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APPLYING THE PRINCIPLE OF VULNERABILITY IN CAREGIVING

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Abstract: *This paper seeks to identify the principle of vulnerability as a key operational ethical resource in the context of caregiving. Those both most susceptible to harm and in need of the greatest empowerment require responsive and responsible caregiving capable of delivering these twin objectives. This paper will first explain the principle of vulnerability and its importance in the context of care. It will then highlight some of the moral pitfalls associated with applying the principle of vulnerability. The paper will then conclude with the articulation of an operational framework for applying the principle vulnerability. In doing so, the hope is to empower caregivers to promote the basic moral imperative that the principle of vulnerability involves: to protect the vulnerable from harm while simultaneously building capacities to realize basic human goods.*

Keywords: *Vulnerability, Harm, Benefit, Protection, Autonomy, Responsibility, Care, Applied Ethics, Framework.*

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I. THE PRINCIPLE OF VULNERABILITY

Maxima debitur pueris reverentia.[1] This is the advice Juvenal gives to his readership, both ancient and modern. The reason why the child is owed the utmost respect is not frivolous. The great respect adults owe to children directly corresponds with the vulnerability of children to the actions and influences of adults. The kind of regard Juvenal seems to be imploring us to have for children is, therefore, not the kind that is garnered by meritorious action, but the kind that is demanded by inherent status. Relative to adults, children stand in a position of **vulnerability**; i.e. a greater susceptibility to harms, be they educational, physical, sexual, emotional, psychological, or institutional. We owe children greater respect precisely because there is much greater opportunity for disrespect - exploitation, degradation, maltreatment, inculcation, manipulation, indoctrination. Thus, the kind of respect we ought to have for children is most clearly expressed in the the ethical **principle of vulnerability**: *the moral obligation to **both** protect against inherent and situational harms **and** to make provision for developing benefit-conferring capacities for those most susceptible to such harms.*[2]

I think Juvenal's imperative is, therefore, instructive for anyone in a state of vulnerability: the greatest respect is owed to them.

Here's what I take this 'respect' to involve:

i) **Positively:** the principle states the degree to which one is susceptible to harm is directly proportional to the degree to which another has an obligation to provide nurturing care; i.e. the focus is on *minimizing the susceptibility* itself to specific harms by *maximizing benefit-conferring capacities*.

ii) **Negatively:** the principle states that the degree to which one is susceptible to harm is directly proportional to the degree to which another has an obligation to provide protection from harm; i.e. the focus is on *minimizing the specific harms* to which one is susceptible by *maximizing protective measures*.

iii) **Particularly:** the maximization of benefit-conferring capacities *and* minimization of susceptibility to harms is a specific, concrete and contextual moral obligation. This obligation is either personal or institutional, or both; i.e. the responsive and responsible care for vulnerability cannot be *merely* contractual, voluntary, or consequential. It may involve all of these moral motivations, but cannot be reduced to any. The ethics of care is, therefore, instructive: responsible caregiving is direct and context-relevant, it is receptive and responsive to the specific nature and needs of the cared-for, and is cooperative, collaborative, and capable of coming to completion.[3]

iv) **Essentially:** positively understood, the principle of vulnerability promotes benefit-conferring capacity building, negatively understood, it provides personal security. Importantly, both the positive and negative aspects of the principle are jointly necessary for its fulfillment. They are, furthermore, inversely proportional: the less developed the ability to assess and repel harm, the greater the necessity for protection and capacity-development from an other; the greater the developed ability to assess and repel harm, the less necessity for protection and capacity-development from an other.[4]

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[1] Translation: "the child is owed the greatest respect"

[2] See The Principle of Respect for Human Vulnerability and Personal Integrity: report of the International Bioethics Committee of UNESCO (IBC), United Nations Educational, Scientific and Cultural Organization 7, Paris, 2013. See also the Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, April 18, 1979) - Part B §1: "Respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection."

[3] This brief articulation of 'care ethics' commitments is sourced from Virginia Held's The Ethics of Care (New York: Oxford UP, 2006). For more on the well-established ethical framework of 'care ethics' see Carol Gilligan's In a Different Voice (Cambridge: Harvard UP, 1982), Nel Noddings' Caring: A Feminine Approach to Ethics and Moral Education (Berkeley: Universty of CA Press, 1982), and Virginia Held's Feminist Morality: Transforming Culture, Society, and Politics (Chicago: University of Chicago Press, 1993).

[4] Wendy Rogers, Catriona Mackenzie and Susan Dodds' "Why Bioethics Needs a Concept of Vulnerability," The International Journal of Feminist Approaches to Bioethics. Vol.5, No.2 (Fall 2012). The authors maintain that "An adequate conception of

v) **Normatively:** the values latent within the principle of vulnerability and the ones it fundamentally seeks to protect, promote or make provision for are *personal security, autonomy*, *integrity, and flourishing.*

The International Bioethics Committee (IBC) asserts that "the human condition implies vulnerability. Every human is exposed to the permanent risk of suffering "wounds" to their physical and mental integrity."[5] This is true, but trivially. That is, the *intrinsic* vulnerability to the 'vicissitudes of life' is ontologically true of any human being. As interdependent beings, we are always in comparative relation to every other individual in existence. Always acting on others and others always acting on us. Sometimes these interactions enhance our abilities to act, other times they are hampered - even to the point of disability or death.[6] But the brute fact of vulnerability is not necessarily what the principle of vulnerability picks out as morally relevant. This principle, as with any other moral principle, is not seeking to entirely eliminate harms that can befall humans *per se*, but only to minimize those harms that humans can inflict on one another through their *conditional* and *conventional* actions, inventions, systems and schemes.[7]

The principle of vulnerability focuses on 1) conditional and contingent susceptibilities to harms, 2) the specific harms relative to these susceptibilities, and 3) the specific benefits necessary for basic human flourishing and capacities necessary to realize them. It addresses, therefore, the specific properties of persons, and the systems in which they operate, that admit of being protected, developed, empowered, and improved to the minimum extent possible (i.e. within the bounds of material possibility and basic morality). It is *those* susceptibilities that can be addressed and, if they are not, would expose others to actions harmful to their autonomy, integrity, and reasonable possibility of flourishing that the principle of vulnerability addresses.

The authors of "Why Bioethics Needs a Concept of Vulnerability" provide a taxonomy of vulnerability that is helpful in zeroing in on the moral responsibility the principle involves. The authors distinguish between *inherent, situational* and *pathogenic* vulnerability.

i) *Inherent vulnerability* is being susceptible to harms common to the 'human condition' - embodied, dependent, needful, affective, social.

ii) *Situational vulnerability* is the context-specific exacerbation of inherent vulnerabilities because of interpersonal, social, cultural, political, legal or educational factors. These can be dispositional or occurrent; i.e. owing to particular characteristics of a person or group, or owing to the certain circumstances befalling a person or group respectively.

iii) *Pathogenic vulnerability* is the exacerbation of inherent situational vulnerability by virtue of morally defective or devoid institutions and systems.[8]

From this taxonomy the inherent vulnerabilities of persons require situational harm protection or reduction as well as the promotion of capacity-building benefit. This responsibility is fulfilled in a case-specific interpersonal care relationship, but may also require addressing pathogenic systems hampering the ability to fulfill the principle of vulnerability in such specific relationships.

For example, as previously mentioned children are inherently vulnerable by virtue of their diminutive stature, impressionable psyche, and developmental state. Simply by virtue of this inherent vulnerability, they coincidentally require the adults morally responsible to care for them protection from: 1) physical, sexual, or emotional predation, 2) cognitive manipulation or indoctrination, and 3) impairment of, or negligence in, providing physico-psycho-

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vulnerability will not be restricted to protecting against harm, but may attend to the way in which development of capacities for resilience and the social conditions for promoting agency and autonomy constitute appropriate responses to vulnerability." (12-13)

[5] The Principle of Respect for Human Vulnerability and Personal Integrity, II.6

[6] For ontological accounts of vulnerability see Baruch Spinoza, Ethics, (1677), Emmanuel Levinas Humanisme de L'autre Homme (1972) and Hans Jonas "The Principle of Responsibility" (1979). The common thread among these diverse accounts is the ontological claim that to exist is to be in a state of interdependent relation to other existing things, the consequence of which is to constantly affect and be affected by others.

[7] For a normative account of vulnerability see the previously cited Wendy Rogers, Catriona Mackenzie and Susan Dodds' "Why Bioethics Needs a Concept of Vulnerability." See also Martha Fineman's "The Vulnerable Subject: Anchoring Equality in the Human Condition." Yale Journal of Law and Feminism 20, no. 1:1-24. See also Fineman's "'Elderly' as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility." Elder Law Journal 20. no. 1:71-111. In this article she asserts that "The idea of vulnerability is anchored in the fact that we are all born, live, and die within a fragile materiality that renders all of us constantly susceptible to destructive external forces and internal disintegration. What significance should the reality of vulnerability and dependency have politically, socially, culturally, and legally … ?" (89).

[8] "Why Bioethics Needs a Concept of Vulnerability" pp. 24-25.

social development. At the same time, they require these same adults to help them build capacities for 1) self-protection, 2) autonomous thought and decision-making, and 3) integrative self-identity. Children are also, therefore, situationally vulnerable to particular others who would specifically harm them or fail to benefit them in the above mentioned ways. And these situations can be embedded within a pathogenic system - be it political, religious, educational, familial or cultural. When children are systematically vulnerable to harms, they find themselves in a structural situation antithetical to their health, safety, integrity and (developing) autonomy. This can occur within a family, religious, cultural, educational, or political system. Specific examples are myriad, but the story of Malala Yousafzi is instructive on how inherent, situational and pathogenic vulnerabilities can converge.[9]

I think it is practically impossible to obtain a normative account of the moral responsibility the principle of vulnerability involves in the absence of a declaration of basic human goods and the intrinsic value of persons. Let's say that something like the Universal Declaration of Human Rights provides us with a basic outline of human goods. The rights outlined in this document serve to protect and promote fundamental human goods, secure or make provision for the intrinsic values of persons - life, liberty, security of person, material needs, education, healthcare, employment, mobility, legal recognition, cultural participation, etc. This is the *moral character* of rights prior to their legal enactment and enforcement. The basic rights determine the minimum standard of what is morally permissible, prohibited and prescribed. Our moral responsibility to protect the vulnerable from harms and make provision for their benefit-conferring capacities is, therefore, predicated on a substantive reverence for basic human goods.[10]

So, while it is the responsibility of those in positions of relatively greater power and privilege to enact the principle of vulnerability, it is not merely the prerogative of those in such relative positions. Responsibility to vulnerability is, rather, predicated on an objective recognition of, respect for, and realization of, basic human goods.

II. SOME PROBLEMS WITH APPLYING THE PRINCIPLE OF VULNERABILITY

A moral agent who wishes to enact the principle of vulnerability has a difficult task. Relative to the specific vulnerabilities of a person or group, a moral agent enjoys significant powers, privileges and possibilities. Since the principle of vulnerability involves *both* promoting the empowerment of vulnerable persons while simultaneously protecting persons against the harms associated with their particular vulnerability, the inherent tension in enacting the principle is between *security* and *autonomy*. Striking a proper balance between these two values is, therefore, the task of a would-be caregiver. Caregivers should, therefore, be mindful of the following pitfalls on either side to which they can fall prey:

I. **Reductionistic reification:** In identifying a person or group as being in a state of vulnerability, we can reduce them to the very vulnerabilities they are experiencing, and consequently define them solely in these terms. In spite of our noble intentions, this serves to reduce, and potentially dehumanize, the very person or group demanding humane respect. While it is both necessary and useful to identify and define the specific conditions, causes and contexts of susceptibility to harm, as well as the specific harms themselves, the would-be caregiver must beware not to define the *person* or group in these terms. The vulnerabilities that can be helped by caregivers are, to borrow a metaphysical distinction from Aristotle, *accidental* properties of persons. Even though we must identify these properties in categorical terms, (i.e. X has an intellectual or developmental disability, or Y is a young child, or Z is experiencing discrimination, displacement, marginalization, illness, instability, etc.), we should yet conceive of these vulnerabilities as conditional, contextual and concrete states that a person is in, however protracted or irremediable. When we mistake accidental for essential properties, we begin to define persons in terms of the vulnerable condition they are in. This then serves to entrench the power

[9] https://en.wikipedia.org/wiki/Malala_Yousafzai

[10] See again, "Why Bioethics Needs a Concept of Vulnerability," wherein the authors maintain "Because we are complex, embodied, social, affective, and intelligent beings, we have a range of needs which must be met in order to flourish, from basic needs for nourishment and shelter through to complex social needs, for example, for friendship and meaningful work. However, given the diversity of human needs, not all needs are equally morally demanding, thus raising the question of which needs and correlative vulnerabilities ought to be given moral priority." (22) I maintain that it is not possible to ascertain which vulnerabilities ought to be given priority a priori, but rather that the prudence involved in the care relationship ought to determine priorities on a case-specific basis. This specificity is, nevertheless helped along by observing the aforementioned basic human goods.

imbalance between the would-be caregiver and the one cared-for which, in turn, has the consequence of indefinitely perpetuating their vulnerable status.[11] For example, designating someone as a 'homeless person' as opposed to 'a person experiencing homelessness' is not merely a semantic distinction. The former substantively qualifies the person as being identical to their vulnerable state, the latter identifies the person as an intrinsic object of respect and qualifies them according to the vulnerable state they're experiencing.

II. **Paternalistic protection:** The perpetuation of vulnerability through reductive reification has a further consequence of placing the caregiver in sole possession of identifying and addressing what is in the best interest of vulnerable persons. This paternalistic impulse tends to focus solely on protecting vulnerable persons from harm at the expense of their autonomous expression, however attenuated it may be. This is understandable, however, precisely because the vulnerable person is, after all, in a state of *impaired, weakened or developing agency*. And yet, this impulse needs to be prudently tempered, if not resisted. To protect against harm without at the same time promoting capacity-building benefit can *never* be in the interest of the vulnerable person. The twin preoccupations of the principle of vulnerability must be maintained simultaneously - immoderate focus on the negative, protective aspect perpetuates or worsens the susceptibility to the very harms that the caregiver must perpetually protect vulnerable persons from. For example, in the developmental services sector, individuals with intellectual or developmental disabilities should be protected from harms: self-harm, abuse, manipulation, reckless permissibility, etc. However, these individuals ought also be given the "dignity of risk,"[12] coincident with self-determined decision-making that is proportionate with their capacities for autonomous expression. That it is often assisted by a network of care providers simply means that cared-for persons enjoy a different degree of relational autonomy than their neurotypical counterparts. It does *not* mean that cared-for persons are to be prescribed benefits and protected from harms without their informed consent (again, however attenuated the capacity for such may be).

III. **Acquiescing to evidentiary autonomy:** Conversely, a caregiver may be inclined to excessively focus on the self-determined expressions of a vulnerable individual as if doing so demonstrated appropriate respect for autonomy. While interfering with another individual in order to force them to realize what is in their best self-interest is morally wrong, it would also be morally wrong for a designated care provider to permit an individual to make decisions, and realize their consequences, when they are incapable of sufficiently understanding and appreciating them. The classical notion of *autonomy* involves rational self-determination; an individual ought to be at liberty to make decisions about their life according to their own private beliefs, values and commitments that they consider worthy of assent. The feminist philosophical qualification of this notion of autonomy, *relational autonomy*, serves as a critical reminder that no individual is so isolated as to either obtain this capacity for self-determination, or to exercise it, in the absence of the influence of, and impact on others. Autonomous agents are interrelated, and are consequently dependent on one another to furnish the capacities, contexts and contingencies of self-determined action. Given this reality, autonomy becomes more than merely the episodic expression of an individual's desires or doxastic states; this is merely *evidentiary autonomy*. Rather, autonomy comes into being as the considered, intentional, and repeatedly developed beliefs, values and commitments of individuals that guide their decision-making over time. This is known as *integrative autonomy* and is what caregivers are charged with cultivating, understanding and respecting in situations of informed consent. When a vulnerable person experiences weakened agency because of inherent status, illness, disability or developmental state, the caregiver is charged with providing *weak paternalism* - acting in the best interests of the vulnerable person *according to their integrative autonomy* and a considered conception of the aforementioned *basic human goods*.[13] This is easier to determine when the vulnerable person is an adult who has experienced a sufficient amount of time to develop integrative autonomy. It is considerably more difficult

[11] In their paper "Individual Vices and Institutional Failings as Drivers of Vulnerabilization," (Social Epistemology, August, 2024) authors Havi Carel and Ian James Kidd differentiate between intrinsic and contingent vulnerability, and assert that the latter form of vulnerability involves "the fact that many individuals are made to be and to remain vulnerable by the actions, omissions and decisions of other people, as well as by material, political, economic, medical, educational and legal circumstances." (3).

[12] See the Mental Health and Developmental Disabilities National Training Center's fact sheet "Self-Determination and Dignity of Risk" (07/2023: https://www.mhddcenter.org/wp-content/uploads/2020/07/Self-Determination-Dignity-of-Risk-Fact-Sheet.pdf; accessed 12/05/2024)

[13] See Gerald Dworkin's "Paternalism" in 'Bioethics: Principles, Issues and Cases 6th Ed.', edited by Lewis Vaughn. Oxford: Oxford University Press, 2025.

to do the same when the vulnerable person is a child or an individual with an intellectual or developmental disability. With these persons we do not enjoy access to the interests informed by their integrative autonomy because it either has not yet, or cannot ever be substantively developed. Caregivers should, therefore, be guided by securing, promoting and making provision for basic human goods while helping them to develop the capacities necessary for the burgeoning expression of integrative autonomy. Merely acquiescing to expressions of their evidentiary autonomy would be both imprudent and irresponsible.[14]

IV. **Ideological influence:** The susceptibility that is involved by being in a state of vulnerability is not restricted to physical, social or economic harms, but psychological, emotional or intellectual harms as well. Persons susceptible to undue forms of psychological, emotional or intellectual influence must be protected from such influence. They must also be provided with the cognitive tools necessary for understanding and appreciating information that they can then assent to at their considered discretion. This is far and away the most difficult pitfall to avoid because would-be caregivers all have their own beliefs, values, motivations and intentions. However, as the National Education Association's "Code of Ethics for Educators" indicates, the instructional care provided by educators involves obligations to *not*: "unreasonably restrain the student from independent action in learning … unreasonably deny the student's access to varying points of view … (or) deliberately suppress or distort subject matter relevant to the student's progress."[15] The obligation of caregivers is, then, to foster an environment conducive to the individual's obtainment of intellectual and character virtues; i.e. dispositions that promote good habits of thought and action. Here "good" is intended to be content-neutral, objectively beneficial conditions that grant the possibility of understanding, appreciating and assenting to ideas, and of freely formulating intentions, motivations and decisions to act. The relational autonomy this implies also has a further implication: the social conditions within which autonomy comes to expression must themselves reduce susceptibilities to harms (viz. again, be they educational, physical, sexual, emotional, or psychological). For example, a child raised in an orthodox religious household is unduly restrained from certain topics of inquiry, prejudicially kept from accessing alternate points of view, or has certain subjects distorted to fit the orthodox ideological commitments of adult educators. This has the effect of psychologically manipulating and intellectually indoctrinating the child, which in turn influences the kinds of decisions they are inclined to make for externally prescribed reasons, intentions and motivations.

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[14] WMA Declaration of Lisbon on the Rights of the Patient (https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/)The legally incompetent patient
If a patient is a minor or otherwise legally incompetent, the consent of a legally entitled representative is required in some jurisdictions. Nevertheless the patient must be involved in the decision-making to the fullest extent allowed by his/her capacity.
If the legally incompetent patient can make rational decisions, his/her decisions must be respected, and he/she has the right to forbid the disclosure of information to his/her legally entitled representative.
If the patient's legally entitled representative, or a person authorized by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution. In case of emergency, the physician will act in the patient's best interest.
WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects
§3: The Declaration of Geneva of the WMA binds the physician with the words, "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "A physician shall act in the patient's best interest when providing medical care."
§19: Some groups and individuals are particularly vulnerable and may have an increased likelihood of being wronged or of incurring additional harm.
All vulnerable groups and individuals should receive specifically considered protection. §20: Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research.

[15] See the National Education Association's "Code of Ethics for Educators" (1975: https://www.nea.org/resource-library/code-ethics-educators; 12/05/2024). See also the Belmont Report: "Because the subject's ability to understand is a function of intelligence, rationality, maturity and language, it is necessary to adapt the presentation of the information to the subject's capacities. Investigators are responsible for ascertaining that the subject has comprehended the information. While there is always an obligation to ascertain that the information about risk to subjects is complete and adequately comprehended, when the risks are more serious, that obligation increases. (…) Special provision may need to be made when comprehension is severely limited -- for example, by conditions of immaturity or mental disability. (…) Undue influence, by contrast, occurs through an offer of an excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance" (§C.1; p.10; 12)

In identifying the essence of the principle of vulnerability and highlighting some of the pitfalls associated with it, my hope is to carve out a conceptual space for its responsive and responsible application. It is to that we will now turn.

III. GUIDELINES FOR APPLYING THE PRINCIPLE OF VULNERABILITY

The following framework is intended to provide a structured guideline for identifying and carefully addressing the vulnerable status of persons requiring the care of others.

First Step: Vulnerability Assessment

In order to determine how to responsively and responsibly care for vulnerable persons, it is essential to determine the nature, causes, contexts and possibilities of their particular vulnerability.

A. Nature, causes and contexts of vulnerability

- Is the vulnerability: inherent, situational (viz. dispositional or occurrent), or pathogenic (or some combination of these)?
- Narrative and phenomenological accounts of vulnerability: from the person cared-for and from their support network (to the extent possible)
  - Invite vulnerable persons to give an account of what they are experiencing, how they came to experience it, what they think is the cause of it, how they perceive the experience itself and the impact it has (physiological, psychological, social, etc.)
- Identify any situational or pathogenic factors contributing to vulnerability: physiological, psychological, social determinants (historical, economic, political, cultural, linguistic) of their condition

B. Harm-Benefit analysis

- Given information from (A) to what **harms** is the person susceptible?
  - List real and potential harms and prioritize severity and urgency based on a numerical scale of 1-5, with 5 being the most severe threat
    - NB: Harms should be understood in normative terms; i.e. those things that would serve to i) disrespect personhood, ii) instigate or perpetuate discrimination or dehumanization, iii) render a person or group unable to obtain basic human goods, or iv) undermine an individual or group's ability to exercise their freedom within the bounds of basic morality
- Given information from (A) what capacity-building **benefits** does the person stand in need of?
  - List real and potential benefits and prioritize intensity and urgency based on a numerical scale of 1-5, with 5 being most intensive benefits
    - NB: Benefits should also be understood in normative terms; i.e. those things that are i) necessary for the expression of personhood, and ii) those things that are minimally necessary for human beings to maximally thrive (i.e. basic human goods)

C. Identification of vulnerability

- Bio-psycho-social Venn Diagrams
  - Distill information from (A) and (B) to create a Venn Diagram that gives an encapsulation of the vulnerable person under your care
  - One diagram should be dedicated to the set of inherent vulnerabilities, the set of situational vulnerabilities, and the set of systemic vulnerabilities.

- Another diagram should be dedicated to the set of intersectional vulnerabilities, the set of harm mitigation strategies, and the set of capacity-building benefits

Second Step: Moral responsibility strategy

In order to best serve the needs of the vulnerable person, it is necessary to identify the moral responsibilities we have to them relative to their vulnerable status. Here, moral responsibility should be understood in pluralistic terms; i.e. to involve interest in basic respect and obligations to persons, realizing the most beneficial outcomes, and enacting principles of justice, all while expressing basic virtues.

A. Building trust

- Recognizing that vulnerable persons are entrusted to another's care, the caregiver must embody and express virtues of honesty, integrity, fidelity, generosity, empathy and understanding - without these, the care relationship can neither function nor flourish
- Authentic trust-building involves: open, honest, consistent and clear communication, making commitments that can be honored and then honoring those commitments; being principled

B. **Prioritized protection**

- Based on the previously identified list of real or potential harms, determine the strategies necessary to fulfill the moral responsibility to protect against or mitigate harms
- This should be done in consultation with the vulnerable person (and the network of care-providers to the extent possible)
  - NB: it may be the case that some actions done for the sake of protecting a vulnerable person against harm are not recognized as such by that same person (e.g. a person with an intellectual or developmental disability should be secured against self-harm behavior even though they may express a desire to the contrary) - effort must be made to clearly communicate the reason for the proposed action
- Determination of the kind, scope, scale, and duration of protection from, or minimization of, harm is the goal here
- Guiding question: *Will the proposed decision cause more harm than it seeks to minimize?*

C. **Prioritized empowerment**

- Based on the previously identified list of benefits, determine the strategies necessary for their realization
- This should be done in consultation with the vulnerable person (and the network of care-providers to the extent possible)
  - NB: it may be the case that some actions done for the sake of capacity-building benefit are not recognized as such by the vulnerable person they are intended to help (e.g. a child that does not at the present time want to receive an education ought nevertheless to receive one) - effort must be made to clearly communicate the reason for the proposed action
- Determination of the kind, scope, scale, and duration of maximization of capacity-building benefits is the goal here
- Guiding question: *will the proposed action promote or undermine the future potential for the individual to make integrative autonomous decisions?*

Third Step: An evolving care relationship

A. Where are we now?

- Provide a brief sketch of the caring relationship based on steps 1-2; this will serve as a baseline for determining the profitability of the care being provided

B. Where would we like to be?

- Based on steps 2 and 3, provide a loose timeline for the potential realization of harm mitigation and benefit enhancement

C. How will care adapt?

- Attendant with the realization of the goals of care comes the change to the vulnerable status of the cared-for; care-providers must adapt to this reality by discontinuing modes of care coincident with a prior state of vulnerability and promoting modes of care consistent with the present state of vulnerability

The above guideline is what I was able to come up with through my own research in vulnerability, moral responsibility and applied ethics, as well as my own varied experiences of seeking to fulfill my responsibility of care to others. It is by no means intended to be either exhaustive or doctrinaire, so please make amendments wherever you think helpful to your own practice of caregiving. I'd be much obliged if you'd share your suggestions and experiences so that we may collectively improve our responsibilities as caregivers.

IV. CONCLUSION

The purpose of this paper was to position the principle of vulnerability in the forefront of the would-be caregivers mind. Those placed in positions of caregiving have a moral responsibility to those being cared-for. I have maintained that in order to fulfill this responsibility it is not enough to merely provide vulnerable persons with protection from harm. This can lead to reification and paternalism that perpetuates vulnerability, making the cared-for indefinitely beholden to, and reliant upon, the caregiver - and that, according to the dictates of the latter. But, the would-be caregiver must neither sail toward the Charybdis of unreflectively acquiescing to evidentiary autonomy in order to avoid the Scylla of paternalism. Doing so fails to fulfill the imperative of the principle of vulnerability.

As explained, the principle of vulnerability must simultaneously involve both the protection from harms to which vulnerable persons are susceptible while also furnishing benefit-conferring capacities. In order to fulfill the positive requirement, the would-be caregiver is charged with helping the cared-for develop the capacities for integrative autonomous decision-making. I finally maintain that in order for the would-be caregiver to fulfill this twin objective, the caregiver must be responsive, sensitive, respectful, open-minded, and adaptive to the needs of the cared-for. Thus, the caregiver must cultivate the corresponding intellectual and character virtues within themselves. There will be occasion in the lifespan of the care relationship where the vulnerable person is no longer as susceptible to the harms they once were at the beginning. This abatement of susceptibility is coincident with the building of capacities for realizing benefits and expressing autonomy. The caregiver must, therefore, always be prepared to adapt the scale and scope of the care they provide: removing protections and permitting risk where appropriate, respecting autonomous expressions where appropriate - even, or especially, to the point where the person no longer wishes to be cared for by the caregiver. This is, of course, a practical judgment made in a complex context. It is my hope that the foregoing will help reduce perplexity for caregivers charged to address the vulnerabilities of those under their care.