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Soft Power: The Over-Determined Politicization of Vulnerable in the #CDC7words

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At first blush, the inclusion of the word *vulnerable* alongside words like *fetus*, *evidence-based*, and *diversity* in the list of 7 words discouraged for use in budget documents from the Centers for Disease Control (i.e., the #CDC7words) evokes a feeling that 'one of these things is not like the other.' Considering the other six words, a critical mind can see the potential for triggering the sensitivities of a polarized polity, even if a budgeteer chooses such words precisely for their neutral technicality. But vulnerable is at once so simple and fungible a word as to seem mostly innocuous, if also somewhat tonally tender for bureaucratese. We might call vulnerable a word about softness, one that denotes susceptibility to attack or a delicacy to being dented or nicked. Yet a tour through the particular health discourses in which the word vulnerable plays a singular role reveals some troubling implications of its inclusion on a list of words in official disfavor.

First, in the field of bioethics, the word vulnerable has dense meanings that respond directly to past research abuses.[1] As defined by federal regulations governing research with human subjects including the Belmont Report[2] and the Federal Policy for the Protection of Human Subjects ("Federal Policy," Health and Human Services 45 CFR part 46[3]), vulnerable groups and individuals require extra safeguards in biomedical research contexts. Bioethicists' concerns center on those with "vulnerability to coercion or undue influence,"[4] a characteristic that would compromise the Belmont Report's principle of respect for persons (i.e., autonomy) according to which individuals should consent to research voluntarily, with full knowledge of its risks and benefits. Other types of vulnerability are also invoked in the Federal Policy, including those vulnerabilities that may undermine the Belmont Report's principle of justice. The principle of justice stipulates that the selection of research subjects "be scrutinized in order to determine whether some classes (e.g., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied."[2] The principle of justice also requires that those who bear the burden of research are not barred from receiving its benefits. In the

Federal Policy, pregnant women, fetuses, neonates, children, and prisoners are defined as vulnerable populations; veterans, those with mental disabilities, individuals who are “economically disadvantaged” (who may be coerced with incentives or have no other access to care) or “educationally disadvantaged,” employees and students (who may experience pressure to participate from supervisors), and those with physical disabilities are also named as vulnerable populations. Federal regulations encourage research review boards to consider vulnerability as a propensity that could lead to abuse in research contexts,[5] for in addition to these specific groups, federal research oversight agencies “[expect] IRBs to use their judgment when determining if subjects enrolling into particular protocols are considered vulnerable and if additional protections are warranted.”[6(p. 4)]

Next, in the field of disaster preparedness, the word vulnerable has a specific definition as a designation for groups and individuals that experience disproportionate injury and mortality in disasters and that therefore require special outreach, planning and support. The World Health Organization (WHO) defines vulnerability as “the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of disasters.”[7] The WHO names pregnant women, children, the elderly, and those who are malnourished, immunocompromised or ill as “particularly vulnerable when a disaster strikes, and take a relatively high share of the disease burden associated with emergencies.” In addition, vulnerability applies to those living in “poverty – and its common consequences such as malnutrition, homelessness, poor housing and destitution.” Domestic disaster planning policies echo the WHO’s attention to vulnerability. Guidance from the CDC,[8] the Office of the Assistant Secretary for Preparedness and Response,[9] and the Federal Emergency Management Agency[10] all emphasize enhancing preparedness for vulnerable groups through improved coordination between health and human services and the adoption of an inclusive and proactive approach to disaster preparedness. In an effort to minimize excess injury and death, preparedness professionals implement special services for vulnerable populations including individuals with physical or mental disabilities, renters (with limited ability to control risk circumstances), those living in nursing homes and other residential care facilities, individuals with limited mobility, the elderly living independently, the homeless, and others. Preparedness professionals recognize vulnerability in order to develop and implement plans to support those with less capacity to support themselves before and after disasters strike.

Definitions of the vulnerable from bioethics and disaster preparedness intersect with those used widely in public health, health services research, and clinical practice.[11] Here, too, vulnerability is invoked in discourses of

relative risk and additive suffering. When I use the word clinically, it is to describe patients who requires extra vigilance and added assistance.[12] Health researchers label as vulnerable those groups or individuals susceptible to negative outcomes or confronting combined burdens of illness and social deprivation. Vulnerability is used to mark those whose lives are defined by precarity and by dependence upon a web of formal and informal resources whose disruption brings about catastrophic consequences. In this discourse, the vulnerable are those left behind, on the margins, actively excluded, or multiply disadvantaged. Simultaneously, researchers and clinicians understand the vulnerable to benefit more than others from well-delivered interventions. They experience "beneficial spillovers"[13(p. 3)] from straightforward health and social service interventions (e.g., nurse home visits for new parents; financial assistance) and they flourish with intensive clinical support.[14]

In these health contexts, vulnerability is permitted some strategic ambivalence. Defined fluidly as a concatenation of risks and encumbrances faced by individuals and communities – a lack of legal citizenship, disability, discrimination, and so on — vulnerability points to some and all factors at once. We immediately grasp that vulnerability is a signifier for the incontrovertible negative impact of certain assemblages of social factors on health, even where we still know little of the precise mechanics of this impact.[15] Moreover, in these flexible deployments, the word vulnerable gains moral valence as an invocation of a responsibility to care for those who are less safe. And, in health discourses, the word vulnerable carries a gentle, if usually silent, political significance because it implies priorities for how resources should best be distributed.

Perhaps especially in its most flexible usages, vulnerable gains its moral traction because of a shared understanding that the word implicates us all. Vulnerability is an inevitable mode of human experience; emotionally, physically, and existentially, vulnerability inheres within us. As Jonathan Lear says, "As finite, non-omnipotent creatures we are constitutively vulnerable in a world over which we have, at best, limited control."[16(p. 679)] Vulnerability is a state we see ourselves pass through, or one we perceive waits for us, if we do not feel we live entirely within it. Subjectively experienced and therefore diversely understood and articulated, we become vulnerable who-knows-where: in moments of intimate connection and caring;[17] in "the reality of our final dissolution,"[18(p. 159)] when confronted with our imperfections;[19] in "the ravages of emotion" of "intense sorrow, loss, anger, and frustration" that come with bereavement;[20(p. 245)] when we come to terms with our dependence on disinterested institutions;[21] when we are "overwhelmed by [our] duties or responsibilities to others and when [our] own needs go neglected or unfulfilled"[22(p. 486)] and even in moments of strength and safety. In fact, in our everyday experience, potency and vulnerability are linked not as antitheses but as mirror

images, identical except in structure and direction. In other words, as many of my current research interlocutors (mostly female surgeons) tell me, vulnerability is a skill and a distinction: “Being able to admit that I was vulnerable…I don’t think many women doctors can,” one told me. Indeed, it may be particularly those times when we imagine ourselves to be invulnerable that we expose ourselves to injury and isolation. As one physician said to me, commenting on how easily some colleagues come to prefer the predictability of work relationships to the give-and-take of regular ones, “you get into some position of authority…and everybody says, ‘Oh you’re the boss. You have all of the information. What would you like us to do, Doctor? We’ll do that right away. Thank you, Doctor.’… and some part of you says, ‘Oh yeah, I guess I’m really pretty special here.’” The desire to feel pretty special and never vulnerable can render us entirely alone.

Given these definitions, both flexible and specific, both subjugated and statutory, what significance can we take from the official disfavor and distrust of the word vulnerable as indicated by its presence on this odd list of 7 words? I will name two possibilities. First, since *by definition* the word vulnerable designates an increased risk for death and injury, we can interpret the eschewal of the word as an example of Achille Mbembe’s necropolitics. As Mbembe says, in a necropolitics, the state is active in “the creation of death-worlds, new and unique forms of social existence in which vast populations are subjected to conditions of life conferring upon them the status of living dead.”[23(p. 40)] If the use of the word vulnerable is first and foremost a form of calling forth protections for those most likely to die, closing off its use allows state power to redirect itself away from the explicit protection of those at highest risk, with certain results. In the process, a necropolitics designates some citizens as disposable and some lives as waste. These are the exercises of state biopower “to make live and let die” that Foucault famously identified,[24] and they are the politics that Flavia Dzodan calls “eugenics adjacent”[25] for they tolerate not only the proliferation of precarity but also of apathy and of demurrals to do what is required to serve and save. Certain lives are not worth the extension of extra protections. Their special designation of risk and adversity revoked, any approach to health will disadvantage the vulnerable, and perhaps that’s the point.

Yet we can also interpret a censure of the word vulnerable as a form of willful and wishful defensiveness against our own obligatory exposures. Avoiding the word vulnerable can be understood as a form of suppression that reflects a wish to create a world in which we are never frail and forever safe. We may hope that, without the word, we could make ourselves entirely unlike those who live with peril. To hope to never encounter the word vulnerable suggests a purposive blindness to our own condition, a motivated turn away from the real forces (the market, a deity,

the climate, our bodies) at whose mercy we live and die. Lear reminds us that illness “gives us direct and immediate insight into who and what we are.”[16(p. 678)] In the same way, the word vulnerable gives a direct and immediate cognizance of the social reality of our existential defenselessness. As far as I can see, no other word could slot in for it. Without it, we are left with a strange gap in our speech, a sudden silence, like a redacted phrase that leaves a black rectangle behind. Jason Throop asks, “What, as an anthropologist, should one make of gaps in one’s own and other’s consciousness?” We might take caution in the “inherent hubris [of] attempting to make sense of putatively disguised motives … by means of one’s own theoretical assumptions and interpretive commitments.”[26(p. 79)] Yet what else but hubris could be behind the forced silencing of a word as capacious, moral, and generous as vulnerable? I would not have guessed it, but apparently, the word carries enough soft power that it needs to be muffled. If that’s the case, then living in full recognition of vulnerability[27] — our own and others’ — is a form of resistance: to a politics of apathy and death, and to the effacement of our shared humanity.

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