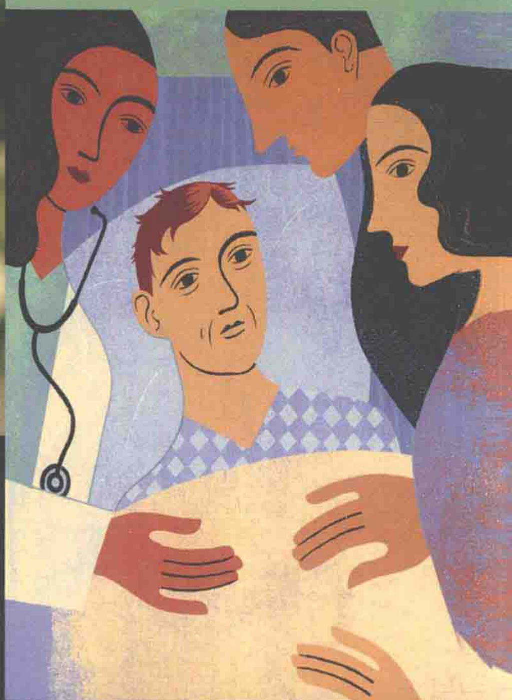

Reconsidering Law and Policy Debates

A Public Health Perspective

Edited by John G. Culhane

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Health Law Institute, Widener University, School of Law

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CONTENTS

Contributors . . . . *page* vii

Introduction 1
John G. Culhane

Part I: Birth and Death

1. Beyond Privacy: A Population Approach to Reproductive Rights 15
Wendy E. Parmet

2. Stretching the Boundaries of Public Health: Should We Consider End-of-Life Care a Public Health Issue? 40
Diane E. Hoffmann

Part II: The Limits of Civil Rights

3. Dying While Black in America: Maslow's Hierarchy of Need and Racial Policy Making 69
Vernellia R. Randall

4. Public Health and Marriage (Equality) 89
John G. Culhane

Part III: Dimensions of Violence

5. Using Public Health to Reform the Legal and Justice Response to Domestic Violence 125
Evan Stark

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6. Law and Policy Approaches to Keeping Guns from High-Risk People 153
Jon S. Vernick, Daniel W. Webster and Katherine A. Vittes

Part IV: Beyond Compensation: Public Features of Private Litigation

7. Tort Litigation for the Public's Health 187
Elizabeth Weeks Leonard

8. Punitive Damages and the Public Health Agenda 221
Jean Macchiaroli Eggen

Index 255

INTRODUCTION: BRINGING PUBLIC HEALTH TO BEAR ON CONTENTIOUS LEGAL AND SOCIAL ISSUES

John G. Culhane

Recently, I participated in a forum on same-sex marriage. The event was open to members of my law school community, but also in attendance were local citizens, media representatives, as well as audience members and participants from the local area. One question that I'd heard before came up again: "Where's the rights problem? Anyone can marry, including gays and lesbians. The same restriction – marry someone of the opposite sex – applies to everyone equally."

The standard law professor move at this point would have been to encourage the student to probe a bit more deeply into the notion of equality, asking whether the opposite-sex-only marriage rule duly respects the rights of same-sex couples to form state-sanctioned relationships with the person of their choice. But for some reason, that wasn't the point that occurred to me immediately. Instead, I wondered aloud whether it was good policy to encourage gays and lesbians to marry people of the opposite sex, given the social costs likely to be incurred: The marriage would likely be an unhappy one, possibly ending in divorce (with its documented effect on any children born to the couple); one or both of the parties might be drawn to more emotionally or sexually fulfilling liaisons outside of the marriage; and often such extramarital affairs are conducted in secret, with potentially grave health and emotional consequences for both the unfaithful spouse and his or her uninformed partner.

What is a law student – or a judge, or a legislator, or a member of the public, for that matter – to do with such a complex battery of arguments? They do not relate neatly to the language of rights, justice, and morality that often seem to define (and even polarize) discussion

and debate. Part of the problem is that this consequential dimension of the problem is complex and multifaceted, so that even if it could be discussed with "rights" rhetoric, its effect on the discussion would be unclear. To return to our example, perhaps so few gay people, especially in an increasingly liberated society, are driven to marry members of the opposite sex that the dire outcomes catalogued above – which are, in any case, difficult to quantify – are minimal when balanced against some purportedly positive effect of denying marriage equality (for example, sending the message that children need two parents of opposite sexes). But maybe such sham marriages are real – and serious – consequences of the denial of marriage equality.

By raising such issues and questions, the law professor, judge, or lawmaker is knowingly or not turning to the language of public health and borrowing its population perspective. Public health is best known as a discipline that works to improve the health of communities and populations, most typically by preventing the spread of communicable diseases. More broadly understood, however, public health concerns itself with the preserving and improving the health of populations. In the expansive and influential definition suggested by the Institute of Medicine, "Public health is what we, as a society, do collectively to assure the conditions for people to be healthy."[1] Hence, public health seeks to benefit groups of people rather than simply individuals, and emphasizes the impact that policies and actions have across populations. Most importantly, it prizes a deeply contextual and empirically informed analysis. Thus in my marriage example, the information known about the impact of gay marriage on different populations is central – not peripheral – to any public health discussion of the issue.

Once the battle over public consequences and population-based outcomes is joined, it will rage far beyond the set of considerations put forth above. To stop short of overwhelming the reader at this early stage, let us cite just a few of the broadest examples of the population-based, or public health, dimensions of the marriage equality debate: What effect does allowing (or denying) marriage have on the physical and mental health and wealth of same-sex couples? On their children? On the welfare of society in general? What court – what mind, for that matter – can hold all of these questions before it?

Further, how could we even assess the competing public claims? Why make an already intractable problem even harder to resolve?

Often, those who favor a population-based approach to problems have compounded the difficulty, dropping the broad legal and moral authority of public health as a boulder that swamps other arguments and approaches. Thus, those who emphasize thinking about issues from this perspective are often frustrated at the unwillingness – perhaps inability – for others to simply "see" the benefit of their contribution. The unfortunate result is that it at times appears that legal rules and norms stand quite apart from public health, with neither gaining from the perspective of the other. The marriage equality debate is one of the most extreme examples of this tendency – the possible public benefits and costs of same-sex marriages, even when discussed, are almost never central.

This situation, however, is neither inevitable nor desirable, and this book is one effort to bridge this needless divide by focusing on a number of controversial and important debates in law and policy. In addition to the marriage equality debate already introduced, these include: reproductive rights; domestic violence; gun policy; racial justice and equality; compensation and punishment through the tort system; and decisions about death and dying. Before setting off on these compelling topics, a few words of background on the development of the public health, population-based perspective might be helpful.

Once upon a time, public health authorities had a comparatively modest goal: the eradication or reduction of contagious and infectious diseases. This uncontroversial aim reinforces the point that public health is concerned with populations, not individuals. This concern was well-founded, given that many of these acute diseases were quite serious – smallpox, bubonic plague, cholera, diphtheria, flu, and so on. Once it was discovered that basic hygienic and sanitary measures could reduce the incidence of these diseases, few quarrelled with public health's authority, under the state's police power, to enact laws for the health, safety, and welfare of the society, to pass basic sanitation laws. The advent of vaccinations to inoculate the populace against disease, beginning with the dramatic smallpox immunization and much later exploding to stem such diverse diseases as polio, measles, mumps, rubella, and varicella ("chicken pox") – to

name just a few – has represented another vitally important advance in the struggle for sound public health outcomes. Antibiotics, widely available since the middle of the twentieth century, have also played a vital role in increasing life expectancy and decreasing the incidence of serious illness.

Even today, there are those who suggest that this basic infectious disease approach to public health should limit and define the field. In this view, the idea of using a public health approach to address difficult and complex social and political issues is anathema.[2] This misguided outlook overlooks the more recent history of public health, a history that reveals a now accepted – and vitally needed – broadening of public health's tools, scope, and mission.

Consider the case of tobacco. Unlike most of the diseases mentioned previously, those commonly resulting from the use of tobacco – according to Philip Morris USA itself, these include lung cancer, heart disease, and emphysema[3] – take years, often decades, to develop. But until quite recently – about the middle of the twentieth century – science was not equipped to demonstrate that chronic diseases resulted from long-term exposure. Laboratory science was dominant but was set up only to show the causal connections between exposure and acute illness. Indeed, much of the tobacco industry's success in long staving off responsibility for the damage caused by its products owed to a reluctance to accept that casual connections could be shown not only by laboratory proof, but also by population-based, epidemiological methodologies. As the science of epidemiology gained traction by the middle of the past century (in large part because of the interests in studying the effects of cigarette smoking itself), policy makers and eventually the public began to accept the probabilistic model of causation that has come to be the accepted "gold standard" in scientific inquiry and proof. In this way of looking at the relationship between exposure and disease, the causality is always contingent and subject to refutation; nonetheless, policy can be made and implemented based on the best available evidence. But note that this model of looking at public health problems is indeed more complex and indeterminate than the simpler cause-and-effect model long used in the case of infectious and contagious diseases.

To return to the example of smoking: A given smoker's lung cancer might have been caused by the cigarettes consumed over two decades, but also by genetic factors or other environmental exposures. Perhaps all of these possibilities were ingredients in the disease that developed. In short, epidemiology, which looks at populations, can establish that smoking is highly associated with lung cancer in general (a "risk factor"), but cannot by itself show that cigarettes caused our hypothetical smoker's cancer. As an epidemiologist might say, there are simply too many confounding factors. A population-based, public health approach attempts to reduce the number of smokers (and thereby the incidence of morbidity and mortality) through a complex mix of education, changes to the social and physical environment (most notably, by restricting the places and situations in which smoking is permitted), and legal rules and incentives (such as heavy taxation of cigarettes) discouraging tobacco use.

Once we see the complexity of assessing any outcome that is population-based in cases such as tobacco-related health issues, it becomes obvious that consideration of even those health outcomes seen as most clearly demonstrable through laboratory investigation can benefit from a broader look at causes and risks. Thus, even where vaccines are available, lack of access and information as well as religious, philosophical, and "health"-based beliefs can at times lead to an underprotected population. Recent outbreaks of measles in areas with unusually high concentrations of objectors makes the point,[4] as does recent public resistance to the polio vaccine in certain parts of India that is based, in part, on a distrust of public health authority itself.[5] In these cases, public health has taken a broader look at the deeper reasons – one might accurately say *causes* – of vaccination resistance.

Those opposing childhood vaccinations, for example, have cited such disparate reasons as religious doctrine,[6] a broad "natural philosophy,"[7] or discredited fears about a connection between inoculation and autism[8] in seeking (and usually obtaining) waivers for their children. A public health approach that does not take these social and behavioral factors into account compromises its own mission and risks irrelevance.

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Thus, not only history but current public health problems continue to demonstrate the need for continuing to develop tools for assessing outcomes. The "old" public health model provides false clarity and risks real danger to the population. Complexity is often painful, but it is unavoidable. The population perspective can provide important lessons about issues that have long been thought beyond its purview, if indeed they were thought about at all. This book gathers some of the most contested and contentious issues currently in the public debate and then examines what insights and information might be imparted through this focus on the public's health and welfare. The chapters that follow offer a rich diversity of such topics, and the authors, drawn from both the law and public health fields, bring a wide range of views about the value and implications of a population-based, public health perspective to each of their subjects.

Violence is a good example of a problem that has traditionally been thought of, and dealt with, on the individual level. Criminal laws punish abusive spouses and those who use firearms to commit violence, but only recently have the various dimensions of the problem been viewed through the population-based lens. In the area of domestic violence, Evan Stark argues, the criminal law approach misses the most crucial effect of persistent, often "low level" violence by men against their spouses, namely the development of a host of physical, medical, psychosocial, mental health and behavioral problems. Professor Stark then situates his argument within a public health model, noting that these effects are seen among no other population of assault victims, including men abused by female partners or women abused by same-sex partners. Professor Stark then introduces and defends the concept of "coercive control" as the most probable explanation for this result: "the combination of social inequality and coercive and controlling strategies in personal relationships that has different effects on women than on men."[9] The chapter outlines the major dimensions of coercive control, identifies its principal harms as its effect on liberty, autonomy, and dignity in personal life, and concludes by calling on the law to address these complex problems by criminalizing not just the relatively infrequent episodes of violence, but also these coercive and controlling behaviors. The chapter shows that the choice of a public health model over the criminal law

paradigm is not merely an academic exercise; as he demonstrates, the current approach has been an abysmal failure.

As for the well-documented problem of gun violence, the population-based perspective can support approaches that the polarized Second Amendment debate sets aside. For example, Jon Vernick and colleagues note that the problem of illegal gun trafficking can largely be traced to a tiny percentage of licensed dealers: Of more than 50,000 such dealers, about half of all guns used in crimes can be traced back to about one percent of them. Given the political difficulty of passing comprehensive gun legislation, the author's use of population-based, targeted results suggests that such an emphasis might be used in support of more modest laws and enforcement efforts to get at the problem dealers. They then use other research suggesting that cities that have employed strategies to address the bad dealers have seen a reduction in gun violence. Perhaps more than any other, this chapter shows what a public health and safety approach can achieve even in the face of daunting political obstacles.

Violence is an issue that, though often thought of in terms of criminal and victim, nonetheless has important public dimensions that are acknowledged, if not always fully appreciated. But so-called rights issues are even less likely to be considered through the broader, population-based perspective. My own contribution on marriage equality, introduced earlier, highlights the gain from such a major shift in emphasis. I advance the argument that the debate should cause us to reexamine the prerogatives and privileged status of marriage more broadly; probably not to abolish it, but to consider more critically the vast legal entitlements that go along with it. Professors Wendy Parmet and Diane Hoffmann achieve a similar shift in their pieces on reproductive rights and death and dying, respectively. Both chapters evince a subtle understanding of the complex and reciprocal relationship between individuals and populations.

In her chapter on reproduction, Professor Parmet moves the debate away from the focus on privacy that often dominates discourse. Focusing on the recent decision by the United States Supreme Court upholding the legislative ban on a certain method of late-term abortion (the so-called "partial birth abortion" issue) she notes that the anti-abortion forces have recently embraced the language of public

health. Professor Parmet argues that public health claims should not be the subject of blind deference. Rather, public health outcomes must be rationally assessed based on sound epidemiological models. Even where such evidence suggests a particular approach or outcome, however, there is a complex interrelationship between the public's good and respect for individual rights, dignity, and autonomy that must be considered. Indeed, *respect* for public health can itself often serve public health goals. Thus, Professor Parmet concludes, a population-based approach to reproductive rights may move the law to where much of the American public already is: supportive of public programs enhancing access to reproductive education and contraception while leaving the ultimate decision of whether and when to reproduce to individual women.

Professor Hoffmann carefully dissects the various meanings we might attach to the question of "end of life care" and makes the case that the public health dimension of the problem will, to an extent, depend on which meaning we might choose. Do we mean the right to choose the care we want (or don't want) at the end of life? Is the problem in access to palliative measures? Or is it rationing of end of life care in cases of medical futility? Adding insights from a public health perspective might lead to further hard questions, which Professor Hoffmann then poses: Would we want government or lawmakers to take certain action as a result of using this lens? Would there be a danger that government might go too far? Would there be appropriate checks on government action? She specifies a range of interventions government might take to address problems of end of life care: from sanctions for physicians/hospitals that do not follow patient wishes, to making advance directives mandatory and changing the definition of death. Professor Hoffmann examines the benefits such interventions would bring to end of life care, the burdens they would impose on individual choice and decision making, and alternative mechanisms for achieving the same ends.

Professors Elizabeth Weeks Leonard and Jean Eggen tackle closely related topics that are seemingly even further from the office of public health, traditionally conceived: tort law and punitive damages awarded pursuant to tort judgments for egregious behavior. Professor

Weeks Leonard anticipates the reader's skepticism: "At first glance, it is perhaps difficult to see the overlap between tort law and public health." But, she notes, tort law does more than compensate injured victims of wrongful conduct. By imposing liability, the tort system also deters negligent (or worse) actors from similar conduct in the future. Yet, because it typically requires a showing of fault, tort law balances this need for the safety (and incidental regulation) achieved by deterrence with other values thought important: efficiency and productivity, and perhaps even education and aesthetic considerations. Similarly, public health must strike a balance, weighing individual rights and autonomy against the community's broader need to achieve good population-wide outcomes. But, she further argues, much additional work needs to be done to draw clear, principled lines between tolerable and intolerable intrusions onto individual rights. Perhaps the tort law approach to balancing, while it will always, to an extent, consider factors different from those involved in public health decision making, can provide valuable insights for making those resource allocation decisions in the public health arena.

Punitive damages, by their very nature and purpose, are not concerned with compensation, but with sending a message to both the defendant and those who might be tempted to emulate the reckless or intentionally harmful behavior that justifies the imposition of such damages. Such damages might also encourage defendants and others to invest in productive research-and-development initiatives. Thus, the public purpose of punitive damages is readily apparent. However, punitive damages have usually gone to the plaintiff, thereby blunting their potentially powerful public message. In Professor Eggen's view, they would be of greater service if diverted to the public treasury where they could be used in ways that might directly affect the public's health. For example, punitive damages obtained in a successful lawsuit against cigarette manufacturers might be directed toward a state's anti-smoking campaign. Thus, she recommends developing rules and mechanisms to achieve the diversion of punitive damages to these public health purposes. She acknowledges the obstacles inherent in trying to do this, and therefore begins the discussion of how we might designate appropriate

agencies and proper purposes, to assure that the monies are spent appropriately.

Perhaps the reason that each of these authors struggles with the complex relationship between public health and individual rights is best captured by Professor Vernellia Randall. In her challenging article on the problems facing communities of color – she focuses especially on health care disparities and poor outcomes – she highlights the shortcomings of the medical and legal models for addressing these issues. The medical model ignores political, social, and communal contexts; specifically, for the most part, it is not able to address racism, problems with social support, stress, and other elements of an individual's lifestyle. It also does little to address the sociological causes of illness and disease. Similarly, the law and legal structure have proven inadequate. The Civil Rights Act of 1964 (Title VI) focuses almost exclusively on intentional discrimination. Case law limits access to the court and does not include physicians and other providers. Most importantly, the legal structure requires that individuals be aware of discrimination and injury.

In fact, the problem is even more deeply rooted, according to Professor Randall's sobering account. Even when policy makers focus on the health of the community rather than on individual medical or legal issues, they tend to miss much of the problem because of their strong tendency to identify with their own communities first (and sometimes solely). This affinity, she posits, is consistent with the theory of Maslow's hierarchy of need, which states that individuals must focus on and address their most basic needs before they have the luxury of concerning themselves with "growth needs," or their pursuit of personal fulfillment. Inasmuch as the life circumstances of most policy makers place them in the highest echelon, their concerns do not reflect those of people lower in the hierarchy.

This observation is likely applicable to the authors (including me), and we do well to remember, and to be humbled by, our own limitations of perspective in addressing these vital issues. But it is well past time to make the effort.

Notes

1. Comm. for the Study of the Future of Pub. Health, Inst. of Med., The Future of Public Health 19 (1988).

2. See, for example, Richard A. Epstein, *Let the Shoemaker Stick to His Last: A Defense of the "Old" Public Health*, 46 PERSP. IN BIOLOGY & MED. (SUPPLEMENT) S138 (2003).
3. From the company's website, this unequivocal statement: "PM USA agrees with the overwhelming medical and scientific consensus that cigarette smoking causes lung cancer, heart disease, emphysema and other serious diseases in smokers. Smokers are far more likely to develop serious diseases, like lung cancer, than non-smokers. There is no safe cigarette." See *Smoking and Disease in Smokers*, online at http://www.philipmorrisusa.com/en/cms/Products/Cigarettes/Health_Issues/default.aspx (accessed February 24, 2010).
4. See CDC, *Outbreak of Measles – San Diego, California, January – February 2008*, MMWR, Feb. 29, 2008, online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5708a3.htm (accessed February 24, 2010) (describing an outbreak in San Diego among unvaccinated children).
5. Aravind Adiga, *What's Behind India's Outbreak of Polio Paranoia?* TIME, Sept. 28, 2006, online at http://www.time.com/time/health/article/0%2C8599%2C1540477% 2C00.html (accessed February 25, 2010) (attributing stubbornness of polio infection to views of influential fundamentalist Muslim clerics).
6. For a comprehensive discussion of religious and philosophical exemptions to vaccination, see Ross D. Silverman, *No More Kidding Around: Restructuring Non-Medical Childhood Immunization Exemptions to Ensure Public Health Protection*, 12 ANN. HEALTH L. 277 (2003).
7. *Sherr v. Northport-East Northport Union Free School Dist.*, 672 F. Supp. 81 (E.D.N.Y. 1987). The case demonstrates that those seeking the objection on such grounds often try to cast their objection in religious language, thereby to gain the protection of the exemption. In *Sherr*, the effort was unsuccessful because the court found the claim that the opposition was sincerely grounded in religion not to be credible.
8. Gardiner Harris, *Journal Retracts 1998 Paper Linking Autism to Vaccines*, N.Y. TIMES, Feb. 2, 2010, online at http://www.nytimes.com/2010/02/03/health/research/03lancet.html?partner=rss&emc=rss (accessed February 24, 2010) (discussing population-based studies refuting the link, and a recent retraction by British medical journal, *The Lancet*, of the one article that had purported to find such a connection).
9. Evan Stark, *Using Public Health to Reform the Legal and Justice Response to Domestic Violence*, *infra* at 125–152.

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