagined human circumstances and not enough faith in what he calls the ‘contemplative role of moral concepts’. He argues that there is a deep issue at stake in all of this. It is not a question about how to push back vulnerability. It is about ‘how to integrate limitation and vulnerability into life without a view to flourishing’. In an even less sanguine gloss on the enhancement industry, he points out that for many ‘flourishing is not an option’ given our limitations, and that we need to pay more attention to the ethics of *renunciation*, for this gives us an understanding of vulnerability that is ‘meaningful and honourable’.

For McConnell, the object of vulnerability is also general: all of us are vulnerable just because the process of self-formation, of narrative agency, itself exposes us to others who shape who we are. Self-formation and degrees of autonomy are a function of the fact that others in our social sphere co-author our narratives. This leaves human persons open to the permanent possibility of both strengthening and undermining our own authorial skills. To bring this alive, McConnell uses first-hand reports of women who survived sexual abuse as children. As he puts it, ‘[t]heir narratives of survival and healing reveal the challenges involved in (re)developing the skills required to manage vulnerability to co-authoring and how others can help in this process.’ Such an account he says has implications for the therapeutic context. He notes three aspects: first, interpretations about the patient made explicit in this context get taken up by the patient’s self-narrative; second, it becomes critical to listen closely to patients telling their stories so as to enable and promote their authorial power and support their autonomy; and third, the healthcare professional needs to provide the right kind of narrative resources, for example, the offering of simple healing narrative archetypes.

The paper by Mianna Lotz [6] begins with a review of the distinctions in Mackenzie et al. and, indeed, recognition of the general and unavoidable nature of human vulnerability. Following this she gives focus to a concept she labels ‘discretionary vulnerability’. In two ways, it results from intentions and decisions that *make* us vulnerable. We can make ourselves vulnerable (‘assumed’ vulnerability) or we can make others vulnerable (‘imposed’ vulnerability’). Recognition of this possibility raises questions about our obligations: under what conditions do such vulnerability-inducing decisions affect resilience? This is introduced in recognition of another standard question in discussions of the connections between the recognition of vulnerability and the promotion of autonomy. Lotz thinks that overlooked in these discussions is an important, and distinct, class of obligations that figure in *resilience-promotion*. If one is rendered vulnerable through a discretionary act, it would seem there is an obligation to provide the tools for coping, tools that lead to an improvement in wellbeing.

The papers by Philippa Byers [7] and by Wendy Rogers and Mary Walker [8] focus on some specific vulnerabilities of patients and research subjects. Byers is curious to understand what grounds our dignity-based obligations to those who are vulnerable but whose autonomy has been undermined or lost. In everyday settings involving decisions in medical practice and those affecting research subjects, dignity and autonomy are spoken of in the same breath as providing the ethical basis

for protecting persons who undergo procedures and for whom consent is not possible. These issues are brought into sharp relief in cases of dementia care. For if it is thought that dignity supervenes on autonomy, then it might be inferred that losses of autonomy automatically generate losses to dignity. This would be a bad result. Byers argues, however, that a Kantian conception of human worth can provide an independent foundation for dignity. This is important because in decoupling autonomy and dignity, what is left over is an argument for grounding respect for the vulnerable—an argument that is based on our humanity as such. Indeed, Byers argues that our dignity can and should be seen as conceptually prior to our autonomy.

Rogers and Walker argue that, though one of the ways in which medicine seeks to overcome our vulnerability is by reducing uncertainty, we are not necessarily better off in a world where clinicians determinedly foster the idea that we can secure ourselves in this way against ill health. Our condition as humans is to remain permanently exposed to ill health and this raises an important question about what efforts are made to overcome this ever-present threat. Uncertainty about one's health status exacerbates the difficulty. Rogers and Walker, however, argue that at least some uncertainty is to be tolerated especially as some of the measures used to overcome our doubts—via health assessments using the tools of diagnosis and prognosis—are themselves inherently imprecise and unreliable. So patients may be better off acknowledging and accepting a degree of uncertainty. Moreover, the contemporary arrangements in which healthy people undertake prevention measures, in the form of tests, screening, and scans, can make things worse. All in all, this leads to a surprising and important conclusion: it may be better to recognise a truth about us, that our fragile health—an inherently vulnerable feature of the human condition—is something worth facing squarely and accepting.

The papers by Justin Oakley [9] and by Christopher Mayes et al. [10] reverse the focus on patients and turn to vulnerabilities on the other side: those possessed by health care professionals. Oakley, then, considers our ordinary human vulnerability to responding poorly in trying circumstances. Rejecting Kant's implausibly high standard for attributing virtue, he goes on to develop an account of how best to conceive and respond to such professional vulnerability. Oakley begins by pointing out that those in medical practice sometimes face challenging circumstances that render them vulnerable in the sense that the virtues needed to properly face the situation are either absent or fail to come to the fore. If this is right, Oakley reminds the reader once again that it would be a mistake to focus on groups traditionally thought of as exposed to the harms vulnerability may bring. So, for instance, consider the health professional whose courage is tested in a medical emergency. To act with professionalism under pressure is not always possible, in which case, such instances can undermine virtuous character itself. Oakley uses this issue as a foil against which to explore an important and highly interesting theoretical question: when is it warranted to attribute virtue when the virtue in question might only be tested in remote scenarios (such as a medical emergency)? Arguing against what he calls the 'probabilistic approach' to the question, Oakley supports recognition of the need to be sensitive to considerations of credit and fault, and that these aspects of character get developed by agents who have 'developed various insurance strategies

and protective capacities against their responding poorly to particular eventualities'. In other words, Oakley advocates not just an awareness of a potential vulnerability in one's professional role, but also an awareness of one's obligation to address it. It might even be the case that repeated failures in fulfilling one's role—due to the failure to address a potential vulnerability—would reveal that this person lacked the relevant qualities needed to be a virtuous practitioner. Oakley finishes by spelling out some implications of his account not just for professional medical practice but for friendship as well.

Finally, Mayes et al. recall how vulnerable medical virtue itself is to aspects of the environment in which medicine is practiced. They argue that neither current policies on conflicts of interest nor contemporary applications of virtue theory to medical practice contain resources sufficient to protect the fragility of virtue from corruption by market forces. One might say that professional virtue, like Nussbaum's metaphor of the plant, must be nurtured, and if the conditions for such nurturing are not right, virtue will be eroded. Thus, Mayes et al. point to the shifting context in which medical practice operates, a shift from a medically driven imperative to one in which a commercial interest threatens the physician's willingness and capacity to live up to the virtues of professional life. What response can be given to the conflicts generated by these divergent interests? They suggest the need for a combined approach, involving external regulation, education, and other virtue-building strategies. But even that may not be enough unless recognition is given to the wider political environment that has facilitated the neoliberal changes to the way health and medicine are governed. These wider influences suggest the need for an interconnected approach to the issue of vulnerability to losses of medical virtue—one that penetrates into society, its institutions, and down to the individuals within them.

In sum, the essays in our Special Issue are suggestive of three important implications. First, a sustained attention to the unavoidability and, at times, desirability of human vulnerability stands as a corrective to that Greek emphasis on the prestige of the intellect, with its elitist view of the meaning of human life as the contemplation of the highest truth and its disvaluing of lives which are not outstanding in this regard. Rather, the attention to vulnerability belongs in the traditions that emphasise the equality of all human beings whatever their capacity for autonomous action. Second, this conception of human vulnerability stands as a corrective to that contemporary view—a legacy of existentialism—according to which an individual's dignity is thought of exclusively in terms of his or her autonomy and is expressed in *whatever* that person desires or wants or prefers or chooses. Third, as an inherent condition, vulnerability is not something we may escape—either through enhancement or luck—and as such, its effects are pervasive. Even the most exquisitely capable, fully enhanced, *Übermensch* surgeon is not immune, and if one recognizes that fact in this case, one can recognize it anywhere. That does not obviate the need for a Rawlsian-style principle of difference in which changes addressing vulnerability must begin with the worst off, if they are to begin at all. Rather, it is simply to acknowledge that we all, both collectively and individually, must respond to the shared vulnerability that infuses the human condition.

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