'Please confirm your HIV-positive status by email to the following government address': Protection of 'vulnerable employees' under COVID-19

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COVID-19 has significantly changed the lives of people worldwide. After one of the most stringent lockdowns in the world, South Africa (SA) prepared to allow increasing numbers of workers to return to their workplaces. Employees received several requests to disclose health conditions to their employers that might put them at higher risk for COVID-19, as some of the regulations issued under the state of disaster by the SA government oblige employers to make special provisions for 'vulnerable employees'. Despite their benevolent intention, such requests constitute a massive infringement of employees' rights, and some of the medical, legal and ethical considerations relevant in this context are discussed. Given the relative scarcity of medical evidence, the constitutional protection of employees' rights and the ethical concerns, a cautious and well-administrated approach within the legally permissible space is necessary.

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Since the end of 2019, the novel coronavirus SARS-CoV-2 has spread worldwide, causing many aspects of life to change on an unprecedented scale in response to the threat posed by the pandemic of coronavirus disease 2019 (COVID-19). In South Africa (SA), a national state of disaster was declared by the president on 22 March 2020,[1] and a far-reaching lockdown was implemented on 28 March 2020.[2] Having eased some of the restrictions on 1 May 2020[3] and again on 1 June 2020,[4] the country is allowing more and more employees to return to work.

Social distancing has been introduced as a mainstay in the prevention of COVID-19 transmission, together with mandatory wearing of cloth masks and measures such as hand washing. As work recommences, the implementation of infection control measures is non-negotiable. Avoiding cluster transmission of the virus in the workplace is essential to keeping the workforce productive, and failure to do so would also entail the reputational and economic risks of closure of the facility – a fate already experienced by companies, public offices and even hospitals.

When dealing with an identified infectious disease, certain characteristics are a given. Means of transmission and the ease with which this occurs are determined, and insight into these patterns is the cornerstone of any preventive measures. When trying to reduce an individual's risk of infection, both the exposure (i.e. the likelihood of coming into contact with the virus) and the susceptibility (i.e. the likelihood of contracting the disease when in contact with the virus) need to be considered. Measures mentioned above (distance, masks, hand hygiene) target exposure to the virus. Susceptibility, on the other hand, is affected by the individual's health (immune competence) and previous exposure (specific immunity) to a similar pathogen. Vaccinations are a well-established way to create specific immunity in order to reduce disposition.

For the protection of employees at their workplaces, 'vulnerability' has come to the forefront. While every effort should be made to avoid exposure to the virus, it appears prudent to identify those at particularly high risk for poor outcomes, and to reduce their potential exposure even further. In attempts to 'COVID-19-proof' workplaces, the authors have witnessed public employers and academic institutions asking employees to disclose health conditions that cause 'vulnerability'. Extreme cases went so far as to instruct employees to submit specific information, including HIV status and other diagnoses, supported by a medical certificate, to their employer. Such requests constitute a massive intrusion into the individual's personal sphere, which results in fear and anxiety as the employee is faced with the decision to either disclose highly sensitive personal information, or alternatively disregard an instruction by the employer.

In this article, a review of the medical, legal and ethical facts relevant to the dilemma of 'forced disclosure of health conditions to enable protection from COVID-19' is presented to guide decisions on how to handle such requests in the workplace.

Medical

What do we know about people at medical risk for COVID-19?

Preventive interventions should be supported by scientific evidence. A random controlled, prospective trial of such an intervention

would provide the strongest evidence, but as COVID-19 is a rapidly emerging disease, this is currently elusive. Given this caveat, the best available evidence comes from association studies of risks and outcomes, which describe the risk of dying or other poor outcomes related to the presence of certain risk factors. As COVID-19 was only identified toward the end of 2019, publications relating to this disease have appeared only in the last 6 months, with the number of articles published seeming to increase almost as fast as the number of cases of the disease, and new insights developing every day.

Cumulative outcomes for groups of COVID-19 cases have been reported from China,[5-9] Italy,[10] and the USA.[11-13] For a cohort of 72 000 cases from the centre of the initial outbreak in China, the well-known estimate of 81% mild cases, 14% severe and 5% critically ill was derived. The case fatality rate (CFR), i.e. the number of patients with confirmed disease who died, was estimated at 2.3% (1 023 of 44 672 virologically confirmed cases), but almost half (49%) of critically ill patients died.[5] Older age appears to be the most consistent risk factor for poor outcomes, with significantly higher CFRs for patients aged 70 - 79 years (8%) and those 80 years and above (14.8%) in this Chinese cohort. In New York, of those who needed mechanical ventilation, 76.4% of the 18 - 65-year-old age group and 97.2% of the >65-year-old age groups died, and of those who were not ventilated, 19.8% of those aged 18 - 65 years and 26.6% of the >65 age group died. Among intensive care unit patients in Italy, 85% (12/14) aged >80 and 77% of the 61 - 80-year-olds died, compared with 44% of those <60 years old.[10] Multivariant analysis of a hospitalised Chinese cohort suggests an increased odds ratio for dying of 1.1 per additional year of age.[9]

Other suspected risk factors for poor outcomes of COVID-19 infection include comorbidities and lifestyle choices. For two cohorts from China, higher-than-average CFRs have been reported for patients with cardiovascular or coronary heart disease, diabetes mellitus, chronic obstructive pulmonary disease (COPD), hypertension, cancer and cerebrovascular disease.[5,6] Other publications mention the presence of comorbidities, but do not report outcomes specifically for groups with and without these risk factors. Comorbidities mentioned include HIV,[7,12] rheumatic disease,[13] chronic liver and chronic kidney disease,[7,10-13] obesity and morbid obesity[12] and obstructive sleep apnoea.[13] Of two publications analysing current smoking as a risk factor, one confirming the risk was retracted,[14] and the other did not find it to be significant.[9]

Recent studies of antibodies as serological signs of infection have suggested that the number of people infected by SARS-CoV-2 might be 20 - 50 times higher than the numbers identified clinically and confirmed with nasopharyngeal swabs,[15,16] implying that the denominator of the CFR is largely underestimated, and adding to the reservations regarding it.[17]

Among the few reports on HIV and COVID-19, recent publications suggest that there is currently no evidence for HIV-infected people being at a higher risk of contracting COVID-19 or of having more severe disease.[18-20] Other conditions such as pregnancy or obesity that have been suggested as risk factors for susceptibility and severe disease share this lack of actual evidence.[21-25]

One method to estimate the susceptibility of risk groups for acquiring the infection is to compare the relative prevalence of the risk factor in the general population with that among COVID-19 cases, which suggests no greater susceptibility of diabetes patients, but more severe outcomes when the infection is acquired.[26]

First data from the Western Cape Province in SA confirm the roles of diabetes, gender and age, but also suggest HIV and tuberculosis as risk factors.[27]

In SA, the National Department of Health's 'Guidance on vulnerable employees and workplace accommodation' lists the following five categories: (*i*) age (≥60 years); (*ii*) one or more chronic medical conditions (chronic lung disease, poorly controlled diabetes or hypertension, serious heart conditions, chronic kidney or liver disease); (*iii*) severe obesity; (*iv*) immunocompromise (cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, immune-weakening medications); and (*v*) >28 weeks pregnant.[28] A USA Centers for Disease Control (CDC) webpage is given as reference in this guidance; however, the CDC criteria differ from the SA ones, in that for example they regard older age as ≥65 years, and include haemoglobin disorders as additional relevant comorbidity, but do not list studies supporting these.[29]

In summary, astonishingly little is known about risk factors for infection with or poor outcomes of COVID-19. Groups that seem at higher risk of dying from COVID-19 are older people and, with less consistent evidence, those with cardiovascular disease, COPD, possibly diabetes mellitus and hypertension, as well as current smokers and males. It needs to be stressed again, however, that this is based on retrospective cohorts of people who had been diagnosed as infected. We do not have conclusive data available on the susceptibility of people with certain conditions for contracting the disease, as this would either require the testing of prospective cohorts or at least the relation of the actual numbers of infected patients and deaths to the larger 'population at risk' they originate from. Only when we know how many patients in a population in total have a risk factor (e.g. HIV infection) can we look at those falling sick and dying and attempt an estimate of whether they are more or perhaps less at risk than those without the risk factor.

According to the current scientific consensus, transmission of COVID-19 between individuals occurs either through aerosolised droplets within a range of 1.5 m, or through touching of surfaces (fomites) contaminated with such droplets.[30]

Legal considerations

Constitutional protection of rights

In response to human rights abuses under the pre-1994 SA government, the Constitution of 1996[31] contains an extensive Bill of Rights (sections 7 - 39). Among these rights are 'equality' (section 9), 'human dignity' (section 10), 'privacy' (section 14), the 'freedom of trade, occupation and profession' (section 22) and 'just administrative action' (section 33). According to section 36, the rights in the Bill of Rights:

> 'may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including –
> (a) the nature of the right;
> (b) the importance of the purpose of the limitation;
> (c) the nature and extent of the limitation;
> (d) the relation between the limitation and its purpose; and
> (e) less restrictive means to achieve the purpose.'

Section 37 explicitly deals with 'states of emergency' and stipulates, *inter alia*, that any derogation from the Bill of Rights under a state of emergency has to be 'strictly required by the emergency' (subsection 4), and a full table of 'non-derogatory rights' is provided (subsection 5). The Disaster Management Act No. 57 of 2002 (as amended in 2015) was passed by Parliament to prepare government responses in the case of a disaster, but does not fall under the provisions of section 37, which is covered by the State of Emergency Act No. 64 of 1997. It is noteworthy that the Disaster Management Act therefore does not require the same parliamentary scrutiny for the regulations issued by the responsible minister under its section 27(2) as would be prescribed under the State of Emergency Act.

The National Health Act No. 61 of 2003 protects the confidentiality of all information concerning a person's health status or treatment (section 14), but makes provision for the disclosure of such information if required by law (14(2)(b)).[32] Specific legislation to protect personal information has been passed by parliament as the Protection of Personal Information Act No. 4 of 2013 (POPIA), which has finally come into effect recently with a 'grace period' until June 2021, and will have major implications for the handling of personal information.[33] Health information is explicitly included in the Act's definition of personal information, and the Act requires that such information only be processed 'to protect a legitimate interest of the data subject' (POPIA 11(1)(d)). It authorises employers to process such information if required to implement legal rights dependent on health conditions (POPIA 32(1)(f)). A review of the legal protection of personal information during contact tracing for COVID-19 has been published,[34] including comments critical of the 'guidance note' on this matter by the information regulator.[35]

Current regulations and labour aspects of the requested disclosure

Published on 28 May 2020, the amended 'lockdown' regulations stipulate in regulation 46(5) that:

> 'Employers must implement measures for employees who are over 60 or those with comorbidities to facilitate their safe return to work, which may include special measures at the work place to limit employees' exposure to COVID-19 infection, and where possible that the employees work from home.'[4]

This relates to regulation 5(5), dated 29 April 2020, regarding measures for 'employees with known or disclosed health issues or comorbidities, or with any condition which may place such employees at a higher risk of complications or death if they are infected with COVID-19'.[3]

Relations between the employer and the employee are regulated in SA through both common law and a body of legislation, including, *inter alia*, the Basic Conditions of Employment Act No. 75 of 1997, the Employment Equity Act No. 55 of 1998, the Labour Relations Act No. 66 of 1995, the Occupational Health and Safety Act No. 85 of 1993 and the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993.

Every employer needs to 'provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees',[36] which includes risk assessments of the workplace to identify potential hazards, and plans to mitigate these.

The latest direction by the Minister of Employment and Labour (MoEL) on 'COVID-19 occupational health and safety measures in workplaces', dated 4 June 2020, defines 'vulnerable employee' with explicit reference to the previously mentioned Department of Health Guidance[28] as an

> 'employee … (a) with known or disclosed health issues or comorbidities or any other condition that may place the employee at a higher risk of complications or death than other employees if infected with COVID-19; or (b) above the age of 60 years who is at a higher risk of complications or death if infected.'[37]

Interestingly, this definition omits the second category mentioned in the reference document of people 'who reside with or care for persons that are at higher risk'.[28] Under '[a]dministrative measures', the MoEL requires in direction 20.3 from every employer that 'it must take special measures to mitigate the risk of COVID-19 for vulnerable employees in accordance with the Department of Health's guidelines to facilitate their safe return to work or their working from home.' No further guidance is provided by the minister, and it is left to the Department of Health document to detail the process of 'assessing a vulnerable employee', stating that ideally the employee's own doctor (or if not affordable, a doctor at the expense of the employer) should provide a confidential note confirming the presence of any of the listed conditions, without giving a diagnosis. The Department of Health guidance also emphasises the need to 'optimise' the control of the chronic condition. Guidance on 'protecting and managing vulnerable employees in the workplace' is also provided in the Department of Health document, rather than the MoEL one, and stipulates that employers 'should have a clear and transparent policy', and that potential exposure to the virus is eliminated or, where this is not possible, other arrangements for the employee are made.

For the SA public service, the national Department of Public Service and Administration has issued a number of circulars regarding COVID-19, and the latest one dated 01 May 2020 states:[38]

> '2.5.4. In deciding an employee's appropriateness to work remotely, heads of department should consider the higher risk COVID-19 poses to vulnerable employees, including those over the age of 60 and those that present with comorbidities … Vulnerable employees must submit relevant documentation in this regard as evidence to their human resource management component'; and
>
> '2.7.2 Employees must familiarise themselves with and adhere to the new health and safety protocols in relation to COVID-19 implemented in their workplace. Employees who do not comply with the relevant protocols and prescripts should be disciplined.'

Given the complex relationship between the employer and the employee in legislation, the common law and collective agreements in the respective bargaining chambers, a formal instruction to disclose health conditions appears problematic. Employees' compliance is expected, which might result in the real or at least perceived risk of disciplinary action for refusal or omission to provide the requested information. Annexure A of the disciplinary code for the public sector lists as misconduct that an employee, *inter alia*, 'fails to carry out a lawful order or routine instruction without just or reasonable cause',[39] and the code of conduct for the public sector determines that an employee shall 'abide by and strive to be familiar with all legislation and other lawful instructions applicable'.[40]

The complexities around the disclosure of an employee's HIV status have been discussed in detail in the literature,[41] and the Department of Labour's code of good practice clearly states that there is no legal obligation for an employee to disclose his or her HIV status to the employer.[42] Taking into account the right to privacy, an employee's refusal to take an HIV test or to disclose a positive HIV status cannot be regarded as failure to carry out a lawful order.

In the context of the rapidly evolving and changing state of knowledge around COVID-19, it is difficult to judge whether the identification of 'vulnerable employees' meets the requirement of being 'reasonable', as the definition for 'reasonably practicable' in the Occupational Health and Safety Act explicitly refers to 'the state of knowledge reasonably available concerning that hazard or risk, and of any means of removing or mitigating that hazard or risk'. In the light of the recently updated direction by the MoEL, and especially taking the Department of Health's guidance into account, it certainly appears inappropriate to request the disclosure of medical details such as diagnoses to the employer. Any instruction to do so would therefore not constitute a 'lawful order', and therefore would not result in disciplinary sanctions if disobeyed. It remains, however, questionable whether the individual employee faced with such a request would be aware of these facts.

Ethics

Ethical considerations

In safeguarding vulnerable employees from COVID-19, an ethical response would be to balance the benefits and risks. Therefore, the following questions are to be considered: Is it realistic to shield vulnerable employees without compromising the provision of essential services? Is collective protection of all vulnerable employees a convincing approach in reducing the risk of transmission? How should the safeguarding of employees be balanced with considerations of privacy and confidentiality? How do we weigh individual freedom against the authority of the employer? In answering these questions, this section discusses the ethical issues around disclosing one's medical condition to the employer.

Confidentiality and balancing risks and benefits

Amid the COVID-19 pandemic, an employee with known or disclosed health issues or comorbidities, or >60 years old, is classified as a 'vulnerable employee'. Vulnerability might have a number of different dimensions, including the vulnerable employee in a labour relations context[43] or vulnerability in the context of medical research.[44] To confirm such COVID-19 vulnerability, a medical certificate has to be provided in some cases. Without requirement for a medical certificate, almost all employees might claim to be vulnerable, and demand to work from home. What information about health problems will make such a certificate credible? Is an employee compelled to subject him- or herself to the employer's request, or would there be a degree of voluntariness in providing the medical certificate? Such an endeavour contradicts the notion of confidentiality of health issues underlying the doctor-patient relationship of trust.

Is it ethically correct to waive deliberations on issues of possible risks, benefits and confidentiality amid COVID-19? McQuoid-Mason[45] insists that divulging a patient's information must be for the purpose of halting the spread of the virus.

The relative weight of the duty to protect and maintain the safety of employees depends on how this duty is valued. According to Tshoose,[46] a reasonable employer should prove with certainty that measures taken will practically prevent the anticipated risks. In the case of COVID-19, the risks would be contracting the disease. How far is such a strategy viable without compromising the delivery of essential services? How ethical is such an approach if it increases the overall vulnerability of those employees considered to be at risk? Fear of contracting the disease, social isolation and loneliness during the COVID-19 pandemic have been identified as hazards inducing psychological distress and mental health issues.[47]

What if the disclosure of health problems by vulnerable employees leads to them being disadvantaged at the workplace in the long run? Can we accept such double effect in the attempt to protect employees? The concept of double effect is used to justify an action that may cause serious harm while pursuing good ends.[48]

Further, it is well known that living standards and realities in people's homes differ vastly. 'Working from home' may therefore have limitations in curbing the anticipated risks, as some employees may face greater exposure to the virus when told to make alternative arrangements with regard to where to do their work.

It may be argued that the employer is acting in the best interests of the employees. Doherty and Purtilo[49] state that the best-interest standard is applicable in cases where one is incapacitated or incompetent, and a proxy acts on one's behalf to make a judgment regarding one's medical information. Employees are supposedly competent to act autonomously in making decisions about anticipated risks, as mental competence relates to the individual's maturity and mental cognition. The individual's preferences and wishes have to be taken into account when trying to protect the interests of an employee. Being obligated to disclose medical conditions to be allowed to work from home may be a paternalistic approach that infringes on the self-determination of employees.

Although the suggested approach equates to acts of beneficence and non-maleficence, it needs to be considered in light of potential harm linked with employees' medical information. With employers having proof of medical conditions irrespective of severity, they may become the gatekeepers of employees' career advancement. How confident can employees be that they will not be in a disadvantaged position when pursuing opportunities within the institution? An employee would be harmed if exclusive benefits and privileges are withheld because of the medical condition. Disclosure may result in psychological, moral and economic risks for employees, and their fundamental dimensions of being human will be threatened.

Conclusions

At the current stage, limited scientific evidence is available when identifying specific risk groups vulnerable to COVID-19. Although striving to protect vulnerable individuals is prudent and morally sound, the relative weakness of the scientific facts would lead to restrictive actions against specific groups being considered not reasonable.

Post-apartheid SA has made great progress in developing a democratic society based on respect for human rights and the Constitution. COVID-19 and the resulting social and political disturbances test the solidity of these foundations. As a first-of-

its-kind situation, the current national state of disaster exposes many of the public systems to new, uncharted grounds. Some of the regulations and directives issued under these circumstances are ambiguous at best, leaving vast spaces for interpretation, and exposing vulnerable parts of the population to additional risks rather than mitigating these. Recent updates in the statutory documents have resolved some of these matters. However, troubled times such as these increase the risk that some vulnerable members of society might not be aware of the legal protections they enjoy, and might disclose sensitive information for fear of disciplinary sanctions. Similarly, well-intended collection of health and illness patterns of the workforce might result in negative long-term effects for identified vulnerable employees owing to the collected information being used in other contexts at the workplace.

Given the fairly universal infection risk in a society, it remains questionable whether the prescribed disclosure of health conditions that would render an employee vulnerable can, firstly, reasonably be expected to result in a marked mitigation of that risk at the workplace, for example, if the majority of the workforce in a health facility falls into the group of vulnerable employees. Secondly, 'working at home' might in certain cases result in increased risk rather than a reduction.

Although it might be considered fairly clear that an employer does not have a right to request information about an employee's specific diagnosis, other matters might result in legal disputes, for example, when compensation for occupationally acquired COVID-19 infections is concerned, the employee may be refused compensation because of non-disclosure of existing comorbidities.

The paternalistic approach of deciding what is best for the individual citizen or employee is certainly an understandable response to an unknown and terrifying threat. However, such notions at the same time might constitute a slippery slope on the path towards a truly free and democratic society.

The following recommendations can therefore be made. Because of the urgency with which they are promulgated and the lack of proper scrutiny that legal regulations would usually enjoy, a particular effort needs to be made that regulations gazetted under emergency conditions are sound in a legal, administrative and scientific sense.

Co-ordination between government departments has so far left some space for improvement, and clear directions by the relevant departments and ministers need to be issued to inform the relevant stakeholders. A clear directive by the Department of Employment and Labour as to how to identify a vulnerable employee and how to issue the relevant confidential note to the employer would go a long way towards avoiding undue infringements of employees' privacy.

In the long run, the process of education and empowerment of the workforce, including human resources practitioners and line managers, should result in a labour environment that respects and protects basic human rights as enshrined in the Constitution.

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