



‘We thank you for your sacrifice’: Clinical vulnerability, shielding and biosociality in the UK’s Covid-19 response

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Abstract The UK response to Covid-19 has been unusually complex in its ever-shifting classifications of clinical vulnerability. By May 2020, 2.2 million people had been identified as ‘clinically extremely vulnerable’ (CEV) and were asked to ‘shield’ at home for over four months. To adhere to this strict guidance, they were enfolded within the patchy infrastructure of the ‘shielding programme’. However, membership of the ‘shielded list’ has changed—often without warning or explanation—through time and across space. Drawing on policy and evidentiary documents, government speeches, reports, press conferences and media analysis of Covid-19 coverage between March 2020 and April 1, 2021, this paper traces the shifting delineations of clinical vulnerability in the UK response across three lockdowns. It argues that the complexities and confusions generated by the transience of the CEV category have fed into forms of biosociality that have been as much about making practical sense of government guidance as a form of mutual support amid crisis. This uncertainty has not eased as restrictions have been relaxed and vaccines rolled out. Instead, tracing individual immune response has become a burgeoning industry as ‘the shielded’ navigate the uneasy demands of taking ‘personal responsibility’ rather than being protected by ‘the rules’.

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Introduction

The potential threat posed by novel emerging infectious diseases has long been known (see for example Morse and Schluenderberg 1990; Garrett 1995; Weir and Mykhalovskiy 2010), even if national governments have chosen to heed such warnings to wildly differing degrees. In the UK, Exercise Cygnus—a ‘command post exercise’ to assess the country’s preparedness for pandemic influenza—concluded that “the UK’s preparedness and response...is currently not sufficient to cope with the extreme demands of a severe pandemic that will have a nation-wide impact across all sectors” (Public Health England 2016, p. 6). Despite this warning, the UK government failed to put into place many of the report’s key findings and recommendations (Scally et al. 2020) and continued with the systematic under-funding and marginalisation of public health (Marmot et al. 2020). While particular attention has been trained on the human price now being paid for a lack of *infrastructural* public health preparedness as Covid-19 emerged and surged in 2020 (see for example Horton 2021), this paper instead focuses on a different, and under-scrutinised, preparatory gap laid bare by post hoc reviews of Exercise Cygnus.

As noted in a recent paper prepared for the UK’s Ministry of Housing, Communities and Local Government (MHCLG) in February 2021, “the testing of plans and policies for the identification and shielding of clinically extremely vulnerable people were not objectives of Exercise Cygnus” (Ministry of Housing Communities and Local Government 2021, p. 7). As a result, the report explains, the government was forced to act “quickly in the absence of detailed contingency plans for identifying and supporting a large population advised to shield” (*Ibid*). This paper explores how the UK’s ever-changing classifications of clinical vulnerability have created a confusing and ‘transient’ category—“not in the sense of afflicting a single person for a while and then going away, but in the sense of existing only at a certain time and place” (Hacking 2006a, p. 4). As Hacking (1998) asserts in his book *Mad Travelers*, transient categories must be understood in relation to the “ecological niches” in which they “can appear and thrive” (2006a, p. 4). As this paper will explore, while categorisations of clinical vulnerability are partly an artifact of the rapidly emerging epidemiological and clinical evidence base around Covid-19, they are also “suffused with traces of political and social work” (Bowker and Star 2000, p. 49). This paper traces this topography and, perhaps most importantly, its human consequences.

The UK Coronavirus response has been unusual—and also unusually transient—in its initial delineation in March 2020 of *two*, easily confused, groups defined as being at elevated risk of serious illness or death from Covid-19 (Schwalbe et al. 2020; Wilson 2020). First, those categorised as ‘clinically vulnerable’ (‘moderate risk’) by virtue of being over 70, having ‘pre-existing’ health conditions, a Body Mass Index (BMI) over 40 or being pregnant. Second, those categorised as ‘clinically extremely vulnerable’ (‘high risk’) by virtue of specific medical conditions including organ transplant recipients, people with specific cancers, severe respiratory conditions and those who are immunocompromised



or immunosuppressed who were then asked to ‘shield’ themselves at home for almost four months. Official demarcations of clinical vulnerability have been roundly critiqued as vague and confusing (All Party Parliamentary Group on Coronavirus 2020). They have also carved out new pandemic subjects and forms of biosociality (French and Monahan 2020, p. 7) not least as a means for those so classified to try and gain some sense of certainty amid a rapidly shifting and unpredictable terrain. By contrast, those who are *structurally vulnerable* (Holmes 2011; Quesada et al. 2011) to Covid-19 through the pernicious effects of inequality, deprivation, ethnicity, place of residence, poor housing or occupation (Public Health England 2020a, b) were, until February 2021, largely outside the classificatory ambit of the UK response even as evidence of their elevated risk and disproportionate burden of mortality grew (Bambra et al. 2020). To further add to the complexity facing the vulnerable, all four nations of the UK have issued different public health guidance in different ways and at different points in time. This paper will thus focus on the situation in England, while also and unavoidably referencing the UK’s national Covid response.

The shifting classificatory landscape of clinical vulnerability is not inert. Rather the ‘making up’ of vastly different cohorts of people (Hacking 1986, 2006a) into the category of ‘clinically extremely vulnerable’ (CEV) to severe illness or death from Covid-19 has been halting and often contradictory. Inclusion in the category has had very real material effects on individuals (cf Epstein 2008). This has led to an often-fraught politics of inclusion and exclusion as patient groups have had to advocate for their particular vulnerabilities to be formally recognised by inclusion on the official ‘shielding list’ which enabled ‘shielders’ to access the support of ‘the shielding programme’. Amid the current surfeit of writing on Covid-19 (Bell and Green 2020; Connell 2020; Will 2020), this paper brings the sociological, anthropological, epidemiological and political into close conversation to trace the shifting topography of official ascriptions of clinical vulnerability in the UK. This is an important point of intervention because amid the tsunami of Covid writings across the social and medical sciences, there has not yet been any critical engagement with the differential ‘making up’ of CEV citizens—a single category which belies significant internal heterogeneity. Attending to this requires first dissecting how such groups came to be composed, a surprisingly complex archival task that has arguably only now become possible as the process itself has come under closer parliamentary scrutiny (House of Commons Committee of Public Accounts 2021). In critically reflecting on the changing topography (and communication) of vulnerability as people were added to and taken off ‘the list’, the paper draws attention to the material and ethical consequences of such seemingly innocuous classificatory shifts.

The paper explores the period from early March 2020 to April 1 2021, a time of three national lockdowns in the UK, a complex tangle of local ‘tier’ restrictions and periods of easing restrictions. During this time, the guidance and advice to those classified as CEV changed through time and across space creating great frustration. Uncertainty was compounded by slippage between the terms ‘guidance’ and ‘advice’ in letters sent to shielders, especially when set against the UK’s use of the term ‘the rules’ as a shorthand to convey a miasmatic combination of coronavirus legislation, guidance and advice, some of which was legally binding and much of



the rest relying on the public exercising their ‘common sense’ (Reicher and Drury 2021). Given that the category of CEV has a ‘material force’—through access to government support and, since December 2020, priority vaccination—membership of the shielded list has moral, economic, and practical significance. Membership has also forced many to make impossible judgements between protecting their health and preserving their livelihoods, in circumstances where strict adherence to government guidance might render them unable to work should they not be permitted to work from home. Given this, it is little surprise that the CEV category has been a potent ‘object of contention’ (Bowker and Star 2000, p. 3) for multiple constituents since its introduction in March 2020.

Drawing on critical analysis of government guidance, correspondence, reports, committee submissions, speeches, press briefings and the papers considered and circulated by its Scientific Advisory Group on Emergencies (SAGE), the paper first examines the changing ways in which vulnerability has been categorised and communicated since March 2020. Second, it explores the communications strategies by which the category of CEV was initially communicated and concretised through appeals to ‘civic duty’, altruism and responsibility (to others and the National Health Service). It then reflects on how this process has ‘made up’ (Hacking 1986) new health subjectivities and forms of biosociality (Rabinow 1996). These have been heightened through social media support groups, the emergence of new charities lobbying for official recognition and the work of patient and disability groups. The paper concludes by reflecting on the most recent moment of lockdown easing. While over 94% of CEV people have received at least one vaccine dose (Office for National Statistics 2021a), many remain vulnerable to Covid-19 due to weak immune responses. While this represents a profound challenge for the CEV, it is also a moment of opportunity. Private testing providers are now capitalising on the ongoing uncertainties of vulnerability to sell ‘immunity tracking’ tests enabling individuals to quantify their immune response to vaccination to make ‘informed decisions’ about their future. The end of the UK’s shielding programme in April 2021 will not mark the end of the forms of biosociality explored here. Instead, the end of Covid-19 restrictions look set to cement new social and cultural fault lines as the shielded navigate uncertain immunological futures amid a political backdrop that is no longer committed to their protection.

The complex classifications of clinical vulnerability

On March 5 2020, almost a month after the WHO declared the novel coronavirus outbreak a Public Health Emergency of International Concern, the UK government published its *Coronavirus Action Plan*. At this point, the UK had 173 lab-confirmed cases. The *Action Plan*’s fundamental objectives were to “deploy phased actions to Contain, Delay, and Mitigate any outbreak, using research to inform policy development” (Department of Health and Social Care 2020a, p. 6). Based on early epidemiological evidence from China (Guan et al. 2020; Huang et al. 2020), the document states that, “the risk of severe disease and death increases amongst elderly people and in people with underlying health risk



conditions... overall illness seems rarer in people under 20 years of age” (2020a, p. 5). This plan thus set out the risk group framework that largely guided the UK response in the first wave of the pandemic. The *Action Plan* warned that additional measures would be needed to “protect vulnerable individuals with underlying illnesses and thus at greater risk of becoming seriously affected by the disease” (2020a, p. 18).

On 5 March and 10 March 2020, meetings were held with SAGE to discuss how vulnerable groups might be identified and, importantly, protected (Ministry of Housing Communities and Local Government 2021, p. 23). The UK’s initial ‘Contain’ phase of early case detection and contact tracing moved into the ‘Delay’ stage on March 12, 2020. This involved slowing the spread of the virus, lowering its peak impact and pushing it away from the winter flu season—what has now become known as ‘flattening the curve’. In its early stages, the Delay phase was centred on public health advice on hand washing, following official travel advice and (self)isolating if experiencing a cough or fever. In practice, many companies asked employees to work from home, public transport use fell dramatically, and parents removed their children from school in advance of any explicit government directive to do so.

On March 12, Johnson gave a speech in which he spoke directly to older people,

This disease is particularly dangerous for you... even though for the vast majority this will be a mild to moderate illness, I know that many people will be very worried. We should all be thinking about our elderly relatives, the more vulnerable members of their family, our neighbours, and everything we can do to protect them over the next few months (HM Government 2020a).

On March 15, the government expanded its public education campaign beyond hand washing, to avoiding older and ‘more vulnerable’ people if exhibiting symptoms. On March 16, now with 1,543 official cases, the government held the first of its daily coronavirus briefings during which the Prime Minister, Chief Medical Advisor and Chief Scientific Advisor announced new social distancing measures, the suspension of mass gatherings, asked symptomatic households to isolate for 14 days, the public to cease all unnecessary contact with others and halt all non-essential travel. Johnson’s speech at the press briefing that same day warned that,

By this coming weekend it will be necessary to...ensure that those with the most serious health conditions are largely *shielded* from social contact for around 12 weeks... this is going to be very disruptive for people who have such conditions, and difficult for them... I know that many people - including millions of fit and active people over 70 - may feel...there is something excessive about these measures (HM Government 2020b, emphasis added).

The linguistic fusion of ‘vulnerability’ with ‘shielding’—a term not previously used in the lexicon of public health responses to infectious disease—quickly become one of the defining narrative strategies of the UK government’s approach to risk reduction. The implications of this will be further explored later in this paper.

During this time, the four national UK Chief Medical Officers met to agree the specific clinical criteria upon which people would be advised to shield. The



Ministry of Housing Communities and Local Government (MHCLG) report is at pains to assert that, at this time, “the criteria for shielding were exclusively clinical to identify people at the highest risk of mortality and severe illness from Covid-19... based on the limited evidence at the time” (2021, p. 23). By 18 March, an ‘interim list of conditions’ had been finalised. These would remain largely unchanged until the early summer, but correctly identifying and informing those on ‘the list’ would prove a significant challenge. It is important to note that, at that time, “age was not an individual criterion for inclusion in the CEV group, but all people aged 70 and over were advised to take extra precautions as part of the group considered clinically vulnerable” (2021, p. 23). Furthermore, “potential risks associated with ethnicity were considered in detail, but the clinical criteria used to determine if someone was CEV already covered those clinical conditions more prevalent across ethnic minority groups. At this time, ethnicity risks could not be differentiated from other non-clinical factors such as occupation” (*Ibid*).

At the press briefing on March 17, one notable difference was the sudden appearance of the banner “Stay home > Protect the NHS > Save Lives”, a mantra that dominated the UK public communications strategy for two months (Calvert and Arbuthnott 2021). At the press briefing on March 22, Johnson announced that, “We have come to the stage of our plan... when we have to take special steps to protect the particularly vulnerable. I said the moment would come where we needed to shield those with serious conditions. There are probably about 1.5 million in all” (HM Government 2020c). This number proved to be a gross under-estimation as many more were forced to self-define as CEV as their ‘shielded status’ had not been officially recognised by a GP letter generated from the central medical records of NHS Digital. In all, an estimated 2.2 million people (including 90,000 children) would end up on the ‘shielded list’ in the UK by early May 2020 (House of Commons Committee of Public Accounts 2021). The period from the official start of the shielding programme on March 22 to early May 2020 was thus marked by a cumulative increase in the number of people on ‘the list’ as GPs were asked to validate and apply their own judgement to the NHS digital data and patients themselves came forward seeking official recognition of their vulnerability so that they could access the social support promised by the ‘shielding programme’. Thus, to paraphrase Ian Hacking (2006a, b), people were both being ‘made up’ by governmental classifications of vulnerability, but also and importantly ‘making up’ themselves to ensure formal recognition of such vulnerability.

This timeline also traces the emergence of two, admittedly confusing (Bradley et al. 2020), segmentations of elevated vulnerability and risk in relation to Covid-19 in the UK. First, those categorised as CEV who were issued ‘guidance’ in the form of an official letter to ‘shield’ at home. Until June 1 2020, this meant they should stay in their home or garden with no visitors at all times (Office for National Statistics 2020a). This heavy demand was made possible by a supportive infrastructure including priority food and prescription deliveries, the ability to request furlough, access statutory sick leave, Unemployment and Support Allowance or Universal Credit. Second, those categorised as ‘clinically vulnerable’ which included people aged over 70, pregnant women, and those with one of a series of chronic health conditions or morbid obesity. This expansive group, comprising an estimated 25% of



the UK population (Jordan et al. 2020), was “strongly advised” to avoid any “social mixing in the community”, to work from home and avoid public transport where possible, be “particularly stringent in following social distancing guidelines” and “try to stay at home as much as possible” (NHS 2020).

With understandable slippage in lay understandings of the two classifications of clinical vulnerability used in the UK until August 2020 and further confusion over the difference between ‘guidance’ and ‘advice’ (in a context where everyone was repeatedly told to ‘follow the rules’), many in the latter group would end up shielding unnecessarily. It is also important to note that although age was not a criterion for inclusion on the shielded list, almost two thirds of those on it were aged over 60 (The Health Foundation 2021a). As an article in the *New Scientist* highlights, “there has been some confusion between the two groups, leaving some people officially classed as at only moderate risk believing they shouldn’t ever go outside” (Wilson 2020). Similarly, a poll by the charity Independent Age of UK adults over 65, found that 43% of people believed that the government had instructed over 70s without any underlying health conditions to stay at home and shield themselves. This interplay between age, health status and risk has, arguably, had significant implications for people’s understanding and perception of their own vulnerability and, as a result, the kinds of subjectivities that were shaped in those early months of the pandemic. These have been rendered more complex because, as recent research from the Health Foundation (2021a) notes, the characteristics of those categorised as CEV varied substantially across the UK’s regions reflecting patterns of health inequalities, ethnicity, deprivation and the methods by which individuals were added to the list. In Liverpool for example, 60% of all CEV people were in the most deprived quintile, while in North West London, the figure was just 18% (*Ibid*). Adding a further layer of moral complexity, while shielding was purely voluntary in theory, the official significance and grave tone of the letters sent to the CEV combined with understandable anxiety and fear over the personal risks posed by coronavirus led to overwhelming adherence to the guidance.

On March 23 2020, the UK officially moved to a full lockdown, with the Prime Minister ordering businesses and schools to close and the public to stay in their homes. These lockdown measures remained in place until May 10 when Johnson announced a change of messaging from the clear imperative to ‘stay home’ to the ambiguous (and much maligned) “Stay alert > Control the virus > Save lives”. At his press briefing that day, he introduced the government’s five-point ‘alert scale’ and announced that lockdown easing would “proceed cautiously” and that those who could not work from home should go to work the next day but avoid public transport to do so. In the foreword to *Our Plan to Rebuild: The UK Government’s COVID-19 Recovery Strategy*, published on May 11, Johnson acknowledged that “people up and down the UK have made an extraordinary sacrifice, putting their lives on hold and distancing themselves from their loved ones. It would have been higher had we not shielded the most vulnerable—providing help and support to those that need it” (HM Government 2020d, 3). This congratulatory statement is quickly contradicted ten pages later when the strategy authors admit that, “It is not possible to know with precision the relative efficacy of specific shielding and suppression measures” (2020d, p. 13). From this time, a series of modifications



were made to the shielding guidance to find “the right balance between continuing to protect those at the greatest clinical risk, whilst easing restrictions on their daily lives to make the difficult situation more bearable” (HM Government 2020e). On June 1, the guidance was relaxed so that those shielding were advised that they could now venture beyond their houses or gardens to exercise if they could stay two metres away from others. When non-essential shops opened on June 15, the CEV were promised “further guidance” a week later. On June 22, in the government press briefing, Deputy Chief Medical Officer, Jenny Harries, stated that “the advice to those shielding is to start taking steps now to start coming back to a more normal lifestyle”. She acknowledged that “this has been a very difficult and sometimes frightening period for those shielding. To give people time to prepare we’re setting out the advice in a stepped approach” (HM Government 2020f). At the same briefing, Matt Hancock offered a rare direct message of thanks to “all those who have been shielding for so many weeks for their commitment to the shielding programme”. He noted that their “sacrifice has been for a purpose... these measures have been vital in saving lives” (*Ibid*).

At this time, the gulf between CEV people only now permitted to form a ‘support bubble’ with one other household and the rest of the population anticipating the wholesale re-opening of hospitality venues on July 4th was growing. This rift was further complicated by changes to ‘the list’ in late May when many shielders—including those with some cancers, liver disease and severe asthma—were notified by text message that they were no longer required to shield (Roxby 2020), with many GPs unaware of this change in the guidance. In practice, this meant that many people who had previously been on the list could now no longer use this designated status to access support services or benefits and were forced to return to work. The rationale behind the changes in the list were flagged in *Our Plan to Rebuild*. The report promises that “as the Government learns more about the disease and the risk factors involved, it expects to steadily make the risk-assessment more nuanced, giving confidence to some previously advised to shield that they may be able to take more risk; and identifying those who may wish to be more cautious” (2020d, p. 23). It terms this ‘smarter shielding’, an approach based on “more effective risk-based targeting of protection measures” (2020d, p. 36) that would seek to minimise both loss of life and some of the negative externalities—on individual physical and mental health—of the shielding programme itself. While the report promised “more precise advice about who is at greatest risk” (2020d, p. 36)—echoing Davey Smith and Spiegelhalter’s call for “stratified shielding” (2020) and Ioannidis’ later call for “precision shielding” (2021)—the shielded list would ironically climb from 2.2 million in 2020 to 3.7 million people by its final iteration in February 2021. When shielding officially ended (for the first time) on August 1 2020, the CEV were advised by letter to “remain cautious as [they were] still at risk of severe illness if they developed Covid-19”, to “adopt strict social distancing measures” and to go to work if unable to work from home as long as the workplace was Covid safe (Department of Health and Social Care 2020b). For many, this letter signalled a fraught moment of impossible risk calculation. This was rendered even more so as the end of shielding coincided with warnings issued in the Prime Minister’s press briefing on July 31 that, “The prevalence of the virus in the community in England is likely to be rising for



the first time since May” and that unless “people follow the rules and behave safely, we might have to go further” in reimposing restrictions (HM Government 2020g).

As the UK’s Covid-19 caseload increased in September 2020, calls started to grow for a short, national ‘circuit breaker’ lockdown to, once again, ‘flatten the curve’. While an increasingly labyrinthine ‘tier’ system of local restrictions would first be imposed, a month-long national lockdown belatedly followed on November 5. A search of Hansard reveals multiple petitions to government arguing for the reinstatement of the shielding programme during this time. These petitions reveal the mounting sense of vulnerability felt by those classified as CEV now concerned about going to work and sending children to school at a time of rapidly rising case numbers. Whether bowing to pressure from these petitions or not, shielding letters were reissued to the CEV during the November lockdown. In late November 2020, people with Downs Syndrome were added to the shielded list, an addition that points to the interlocked complexities of mental and physical health risks and learning disabilities, as well as the lobbying efforts of various disability charities (Royal Mencap Society 2021). When the UK went back into its third national lockdown in early January 2021, the shielding programme was reinstated. This coincided with UK’s much-lauded vaccination drive that was undertaken according to priority risk groups developed by the Joint Committee on Vaccination and Immunisation.

On February 17, a ‘living risk prediction algorithm’ called QCovid that had been in development for ten months was launched (Clift et al. 2020). Unlike previous designations of CEV, the QCovid tool included age, ethnicity, domicile type and a deprivation score (postcode). This new clinical risk prediction tool identified a further 1.7 m people as CEV who were then asked to shield until the programme ended on April 1 2021 (Mahase 2021). Readers of *Pulse*, a magazine and website for GPs, expressed confusion as to why, for example, women who had gestational diabetes in past pregnancies with no further complications were now being asked to shield while those with current type-2 diabetes or pre-diabetes were not (Mohamoud 2021). This model would also have implications for the initial nine vaccine priority groups (of the over 50s) as it placed those classified as CEV in group four and those in a more expansive ‘at-risk group’ (according to a broad range of clinical conditions) in group six. In all, the switch to QCovid would identify an additional 820,000 people as being prioritised for vaccination, but also now having to remain in their homes.

Tracing the shifting sands of clinical vulnerability in the UK since March 2020 is no simple “archaeological expedition into the records” (Bowker and Star 2000, 46). As designations of vulnerability have changed through time and across different local authority areas of the UK, so too have government records and official guidance—quickly erasing the evidence of what came before. Caught amid this confusion have been some of the country’s most at-risk people, unsurprisingly often *choosing* to shield as one of the few ways of exercising agency and minimising risk amid a landscape of pernicious uncertainty. On one hand, the story of clinical vulnerability through the shielding programme indexes the ever-expanding global and local evidence base on Covid-19, but it also reflects the work of patient groups, medical organisations, charities and an expansive group of ‘lay experts’ (Epstein 1998) in pushing for official recognition of a panoply of existing clinical vulnerabilities



through inclusion on the list and its associated social protections. However, alongside this, list membership raised the spectre of profound mental, physical and economic hardship as the vulnerable felt compelled to follow official guidance to protect themselves or family members (Wise 2020). As such, the shielding list and the programme that scaffolded it, have been accompanied by fractal forms of biosociality made possible through new organisations, social media groups and networks of local support groups. Crucially, however, members of the shielded group, as the Health Foundation (2021b) recently notes, were far from homogenous. And, while the needs of many were rendered visible through inclusion on the list, many other forms of vulnerability remained invisible (and thus reinforced) by individuals' inability to access the enhanced social protection offered by shielding.

From subjectification to biosociality

The 1986 *Ottawa Charter for Health Promotion* arguably ushered in a new era in public health (Peterson and Lupton 1996; Awofeso 2004). What some have termed the 'New Public Health' emerged as concern grew with repurposing the field towards prevention and addressing the risk behaviours (also commonly phrased as 'lifestyle') most commonly associated with the chronic, non-communicable diseases that had become the majority cause of mortality and morbidity across the global north. As Sarah Nettleton asserts, this era was characterised by the belief that, "it is not environmental factors, or bacteria, or viruses per se that cause illness; the critical factor resides in individuals, more particularly their self-control" (1997, p. 215). Scholars of the New Public Health thus brought critical attention to questions (and consequences) of ideas of 'the self', personhood and subjectivity and, with this, new relationships to risk. This arena of health policy and research dove-tailed not only with the cementing of neoliberal health policy, but also a post-structuralist turn—heavily influenced by the work of Michel Foucault—in sociology and beyond that traced the intersecting roles of power, discourse and knowledge in health and medicine (Petryna 2004; Rose and Novas 2005). It was further accompanied by interest in the ever-expanding domains of health expertise (Rose 2007), in particular, the rise of epidemiology and biotechnological innovation, the identification of risk factors and classification of risk groups and the new forms of biosociality emerging from this (Rabinow, 1996).

At root, therefore, ideas of health and modes of health communication have long been underpinned by an "emphasis on risk factors which are within the control of the individual [which] contributes to the confirmation of the active citizen, the self who can be, and indeed *ought* to be, in control of his or her self" (Nettleton 1997, p. 215). This assumption of self-control, agency and self-knowledge has been central to neoliberal approaches to the government of lifestyle as a risk factor for chronic disease over the last three decades. The longstanding assumption (and hope) by those governing that individual subjects are "rational, calculating actor[s] who adopt a prudent attitude in respect to risk and danger" (Peterson and Lupton 1996, p. 15) has, however, been fundamentally challenged by the profound differences in risk and



vulnerability presented by a novel virus (Maunula 2013), which so often produces unanticipated and complex sequelae even in 'low risk' groups (Yong 2020).

Nikolas Rose has argued that medicine "makes us what we are by reshaping the relations of meaning through which we experience our worlds" (2007, p. 701). This is seen clearly in relation to Covid-19, where emergent clinical and epidemiological evidence—combined with the theatre of daily press briefings delivered by politicians and given 'evidentiary charisma' by scientific advisors (Kelly 2018)—has necessitated and produced new strategies of subjectification. These have seen people, such as those aged over 70 who had previously considered themselves to be 'healthy' by virtue of their lifestyle choices, reconstituted as 'clinically vulnerable' subjects (see Katz 2011, 2015) and called upon to make profound behavioural changes and personal sacrifice. However, by contrast to the governance of chronic disease and its risk factors, agency alone is not necessarily a route to "influence one's own trajectory" (Nettleton 1997, p. 212) and escape a risk grouping (e.g. by modifying diet and exercise to move out of a pre-diabetic category). Instead, agency is a means by which the newly vulnerable can render this designation visible, while those around them are implored to act 'responsibly' and 'do the right thing' to protect them. This has marked a profound refashioning of health subjectivities not just for the estimated 25% of the UK population interpellated into the shielded category, but also for those responsabilised with protecting them. To echo Hacking, the example of shielding shows, in really fascinating ways, "how names interact with the named" (2006a, p. 2). This interaction has been propelled through a suite of technologies—press briefings, interviews, op-eds, GP letters, quarantine, the news, technical guidance, and public information campaigns—that have created the 'conditions of possibility' by which new understandings of risk and vulnerability of the self and others have been brought into being.

The kind of 'active citizen' inherent in the New Public Health thus stands in stark contrast to the passive docility that contagion control or preventative medicine, for example, have assumed (and mandated) of their citizens (Awofeso 2004; Stephenson et al. 2014). To be classified as CEV in the context of Covid-19 comes with certain assumptions of the capacity for "self-control, responsibility, rationality and enterprise" (Nettleton 1997, p. 213) to "follow the scientific advice". But, unlike chronic disease risk behaviours, risk in this instance is determined neither by "one's personal *circumstances*" nor their "personal *capacities*" (ibid, emphasis in original). Instead, risk operates as an artefact of epidemiological data in which the usual neo-liberal promise of 'self-transformation' or 'self-knowledge' does nothing to alter this categorisation. These new forms of contingent and relational subjectivity are consequently bound closely to the forms of epidemiological expertise that have uncovered the risk profiles of Covid-19 mortality and developed the prognostic models that have concretised taxonomies of clinical vulnerability and a panoply of new public experts who have communicated the 'science' to the public. This is what Hacking has termed "the vector of labelling from above" (1986, p. 168). Pandemic subjects, in other words, are made up through heeding expert advice in ways that bring about certain ends of government, namely reducing viral transmission to 'protect the NHS'. Yet, there remains a productive, political power in hailing people to the category (and thus subjectivity) of 'clinically vulnerable' or 'clinically extremely



vulnerable’ and the concomitant necessity to ‘be shielded’. This is not least as it enables government to demonstrate their moral commitment to providing ‘the shield’ needed to protect the vulnerable. This clear narrative of salvation is complicated by Hacking’s ‘second vector’—the “autonomous behaviour of the person so labelled, which presses from below, creating a reality every expert must face” (1986, p. 168).

Vulnerability and risk may be lexically synonymous in the designation of ‘high risk/ clinically extremely vulnerable’, but the two terms do different technical and moral work. For example, “vulnerable populations... [are those] that share social characteristics that put them at higher *risk of risks*” (Frohlich and Potvin 2008, p. 218, emphasis added). Such vulnerability can thus technically be found, among “those who concentrate numerous risk factors throughout their life course because of shared fundamental causes associated with their position in the social structure” (2008, p. 219; see also Ecks 2021). Designations of ‘clinical vulnerability’ to Covid-19 are thus actually foremost categorisations of what a recent British Medical Association “Covid risk assessment tool” terms “biological risk” (2020), given that they are largely de-coupled from questions of “position in the social structure” or indeed the kinds of ‘structures’ that have animated more public health and anthropological concern with vulnerability. And, as Hacking has argued, “a set of people with a risk factor is a biological not a social group. But people at risk for the same disease will clump together for mutual support, joint advocacy, and, in many cases, activism... they are, of course biosocial, that is societies formed around a biological condition” (2006b, p. 91). He continues, “while their initial motivation might be advocacy or support, increasingly we shall have ‘making up people’ with a vengeance. That is new kinds of people will come into being, people characterised by a certain risk factor, who band together to create a social group that evolves its own collective characteristics” (2006b, p. 94). It is to these new forms of biosociality (Gibbon and Novas 2007) grouped around new sites of both knowledge (and crucially the gaps in it) to which this paper now turns.

Creating biosociality, ensuring compliance

It is impossible to consider the taxonomies of risk and vulnerability in the UK’s response to Covid-19 without reflection on how they have been communicated and, as such, come to compose individual subjectivities. As Des Fitzgerald argues, the imperative to “Stay home > Protect the NHS > Save lives” is not just a government order, it is also an “aesthetic and textual force” in which language and imagery have become key strategic tools in the maintenance of public trust and adherence (2020). The designation of clinical vulnerability cannot be considered apart from the strategies used to ensure that individuals obeyed the rules imposed by their taxonomic subjectivities. While much attention has been trained on the epidemiological modelling of SPI-M (the UK government’s Scientific Pandemic Influenza Group on Modelling), far less consideration has been paid to those of SPI-B (its group on Behaviour). The latter, composed of over 30 academics, representatives from government, the Behavioural Insights Team, the Office for National Statistics (ONS) and the police is charged with “anticipating and helping people adhere to interventions



that are recommended by medical or epidemiological experts”. On March 4, SPI-B released a short report entitled “insights on combined social and behavioural interventions” (HM Government 2020h). The document considers the “social acceptability” of a range of interventions being considered by SAGE. They suggest that “the combination of interventions most likely to be socially acceptable involves isolation of symptomatic cases and isolation of at-risk members of the public”. The rationale for this being that these are “the most closely targeted, and therefore obviously legitimate, strategies” (*Ibid*). On the question of asking at-risk groups to isolate, the authors make two observations that are particularly pertinent. First that because isolation is “aimed at protecting the self, rather than others...it may be more difficult to ‘persuade’ people to adhere [as] some people may simply choose to accept the risk of leaving of their home”. Second, that “setting the criteria for who falls into an at-risk category requires sensitivity: A blanket application of ‘over 65’ may be unambiguous but will not be helpful if this includes healthy individuals such as recently retired doctors or MPs”. The report ends by reflecting on the linguistic and classificatory challenges of these “non-pharmaceutical interventions”.

They stress that “an appropriate term is needed. ‘Cocooning’ [a term infamously used in an interview by the founder of the Behavioural Insights Team, David Halpern, on March 11; but also formally used in the Irish response] feels patronising”. They also suggest that “‘isolation’ has negative overtones for older adults”. To overcome this, a further SPI-B report on March 9 (HM Government 2020i) suggested that “messaging on isolation could be more powerful if framed as both an act of protecting oneself, as well as protecting others”. Moreover, for those isolating, “there is a risk of stigma, so [it] should be portrayed as an act of altruistic civic duty” (*Ibid*). It is notable that the term ‘vulnerable’ is not explicitly used to denote risk within these SPI-B documents, but it appears in the SPI-M-O “Consensus view on behavioural and social interventions” released on March 16 which asserts that, “the addition of both general social distancing and school closures to case isolation; household isolation and social distancing of vulnerable groups would be likely to control the epidemic when kept in place for a long period” (HM Government 2020j). The tropes of civic duty, protection of others and altruism would become commonplace in government briefings and interviews and, when combined with the language of vulnerability, serve to ‘make up’ pandemic subjectivities.

Focussing again on language, it is interesting that, while the *Coronavirus Action Plan* and the SPI-M-O document of March 16th write of ‘isolation’, the Prime Minister’s speech on the same day instead warned that it must ensure “that those with the most serious health conditions are largely *shielded* from social contact for around 12 weeks” (HM Government 2020b) and that this would be an act of “maximum protection”. In his speech the following day, Johnson added that “the shielding of vulnerable groups will reduce suffering” (HM Government 2020k). Yet the provenance of the term ‘shield’ remains something of a mystery given it only appears in Hansard returns from March 16 and was completely absent from SAGE papers until April 11. Indeed, Shadow Secretary for Health, Jonathon Ashworth noted just this in a parliamentary debate on the Coronavirus Bill on March 23 2020, when he asked the Secretary of State for Health, Matt Hancock,



Can we have more adverts on television and more adverts on radio stations? Can we have a leaflet going through every door, explaining what social distancing means, explaining what shielding means? Before this virus took hold, the words ‘social distancing’ and ‘shielding’ were probably not often used in the Chamber, so if they are not words that we are familiar with, we can bet that our constituents are not entirely familiar with them either.

Given the overtures of protection, duty and weakness bound into the word ‘shield’, it serves to convey a sense of vulnerability far better than ‘isolation’. However, beyond this, its use—as both a technical term and a moralised political trope—is deeply significant, particularly in its creation of a new category (and thus subjectivity) of ‘shielders’ (Poole 2020). This is more so because, despite now being a mainstreamed term in the UK, it has never been a commonly used public health or epidemiological term in the context of viral containment or pandemic response. Rather ‘shielding’—or more precisely the passive ‘being shielded’ that is most common in government guidance (Bradley et al. 2020)—is a political construct that cannot be considered apart from the rampant use of military metaphors by politicians and the media in talking and writing about Covid-19. As a letter to the British Medical Journal notes, “the UK shielding policy is unique internationally” (Evans 2021), even if it was arguably far from unique in its effectiveness.

In the US for example, CDC guidance recognises “people at increased risk” of severe illness as those who need “extra precautions”. Australian guidance singles out those “at higher risk of severe disease”. The WHO identifies those over 60 and those with underlying medical conditions as being “at higher risk of getting severe Covid-19 disease”. By contrast, it defines “vulnerable population groups” as those who are *socially* vulnerable by virtue of being homeless, migrants, refugees, disabled, living in remote locations or closed facilities or being in poverty (World Health Organization 2020). The French response categorises “personnes fragiles” as those “at risk of severe Covid-19 illness”. Similarly, the Swiss classify those at “higher risk” as “personnes vulnérables”. Finally, the European Centre for Disease Prevention and Control, makes a distinction between those people “at higher risk of severe disease” (high risk groups who are “medically vulnerable”) which is counterposed against those populations who are “socially vulnerable” to “the consequences of the public health measures that have been imposed to control the spread of the virus” and which may exacerbate their already challenging life situations (ECDC 2020).

While these countries issued lockdown or ‘stay at home’ orders (or *confinement* in French) from mid-March onwards, the UK was alone in creating a new, distinctive, category of people ‘being shielded’ whose status depended on being on a ‘shielded list’ and having an official letter that granted access to the ‘shielding programme’. As Bowker and Star have argued, classifications are material as much as they are symbolic (2000, p. 39) and, in this case, deeply imbricated in the lives of those who either found themselves on the list or felt that they needed to be on it. While the use of this terminology might be dismissed as a minor semantic difference in an ocean of Covid neologisms, these words have nevertheless had a profound effect on how people have imagined and constructed their own sense of vulnerability and, in turn, self. Indeed, as Bradley et al. have argued and



returning to the question of agency raised earlier in this paper, “NHS correspondence that refers to people ‘being shielded’ rather than who ‘are shielding’ understates the autonomy of individuals in choosing how they wish to reduce their risk of infection” (2020, p. 2). These linguistic choices also then place responsibility for the protection of those ‘being shielded’ on family, friends, the NHS, government and, often, the kindness of strangers. The traction of the language of shielding can be seen in one simple (if obviously imperfect) metric—that the number of social media support groups making reference to shielding in the title far outstrips those using the term CEV.

The narrative strategy of shielding and ‘protecting the NHS’ was clearly successful if widespread British adherence to the strictures of lockdown is any indicator (Reicher and Drury 2021). Among those people on the shielded list, ONS (2020a) data show extremely high levels of compliance with government guidance, despite placing often impossible restrictions on people’s lives. From May 28 to June 3 2020, a little over two months after the shielding programme began, 95% of people were still mostly or completely following the guidance and 51% reported not having left their home at all since shielding started. Of those shielding, 28% had previously been working and, of these 623,000 people, 31% were furloughed and 17% had stopped working altogether. It is of note that 35% reported deteriorating mental health, with the greatest decline in those aged under 59. By a later wave of data collection in early July, 32% of those who had previously worked were now either not working, were furloughed or collecting income support. Despite a backdrop of eased restrictions and the opening of shops and hospitality, 60% were still completely following the shielding advice, a drop of only 3% since early May when national restrictions were still in place (Office for National Statistics 2020b).

After a national lockdown was re-imposed in January 2021, the shielding programme resumed. At this time, 95% of people reported mostly or completely following the guidance and 77% reported receiving no visitors at all in the past week (Office for National Statistics 2021b). As the classification of CEV expanded to include those identified by QCovid, the March 22–March 31 2021 ONS data noted virtually no difference between the original and new CEV cohorts in those following government guidance at 49% and 48%, respectively (2021c). A greater proportion of those in the new group (24%) reported not leaving the house at all in the past week, compared to those in the original group (17%). Somewhat counterintuitively, high levels of adherence may be because (and not despite) the fact that government advice was “too slow and complicated” and “the level of risk to many individuals was not effectively communicated” (All Party Parliamentary Group on Coronavirus 2020, p. 45). Given this, it is unsurprising that multiple online support groups emerged to support those who were either on the shielded list or felt that they should be and made the decision to shield themselves regardless. These are clear instantiations of the “new group and individual identities and practices arising out of these new truths” (Rabinow 1996, p. 102). They demonstrate the need, on one hand, for practical support with accessing the shielding programme and dealing with the innumerable challenges of daily life confined to the home. But they also serve a broader political imperative of trying to ensure the greater visibility of a new category of CEV people and their heterogenous conditions, as well as providing



ongoing support to followers trying to navigate their way through an ever-changing epidemiological, public health and policy landscape.

For example, social media groups such as “We’ll shield again!”, “Shielders United UK”, the “Covid Shielding Support Group” or “Shielding healthcare workers” may count over 12,000 members (a fraction of the 3.7 million final shielder tally), but nevertheless demonstrate the existence of such biosocial collectivities. Recently formed charities such as ShieldUs have also emerged with the aim of creating a mainstream symbol that the CEV can wear (as badge, t-shirt, high vis jacket etc.) to denote their vulnerable status, raise public awareness and educate others to ‘give them space’. While of limited reach, the symbol has been used by a number of NHS Trusts for their CEV staff and the charity has set about campaigning to ensure the continued ‘public profile’ of shielders to ensure they are not forgotten (see Petersen et al. 2019). It offers template letters to MPs and to share on social media highlighting how, for many CEV people, the pandemic is far from over and their need for protection remains.

The degree of mobilisation around the notion of shielding can also be seen by the sheer volume of online chats on websites such as Mumsnet, ostensibly a site about parenting, but frequently used as a barometer of (middle-class) public sentiment by politicians and the press (Pedersen 2020). Shielding threads started to appear on the site on March 22 2020 with members asking for practical advice on the difference between social distancing and shielding and asking for peer support to help manage the new challenge of domestic and work lives. Online chats expressed dismay at the complexities of following the advice (especially when one household member was told to shield and they lived with a key worker who had to go to work), asked how to access support, what to do if not on the list and how to get on the list, how to care for children who were shielding, questioning how long the programme would continue for, dealing with loneliness and isolation, anxiety and fear, arranging furlough, accessing sick pay, returning to work and school and coping with the end of shielding and a return to ‘normality’. Many of the chats are highly critical of the confusing government advice and looking to others for reassurance on how to mitigate and manage the risks of essential activities and new-found freedoms as the first lockdown was eased. Frustration and disquiet across these online groups notably surged as the economy opened up and those who were still shielding felt their vulnerability being magnified by the failure of others to ‘respect the rules’ and exercise common sense. As the press debated the prematurity of relaxing restrictions, news headlines such as “some people shielding allowed outdoors from Monday” (Kleinman 2020) sparked intense debate about the degree to which shielding was impelled by law or voluntary and how such headlines were contributing to the ‘othering’ of the CEV. At the same time, growing numbers of people out and about also made it progressively harder for those classified as CEV to be able to exercise even these small freedoms as it became harder to always stay two metres away from anyone outside their household.

Many of these threads reveal the deep anguish felt by the CEV at being consistently forgotten in government communications and in the planning for lockdown easing. This was a sentiment echoed by a submission by the Multiple Sclerosis Society to a parliamentary committee. It points out that while grand communications



to the nation were the hallmark of the Westminster Government’s early pandemic response,

Communication regarding vulnerable groups often felt lacking or belated. The Government failed to directly address CEV and clinically vulnerable groups at key points throughout the year, leaving many people with MS feeling forgotten or uninformed. On numerous occasions, the Prime Minister and other Government ministers made significant announcements to the public that had life-changing implications for CEV people, but without mentioning them at all. This made vulnerable people feel forgotten and anxious and ... eroded trust in Government messaging among some people in our community and among other vulnerable groups (MS Society 2021).

Threads also show a divide between those confident in making individual risk calculations about daily activities and those looking for stronger government and societal commitment to their protection. The cadence of these threads reflect key moments of transition in the government response, bursts of news reporting, press briefings and the implications of new scientific findings or advice. They also reveal the extreme heterogeneity of the CEV group whose constituents live with a vast array of clinical conditions that affect their lives in very different ways and view the pandemic response through vastly different political perspectives. Thus, while shielding led to new forms of biosociality in the search for peer support at a time of great uncertainty, there is a fractal nature to these that must be acknowledged (Bradley 2021). In other words, the people ‘made up’ into the ‘transient’ CEV category had *already* been ‘made up’ in varying ways and to varying degrees by the very conditions that made them vulnerable in the first place. This complexity was rendered more so by the widespread confusion caused by the semantic slippage between clinical vulnerability and *extreme* clinical vulnerability. As a written submission by the charity Diabetes UK notes, despite the fact that one third of Covid deaths in the UK were people living with diabetes, many people with the disease were not automatically added to the shielded list and instead found themselves in the liminal category of ‘clinically vulnerable’. As the submission continues, “it has never been clear what extra protection was provided for the clinically vulnerable group which people with diabetes are in” (Diabetes UK 2021). Arguably, the legacy of this incomplete interpellation into the CEV category remains among many people even as the UK emerges from its third lockdown.

Looking forward to conclude

This paper has traced a genealogy of the CEV category and its role in ‘making up’ a new—and profoundly heterogenous—group now known as ‘shielders’. Through the ‘scientific evidence’ collated by SAGE and its allied groups and communicated through daily press briefings, radio and TV interviews with politicians, public information campaign and extensive media coverage, Covid-19 has created new forms of subjectivity and biosociality that have been legitimated



and reinforced through endless moral appeals to altruism, civic duty and a kind of ‘national pandemic solidarity’ (Caduff 2020). Arguably, Covid-19 has hailed many people to the status of being vulnerable that have never previously considered themselves such: the ‘otherwise healthy’ older person (c.f. Katz 2011), someone with a managed chronic condition or living with obesity. That said, many of those classified as CEV may have long and acutely felt this designation due to the quotidian precautions ordinarily needed to manage their health risks. Some members of the CEV grouping have, indirectly at least, a strong voice and political sway through the vast number of patient and advocacy groups that represent different diseases and whose submissions to parliamentary committees supporting the needs of their constituents have been examined here. But, with lockdown now easing for the third time and the forms of altruism and civic duty that formed the bedrock of public adherence to ‘the rules’ inevitably dissolving, what is next for these vulnerable subjectivities? It is here that the biosociality approach has particular importance: not just tracing what has past, but to place the changes that are coming in critical context.

The shielding programme officially ended on April 1 2021; yet by April 26, the ONS was reporting that 50% of the CEV were still shielding, despite the fact that 84% knew that shielding had ended and 67% were fully vaccinated (ONS 2021a). At this time, 11% of the CEV had not left their house at all in the last seven days. These statistics strongly suggest that the warnings of the British Medical Association have not been heeded:

It is particularly important that the needs of clinically vulnerable people are considered when working through strategies for exiting lockdown. Many people in these groups have been shielding and isolated for months, with all the associated economic and health issues that entails. It is important that lockdown exit strategies are not predicated on curtailing personal liberty for people within this group (British Medical Association 2021).

As the UK opens up again—whether for good or temporarily—new fault lines between the clinically vulnerable and the rest of the population are emerging amid a context where ‘the rules’ have been replaced by the mantra of personal responsibility and choice. For many people who have been shielding, the mass rollout of vaccinations has been greeted with relief that the risks of social interaction, returning to work and daily life have been significantly reduced. However, as evidence is emerging of poor immune response among some of the CEV—such as those who are immunocompromised (Benotmane et al. 2021; Moss 2021; Sonani et al. 2021)—fears are growing among this group that their immunological vulnerability will be forgotten just as the visibility once granted to them by the shielding programme ebbs. Given that those with rare genetic and autoimmune diseases compose an estimated 18% of those classified as CEV (The Health Foundation 2021b), this means that at least 400,000 people now find themselves in a new, liminal and as-yet unnamed category and thus detached from the kinds of supportive infrastructure that, as Hacking (2009) reminds us, diagnosis often provides. Online support groups are once again awash with new biosocial conundrums: how to *visibly* mark out invisible vulnerability in a public sphere where restrictions have evaporated and mask



wearing is now a choice. Amid this, groups such as Blood Cancer UK have lobbied hard for public and political recognition that vaccination is not universally effective and many patients remain vulnerable as the protections of lockdown evaporate.

The UK’s thriving private Covid testing sector has capitalised on this latest moment of uncertainty, advertising a range of ‘immunity tracker’ products. As one website sells it, “we put test data in your hands, so you can make informed decisions to keep yourself, and those who matter to you, safe. Our fast and efficient process means you can be equipped with the right information to identify risk and take appropriate measures to prevent the risk of spreading Covid-19 further” (<https://www.testingforall.org/how-it-works/>). Recent updates to the shielding fora suggest that the marketing is working and the promise of a ‘standardised count of antibodies per u/l’ is enough to persuade some of those who had been shielding to part with £49 to assess their own immune response to vaccination. Taking a test to know whether the Covid-19 vaccination has worked raises questions of how to interpret the quantitative results given that there are not yet any standardised global figures for a protective immune response. But it also raises the more existential question of what difference knowing the results might make to individuals. Just as those who were classified as vulnerable back in March 2020 have often managed the uncertainties of this designation by avoiding all risk of exposure through shielding, ongoing immunological vulnerability arguably places yet another impossible burden on individuals. Bowker and Star’s question—“what happens to the cases that do not fit?” (2000, p. 9)—seems particularly poignant here. Those who remain CEV despite vaccination exist in a punitive double bind for which there would seem little immediate solution. Hacking’s assertion that there is no “general story to be told about making up people. Each category has its own history” (Hacking 1986, p. 168) is thus particularly salient for the genealogy traced here. This history may still be unfolding, but it will judge us if we do not attend equitably and empathetically to individual lives behind ‘the cases that do not fit’.

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