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OPINION

Health system mistrust, ultra-orthodox Jews in the US, and vaccine hesitancy

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Abstract

A minority of ultra-Orthodox (Charedi) Jews choose not to be vaccinated, and their refusal has assumed significant importance from a variety of perspectives. Clinicians often encounter patients whose beliefs are different from their own. Vaccine hesitancy within the US Charedi Jewish community is a factor contributing to outbreaks of disease, reflecting a growing mistrust between communities and arms of the State played out on the terrain of bodies and societies. Clinicians need to be aware of and understand this broader context as a foundation of empathetic listening and epistemic humility that might lead to improved health for the Charedi community based on reinforced trust.

Keywords: Disease ecology; education; migration and social mobility

Medicine as a politically embedded endeavour

In considering vaccine hesitancy among ultra-Orthodox Jews (more properly known as Charedim, a term in use by the majority of group members), I here briefly review its recent history, potential political and social influences, and relevance to treatment of individual Charedim. The goal in this paper is to add such political and social understanding, and an appreciation of recent changes within the Charedi Jewish community, to a mere passive appreciation of Charedi culture, so that the clinician can understand the barriers to healthcare and become a trustworthy ally in health. I note that Charedim, like other groups, are internally heterogeneous and comprise multiple subgroups; no individual's behaviour is completely determined by their group membership. Furthermore, such groups differ from country to country, and in each country, there exist different kinds of Charedi communities. In this paper, I mostly concentrate on Chasidim, a particular subgroup of Charedim which are the most numerous variety.

Healthcare hesitancy among Charedim

Preventive medicine has had its advocates but also its opponents in the Rabbinic tradition of which the Charedim are a part. Vaccine hesitancy among Charedim dates to the late 20th century if not before. Infections associated with orogenital suction at the time of circumcision (metzitzah b'peh), with fatalities noted in the late 1990s, were the subject of an educational publicity campaign by the New York City Department of Health. The campaign was not effective among

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Charedim and did not lead to eradication of the practice (CDC, 2012; Tanne, 2006). Regulation of scientific education, including health, among Charedi yeshivas (high schools) on the part of state and city government has been a long-standing source of stress (McCluskey, 2021). Even vaccines not associated with coercion on the part of the public health establishment, e.g. human papilloma virus vaccination, have been associated with controversy among US Charedim (Muravsky *et al.,* 2021).

In 2019, when a measles outbreak affected more than a thousand across the US (Patel *et al.,* 2019), a number of the associated cases were found among Chasidic communities in Kiryas Yoel, Boro Park, and Williamsburg (Williams, 2019), all different Chasidic communities in New York State in the US (the last two are in New York City). In the wake of that outbreak, both state and city authorities in New York implemented restrictions on public activity in Charedi (Williams, 2019) communities in particular, including the closing of yeshivas and barring unvaccinated children from school attendance. Such state and city actions, without collaboration with Charedi communities, led to increased tensions. During the COVID-19 pandemic, the New York City and New York State departments of health also implemented interventions in Charedi communities without consultation with the affected communities themselves, likely impacting vaccination rates and openness on the part of such communities to Covid mitigations in general (Carmody *et al.*, 2021).

Thus for decades, political, social, and cultural conflict has marked the relationship between public health professions, medical professionals, and Charedim – e.g. during the COVID-19 pandemic.

Not all healthcare interventions are met with hesitancy by Charedim (Kasstan, 2021). This interaction often takes place on Chasidic communal terms. For example, the Chasidic communities make use of Dor Yeshorim, a system recommending premarital genetic screening based on the medical histories of the potential couple and the frequencies of genetic abnormalities in the Chasidic population. Similarly, Chasidic populations make considerable use of reproductive technology (Raucher, 2016; Kasstan, 2022). By contrast, multiple public health interventions designed without collaboration or attention to Chasidic communal priorities have met with failure.

Vaccine hesitancy, Charedim, and state coercion in the name of public health

In order to collaborate effectively with Charedim, a sympathetic clinician must consider the ways in which government coercion might be received and opposed by its targets and resultant mistrust in the medical system. An effective interaction between Charedim and clinicians includes both clinical outcomes and care of the patient in their context. (Betancourt *et al.*, 2000)

The person reasonably familiar with Judaism might be aware that many strictly observant Jews take advantage of contemporary medicine and are not resistant to preventive interventions. However, Jewish law, called halacha, is not determinative of Charedi behaviour. Charedim, at least in some communities, do not routinely frame their support of or hesitation regarding vaccines in halachic terms (Kasstan, 2019); thus, citing the halachic judgements regarding the normative desirability of medical care are not relevant to a discussion of vaccine hesitancy among Charedim. Neither do Charedim obediently follow the judgements of their rabbinic decisors nor rebbes (Keshet and Popper-Giveon, 2021).

For example, Charedi women can ignore or refuse to solicit the halachic decisions of rabbinic decisors who are often seen as authoritative within the community (Raucher, 2020), as the agents of their own reproductive health and family planning. The agency of women within the Charedi community is an example of 'a mode of being woman that is incomprehensible within a normative feminist framework' (Halberstam, 2011) and, more broadly, can help orient the clinician to an appreciation of Charedi society that does not conform with the preconceived notions of the clinician (Taragin-Zeller *et al.*, 2020).

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Vaccine hesitancy among Charedim is not without precedent, nor has the state's involvement in public health only recently been coercive (MacDonald *et al.*, 2018). Public health has been coercive as long as there has been a state. Previous examples of surveillance in the name of public health are numerous. Jacobson vs. Massachusetts, the 1905 Supreme Court case, upheld the authority of states to enforce compulsory vaccination laws; in that same year, the Anti-Vaccination League of America was founded (Walloch, 2015). In the same decade, San Francisco laws mandated vaccination against plague of any Chinese residents who ventured outside the city. In 1927, in Buck vs. Bell, another US Supreme Court case, the Jacobson case was cited to support a Virginia law mandating forced sterilization (Mariner *et al.,* 2005).

Coercion and the politically aware physician

The clinician with a patient demonstrating vaccine hesitancy might ask themselves, 'Why does this person not want to be vaccinated, when I know that vaccination would be for their benefit?' Rather than assuming the public health system is trustworthy, the clinician should ask who can trust it and for what ends. If canonical religious language, or the statements of religious authorities, do not determine the choices or behaviours of Charedim, how do I, as a clinician, go about understanding why mistrust in the health system comes about and why it leads to vaccine hesitancy? Trust can be associated with political and institutional characteristics as much as cultural ones. While trust is only one characteristic, clinicians can understand it as a representation of individual interaction with failed or failing institutions (Mishler and Rose, 2001).

There are a number of potential sources of health care mistrust among Charedim. Trust is not located in a single relationship but can be noted in the relationship of people to institutions and individuals in multiple domains, including healthcare, government, pharmaceutical manufacturers, and individual healthcare providers, as well as institutions and individuals affiliated with Charedi communities themselves. While we focus here on Charedi communities in the US, the analysis of Freiman (2023) of trust relations in the context of vaccine hesitancy among Charedim in Israel demonstrates the interrelations between political, institutional, and cultural factors in shaping public trust (Freiman, 2023) Similarly, an analysis of vaccine-related mistrust in Israel found that mistrust of the Ministry of Health in particular was related to such vaccine-specific mistrust (Muhsen *et al.*, Muhsen *et al.*, 2012).

Whether such analysis can be extended to Charedim in the US, with its fragmented healthcare system and public health agencies that are not nationalized, is unclear. There exists a copious literature on mistrust and its relationship to vaccine hesitancy, unfortunately, little of it is generalizable to US Charedim and much of it largely depends on single psychological measures. (Larson *et al.*, 2011; Larson *et al.*, 2018)

With respect to cultural and political factors specific to many Charedim in the US, the Trumpian political revolution has affected the Charedi community in the US (Deutsch, 2017) in both stabilizing and destabilizing ways. This revolution did not occur in isolation, but in the setting of pre-existing tensions between the public health establishment and the Charedi community as noted above.

Trust in healthcare is a social relationship, dependent on how one understands one's own role in going to a doctor or a nurse, or receiving treatment in a hospital (Katz, 2002). A sign that patients might find relationships with doctors and nurses less than trustworthy is that alternative medicine has achieved a certain level of popularity among Charedim (Garb, 2010). Because so much of the customary healthcare relationship can be strange and off-putting, we should not find it remarkable that someone should choose not to play such a role. Healthcare can be alienating and its providers can be distrustful. Antisemitism is a prevalent phenomenon in the US, and while the prevalence of anti-Semitic behaviour among health care providers is not well documented, it cannot be assumed to be absent (Qureshi, 2020).

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How can the clinician help in the context of mistrust?

Given the history affecting such healthcare mistrust among Charedim, and potential lack of culturally appropriate care on the part of health care providers, what can the individual clinician do, apart from the epistemic humility advocated above? In considering the daunting nature of such a goal, a multidimensional understanding of the patient's milieu, one should consider the possibility of cultural concordance between physicians and patients. Such concordance has been advocated in the care of other minorities, and such consideration can be relevant to Charedim too who might be encouraged to enter healthcare professions (Saha *et al.,* 1999).

In general, the clinician must adopt an attitude of positive regard to the decisions made by individual Charedi patients even if they are not the ones that the clinician would have made. Concrete understanding of Charedi society can lead to a more useful appreciation of vaccine hesitancy on the part of the Charedi patient. For example, Charedi families often have a higher number of children than surrounding societies. This natality renders school-related decision on the part of public health authorities particularly fraught.

With detailed knowledge of their current status, challenges, and changes, clinicians might be part of changes in the Charedi community to encourage vaccination. Charedim must negotiate between integration with the outside society and fidelity to their own values, while navigating a perplexing set of changes: the authority of text, rabbi, institution, and 'eyes of the street' is not what it once was, and outside challenges question the very veracity and sustainability of Charedi culture (Davidman, 2015; Myers, 2022). As with other subcultures, the past decades of socioeconomic change, immigration, influx, and departure from Charedi communities, all of which have continued during the years of the pandemic, have affected the structures that are basic to Charedi life. This can lead to insecurity, mistrust, and transformation with wide-ranging effects that public health, and individual practitioners, should consider.

What factors influence trust relationships for Charedim, both within and outside their communities? There are disadvantaged groups within Charedi society. Do they mistrust health systems because the systems represent a threatening outside world – or an uncaring elite? Who is trustworthy within this system? Are Charedi clinicians themselves seen as worthy of trust by those communities? How do they establish, manifest, ground, and reinforce that trust, particularly in a changing society? Significant in this regard are the activities of askanim, community, and business leaders within Chareidi, and particularly Chasidic society, who act on behalf of community members (Zalcberg and Block, 2021). However, the involvement of askanim is also viewed with skepticism in certain quarters. There exists a considerable literature addressing Charedi health beliefs, though, as noted above, beliefs, behaviour, and trust do not always tend in a single direction (Coleman-Brueckheimer and Dein, 2011).

Mistrust on the part of the healthcare practitioner and on the part of Charedim reinforce each other. Vaccine hesitancy can be related by an individual's relationship to structures of power (Cockerham, 2005). Making sure such structures support the ill and vulnerable should be the concern of those who are their neighbors in their community (that is, Chareidim) but also the concern of those who treat them.

That is, participation in the health system on the part of Charedim involves two separate issues: whether clinicians and systems can treat Charedim with the compassion and empathy they need as a group and as individuals and whether Charedim, as a group, are able to construct a society that responds to the needs of the most vulnerable among them (Major *et al.,* 2013).

Healthcare providers should aim to provide effective treatment and care to all patients, regardless of who they are. Indeed, providers should attempt something even more difficult, to bring notions of cure, healing, and treatment into encounter with the beliefs, perhaps different from ours, of different sorts of groups. The non-Charedi clinician should be able to provide treatment to Charedim who have different expectations, needs, beliefs, and sources of trust than she herself might have. On occasion the clinician might change their own practices, there are other

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occasions in which the clinician might encourage the patient to think differently about their own mode of life, as a part of Charedi society (e.g. in confronting a pandemic or other controversial topics).

Fostering trust among individual Charedim is not the end of a clinician's responsibility. Clinicians need to understand and even encourage a process whereby Charedi communities can achieve health for their members. These issues are not only relevant to vaccination. Whenever Charedi society comes into contact with the health care system this misalignment of response and need comes to the fore (BoroPark24.com, 2020). Thus, individual clinicians can encourage trust in the public health and medical establishment among Charedim by (a) being empathetic clinicians; (b) encouraging cultural competence within their practices and systems; (c) encouraging community-centered, science-based care in Charedi communities; and (d) and discouraging top-down, unilateral control, and surveillance on the part of outside authorities instead treating these communities in a way that is worthy of trust.

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