

# Ethics of sharing medical knowledge with the community: is the physician responsible for medical outreach during a pandemic?

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## ABSTRACT

A recent update to the Geneva Declaration's 'Physician Pledge' involves the ethical requirement of physicians to share medical knowledge for the benefit of patients and healthcare. With the spread of COVID-19, pockets exist in every country with different viral expressions. In the Chareidi ('ultra-orthodox') religious community, for example, rates of COVID-19 transmission and dissemination are above average compared with other communities within the same countries. While viral spread in densely populated communities is common during pandemics, several reasons have been suggested to explain the blatant flouting of public health regulations. It is easy to fault the Chareidi population for their proliferation of COVID-19, partly due to their avoidance of social media and internet aversion. However, the question remains: who is to blame for their community crisis? The ethical argument suggests that from a public health perspective, the physician needs to reach out and share medical knowledge with the community. The public's best interests are critical in a pandemic and should supersede any considerations of cultural differences. By all indications, therefore, the physician has an ethical obligation to promote population healthcare and share medical knowledge based on ethical concepts of beneficence, non-maleficence, utilitarian ethics as well as social, procedural and distributive justice. This includes the ethical duty to reduce health disparities and convey the message that individual responsibility for health has repercussions within the context of broader social accountability. Creative channels are clearly demanded for this ethical challenge, including measured medical paternalism with appropriate cultural sensitivity in physician community outreach.

## INTRODUCTION

In October 2017, the original 1948 Geneva Declaration chartering the course of medical ethics for physicians worldwide, and which was adopted by the World Medical Association, was updated. One of the three principal changes for physician commitment stated that '*I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare*'.<sup>1</sup> This was a paradigm shift for an international medical oath, referred to as the 'Physician Pledge'. Prior to this inclusion, the medical oath contained no explicit requirement for the physician to leave the confines of the clinical treatment room and share medical knowledge with the public. This laudatory sharing of knowledge could be perceived as diminishing the physician's strength and status, with the 'almighty physician'

no longer seen as the sole protector and keeper of medical information. Conversely, such sharing of knowledge would definitely be in the interests of individual and public health and would promote both local and international health advancement.

## COVID-19 AND THE CHAREIDI COMMUNITY

While COVID-19 is a worldwide pandemic, there is evidence of a varying spread of the virus in each country, even between separate cities and communities. The expression of the virus has seen different pockets in every country, such as the case of the Chareidi ('ultra-orthodox') religious communities around the world. Among this population, the transmission and dissemination of those who are COVID-19 positive is well above the average rate of other communities, both in Israel and in other countries with sizeable Chareidi communities. For example, figures from Israel's Ministry of Health for the first week of April 2020 indicate that one out of every three Chareidi individuals tested in Bnei Brak, a densely populated ultra-orthodox city of 250 000 in the centre of Israel, tested positive for COVID-19, whereas numbers for the rest of the national population were much lower.<sup>2</sup>

The Chareidi population can be defined by its absolute adherence to strict Jewish Law, and its devout and rigorous following of specific rabbinic rulings. Different groups of Chareidi Jews are distinguished according to their origins, leaders and schools of thought ('Hassidic' and 'Lithuanian' from Eastern Europe, 'Sephardi' from Middle East and North Africa). The Chareidi community places great value on family: marriage rate is high (82% vs 63% for the rest of the Jewish population), as is fertility rate (6.9 children per woman vs 3.1 in the general Israeli population). Boys attend ultra-Orthodox schools (*yeshiva*), where absolute priority is given to the study of holy texts and religious precepts. Adults generally pursue study of sacred texts in religious institutions (*Kollel*).<sup>3</sup> Though they emerged as a 19th-century reaction to the burgeoning of modern European society, Chareidi Jews self-define as the principal expression of 'authentic Judaism'. They generally elect to live in insular communities that protect them from the 'negative' influences of secular modernisation. In the context of the COVID-19 crisis, such detachment from mainstream culture and community is simply not salient. Ignoring the Chareidi community during public health efforts to restrain the spread of COVID-19 in the wider community can have dire consequences.



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While the spread of any virus in densely populated communities is common during periods of epidemics and pandemics, other factors seem to be at play with the Chareidi community, including the blatant flouting of public health recommendations and regulations in Bnei Brak (95% ultra-orthodox) and other heavily populated Chareidi cities and neighbourhoods. The phenomenon is not unique to Israel, with a similar picture in the USA. Many ultra-orthodox communities in the greater New York area did not adopt the strict social distancing restrictions because these restrictions drastically limited religious life. As a result, in the first few weeks of the COVID-19 outbreak in New York, several hundred Chareidi Jews died, including well-known community leaders.

Several explanations have been suggested. First, the ultra-orthodox community is characterised by large families, overcrowding and often relative poverty. Second, there is considerable distrust between the Chareidi population and the outside community, especially in Israel. This is especially the case when for whatever reason, the state, which is perceived as a secularising outside authority, is seen as restricting religious practices. In the past, this included compulsory military conscription and essential school studies. As part of the national COVID-19 precautions, this includes public prayer and study. Third, the Chareidi community is characterised by fervent dedication and subservience to the pronouncements and decrees of their rabbis. On 11 March 2020, during the peak of national restrictions on group gatherings, cancelling of schools and prayer gatherings, one of the most respected and venerated Chareidi leaders, Rabbi Chaim Kanievsky, declared in a video that closing schools and institutions of learning was more dangerous than keeping them open. Larger religious prayer gatherings, mass funerals and yeshiva studies continued in several communities regardless of national restrictions. As a result, while the Chareidi population constitutes only about 12% of Israel's population, some 40%–60% of all patients with COVID-19 admitted at several local hospitals were from the Chareidi community.

The secular media led the condemnation of the Chareidi population for ignoring public health regulations. For fear that the virus would spread throughout the country, Bnei Brak was subjected to a special lockdown, more than any other city in Israel. The Chareidi community nationwide became stigmatised as the COVID-19 'lightening rod'. The community was blamed by the non-Chareidi of damaging the rest of the country by resisting efforts to curb the viral spread.

#### WHO IS RESPONSIBLE FOR MEDICAL INFORMATION SHARING?

Beyond the self-inflicted proliferation of COVID-19 in Chareidi communities, the question remains: who is to blame for the crisis in their community? In general, the Chareidi community and its leaders avoid electronic media and social media. The advent of a national or international health crisis can find the Chareidi community largely uninvolved and unfazed since they are not exposed to channels of communication that spread awareness of the severity of the crisis. Even those Chareidi Jews who did hear about COVID-19 were told by their leaders to remain focused on prayer and study. Unfortunately, when the leaders eventually banned public prayer and study, it was too late for too many. It is tempting to claim that the Chareidi community brought the crisis on themselves. However, this does not absolve the national health authorities and medical bodies from not adequately conveying the very dire nature of the pandemic. Health and medical authorities should have been quicker in proactively

reaching out to the relatively closed Chareidi public and sharing with them essential health-related information.

#### THE MEDICAL ETHICS OF INFORMING THE COMMUNITY IN TIMES OF A PANDEMIC

The ethical argument would dictate that even though the responsibility of the physician in clinical medicine is limited to him or her and the patient lying in the treatment bed, from a public health perspective, the physician needs to reach out beyond the patient bed. This ethical responsibility of physicians is part of the Geneva Declaration's 'Physician Pledge' adopted by the World Medical Association. Sharing of knowledge and educating the public should be the worldwide practice of physicians and their representative bodies, irrespective of whether the country leans more towards private medicine or community-based medicine. During a pandemic, the public interest is critical and should supersede any considerations of cultural differences, especially when there is community resistance. The value of cultural competence is no less critical for public medicine than clinical medicine.<sup>4</sup> Awareness of cultural differences and how to manage them is crucial in risk prevention and in lowering barriers in healthcare.<sup>5</sup>

The over-riding medical ethics principle at play here is the ethical obligation of the physician to promote good healthcare. The need of the physician to focus on individual healthcare must be unified with the goals of both personal care and whole population care. While personal care focuses on the 'individual good' in specific interactions, whole population care focuses on the overall 'good health' of a population, without reference to the distinctiveness of each individual in that population.<sup>6</sup> This essentially reflects utilitarian care, as described by John Stuart Mill, whereby any moral agent ought to choose the action that contributes most to and maximises the benefit for others in the world.<sup>7</sup> Attention to the population also reflects the ethics of social justice, just and available access to healthcare resources and adjusting or upgrading the definition of health from individual based to population centred. Social justice entails distribution of health for all elements of society, so as to alleviate health disparities and to demand that healthcare providers share health information to achieve this ethical goal.<sup>8</sup> This is important since there is a growing awareness that health inequality, often based on poor community healthcare response, may be an indicator of general injustice in society.<sup>9</sup> From a community health perspective, an ethical medical care component could compensate for this disparity when it is caused by poor community health knowledge. In terms of justice, this would constitute distributive justice.

Enrichment of individual and community education by means of this ethical duty of the health profession will significantly contribute to reducing and eradicating disparities in healthcare and to improving access to health services.<sup>10</sup> In terms of the current COVID-19 pandemic, health knowledge sharing includes conveying the reality that individual responsibility for health has repercussions for the broader social accountability to others.<sup>11</sup> This would be especially critical with the Chareidi subpopulation where care for others has such high value. Conversely, if the importance of this is *not shared* with the community in a culturally sensitive manner and without recourse to the proper channels and appropriate means, warnings and regulations will be neither respected nor heeded.

The medical profession needs to invest in ways of presenting community health intervention and the qualities and attributes of an implementation strategy.<sup>12</sup> Achieving this goal requires

interprofessional teamwork among healthcare providers—not always simple to achieve, but nevertheless part of the ethical challenge.<sup>13</sup>

Evidence that this can work is underscored by the fact that when the Chareidi community did become aware of the extent of the medical emergency, they did comply en masse, especially after their leaders openly supported such health measures as banning group prayer and study. When the medical community, including public health specialists from the Ministry of Health, finally engaged in intensive education and outreach efforts, a marked across-the-board change in compliance was noted including social distancing, wearing of masks and cancellation of social and religious gatherings.

The ethical necessity incumbent on the medical community to educate the public during a pandemic is not a new concept. It has long been recognised that a critical duty of healthcare workers in a pandemic is the application and execution of education and communication strategies among the public.<sup>14 15</sup>

Other key ethical principles guiding the responsibility of the physician and healthcare providers regarding sharing of health-related information include beneficence, as applied to the good of the community. Beyond merely preventing the spread of the virus, and merely treating those who are sick, physicians need to promote the ethical principle of non-maleficence (*primun non nocere*). The physician is duty bound to warn of the dangers of community gatherings and to point out the perils of ignoring these warnings. There is an ethical requirement of justice—in this context, justice in the community by means of enhancing health optimisation. Another requirement is achieving a procedural justice framework with coalitions built together with the community.<sup>16</sup>

Given the principle that medical ethics is about respect for the patient's autonomy in deciding for himself or herself, it could be seen as if the physician has no role in community health enforcement of healthcare measures that are important for the health of all the people. In a pandemic, however, there is a case for medical paternalism, even to the extent of assistance in enforcement. Paternalism from an ethical perspective can be defined as over-riding or restricting certain rights or freedoms of individuals for the best interests of the overall community. This would be particularly relevant where individuals, either from ignorance or disregard for outside 'threatening laws or regulations', behave in a manner that endangers themselves, their families, their neighbours and the wider society. The paternalistic approach is based on the ethical argument that if individuals fully understood the hazardous consequences of disregarding pandemic measures, they would behave differently. Once again, healthcare providers, among others, are responsible for proactively sharing knowledge of the COVID-19 with the community. This links to yet another principle of medical ethics: virtuous behaviour on the part of the physician.<sup>17</sup> While not in direct fulfilment of clinical duties in the treatment room, virtuous behaviour requires the physician to reach out to the Chareidi community in order to communicate community health paradigms made urgent by the very dire nature of the COVID-19 threat.<sup>18</sup>

#### COMPETING ROLES OF THE INDIVIDUAL CLINICAL PRACTITIONER VERSUS THE PUBLIC HEALTH PHYSICIAN

Should there be a distinction between the various roles of physicians regarding the responsibility for educating the public about the dangers of an epidemic and how to prevent spread of the infectious agent? Essentially, while the public health physician is obligated to educate communities, the role of the clinical

practitioner is to treat the individual patient. The COVID-19 crisis in the Chareidi community is an example of where the system failed at several levels. Specifically, public health physicians were not successful in conveying the relevant information to the community. Although the community is insulated and resists outside intervention, its leaders would have been open to influence and rational explanation of what needs to be done. Public health physicians should have considered alternative and creative means of communication with the Chareidi community via their leaders and other influential community members and channels. While remaining aware of competing obligations, and while taking care not to intrude on an already vulnerable community, some of these issues needed to be over-ridden in the context of the pandemic. Everything possible must be done to penetrate the barriers so as to enable effective communication regarding a serious medical threat that affects both the insular Chareidi community as well as the wider population.

Acknowledging the key role of the public health physician during a pandemic, the individual clinical practitioner also has distinct obligations. During the initial few weeks of COVID-19, one-on-one clinical contact decreased to approximately 20%. This underlines how critically important it is for the individual physician to make his or her mark on every clinical intervention regarding public health interests. A physician who becomes aware of any relevant patterns, trends or clinical phenomena that should be shared with patients and the medical and general community must make their voice heard. It was, after all, an individual physician in Wuhan, China, who first alerted the medical and general community to the impending danger of COVID-19. When possible, responsibility for community outreach must extend beyond the public health physician to include the individual treating physician who can do much in community outreach (radio, community meetings, preprayer and postprayer announcements, clinic poster boards and more). This is especially the case when individual physicians are familiar with the community and understand the importance of cultural sensitivity.

Ideally, both individual physician practitioners and public health physicians would be encouraged to participate in information-sharing sessions regarding the pandemic and ways of preventing its spread. Individual physicians would contribute to the impact and credibility of the message because familiar physicians are fundamentally more trusted by the Chareidi community than anonymous government and/or secular authorities.

In sensitive communities, where cultural competence and forms of deliberative democracy are at times called for, the physician may play a significant role. While roles and duties for public versus clinical physicians are fundamentally different, obligations for outreach and intervention in the context of a pandemic, although in different modes, remain similar and overlapping.

#### CULTURAL SENSITIVITY AND MEDICAL INFORMATION SHARING

There is growing awareness in the medical community of the importance of cultural sensitivity and the fashioning of health services to fit diverse religious and ethnic populations. Cultural competence describes the ability of services to meet the cultural, social and linguistic needs of people from different cultures and religions. Instead of dictating to communities what is needed, Jalloh *et al*<sup>19</sup> have shown that involving community members in the development and implementation of community-based projects is most efficacious and effective. This endeavour would

mandate 'regular communication, on-going capacity building, and a commitment to respect the experience and expertise of community members'. In the Chareidi community, this has particular relevance given the power and persuasive influence of the *askanim* (advisors), the 'movers and shakers' who get things done including harm reduction. Given the critical importance of sharing health knowledge to prevent spread in a viral pandemic, it also becomes an ethical duty and obligation of the physician. This may even require the physician participating in meetings that encourage deliberative democracy and in consultation forums, where fair and reasonable discussion and debate among the citizens could enhance medical decisions. Consensus decision making has a much greater chance of success when attention is given to cultural sensitivity and community engagement.

The physician also has a role in protecting the community against unfair criticism when a lack of knowledge of stipulated guidelines leads to not abiding at an early stage. Perhaps the locus of responsibility and accountability for management of the health discrepancy should be shared between the physician and community leaders. In terms of distributive justice, the question still remains: to what extent and to what lengths do physicians have to go in order to carry out this lofty objective?

## CONCLUSIONS

It is oftentimes simplest to condemn particular communities during the COVID-19 crisis for not adhering to community health guidelines. It is a convenient way of lessening the accountability of the medical profession and other health officials. However, the entire healthcare profession is responsible for sharing knowledge of the public health threat and subsequent safety requirements including social distancing, hand cleansing, mask wearing and more. The execution of the social determinants of healthcare coupled with promotion of social justice and equity<sup>20</sup> is a precise fulfilment of the newly added clause to the revised international Geneva Declaration, often referred to as the 'Modern Hippocratic Oath': 'I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare'. In terms of cultural sensitivity and community engagement, nothing less should be demanded from members of a noble profession held to a higher standard.

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