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The Duty to Treat Versus the Right to Refuse Unsafe Work of Healthcare Workers in Kenya: Implications for Public Health Emergencies

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Abstract

Whenever a jurisdiction is faced with a public health emergency or crisis, the focus of attention is usually the patients who need medical attention. The supply side of the healthcare provision equation (healthcare workers) is usually ignored, particularly in Low to Middle Income Countries (LMICs). The working conditions that healthcare workers are subjected to may be less than ideal and in many instances, unacceptable and unsafe, due to many factors such as long working hours, poor infrastructure, inadequate personnel, lack of personal protective gear, inadequate remuneration, etc. The duty of healthcare workers to treat their patients is pitted against their right to refuse unsafe working conditions.

This article seeks to trigger this debate in Kenya, in light of the recent pandemic and other public health emergencies that have gripped and that may grip the country in the future. It explores the nature of the duty to treat, its origins and justifications and whether indeed there is a duty to treat among healthcare workers in Kenya. It then goes on to consider the right to refuse unsafe work and explore whether this right is implicit in our regulatory system in Kenya. It concludes by proposing a system of reporting unsafe working conditions that will balance the rights of the healthcare workers and the rights of patients with a view to enhancing the realisation of the right to health in times of a health crisis.

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Introduction

"We are at war, with an invisible, relentless enemy!"

These words could easily form the lyrics of the chorus of a song that was sung by the President of the Republic of Kenya and his cabinet secretary for health for a time since the Corona Virus Disease (Covid – 19) pandemic reached the shores of Kenya in March 2020.[1] The sentiments were echoed by the High Court in a case, where Justice Weldon Korir declined to summon the cabinet secretary for health to appear in court to submit a plan for the prevention, surveillance, control and management of the virus. He stated:

> *"I decline to summon the CS…We must all appreciate that we are now at war with an enemy unknown to man. The man leading Kenyans in fighting that war is the President mostly supported by the Cabinet Secretary for Health."*[2]

In any war, there are soldiers and generals, and also civilians. The soldiers in this scenario would be the healthcare workers. Those at the frontlines are particularly vulnerable to death and injury. The generals, in this case, the CS and his team at the Ministry of Health, are the instructors and strategists. The likening of the pandemic in Kenya to fighting of a war creates an impression that no one should abandon their post, no matter how difficult it gets. Abandonment would deem one unpatriotic and would even lead to them being ostracised. In fact, if a soldier abandoned his or her post, they would be court martialled as that is considered a military offence. Herein then lies the dilemma for healthcare workers in a public health emergency. There is the duty that they must fulfil as a result of the oaths that they took and due to medical ethics on the one hand, and there is the right that they have to safe and healthy working conditions on the other. How are these soldiers to manage to balance this dilemma?

[1] See Presidential Speech of 6th April 2020 available at http://www.mfa.go.ke/wp-content/uploads/2020/04/presidential-address-enhanced-measures-in-response-to-the-COVID-19-pandemic-6th-April-2020.pdf accessed 4th August 2020

[2] See *https://citizentv.co.ke/news/court-declines-request-to-summon-health-cs-mutahi-kagwe-over-coronavirus-report-327126/* accessed 4th August 2020

The Covid – 19 pandemic is not the only pandemic to affect the globe. The 1918 Spanish Flu had an even more devastating effect in terms of the number of infections and deaths. There have also been other epidemics and public health emergencies that have had an impact on healthcare workers and have contributed to the debate about the dilemma as to whether there is a duty to treat and attend to patients when there is a real and significant risk of infection and death to the healthcare worker. Does the patient's life matter more than the healthcare worker's life?

It is no small mercy that Kenya has largely been spared the wrath of many epidemics that have broken out in neighbouring countries as well as in other countries which we have ties to – such as the Ebola crisis, Sleeping sickness epidemic, SARS, the Avian flu, etc. Though the country has suffered from the HIV/AIDS crisis of the early 1990's, the effects were not as devastating as countries such as Uganda and South Africa. The dilemmas that the treatment and management of these epidemics raised for healthcare workers were also not readily present. With the Covid – 19 pandemic, these dilemmas have strongly presented themselves, and rather than sweep them under the carpet of political correctness, it is prudent to address these questions and come up with answers that will form the basis of guidelines that can be used, should another pandemic or epidemic arise.

I. The Interrelationship between Ethics and Law

Before embarking on the nature of the duty to treat, and exploring whether the duty is anchored in law or ethics, it would perhaps be useful to set the foundation by examining the relationship between ethics and law. This relationship somewhat can be likened to two lovers who wish to dance together in sync, but because of their awkwardness with each other, keep stepping on each other's toes and hurting each other. This metaphorical illustration of the relationship between law and ethics seeks to bring out the fact that sometimes what is legal may be unethical and what may sometimes be considered illegal may be ethical. The ideal situation is when the two are synchronised i.e. what is legal is ethical and what is illegal is unethical. For health care workers, the distinction between ethics and law is particularly important due to the fact that the two have different sanctions and

consequences for them. If one breaches an ethical rule that is not couched in law, the consequence is meted out by their professional body. But if the action concerned is regulated by law, then the sanctions will be meted out by a court of law. During a pandemic, this relationship needs to be set right. Is there a duty to treat and is it ethical or legal? How does this duty correspond to the right of the healthcare worker to life and health as they treat patients? The healthcare profession has largely been a self – regulating one with various codes of ethics and professional conduct guiding their relationship with patients and with each other. However, in the wake of the Constitutionalisation of the right to health, the rights and responsibilities of health workers have been set out in statutes that seek to operationalize this right.

II. The Duty to Treat: Is it an Ethical or a Legal Duty?

Is there a duty to treat or attend to patients by healthcare workers during a pandemic or other public health emergency, when they are faced with unprecedented risks to their health and lives? This question is not really a unique one considering the past epidemics and pandemics that have occurred in history. The question arose during perhaps one of the worst global pandemics in the 20th century – the Spanish flu. It arose again in the later part of the 20th century with the HIV/AIDS epidemic and the early part of the 21st century with the outbreak of the Severe Acute Respiratory Syndrome (SARS)[3], and the avian flu as well as the recent outbreak of Ebola in West and Central Africa. The exposure of healthcare workers to such highly infectious diseases renders a consideration of their duties to patients and whether they have a duty to treat or attend to them. The question is particularly pertinent in a low to middle income country setting where there are resource restraints and the challenges of protecting healthcare workers from infections are greater. Anchoring the duty on ethics or law is important due to the different consequences that a breach of that duty will attract. If the duty is a legal one, the healthcare worker who breaches this duty can face termination of employment under labour law, or a law suit for breach of their

[3] When the SARS outbreak occurred in 2003, approximately 30 per cent of the global reported cases were of healthcare workers. Many died as a result of the infection.

statutory duty, or negligence for breach of the common law duty of care. If it is anchored in ethics, then a breach of the duty will attract professional sanctions such as suspension or revocation of one's practising licence for professional misconduct. Indeed as Brody and Avery observe, ethical duties may hold health practitioners to a greater standard than legal duties as they are seen as a symbolic communication of reassurance to the public of the responsibilities of healthcare professionals.

III. Duty to treat as an ethical duty

The duty to treat has several ethical foundations. These include: beneficence, non – maleficence, deontology, consent, and social contract arguments. The duty as an ethical one may also be internalised within professional codes of ethics. Clearly codifying the duty to treat and setting out its parameters makes it relatively unproblematic. The rights and responsibilities of health practitioners would be clearly set out, particularly their duties in times of a pandemics and public health emergencies.

Beneficence entails a duty to do good and to act in the best interests of the patient. Within the Hippocratic Oath for instance, the physician swears that they "will use those…regimens which will benefit my patients according to my greatest skill and judgement..." Some interpretations of the principle of beneficence would require the healthcare worker to put the interests of the patients above their own – a form of self – sacrifice, or what would be termed as "medical heroism." In a pandemic therefore, beneficence as an ethical basis for the duty to treat would not be controversial. They healthcare worker would be bound to treat any patient that presents themselves, even if there is risk to the healthcare worker's life. This perception is particularly relevant in Kenya, where in the early days of the pandemic and upon the first case being diagnosed in the country, many hospitals refused to treat patients who exhibited Covid – 19 like symptoms. Some health workers were reported to have abandoned their work stations and left patients in pain and untreated.

Non – maleficence means that the health provider should do no harm. It is couched in the Latin phrase *Primum non nocere* – first do no harm. Failing to treat a patient creates a risk of harm whether it is unintended and careless

harm risk of harm, or it is intentional and reckless risk of harm. Failing to treat a patient during a public health emergency is arguably a breach of duty of care and should harm occur to the patient, in terms of exacerbation of the illness or even death, the health worker could be liable for under negligence. Both non – maleficence and beneficence are ethical principles that strongly support the purposes of medical care i.e. to promote healing, to prevent further harm as a result of illnesses or the possibility of them, to rehabilitate, palliate and educate. Medical care is about the alleviation of patient suffering and the promotion of patient wellbeing.

Perhaps the most relevant ethical foundation for the duty to treat would be deontological ethics or duty based ethics. The main proponent of this ethical principle is Immanuel Kant. Using Kant's categorical imperative, one would ask the question, would healthcare workers elsewhere in the world, take the same action as this particular healthcare worker is about to take? To Kant, situational contexts do not matter. The decision or action must be one that is not situation or context – dependent.

Apart from these mainstream ethical theories, it has been argued that the duty to treat is derived from the consent of the healthcare professional. By choosing to engage in this profession, the healthcare worker voluntarily takes upon themselves the consequent risks that emanate from the treatment of patients – a form of *volenti non fit injuria.* The risk of death and of infection is part of the job, as it were. They are implicit in the nature of the practice of medicine. It can be put this way:

> *"Risk is a part of medicine as it is a part of the work of the police, fire-fighters or soldiers. No one has any of those social roles. If however, they chose to enter public safety roles, then society has the legitimate moral expectation that they will accept the risk attached to those roles…The same is certainly true in medicine."*[4]

[4] Heidi Malm, Thomas May, Leslie P. Francis, Saad B. Omer, Daniel A Salmon & Robert Hood, "Ethics Pandemics and the Duty to Treat" (2008) 8(8) The American Journal of Bioethics 4

However, the assumption that is made in grounding the duty to treat in consent, is that the healthcare worker, at the time of entering the profession and signing the contract of employment, had sufficient information concerning the risks that they would be facing, including a risk of a pandemic or a public health emergency, and sufficient mitigation measures have been put in place. In other words, the contract – based consent was given against the backdrop of proper bargaining power where, in light of the risks that they are bound to face, have the following: adequate remuneration, risk and hazard allowances, compensation for working overtime and sometimes being in quarantine, measures to mitigate for the time away from home and family and also psychosocial support.[5] The other assumption that is made is that at the time of entering into the contract, the healthcare worker envisaged the kind of risk that a pandemic poses. During a pandemic, health workers are called to take upon themselves risks that are perhaps not within their original training and job descriptions. It is arguable therefore, if the ethical foundation of the duty to treat is contract based consent, they can refuse to treat because it is not part of their contract. It is also doubtful whether Kenyan healthcare workers, have such a detailed work contact that envisaged the pandemic that we are now facing. Furthermore, the mere presence of a risk within a certain profession does not necessarily mean that a person has consented to its materialisation. A non – medical example would be that a young female law lecturer, may be aware of the risk of sexual harassment and discrimination from unprofessional and insecure male colleagues and students, but that does not necessarily mean that she consents to it. In the same way, the knowledge that there are risks of death and infection, particularly during a pandemic, does not mean that the healthcare worker consents to the materialisation of that risk. This is particularly the case for such healthcare workers such as laboratory technicians who are involved in the testing of patient samples, nurses and clinical officers.

Indeed, it has been argued that there is a moral duty placed on the healthcare professional to treat. Brody and Avery argue that "physicians arguably have a role – specific duty of rescue by virtue of their medical competence to

[5] Ibid

provide the help that victims of infectious diseases and outbreaks require."[6] Malm, et al posit that healthcare professionals have a special positive moral duty to help those in medical need as a result of the special relationship that is created either by law or by contract. This type of duty creates obligations to take on greater risks than those of general positive duties, which every human being has. The question that arises is whether they are limits to the kinds of risks that they are exposed to. Does this moral duty mean that health workers should take up every kind of risk? What about their duties to themselves or to their families and loved ones? Do those duties matter vis a vis their duties to their patients? Perhaps the limits can be grounded in the ethical principle of utilitarianism. In order for the common social good to be attained, there must be limits placed to exposure to extreme risks in order to preserve society. The exposure of health workers to the risk of death and sickness without any mitigation measures could lead to a healthcare crisis in terms of shortages of healthcare workers in hospitals as a result of death, sickness or even their withdrawal of labour through industrial action or turning away of patients. Healthcare facilities could in turn be seen as unsafe environments for patients who could in turn change their health seeking behaviours to unverifiable sources of treatment.

Healthcare workers are fiduciaries to their patients. They have been entrusted with the knowledge and skill, as well as resources that are not readily available to other members of the public. Clark 2005 states that "the expert knowledge and ability of the (healthcare professional) leads to a higher burden of responsibility to render aid." They cannot therefore in good faith, refuse to treat patients. There is some form of public trust that is placed on them to care for the ill in society. The trust is even higher when it comes to health workers in public facilities, as the resources that they are exposed to are funded by taxpayers. However, if knowledge and trust are the only basis upon which a duty to treat is hinged on, then it would mean that during a pandemic, particularly in resource challenged countries such as Kenya, it would be justifiable to recall retired health workers or restore those who have

[6] Howard Brody and Eric N. Avery, "Medicine's Duty to Treat Pandemic Illness: Solidarity and Vulnerability" (Jan – Feb 2009), Hastings Center Report 40, 41

had their licenses revoked or suspended due to misconduct, because they have the knowledge and the skill. Both these propositions are dangerous.

For healthcare workers who were trained in public universities and medical schools, and perhaps conducted their internship in public hospitals, it is argued that they have a duty to treat as part of their social contract with society. This is because of their fees may have been subsidised using tax payers money, and the resources that they used for their training were also funded using public money. For those employed in the public sector, their salaries come from the public coffers. There are also certain benefits that society confers on healthcare workers as a special privilege for the sacrificial work and the special skills that they have in saving lives, for instance, status and social prestige. In exchange for these benefits, there is considered a reciprocal duty to treat. This argument would hold a lot of water in Kenya, but for the fact that healthcare workers, particularly those in the public sector, do not enjoy these social and professional perks, in the same manner that holders of political positions do. Hence the perennial strikes and protests that have plagued the health sector in Kenya from the onset of the devolution of the health function in 2013. It also would depend on the cadre of the health professional, as not all cadres enjoy social prestige.

Perhaps it would be a stronger argument to ground the duty to treat in professional codes of conduct. Codes of ethics are "guides for ethical reasoning, and frameworks for treatment of individual patients."[7] Many professional codes of ethics, especially in Africa, are silent on the duties of healthcare workers in times of disasters or pandemics. Following the 9/11 terrorist attack in the USA, the American Medical Association came up with a policy document setting out the duties of healthcare workers in such situations. It provided thus:

[7] Carly Ruderman, C. Shawn Tracy, Cecile M. Bensiman, Mark Bernstein, Laura Hawryluck, Randi Zlotnick Shaul and Ross E.G. Upshur, " On Pandemics and the Duty to Care: Whose Duty? Who Cares?" (2006) 7 BMC Medical Ethics, 5 at 7; see also David Orentilecher, "The Physicians Duty to Treat During Pandemics" (2018) 108(11) AJPH 1459

> *"Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This ethical obligation holds even in the face of greater than usual risks to their own safety, health or life. The physician however, is not an unlimited resource; therefore when participating in disaster responses, physicians should balance immediate benefits to individual patients with ability to care for patients in the future."*[8]

It would then be prudent to analyse the current codes of conduct in Kenya, in order to verify whether there is a duty to treat, particularly in times of a pandemic. For physicians – these include, medical doctors of general and specific specialisations as well as dentists - they are regulated by The Code of Professional Conduct and Discipline.[9] Whereas there is no exact duty to treat that is set out in the code, it does provide within its core values, the "respect for quality of human life and dignity" as well as "total commitment to service delivery." There is nothing within the acts that would raise disciplinary issues that suggests that failure to treat patients due to the risk of infection or death in a pandemic would be misconduct on the part of the health professional. However in Chapter V of the Code, reference is made to various international declarations and codes which are applicable to doctors in Kenya, some of which allude to the place of the patient vis a vis the interests of the doctor. For example, in the Geneva Declaration, doctors pledge that "the health of my patient will be my first consideration." This however, does not necessarily create an absolute duty to treat. Clinical officers are also governed by the same code of ethics, *mutatis mutandis.*[10]

With regard to nurses, their code of conduct and ethic[11]s also does not contain a general or specific duty to treat. However, the philosophy of the code states that "all people have a right to quality healthcare regardless of race, creed, ethnic background, political convictions, age, sex or colour."[12] It may have

[8] AMA, "Physician Obligation in Disaster Preparedness and Response" (June 2004)
[9] The Code of Professional Conduct and Discipline (6th edition, Revised 2012)
[10] Clinical Officers (Training, Registration and Licensing) Act (Cap 260, Laws of Kenya), section 15(1)
[11] National Nurses Association of Kenya (NNAK): Code of Conduct and Ethics (July 2009)
[12] Ibid p. 3

been useful to add, and illness. As part of their responsibilities under the code, it states that "The responsibility of nurses is to endeavour to help people attain, retain and regain health."[13]

What is clear from the discussion on the duty to treat as an ethical duty, unless the duty is clearly spelled out and cited as a specific duty on the part of the healthcare professional, it may be difficult to ethically compel a health worker to continue working in an environment that is unsafe and dangerous to their health. One may argue, that, the greater the mitigation and risk minimisation measures, the higher the duty on the health worker. In other words, if the healthcare worker is given personal protective equipment of good quality and is also protected from the other risks and hazards of the workplace or the harm that would occur as a result of working under such dangerous conditions, then there is a higher expectation that they would not engage in any medical discrimination, and be able to handle patients who have highly infectious conditions. Certainly, this was the situation during the HIV/AIDS epidemic, where health care workers had expressed reservations about treating patients with HIV/AIDS for fear of infection. However, when the risk of patient to health worker transmission was reduced as result of proper protective equipment and protocols, then it would be unethical to refuse to treat a patient with the condition. The same argument can then apply in the case of a pandemic. The duty to treat should be measured up against the protection that is offered to the health worker. If there are no mitigation measures, perhaps it should not be considered unethical for the health care worker to refuse to treat a patient where there is a significant risk to the life and health of the healthcare worker.

IV. Duty to Treat as a Legal Duty

As the debate rages on as to whether there is an ethical duty to treat, legal scholars have also been keen to find out whether the duty to treat can be construed as a legal one, and on what basis. This is not to suggest that there is no connection between ethical and legal duties. As pointed out earlier, the consequences could be different, but the ethical basis of the duty to treat can

[13] Ibid p. 5

inform whether it should also be a legal duty and the consequences of its breach. Shwartz emphasises the need to define the legal duty to treat, particularly in pandemics and epidemics. He states that: "..The failure to address the issue of whether and to what extent physicians have a duty to treat people with fatal, highly infectious diseases could have devastating consequences during an epidemic."[14] The increased risk to the healthcare worker, their patients, their family, the exposure to longer working hours, separation from family and quarantines, would make a legal duty difficult to justify if there is also no corresponding duty on the part of the employer of the healthcare worker. Where then, in Kenya, does the legal duty to treat emanate from?

The first point of reference is the Constitution of Kenya. Article 43 (1) (a) provides that:

> *"Every person has the right – to the highest attainable standard of health, which includes the right to health care services, including reproductive health care."*

It goes on to provide:

> *(2) "A person shall not be denied emergency medical treatment."*
> *The duty to treat patients is a significant aspect of the right to health, and particularly the aspects of access to and availability of health services.*[15] *The Corona virus disease has presented in different ways in different patients. For many, they have found themselves as patients requiring emergency and critical care. There is a constitutional duty not to deny any person emergency care. The requirement is couched in negative terms and not positive terms. But the legal import of this difference may not be practically different.*
> *There is also a statutory duty on healthcare providers in both the public and private sector "to provide health care, conscientiously and to the best of their knowledge within their scope of practice and ability, to every*

[14] Ariel R. Schwartz, "Doubtful Duty: Physicians' Legal Obligations to Treat during an Epidemic" (2007) 60(2) Stanford Law Review 657, 659
[15] General Comment No 14 on the Right to the Highest Attainable Standard of Care

person entrusted to their care or seeking their support."[16] *They are also under a duty to "provide emergency medical treatment."*[17]

The duty can also be construed within the common law tort of negligence. Medical negligence has been described as the conduct by a health care professional that falls below the accepted standards of medical practice due to an act or omission on the part of the health care professional. The conduct must cause some foreseeable harm. There are three established elements of medical negligence – duty of care, breach of the duty, and damage as a consequence of the breach of duty. Once a duty of care has been established, then the other two elements will be considered. Does a healthcare worker owe a duty of care to a patient who has a highly infectious disease? How far does the duty go in a pandemic? For health workers in the public sector, the answer would be in the affirmative. For healthcare workers in the private sector, the answer would be dependent on whether this is a patient that they had specifically established a relationship with i.e. through contract. However, as has been seen above, the healthcare worker, even in the private sector may find themselves statutorily and constitutionally bound to provide care to any patient who seeks their support or who is in an emergency situation. If the foreseeable harm as a result of being turned away upon seeking medical attention materialises, then the health worker may be liable for negligence.

Aside from these statutory and common law obligations, a healthcare worker's refusal to treat can be construed as discriminatory and contributing to the stigma that the infectious condition already carries. In Kenya, there is a significant level of social stigma that is attached to the coronavirus disease that would be fuelled if medical discrimination were to also occur.

V. The Right to Refuse Unsafe and Hazardous Work

The COVID – 19 pandemic has brought to the fore, many challenges and weaknesses in the healthcare system in Kenya. Not only does the health system not have a resilient built in surge capacity, but the working conditions

[16] Health Act, No 21 of 2017, section 12(2)(a)
[17] Ibid, section 12(2)(b)

that healthcare workers are subjected to, are in violation of their international, constitutional and statutory rights to decent, safe and healthy working conditions. Health workers, particularly the frontline workers, face a myriad of hazards and risks as they attend to patients during the pandemic. The hazards include "pathogen exposure, long working hours, psychological distress, fatigue, occupational burnout, stigma and physical and psychological violence."[18] The risks are higher for the frontline health workers – the first responders, EMT specialists, ICU specialists, nurses, and physicians as well as ambulatory health workers.

The dilemma that this paper seeks to bring out lies in the two-pronged question i.e. what are the acceptable levels of risk that healthcare workers should face in dealing with patients with highly infectious diseases like COVID – 19? How do you protect the rights of patients while not ignoring the rights and interests of healthcare workers to work in safe and healthy environments?

Placing the right to refuse unsafe work under individual employment law would mean that a hazard is defined and would have to meet a certain pre-determined legal standard for the worker's rights to be enforced. The framework that would be needed would entail the following:

a. A determination would be needed of the type of hazard that would justify a refusal to work
b. A mechanism needs to be put in place to assess the risk levels in the workplace
c. A standard for reviewing a worker's perception of danger
d. A way of allowing the employer to respond to the complaint of danger and of the refusal to work
e. Legal limitations or boundaries of the worker's refusal to work, that would give the employer the right to take certain actions such as

[18] See *https://www.who.int/news-room/detail/28-04-2020-who-calls-for-healthy-safe-and-decent-working-conditions-for-all-health-workers-amidst-covid-19-pandemic* accessed 28th August 2020

disciplinary measures, termination of employment or replacement with another worker.

It is also part of the Decent Work and Future of Work Agenda of the ILO, as well as part of the Sustainable Development Goals.

The neo-liberal tendencies within the labour sector, including the public sector, have led to commodified views of labour, and workers seen only as a means to an end – the employer's end. A commodified view of labour would cause an employer to dismiss an employee and tell them to find alternative work should they find their current working circumstances unbearable. However, the concept of safe work nullifies the concept of commodification of labour and seeks to promote a social justice agenda for the worker as well as their right to decent and safe working conditions.

VI. Is there a Right to Refuse Unsafe Work in Kenya?

To address this question, it is prudent to consider the various grounds/basis upon which the right could be founded.

International Regulatory Framework

By virtue of Article 2(5) and (6) of the Constitution of Kenya, there are several international instruments and general rules that form the basis of the right to refuse unsafe work.

Under international human rights law, the right to safe and healthy working conditions is a component of the right to just and favourable working conditions, as set out in the International Covenant of Economic Social and Cultural Rights.[19] The right to refuse work is then considered as a corollary of the right to just and favourable conditions of work as well as the right to work.[20] The right to work, is the right to decent work which recognises and

[19] Article 7, ICESCR
[20] Article 6

protects the fundamental rights of the worker.[21] According to Hilgert,[22] it is also considered an aspect of the freedom of association because it entails a worker exercising their right to dissent against inhumane and indecent working conditions. Workers are able to collectively form associations to bargain for better working conditions, and to have the bargaining power to withdraw labour should their concerns not be addressed. He argues that anchoring this entitlement within human rights enables workers to "act to improve their working conditions, not in order to enforce pre-determined health or safety regulations, but through their status as workers."

In line with the ILO Constitution which provides for the protection of workers from sickness, disease and injury at work, certain instruments and standards have been developed which are key to member states and signatories to those instruments, regarding safe and healthy conditions of work and the right to refuse unsafe work. The key instrument under the ILO regime is the Occupational Safety and Health Convention and its Recommendation. Member states are required to formulate an occupational safety and health policy that provides ways of minimising and eliminating hazards within the work place that cause accidents and injuries to workers in the workplace.[23] The Convention also provides that workers should not be subject to disciplinary measures as a result of undertaking actions in conformity to the measures that are contained in the nationally formulated policy.[24] Article 13 of the Convention provides for the right to refuse unsafe work in the Convention. It states that:

> *"A worker who has removed himself from a work situation which he has reasonable justification to believe presents an imminent and serious danger to his life or health shall be protected from undue consequences in accordance with national conditions and practice."*

[21] General Comment No 18 on the Right to Work
[22] Jeffrey Hilgert, "Hazard or Hardship: Crafting Global Norms on the Right to Refuse Unsafe Work" (2013) PP53 - 54
[23] C. 155 – Occupational Safety and Health Convention, 1981 (No. 155), article 4
[24] Ibid, Article 5(e)

What the worker must do is to report to his or her immediate supervisor "any situation which he has reasonable justification to believe presents an imminent and serious danger to his life and health." The employer has the obligation to take remedial action and "the employer cannot require workers to return to a work situation where there is continuing imminent and serious danger to life or health." a social dialogue approach is encouraged where the employer and employees engage in discussions as to the threats and what measures can be taken to eliminate them. Unfortunately, Kenya is not a signatory to this Convention. Lessons, however, can be learned from its provisions as to what type of framework can be useful in a domestic situation.

In the present situation in Kenya, the threats to the lives and safety of healthcare workers have been outlined previously. The on-going healthcare workers' strike in various counties is evidence of the threat that they feel towards their health and lives. There are inadequate PPE's and the available ones are of sub-standard quality, leaving them at risk of being infected as they attend to patients. The testing protocols and speeds are also a threat to them, as they could be attending to admitted patients who have the virus, and yet the results would be released after they have already been exposed to the patient without the proper protective gear. The long working hours and the work related stress associated with that and the stigma are also combined work related threats to their health and lives. One can argue that there was no time to conduct a health facility readiness assessment to address the concerns that the Covid – 19 pandemic brought with it. Yet, the hospitals needed to still open its doors to patients. The emergent nature of the pandemic meant that, at the time when the numbers of infections were still low, health facilities would have been equipping and preparing their workers for the risks involved. The World Health Organisation (WHO) in June 2020, released a rapid hospital readiness checklist that is useful to audit the conditions of the working environment for healthcare workers.[25]

[25] WHO, "Rapid Hospital Readiness Checklist: Harmonised Health Service Capacity Assessments in the Context of the COVID – 19 Pandemic" Interim Guidance (June, 2020)

Constitutional Basis

Any right to refuse unsafe work would first be anchored in the right to dignity of the worker. Article 28 of the Constitution provides that: "Every person has inherent dignity and the right to have that dignity respected and protected." Since labour is not a commodity and cannot be separated from the worker, the dignity of the worker must be protected at all times in the workplace. Any factors which would undermine the dignity of the worker in the work place, must be minimised or eliminated. Dignifying the worker, particularly in a capitalistic society, would mean that the worker has a choice to refuse work that devalues and demeans them not just as a worker, but as a human being.

Article 41 of the Constitution, creates a general protection for workers to have the right to "fair labour practices" and to "reasonable working conditions." The Employment and Labour Relations Court has defined what fair labour practices are in this way:

> *"... it is the opinion of the court that the right to "fair labour practices" encompasses the constitutional and statutory provisions and the established work place conventions or usages that give effect to the elaborations set out in Article 41 or promote and protect fairness at work. These include provisions for basic fair treatment of employees, procedures for collective representation at work, and of late, policies that enhance family life while making it easier for men, women and persons with disabilities to go to work."*

Protection of the right to refuse unsafe work can also be anchored within the right to the highest attainable standard of health[26], as well as the right to life.[27]

Statutory Protection of the Right to Refuse Unsafe Work in Kenya

There is little doubt as to the nature of the employer's duty to provide a safe and healthy working environment in Kenya. Indeed, there is a substantial body of jurisprudence to back this. The employer's obligations under the

[26] Article 43(1)(a), Constitution of Kenya 2010
[27] Article 26(1) Constitution of Kenya, 2010

Occupational Safety and Health Act are quite clear.[28] The employee is also under a duty to "ensure his own safety and health and that of other persons who may be affected by his acts or omissions at the workplace."[29]

There is however, interestingly a little utilised and implemented provision within the OSHA that seems to implicitly protect the right to refuse unsafe work for employees. Section 14 of the OSHA provides that:

> *"Every employee shall report to the immediate supervisor any situation which the employee has reasonable grounds to believe presents an imminent or serious danger to the safety or health of that employee or other employee in the same premises, and until the occupier has taken remedial action, if necessary, the occupier shall not require the employee to return to a work place where there is a continuing imminent or serious danger to safety or health."*

It further provides that:

> *"An employee who has left a workplace, which the employee has reasonable justification to believe presents imminent and serious danger to life and health shall not be dismissed, discriminated against or disadvantaged for such action by the employer."*

Several points need to be noted here. Firstly, the right to leave the workplace is couched as an individual employment right rather than a collective right. This means that this right is not the same as industrial action which is a collective right that can only be exercised through a trade union.[30] It therefore implies that even if other employees do not complain, a particular employee who has reasonable grounds to believe there is imminent and serious danger to their life and health, is permitted to refuse that unsafe work. This view however, does not seem to have been applied in this country going by the available jurisprudence. The Court was of the view that it must be all the employees who feared for their safety in order to warrant consideration

[28] Occupational Safety and Health Act, 2007 sections 6 - 9
[29] Occupational Safety and Health Act, 2007 section 13(1)(a)
[30] See the Provisions of the Labour Relations Act 2007

of the right to refuse unsafe work.[31] Secondly, the leaving of the workplace due to the threat of imminent and serious danger, should not be construed as an absconding of their duties or absenteeism as is understood under the Employment Act.[32] The employee should therefore not be subjected to disciplinary proceedings or summary dismissal from employment. There is protection against retaliatory dismissal. Finally, the provision seems protective of employee rights but does not elaborate what is meant by "imminent and serious danger" or "reasonable grounds".

Does a pandemic pose a threat of imminent and serious danger for the healthcare worker? The answer is in the affirmative if the risk of contracting the infection is significantly higher in the workplace than it is in the general community. The employer is therefore under an obligation to not only put in protocols for safety and reduction of chances of infection, but also to provide the protective equipment necessary to minimise infection from the patient to the healthcare worker. Lessons can be drawn from a country like Canada which has a well-developed regime for the right to refusal of unsafe work. The four main criteria that labour boards in Canada have set out for the right of refusal of unsafe work are as follows:[33]

a. There must be an honest belief by the worker that their health, life and wellbeing are in danger

b. The belief must be reasonable, making the test an objective one. It would entail considering whether another healthcare worker in the same position as the complainant would also refuse to work under those circumstances

[31] Kenya National Union of Nurses v Nairobi County Government & 5 Others (Cause No 593 of 2015, ELRC, NBI) at paras 89-91
[32] Employment Act, 2007 section 44
[33] Cara E. Davies and Randi Zlotnick Shaul, "Physicians Legal Duty of Care and Legal Right to Refuse Work during a Pandemic" (2010) 18 (2) CMAJ 167

c. There must be communication to the supervisor in a reasonable and adequate manner. The reasons for refusing the unsafe work must also be stated.

d. The danger must be sufficiently serious, immediate and "more than a matter of repugnancy, unpleasantness or fear of a minor injury."

There are however limits to the refusal of the right to unsafe work. If the hazard is acceptable for the kind of work involved, then it may not be in order for the worker to refuse the unsafe work. There are two types of acceptable hazards – those that are intrinsic to the particular profession or work and those that are part of the normal job description. For healthcare workers, it may be argued that there are some dangers that are inherent to the profession and to the job. They must accept those inherent risks and those that are part of the normal working conditions. Another limitation to the right to refuse unsafe work would be if the refusal puts the life, health or safety or another person in danger. It may be argued that in a health facility where there are a number of health workers who can cover for the withdrawal of a particular employee, then the right can be exercised. However, if there are not enough health workers or if that health worker is alone in some remote part of the country, then they may not refuse the work.

The Health Act does not specifically give the right to refuse unsafe work, but does give the healthcare provider the right to refuse to treat a patient if they are "physically or verbally abusive or who sexually harasses him or her, except in an emergency situation where no alternative health care personnel is available."[34]

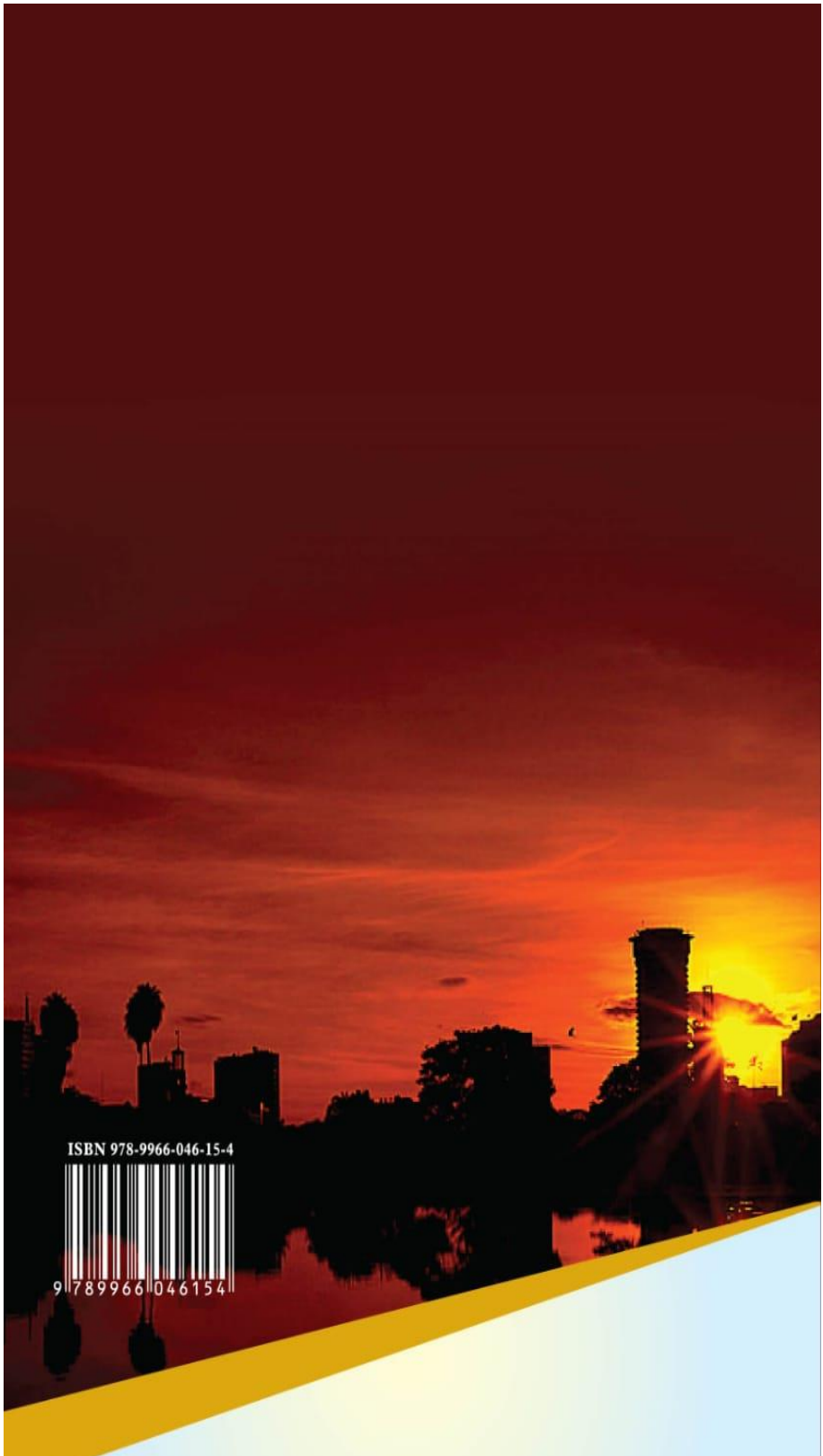
Conclusion

Is there then a duty to treat on the part of health workers and is there a corresponding right to refuse unsafe work during a pandemic? The discussion in this article brings out the following conclusions:

[34] The Health Act No 21 of 2017, section 12(1)(c)

There can be construed both a legal and ethical duty to treat during pandemics and emergency situations. There is also a legal right to withdraw work when the environment is unsafe and a threat to the life and health of the healthcare worker. What is required in this country, is a clear framework on the circumstances under which these duties and rights can be exercised, the tests that will be used to determine the imminence and seriousness of the threat to health and life, the standards that will be used to judge the particular perception of the healthcare worker of the danger posed to them (for example, a pregnant health worker, or a health worker with underlying susceptibilities e.g. diabetes, heart conditions, etc.) and an audit of the mitigation measures that the employer has put in place. Examples of some mitigation measures would be: Safety protocols, adequate PPE's of acceptable quality, mitigation policies for long working hours, quarantine and isolation, increased hazard allowances, payment for extra personal expenses incurred as a result of prolonged separation from family, insurance or free medical treatment for healthcare workers and their families who contract the infection. The regulatory framework should clearly set out the rights and responsibilities of both the employee and the employer during a pandemic, as well as levels of compensation and remedial measures should the risk of infection or even death materialise.

The reality is that this may not be the only pandemic or emergency public health situation that the country will face in the future. Sorting out these ethical and legal dilemmas now, when the country is in the throes of the COVID – 19 pandemic, will better secure health services to patients by avoiding industrial action by health workers, and will better protect health workers and give them the motivation to work and save lives during a pandemic.



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