How to protect the Vulnerable?

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On April 2, 2020, the front page of the *Zeit* asked its readers „Wie schützen wird die Schwachen?“ (How do we protect the vulnerable?). Indeed, the protection of vulnerable groups has been one of the major aims of states’ interventions since the pandemic outbreak.

Rooted in rather clear cut medical categories indicating specific high-risk members of the population facing serious virus complications, the enigma of vulnerability has found its way into public discourse and eventually into the law.

Politicians and governmental representatives call upon this exact human vulnerability as a shared condition when they refer to societal solidarity for the introduction of protective albeit restrictive measures. So far, this call for solidarity has fallen on fertile ground. However, it is foreseeable that the longer the lockdown continues the less affirmative the public opinion will become. Vulnerability in fact presents a focal point for states’ obligation to protect, but triggers the question of how we deal with issues arising in the context of equality and proportionality.

Therefore, starting from some consideration on how to protect vulnerable groups in public health emergencies, we take a closer look at immediate reactions to the virus outbreak and reflect on the legal implications of vulnerability for the exit-strategies from the current lockdown, focusing on the proposal of maintaining restrictive measures for vulnerable groups only. We argue that the balancing between containment measures and the protection of fundamental rights becomes even more pressing with respect to vulnerable groups, especially in view of proposals aiming at restricting curfews to high-risk populations. Over-emphasizing their need for protection bears the risk of disregarding their rights and autonomy and one-sidedly imposing paternalistic measures in order to urge a solution and alleviate economic consequences.

Vulnerability in Public Health Emergencies

In the context of public health ethics in case of pandemic, there is broad consensus on the need to safeguard the groups at highest risk of suffering adverse health outcomes if infected. However, regulators’ responses to the outbreak, which primarily consist of restrictions on freedom of movement as well as decisions regarding the allocation of healthcare resources, may put some groups in a (more) vulnerable position. This is due to a narrow conception of vulnerability (limited to previous medical conditions) and of its protection (limited to the reduction of the infection risk).

At first glance, it seems rather simple to define vulnerability in case of a pandemic. Identifying groups exposed to higher health risks is, indeed, feasible on the basis of

fairly straightforward clinical criteria. For instance, the UK Government's strategy to fight the virus outbreak includes specific recommendations for a well-defined list of patients who are deemed at higher health risk and, therefore, extremely vulnerable. This list is updated daily by an algorithm that employs NHS data from hospitals and general practitioners, and includes, *inter alia*, organ transplant recipients, patients with respiratory conditions or on immunosuppression therapies.

However, the category of vulnerable groups must not be reduced to this "clinical" vulnerability. It is indeed clear that pandemics as well as the respective governmental countermeasures affect not only high-risk populations, but also people who are socially worse off and at greatest risk of economic and psychological harm, including for instance migrants, homeless people and elderly living alone (see here, p. 8), and thus exacerbating what could be defined as "social" vulnerability.

The protection of vulnerable groups is linked not only to averting the risk of infection, but also to building resilience to cope with the crisis in general. In contrast, containment strategies based on social isolation are likely to negatively affect especially the elderly, thus resulting in a "serious public health concern". This effect is particularly severe when curfews are limited to the most vulnerable groups, as currently discussed (see below). Such measures are likely to have a particularly marginalising effect, to increase social and psychological vulnerability, as well as to reduce autonomy.

Finally, if hastily taken in a context of emergency, decisions regarding the allocation of scarce resources are likely to disproportionately affect vulnerable subjects. In Italy, the first country in Europe dramatically struck by the virus outbreak, the guidelines of the Italian Society of Anesthesia, Analgesia, Resuscitation, and Intensive Care (heavily criticized, also on this blog) potentially affect the right of access to intensive care for vulnerable patients, by giving triage criteria based on a patient's age and overall health status. In contrast, the *Deutsche Interdisziplinäre Vereinigung für Intensiv- und Notfallmedizin* advises to rely on treatment success, which cannot be assessed merely on the basis of the patient's age (as welcomed here). Nonetheless, precedent vulnerabilities such as comorbidities might curtail patients' chances of treatment.

Immediate Reactions to the Virus

The immediate reaction in Germany shows two different lines of intervention: measures explicitly targeting vulnerable groups and others applied generally to society as a whole. The underlying strategy for both types of interventions seems to follow the pattern of "containment, protection and mitigation" mentioned, for instance, in the "*Nationaler Pandemieplan Teil I*". As soon as infection tracing fails and the spreading of the virus cannot be contained anymore, the focus of action is supposed to shift from containment to the protection of vulnerable groups (see here, p. 8), including selective segregation, exclusion of patients from certain facilities, ban on admission of certain groups of people, physical separation of patients and non-patients.

Indeed, the first legal interventions pertained to vulnerable groups. While school closings primarily aimed at containing the virus, schools being known as local accelerators for the spread of “ordinary” influenza, the restrictions on visits to retirement and nursing homes mainly served to protect the inhabitants. Despite their necessity, those measures lead to social isolation and restriction of substantial rights. For instance, the regulations on Corona in Baden-Württemberg additionally forbid mother-child-measures according to Sec. 111a Social Code Book V, and temporarily suspended care or support services performed in groups, due to increased risk of infection, especially for the vulnerable groups (see here, Sec. 7). The latest amendment regulation permits nursing homes residents to leave the facilities only for essential tasks, such as accessing medical treatment or exercising in the fresh air. Another example for the legal irritation induced by vulnerability in times of Corona, is Sec. 5 of Baden-Württemberg’s Corona Regulation: It orders asylum seekers to stay in their assigned initial reception center for two weeks, while the federal law, in contrast, foresees in Sec. 49 para. 2 Asylum Act that the obligation to take residence “may be terminated for reasons of public health”.

Those rather targeted measures were accompanied by interventions on all members of society, primarily the “lockdown” implemented by the *Länder* and imposing the practice of “physical distancing” on all citizens (e.g. see here). Those restrictions affect vulnerable individuals tremendously, although not specifically addressed to them and aimed at their protection. Due to their embodied or societally embedded vulnerability, they face additional challenges that have to be accounted for when assessing the proportionality of restrictions. Depending on the individual circumstances, the respective measures might even increase the risks for those groups (see here).

Legal Implications of Vulnerability for Future Strategies

Given the unprecedented constraints on fundamental rights, the principle of proportionality has been widely invoked (see here and here). Since the growth of new infections is gradually slowing, more detailed information on the virus is obtained and the economic and psychological damages keep increasing, the call for exit-strategies from the lockdown and the implementation of differentiated measures arises. One of the suggested solutions requires isolating clinically vulnerable groups instead of restricting society as a whole (see here, here and here). From an ethical point of view, this would accommodate the fact that inter-societal solidarity is not limitless (see here and here). Put in legal terms, this distinction could offer an overall mitigated interference with fundamental rights and would even be demanded by the principles of equality and proportionality (see here, p. 25, 26).

Indeed, special recommendations for certain risk-groups have already been adopted by other European countries. In Italy, according to art. 3 of the Prime Minister’s Decree of 8 March 2020 all elderly people or people with comorbidities are expressly recommended to avoid leaving their homes or residences if not strictly necessary. In the UK, individuals from extremely vulnerable groups are approached individually by

an NHS letter strongly recommending the adoption of stricter measures than those applicable to the whole population, and for a longer duration (at least 12 weeks).

According to the *Bundesverfassungsgericht*, art. 2 II GG requires the state to protect life but, given the gravity of the current restrictions, the principle of proportionality requires a close and continuous monitoring and assessment as to possible lifts of constraints (see here para. 15, 16). In this process, a comprehensive understanding of vulnerability plays a major role. If included in the balancing act, the concept of "social vulnerability" would help contextualising the effects of certain measures on individuals.

A gradual exit from the lockdown is certainly desirable, but should not be accompanied by a prolongation of mandatory measures (enforced by sanctions) for vulnerable groups only. In fact, neither the principle of proportionality nor equality demand or *per se* justify mandatory additional restrictions of high-risk groups. While it is true that states have elevated obligations to protect medically and socially vulnerable individuals, this does not give cause to a more intense and far-reaching intervention in their rights, which can often be observed (see here). On the contrary, the established case-law of the ECtHR prescribes that, when a restriction on fundamental rights applies to someone belonging to a particularly vulnerable group, the state's margin of appreciation is substantially narrower. It must therefore have very weighty reasons for the restrictions in question (see for instance here). Against this background, economic interests and a paternalistic protection of high-risk groups do not meet the aforementioned threshold. Utilitarian arguments placing the freedoms of the majority above that of vulnerable groups are tobe deemed disproportionate. In light of their significant effects, additional restrictions targeted at vulnerable groups should therefore be voluntary to the greatest extent possible and complemented by tailored information (see here, p. 8). In this regard, recommendations for self-protection as issued by Italy and the UK are preferable over mandatory restrictions. Appeals to individual responsibility would in fact prove more effective than sanctions, since they call on intrinsic motivation based on solidarity as well as self-interest (see also here, p. 8).

With respect to the principle of equality, the mere reminder that "treating equal things equally and unequal things unequally" does not substitute a proportionate balance of interests, and must not lead to a single-sided burdening of "clinically" or otherwise vulnerable groups. Moreover, the choice of the respective comparison group and the definition of a *tertium comparationis* is crucial. So far it seems that the different treatments have been grounded on the clinical vulnerability of certain risk-groups. However, it must be recalled that COVID-19 is not exclusively harmful for those patients, but can also affect other parts of the population, albeit with a lower likelihood. Moreover, the primary aim of mandatory restrictions (enforced by sanctions) is the protection of public health as a whole rather than the imposition of a paternalistic shield to vulnerable groups (see, also, the recent 3rd ad-hoc opinion of the Leopoldina Academy, p. 11). Their justification should thus rather lie within the risk that the targeted population poses to public health (see here, p. 27). Vulnerable groups might indirectly pose a risk to others to the extent that they are likely to exhaust resources in terms of hospital beds. The immediate risk

they pose to the health of others though is no higher than that of any other person able to transmit the virus. This, in turn, means unequal restrictions can only be justified when this (indirect) specific threat to public health is imminent and likely to materialize.

Finally, solidarity is bi-directional. The burdens borne by all members of society over the last weeks to fight the Coronavirus are commendable, and it is reasonable to expect those who are at higher-risk to take precautionary measures. Nonetheless, reversing the solidarity argument to justify restrictions limited to clinically vulnerable groups stretches the boundaries of the principles of proportionality and equality.
