

Intersecting Professions

A Public Health Perspective on Law to Address Health Care Conflicts

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Abstract

This paper examines the intersection between the two professions – law and medicine – with reference to systematic transformations that have characterized their development in the past century. In particular, the paper examines the co-emergence of the new public health and health promotion scholarship along with the development of the Alternative Dispute Resolution (ADR) movement in the second half of the 20th century. The two movements, with their later developments, have aspired to change the focus of professionals in the field, and both have been tremendously successful on the one hand, and on the other have remained marginal to mainstream training and identity building of contemporary lawyers and doctors.

Keywords: public health, Alternative Dispute Resolution, public law, health promotion.

1 Introduction

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The article examines possible mutual enrichment between these reform movements and develops a conflict resolution perspective of public health, along

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with a public health perspective of law. In particular, the paper uses two case studies to demonstrate its claims: 1. Responding to medical errors and preventing them. 2. Resistance to vaccination. In these two case studies, the interaction between law and medicine will be analyzed, with a special emphasis on a new understanding of the role of law within health policy as well as the opportunities and challenges of the incorporation of public health principles into the legal system, thus developing a public health perspective on law.

2 Conflict Resolution and Public Health – a brief historical introduction

The ADR movement emerged in the US during the 1970s as a response to “the popular dissatisfaction with the administration of justice,” (Sander, 1976. p.111) and suggested a variety of dispute processes to address legal disputes instead of the sole prospect of adjudication (Menkel-Meadow, 184). ADR proponents have introduced mediation, negotiation, arbitration and other processes as methods that may supplement or substitute the mainstream rush to adjudication and have praised the values of face-to-face interaction, interests-based negotiation and problem solving collaboration. The idea of “the multi-door courthouse,” as developed by Frank Sander at that time, captured the essence of a new legal paradigm of a more holistic functional approach to court management. “Fitting the forum to the fuss” (Sander & Goldberg, 1994) and process pluralism became the leading motto since that time. Later, during the 1990s, this approach developed into a Dispute System Design (DSD) perspective in businesses and organizations as well, and evolved into a more systematic approach to prevent and manage conflicts effectively (Martinez, 2013).

Conflict resolution models have developed and spread in the past decades, including new schools and practices such as restorative justice, transitional justice, therapeutic jurisprudence and transformative mediation (Alberstein, 2014). Organizing principles that characterize conflict resolution models are: (1) *Process emphasis*. Conflict resolution models begin with a reflection on the proper way to address a conflict constructively and avoid a straightforward intervention in the negotiation before thoughtful planning. (2) *Constructive future-oriented intervention*. Addressing conflict as a positive phenomenon and conveying optimism as to the possibility to grow and learn from conflict engagement. This state of mind repeats itself even in moments of relapse or conflicts involving severe trauma. (3) *Deconstruction and hybridization*. Complexifying the image of the binary one dimensional conflict and addressing it as composed of small units that need to be addressed separately. This is one of the basic techniques all conflict resolvers use. Conflicts are considered polycentric, multilayered, and complex. Parts of them may point to different solutions, yet this diversity is not perceived negatively, but rather may increase creativity and possibilities for synergic outcomes. (4) *A search for an underlying hidden layer*. Conflicts are not about positions claimed by the parties, but more about needs, interests and underlying motives that often do not surface during the discussion and yet need to be addressed. Focusing on needs, interests, emotions, relationship or identities as underlying layers enables crea-

tive solutions and the potential to escape the zero-sum game perceived by the parties. (5) *Acknowledgement of emotions and addressing relationship*. Conflict resolution models share a reconstructed perception of the human subject and they strive to enrich and transform the common individualistic consciousness through the emphasis on the relational aspect of conflict interactions. The acknowledgement of emotions as a significant element in human conflicts is central for such an emphasis and a procedural space is given in each model for the processing and regulation of emotion in order to encourage conflict transformation. (6) *Community work and bottom-up development*. Unlike legal institutions that exercise authority from above, conflict resolution models share a “grass roots” emphasis of working from the bottom up and avoiding authority and fixed plans. Deliberation and engagement in dialogue are considered key to achieving best outcomes. Work in interdisciplinary teams in search for consensual solutions is considered better than advising or imposing solutions.

Public health emerged as an organized discipline during the 19th century with the goal of improving the health of the nation (Porter, 1999; Berridge, Gorsky & Mold, 2011). While its initial interests focused on infectious diseases, sanitation, and hygiene, its current health scope has grown to include issues such as health promotion, the rise of chronic diseases, and health inequalities. Yet, emerging and re-emerging infectious diseases constantly remind us that the battle against contagious diseases is far from over. In many parts of the world, the “double burden” of both infectious and chronic diseases imposes a growing burden especially upon low- and middle-income countries, which have limited resources and struggle to meet the challenges of long-existing problems associated with infectious diseases and the rapid rise in cardiovascular diseases, diabetes, cancers and obesity-related conditions (Bygbjerg, 2012, <http://science.sciencemag.org/content/337/6101/1499>).

Public health is defined as “the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations – public and private, communities and individuals” (Wanless, 2004. p.23). Public health concerns and practices have existed since antiquity, but developed into modern form with the rise of the modern state, mainly from the 19th century onward. Public health joined other social reform movements, entering into previously considered “private spheres” areas such as the family, communities, and education. These new practices, especially developed in the second part of the 20th century are sometimes defined as the “New Public Health”. As Tulchinsky and Varavikova wrote: “The New Public Health is a contemporary application of a broad range of evidence-based scientific, technological, and management systems implementing measures to improve the health of individuals and populations. Its main objectives are the political and practical application of lessons learned from past successes and failures in disease control and the promotion of preventive measures to combat existing, evolving and re-emerging health threats and risks.” For clinical medical practice and education,

this offered new perspectives and professional challenges.¹ The move between the more individual and clinical-oriented model to prevention and community-based approaches with strong emphasis on social, economic and political determinants of health is still ongoing and is still far from reaching full potential. While many declare prevention as better than cure (as it adds quality of life, is easier to accomplish than cure, and is often cheaper) prevention is marginalized and the first to be cut during times of austerity. Harvard's former dean of the School of Public Health, Harvey Feinberg, described this as the paradox of prevention (Feinberg, 2013).²

The principles of public health, distinct from those of clinical medicine that are more focused on medicalized treatments of individuals in clinical setting, are based on a population approach, an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health. Components include: (1) a focus on primary care prevention and health promotion; (2) targeted studies of the economic, political, and environmental factors that may affect populations and cause diseases; and (3) ways in which the modification of social and environmental variables may promote public health aims (through active social and political involvement).³ This strategy contrasts sharply with that of "traditional" clinically oriented medicine, especially as practiced in hospitals. As a result, although clinicians and public health practitioners cooperate on many levels, tensions continue to exist.⁴

Public health preservation is a function of the complex relationship between the social actions of the state, institutions, and groups of citizens – best conceptualized by understanding the socio-philosophical basis of the relationship between the individual and the state. The liberal approach focuses on the right of an individual to defend his/her freedom in the face of coercive state actions, even when these actions are carried out in the interest of the greater good. On the other hand, a communitarian approach views public health care as part of com-

1 On the connection between public health care and the rise of the welfare state in such contexts, see Porter D. *Health, civilization and the state: a history of public health from ancient to modern times*. New York: Routledge; 1999.

2 Among the obstacles mentioned by Feinberg: the success of prevention is invisible – if successful nothing happened as it was prevented, prevention lacks drama, often requires persistent behavior change, and may be long delayed; statistical lives have little emotional effect, and benefits often do not accrue to the payer; avoidable harm is accepted as normal, preventive advice may be inconsistent, and bias against errors of commission may deter action; prevention is expected to produce a net financial return, whereas treatment is expected only to be worth its cost; and commercial interests as well as personal, religious, or cultural beliefs may conflict with disease prevention.

3 For a recent general overview of public health characteristics, see Institute of Medicine (US). *The future of the public's health in the 21st century*. Washington: The Institute; 2003.

4 On the tensions between public health and clinical medicine, see Brandt AM, Gardner M. Antagonism and accommodation: interpreting the relationship between public health and medicine in the United States during the 20th century, *American Journal of Public Health* 2000; 90: 707-711.

munity welfare (e.g., Walzer, 1983). The authority of the state in public health is broad, permitting extensive interventions in the private sphere. Hence, critics view public health care as open to exploitation by the state, which can engage in coercive practices, trampling on individual rights. Traditional issues of contention have included measures such as vaccination, quarantine, medical examination of immigrants, forced sterilization, and other eugenic measures.⁵

To consider public health policy and ethics seriously, one must contemplate the intersection between public health and law. The law is interwoven into each segment of public health,⁶ defining the boundaries of what public health authorities can and cannot do, setting limits to their power, and placing restrictions on their relationships with individuals or social groups. With differing degrees of success, the state attempts to use the law to construct and impart lifestyle norms and healthy, safe behavior (Gostin, 2000).

To a great extent, institutions of law constitute a central arena for discourse on public health measures. A wealth of literature exists on health law, but it is mainly concerned with medicine and personal health care services governing clinical decision making, delivery, organization, and finance. Public health law should have a different focus from the aforementioned laws.

Traditionally, public health law was largely aimed at dealing with communicable diseases and negative externalities with large-scale health impacts such as pollution (Gostin, 2000). Recently, the main impetus for public health law reforms has been the enforcement of public health measures, such as quarantine in the case of infectious diseases such as SARS (Gostin, Bayer & Fairchild, 2003) and the enforcement of environmental standards in the case of pollution (Gostin, 2000). Although this level of enforcement is crucial for protecting public health, there are alternatives to the law that are more in line with the archetypal public health principles of promoting good health and civic participation in advancing public health. Understanding cultural, social and political determinants of health can inform public health practitioners when applying health promotion programs. Public participation and trust-building between the establishment – medical and non-medical – are crucial and must be considered when designing public health interventions.

5 Porter, *supra* note 1, at 128-46 discussed the issue of coercion and resistance in Chapter 8: The enforcement of health and resistance. For specific analyses, see Colgrove J. *State of immunity: the politics of vaccination in twentieth century* (2006); Schoen J. *Choice and coercion: birth control, sterilization and abortion in public health and welfare* (2005); Alexandra Minna Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (2005); Markel H. *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (1997); Fairchild AL. *Science at the borders: immigrant medical inspection and the shaping of the modern industrial labor force* (2003).

6 On the intimate relationship between the law and public health care, see Gostin LO. *Public health law: power, duty, restraint* (2000).

3 Public health and conflict resolution as reform movements

Both the legal and the medical professions developed significantly during the 20th century and are considered central for the promotion of healthy and just societies. Scientific medicine emerged as a central emphasis in medical education during the early 20th century, especially after the publication of the Flexner report in 1910 on the situation of medical education in the United States and Canada; at the same time, legal science as based on normative order and doctrinal proficiency became the norm for legal education. While in medicine the aspiration for clinical education combined with empirical testing has become the paradigm, in law a normative approach based on law in books has become the paradigm. An equivalent to the Flexner report, the Reed report (1921), was rejected by legal scholarship: Studying law was considered abstract science focused on doctrine and analytic thinking. Although these approaches are central pillars of medical and legal education today, plurality and critique were part of their development, especially during the second half of the 20th century. Scholars from within the professional circles and various external players have constantly criticized the claims of doctors to accuracy and pure science, as well as the aspiration of lawyers for precision and order, and have suggested various perspectives on the failure of the professions to fulfil their promise.

In law, the intellectual wave of Legal Realism exposed, as early as in the 1920s, the indeterminacy of legal rules, the inability to determine facts objectively and the bias and subjectivity of judges' work (Fisher et al., 1993). In medicine, the rise of Evidence-Based Medicine (EBM) and, later, its critique and further developments in evidence-informed decision making were also important stages in the development of the profession.

In parallel to waves of critique that developed during the 20th century, and sometimes in response to these trends, reconstructive movements have developed during the last decades, suggesting new images for physicians and lawyers, and claiming to overcome the failures that were emphasized by the critical camps. Public health and conflict resolution reflect such movements.

EBM developed as an attempt to ground clinical practice on scientific facts and diminish the idiosyncratic scope of different therapeutic approaches by basing clinical research on statistical methods, using Randomized Clinical Trials (RCT) and meta-analysis as emblematic methods. Since its introduction in the 1990s, EBM has become one of the most influential concepts in the medical sphere, from clinical practice to health policy making.

In recent years, some proponents of EBM have moderated their former rhetoric that stressed the inability of practicing physicians to make rational decisions, while facing clinical problems. The critique of EBM should not amount to the rejection of using scientific knowledge in order to improve public health practice. EBM should continue to have a role in medical and public health practice, yet an alternative, more democratic, vision of the incorporation of evidence-based decision making into public health should be developed. This vision, also framed as evidence-informed decision making, should not be limited to quantitative thinking, giving a sole role to methodologies deriving from statistics and cost-contain-

ment methods, but to a more diverse mode of knowledge production. Thus, knowledge produced by a variety of disciplines (ranging from biomedical science to social science and humanities) and stakeholders (ranging from experts to NGOs and communities involved) can inform democratic public health policies.

In law, development of schools such as The Legal Process (Hart & Sacks, 1994), empirical legal studies (Eisenberg, 2011) and public law (Eskridge & Peller, 1990) has inspired perceptions of law which do not focus on legal rules. Instead, legal practice was presented as a procedural structured formula of decision making (Legal Process), a search for a normative order (Public Law) or a measured intervention which can be assessed by empirical measures. The ADR movement has suggested to replace the authoritative figure of the scientific judge by an alternative image of the open-ended problem-solving mediator. Instead of hierarchy and science of the law in books, it offered management and transformation of the law in action. It proposed that negotiating skills be taught in law schools in light of ADR, and that creativity and needs-emphasis should supplement rigorous norm application.

The evolvement of the public health approach and the ADR movement in the last 50 years had a remarkable influence on the perception of law and medicine. On the one hand, the two movements can be defined as successful in expanding the boundaries of the professions, and influencing the management of health and legal systems. The understanding that hospitals should be only used as a last resort and more emphasis should be placed on community care and public health education has become the norm in many health systems. In many legal systems, trials are vanishing, and various reforms of court administration and legal alternatives have dramatically reshaped the landscape of dispute processing (Galanter, 2004, 2004a). On the other hand, despite these major changes, radical transformation of the two professions is still not the case today. On many levels, the mainstream approach has retained its scientific claim, and many changes are coopted into the scientific or adversarial core values and do not really transform the systems. The major institutions, such as the hospital or the court, are still perceived as the most influential and prestigious, even though in practice, more exciting changes are taking place in the community. The following case studies will examine the strengths and limitations of implementing a public health approach combined with an ADR approach for processing of medical conflict, and will evaluate the combined approach's potential.

4 Public health and conflict resolution concepts applied in medical conflict

4.1 *Dealing with medical errors*

Medical malpractice lawyers usually recommend silence when their physician clients are sued for a medical error, especially one leading to serious injury or death. This approach is based on the common assumption that admitting responsibility for any error simply sets the stage for a prolonged lawsuit and massive settlement (MacDonald & Attaran, 2009). Behind this assumption lies the dichotomy, whereby apology is relegated to private interactions while law is the primary tool

for handling institutional and professional interactions. A health care provider is not supposed to apologize even if she feels the need to do so, since the legal consequences of such an act will be liability and high damages for the hospital. Such costs, according to traditional legal thinking, should only be the product of due process of law through presentation of evidence and application of strict legal procedures.

Recently, more and more voices are trying to change the incentive not to apologize by promoting disclosure of medical errors and presenting the apology as both an ethically and professionally responsible act. An apology under this perception is presented as a reasonable choice stemming from utilitarian motives and a crucial way to improve patient safety and quality of care.⁷ In order to encourage medical apologies, several countries have introduced apology laws to reduce the concerns regarding the legal implications of disclosure and apology.⁸ In the American context, these laws have been in place since the 1990s, mainly as a part of efforts to enhance medical error reporting and patient safety. An important document representing the change in medical culture with respect to medical errors and the proper response to such errors was a report by the Institute of Medicine (IOM), *To Err is Human: Building a Safer Health System* (Linda T. Kohn et al. eds., 2000). This document broke the silence that has surrounded medical errors and their consequences by recognizing that “to err is human” and refusing to blame well-intentioned health care professionals for making honest mistakes. Instead, the report aimed to promote an agenda for reducing medical errors and improving patient safety through the design of a safer health system. Although the report prominently noted the rough legal atmosphere surrounding medical errors, it does not seriously question the current legal framework; rather, the report perceived the framework more as a constraint within which the design of more efficient workplaces and encouragement of disclosure for future preventions of mistakes must operate. The report considered the problem in the context of (1) rising numbers of medical errors, with more people dying in a given year in the U.S. as a result of medical errors than from motor vehicle accidents, breast cancer, or AIDS; (2) rising costs of medical care, including litigation costs; (3) increasingly technology-oriented hospitals and health care interactions; and

- 7 Ashley A. Davenport, *Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractices Cases*, 6 Pepp. Disp. Resol. L.J. 81, 107 (2006) (concluding that a practice of apologizing effectively may result in “a team-based atmosphere that ultimately reduces errors and protects patients”). See also Lauris C. Kaldjian et al., *An Empirically Derived Taxonomy of Factors Affecting Physicians’ Willingness to Disclose Medical Errors*, 21 J. Gen. Internal Med. 942, 943 (2006) (finding ninety-one factors recognized in existing literature that impede or facilitate physicians’ willingness to disclose errors); Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 Annals Health L. 55, 85 (2005) (“Discussing errors openly creates educational opportunities that help others avoid similar mistakes in the future.”). See generally *Medical Malpractice, Apologies, and Litigation*, Perfect Apology, <http://www.perfectapology.com/medical-malpractice.html> (last visited Dec.9, 2010) (promoting medical apologies in cases of medical malpractice).
- 8 Some countries, such as France and Sweden, have no-fault compensation systems. For an analysis of the various effects of apology laws, see John C. Kleefeld, *Thinking Like a Human: British Columbia’s Apology Act*, 40 U.B.C. L. Rev. 769, 771–773, 777–783 (2007).

(4) growing alienation between patients and physicians. While this context invites the idea of reducing these rising tensions, the term “apology” cannot be found in the IOM report; instead, the main framework is patient safety.

Apology within the health care system is unique in that situations that call for apology constantly occur within public institutional settings, such as hospitals or community health care services. Thus, apology in the contexts of health care services transcends its interpersonal quality and becomes a target for regulation and careful design. Another important characteristic of apology within the health care system is related to the inherent structural imbalance between patients and health care providers. Patients are, by definition, less powerful, unfamiliar with the system, less knowledgeable, and less able to control the interaction with health care providers.

It can be argued that apology regulation aims to encourage doctors and health care providers to develop more sincere human interaction with their patients without fear of sanction by law for such efforts. In other words, legal regulations may provide a safe area where sincere human gestures do not have legal consequences. Health care apologies are designed in ways that neutralize the legal consequences – as expected in private apologies – and still enable the advantages of amicable dispute resolution without legal litigation. Although there is an acknowledgement of the importance of apology in transforming relationships and improving health care services (Lazare, 2006),⁹ many of the current legal arrangements fail to construct circumstances permitting apologies to follow all of the conditions above and thus do not produce effective apologies.¹⁰ Regarding *acknowledgement of the wrong*, many countries only exempt benevolent expressions. Thus, physicians and hospitals may fear liability depending on the type of apology they offer.¹¹ When the law enables only an expression of sympathy and does not include acknowledgement of wrongdoing, an apology might lead to worse outcomes than the expected legal dispute (Mastorianni et al., 2010).¹² The condition of *acceptance of responsibility* is also not covered by apology law: Even when apology regulation exempts the acknowledgment of a wrong, it will rarely

9 Lazare describes ten healing mechanisms effected by apology: restoration of self-respect and dignity; feeling cared for; restoration of power; suffering in the offender; validation that the offense occurred; designation of fault; assurance of shared values; entering into a dialogue with the offender; reparations; and a promise for the future. For additional discussion of the healing aspects of apology, see generally Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 Yale L.J. 1135 (2000); Lee Taft, *On Bended Knee (With Fingers Crossed)*, 55 DePaul L. Rev. 601 (2006).

10 See Lazare, at 1402 (“All [four] parts are not necessarily present in every effective apology, but when an apology is ineffective, one can invariably locate the defect in [one] or more of these [four] parts.”).

11 These fears are reflected in state legislation impacting the legal effect of apologies. For example, in 1986, Massachusetts enacted a rule of evidence that rendered inadmissible “[s]tatements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence” as evidence of an admission of liability in a civil action. Davenport, *supra* note 7, at 98 Other states have equivalent rules.

12 Mastroianni, at 1614 (“Our analysis reveals that most [state disclosure] laws have structural weaknesses that may discourage comprehensive disclosures and apologies and weaken the laws’ impact on malpractice suits.”).

encourage acceptance of responsibility for that wrong.¹³ An apologetic act might also fail when *remorse* is expressed in reserved, legal language and *reparation* is offered, not as full compensation, but only as a symbolic act.

The difficulties of regulating apology through special exemption clauses and the imposition of duties to report on medical errors are related to the over-emphasized contrast between apology and law nurtured by mainstream legal culture. In contrast to this gap, an alternative legal culture presenting mediation as the primary legal method to deal with health care disputes has the potential of transforming relationships without falling into individualistic assumptions of apology and law.¹⁴ The most effective health care apology might be possible within a mediation process due to its confidentiality.¹⁵ When statements made in the course of mediation are privileged under state law, they can be excluded from admissibility. Many states have such exclusionary provisions, since mediation fundamentally seeks to overcome the rigidity and alienation of the law by encouraging enclaves of private interactions protected by law. Indeed, mediation is probably the preferred forum to encourage an apology (Pavlick, 2002) within the health care system, but since entrance into, and participation in, the process require informed consent, not all health care apologies can be handled by this process.

Despite the fertile and safe ground which mediation provides for apologies, and the advanced approach it carries regarding the intersection of legal rules and human relationship, in reality many mediations of legal disputes regarding medical errors remain adversarial and tend to downplay the emotional and relational aspects of the disputes. They also tend to put less emphasis on prevention and future learning as a dispute resolution approach would suggest. The compensation rate and the legal deal becomes the focus of the discussion among the lawyers, and no room is given to the patients' pain or to the doctor's humanity. When legal culture is adversarial and formalistic, and traditional lawyers are facilitating the negotiations, preserving the "safe heaven" of the mediation room becomes impossible.

- 13 Jennifer K. Robbennolt, *What We Know and Don't Know about the Role of Apologies in Resolving Health Care Disputes*, 21 Ga. St. U. L. Rev. 1009, 1013 (2005) (referring to an Oregon statute's provision that "any expression of regret or apology made by or on behalf of [a licensed medical provider] ... does not constitute an admission of liability for any purpose").
- 14 For a presentation of mediation as transcending individualism with a basis in a relational worldview, see generally Robert A. Baruch Bush & Joseph P. Folger, *The Promise of Mediation: the Transformative Approach to Conflict* (1st ed. 2004). For a discussion of the importance of a relational worldview in mediation, see Michal Alberstein, *Forms of Mediation and Law: Cultures of Dispute Resolution*, 22 Ohio St. J. on Disp. Resol. 321, 365-366 (2007); Ran Kuttner, *Human, Not Too Human: Why Is Mediation a Profound Alternative to the Legal Proceedings?*, in 50 *Studies in Law, Politics and Society* 139, 156-159 (Austin Sarat ed., 2009).
- 15 See Deborah Levi, *Why Not Just Apologize? How to Say You're Sorry in ADR*, 18 *Alternatives to High Cost Litig.* 147, 163, 165-168 (2000) (noting the potential for benefit from apologies in mediation settings and factors maximizing that potential).

4.2 *Increasing vaccination compliance – between persuasion and compulsion.*

Vaccination stands out as one of the most effective, widely used, and highly lauded medical technologies. The routine provision of infant and childhood immunization is a cornerstone of health care systems in nations around the world. By achieving high levels of coverage among their populations – 90% or above for many vaccines – over the course of the 20th century, countries around the world, initially mainly rich countries and gradually more and more poor countries, were able to control and even eliminate previously endemic infectious diseases, such as smallpox, polio, diphtheria and tetanus, from their borders. Vaccines also raise a host of uniquely challenging ethical, legal and policy questions. Like any medical intervention, vaccines carry the small risk of severe side effects. Unlike most other procedures, however, vaccination is performed on healthy individuals. It is most commonly administered to infants and school-age youth, and therefore entails questions of parental control over children's welfare (Diekema and Marcuse, 1998). While with exemptions, religious or philosophical (depending on the specific state), it has been mandated by law for children entering school in the U.S. because of its societal benefits (Orenstein and Hinman, 1999). Vaccination policy exemplifies tensions at the heart of public health in democratic societies, and indeed can serve as a lens through which to explore central issues of public health ethics. These include the balance between the rights of the individual and the claims of the collective, the acceptability of compulsory measures, and the trade-off between risks and benefits in implementing a population-level intervention.

The foundation for the societal benefit of vaccination is herd immunity, a theory first formally articulated in the 1920s, through which the entire community is protected against a contagion if a sufficiently large percentage of the group is immune (Fine, 2004). From the perspective of the community, the optimal situation occurs when each member assumes the small risk of undergoing vaccination in order to protect both herself and the community as a whole. A successful vaccination program thus depends at least in part on individuals making an altruistic decision. But as one analysis noted, “an individual's ideal strategy would be to encourage everyone else to be vaccinated, [except] himself or herself (or his or her child)” – and thus a paradox exists: The decision of any one individual to refuse vaccination will not affect the group's protection, but if too many people make that same choice, the decisions in the aggregate would undermine herd immunity (Fine & Clarkson, 1986). People who are fit to undergo vaccination but choose not to have been termed “free riders,” since they enjoy the benefit of herd immunity that results from other members of the community having assumed the small risk of vaccination (Diekema & Marcuse, 1998).

Those responsible for vaccination programs have adopted a wide variety of approaches to achieving high levels of coverage. These have included traditional health education and promotion campaigns in the mass media; recommendations given to patients by individual practitioners and issued by official medical societies; incentive programs that reimburse health care providers who achieve high coverage among their patients; installation of a network of mother-and-child care centers with free delivery of vaccination; and compulsory measures such as man-

dates for immunization prior to school entry (Orenstein, Rodewald & Hinman, 2004). All of these approaches attempt to strike a balance between the potentially competing values of respecting individual choice and assuring a sufficiently high degree of population immunity. One of the greatest challenges facing health officials is that a successful immunization program will almost inevitably become a victim of its own success; part of the prevention paradox described above, is that the more a vaccine suppresses an infectious disease, the more it engenders complacency by diminishing the threat that initially led to widespread acceptance of the vaccine (Karzon, 1977).

In all countries, the recommended schedule of vaccines is crafted by a unit of the central government in collaboration with advisory or consulting bodies. Yet there are numerous differences in standard clinical practices between the countries, including the choice of vaccines that are routinely administered, the ages at which they are given, the use of combination vaccines and the number, timing and frequency of booster doses. Even greater variations exist in terms of vaccine delivery: whether childhood vaccines are given by general practitioners, pediatricians, and public health physicians and nurses; whether or not vaccination is mandatory in certain circumstances, such as for children in school or day care or for members of the military; what portion of vaccine costs are paid by the government, individuals, or third-party payers; and whether computer tracking systems are used to monitor vaccination coverage in the population.

Among democratic nations, the United States has been one of the most aggressive in its use of compulsion. Vaccinations are required prior to entry to schools and day care centers under a national network of state laws (Orenstein & Hinman, 1999). Although many states provide exemptions for parents who have religious or philosophical objections to vaccination, the laws have nevertheless come under attack as an unwarranted intrusion by the government into parental autonomy and responsibility for their children's health care (Hodge & Gostin, 2001-2). In recent years, parent activists opposed to vaccination have pressured some state legislatures to change their laws in order to make it easier to obtain an exemption (Feudtner & Marcuse, 2003). In addition, exemptions have been subject to court challenges on constitutional grounds, with no clear pattern of jurisprudence emerging. If written too narrowly to provide exemptions only for certain belief systems, the exemptions may represent an unacceptable establishment of religion by the state; alternatively, their very existence may violate the equal protection of the non-exempt majority (Silverman, 2003).

In Israel, on the other hand, different strategies have been used to encourage vaccination. Public health in Israel has its roots in a health culture based on communalism, and on a tradition of an interventionist state. Already during the British Mandate period, before the establishment of the Israeli State, a network of mother-and-child health centers was founded all over the country with vaccinations given free of charge. The reach of this public health system was complemented by the use of schools as a site for encouraging vaccination. Parents may object to vaccination of their child with no need of explaining their objection, and in contrast to the United States, children may still attend school without having been vaccinated. Under normal circumstances there is no legal basis for compul-

sory vaccination in Israel. Most Israeli public health officials believe that their more flexible system strikes a better balance between protecting the community and respecting the rights of individual parents who might object to vaccination. Yet there are situations in which, according to the Israeli Public Health Ordinance, compulsory public health measures such as quarantine or vaccination are justified – particularly when the Minister of Health declares that “the health of the public is seriously threatened” by the prospect or existence of a “formidable epidemic, endemic or infectious disease” (Public Health Ordinance, Palestine, 1940). This ordinance, which was enacted during the British mandate in Palestine, has remained almost unchanged, and was used only twice in Israel history: in 1949 after a smallpox exposure in Jerusalem and in a measles outbreak in the Israeli Southern district in the early 1990s.

As in Israel, Canadian lawmakers – for legal and philosophical reasons – have eschewed a U.S.-style system of exclusion. Under the Canadian constitution, vaccination cannot be made compulsory (Health Canada, 1997). Interestingly, at least one state in the United States, Indiana, used such a “certification” system in the 1950s but subsequently replaced it with a stricter exclusionary law (Marshall & Offutt, 1960).

The difference between Israel and the US illustrates the wide variation in vaccination policy that exists among industrialized democracies. Other countries have adopted a range of strategies to boost their immunization rates. In both France and Australia, parents must provide proof of their children’s immunization in order to receive state child benefit payments (Rogers & Pilgrim, 1995; McIntyre, Williams & Leask, 2003). In England, general practitioners are given a monetary incentive in the form of cash payments when 90% of the infants in their care are fully immunized. Some commentators have suggested that such a system undermines public trust in the safety of immunization by creating a conflict of interest, or at least the appearance of one, in clinicians who should be neutral providers of “objective” scientific information (Rogers & Pilgrim, 1995).

Vaccine safety – actual and perceived – has been a significant source of controversy over the course of the twentieth century, and in the past three decades in particular (Offit, Quarles, Gerber et al., 2002). Because vaccines are given to healthy people, the standard for their safety is higher, and tolerance for adverse events lower, than for other kinds of drugs (Clements, Evans, Dittman et al., 1999). The vast majority of vaccine side effects are transient and mild, such as pain and swelling at the injection site or fever; but rare severe events have been well documented. Paralytic polio is caused by one in several million doses of the oral polio vaccine, for example, and dangerous encephalitis results from one in several thousand doses of the whole-cell pertussis vaccine, which has been phased out in favor of a safer a-cellular formula. As incidence of a vaccine-preventable disease declines, so does the ethical acceptability of adverse events associated with the vaccine (Chen, 1999).

The inherent risk of vaccination has led most nations to recognize their obligation to assure compensation for the small number of people inevitably harmed by vaccines. The first no-fault compensation programs were established in Germany and France in the early 1960s, and over the following three decades most

industrialized nations have set up some type of system to compensate victims and release manufacturers from liability for non-negligently caused harms. These systems vary widely in their specific provisions and methods of administration (Mariner 1987; Evans 1999). The U.S. enacted a compensation law in 1986 in response to a growing tide of litigation against manufacturers of the oral polio vaccine, which in rare cases causes vaccine-induced paralysis, and a controversy over the safety of the whole-cell pertussis vaccine, which was suspected of causing neurological damage in some children. The program has had a turbulent history. In the early 1990s, a huge backlog of cases and budgetary shortfalls forced it to temporarily shut down, and parent activists have bitterly criticized the “Vaccine Injury Table,” the listing of adverse events associated with various vaccines that are presumptively compensable. As of 2003, almost 9,000 claims had been filed with the program, with about 1,800 being judged compensable (Evans, Harris & Levine, 2004). In Israel, a compensation law was enacted in 1989. The Knesset – Israeli Parliament – acted after a district court decision had called for legislation modeled on the UK paradigm. Such legislation would shift the burden of proof placed on parents to the State in cases of adverse effects to vaccination. Under the act, an expert committee decides whether there is a causal relationship between vaccination and injuries. By 2018, only a dozen of claims were submitted, and very few approved.

The view that vaccines constitute an unalloyed good is increasingly being challenged. One important factor in the spread of dissenting views of vaccination has been the explosive growth of the internet. Dozens of websites now challenge the orthodox view of vaccination (Wolfe, Sharpe & Lipsky, 2002; Davies, Chapman & Leask, 2002). As a result, parents seeking to inform themselves by searching online are likely to find not only pro-vaccine material from government health agencies and medical societies, but also websites that cast vaccines in a negative light, showing dramatic vignettes and photos of damaged children and characterizing the medical establishment as a conspiracy between greedy pharmaceutical companies and corrupt health bureaucrats. The growth of the internet is especially consequential with respect to the international transfer of ideas, information and beliefs. One analysis has suggested that it was the growth of the internet that helped the controversy about the alleged link between the measles vaccine and autism spread from the United Kingdom to the United States much more quickly than the pertussis vaccine controversy had spread two decades earlier (Baker, 2003).

In this climate, medical and public health experts have begun to engage more directly with perceptions of risk. They have drawn on extensive literature on risk psychology that articulates several principles about the kinds of risks that are acceptable or unacceptable to the public and how people can best be reassured under conditions of uncertainty (Balinska, 2004; Ball, Evans & Bostrom, 1998; Clements, Evans, Dittman et al., 1999). The heightened scrutiny and mistrust of vaccination came at a time when coercive measures were being considered in response to bioterrorism and new pathogens such as the virus that causes Severe Acute Respiratory Syndrome (SARS). The governments campaigns in the US and Israel in 2002-2003 to vaccinate health care workers against smallpox – an effort

that collapsed amid the widespread perception that the dangers of the vaccine outweighed the risk of a smallpox attack – vividly illustrated the challenges in gaining the cooperation of an unwilling public and the healthcare worker community. The vaccination debate illustrates the inability of coercive legal measures to answer problems of compliance and preserve public trust. On the other hand, enabling a free choice and encouraging a free dialogue on this matter without a clear “shadow of the law”¹⁶ at the background of the negotiation does not seem to be effective enough. Perceptions of law as one possible agents to promote compliance, and integration of formal law with softer methods of conflict resolution and dialogue are emerging in order to deal with this complex phenomenon.

To address vaccine hesitancy and ensure that vaccination coverage remains at levels necessary for sustaining herd immunity, a variety of different policy levers have been recently proposed and/or implemented in the U.S., Canada, and elsewhere. These efforts can be broadly classified into four domains: (1) information and service provision (e.g., social media campaigns; public reporting of school-specific coverage rates; expanded access via pharmacies; Corcoran et al., 2018; Weaver, 2015); (2) requirements or mandates (e.g., preventing a child’s school enrollment until required vaccinations are received); (3) penalties (e.g., fines and denial of social welfare benefits for parents whose children are not vaccinated); and 4) incentives (e.g., tax benefits or payments) to encourage parents to vaccinate their children.

Such policy efforts strike at the very heart of public health ethics and the broader history of public health itself, raising questions about balancing the health of the collective with personal (in this case parental and child) autonomy. Given that such policies are implemented by government agencies, public support for particular measures and trust in state institutions are paramount. The political feasibility of different policy directives – even if ethical and legal – may rely on the extent that the public views them as necessary, intrusive, and/or even coercive.

In 2008, Israel’s Advisory Committee on Infectious Diseases and Immunization, which advises the Israeli Ministry of Health, discussed the possibility of children’s vaccination as a condition to admission to the education system. The committee advised that less intrusive measures should be adopted in order to increase vaccination compliance, and also stated that a mandatory vaccination requirement would not be effective due to enforcement difficulties and the expected number of exemptions that would be granted to parents opposing vaccination. The decision to reduce children allowances for non-vaccinating parents, though approved by the Israeli Supreme Court, was not adopted by the Israeli Ministry of Health.

Recently, during a measles outbreak in Itamar (a Jewish settlement in the Occupied Territories, near the Palestinian city of Nablus), which has a relatively high percent of vaccination hesitancy, the Public Health Officer sent a warning letter suggesting that due to the epidemic, he is considering to implement the

16 The expression is taken from Robert H. Mnookin and Lewis Kornhauser, “Bargaining in the Shadow of the Law: The case of Divorce”, 88 *Yale L. J.* (1979) 950.

Public Health Ordinance, including sanctions. The letter created a public debate (Ha'aretz, 2018).

In a recent proposal, the Israeli Pediatric Association called for the universal adoption of an initiative introduced recently in a private preschool network in the Tel Aviv suburb of Ramat Hasharon. The suggestion was sent in a letter to the ministers of health, education, labor, and social services, as well as to the Union of Local Authorities in Israel (Ha'aretz, 2018). Other approaches, ranging from evoking solidarity to conflict resolution might be more efficient to deal with vaccination resistance (Prainsack & Buyx, 2011; Rock & Degeling, 2015). The act of solidarity, according to Prainsack and Buyx, is embodied and enacted rather than merely 'felt.' Thus it might be considered how solidarity as a measure to increase vaccination rates should be integrated in the system within the spirit of alternatives to the law. ADR has been considered highly successful in resolving Vaccine Act cases in the US.

5 Integration: Implementation of a public health approach of law on healthcare conflicts

The two case studies discussed above demonstrate the difficulties in applying strict legal rules and enforcement mechanisms on health care conflicts with their complex social context and repercussions. They also demonstrate the potential of ADR processes and alternative legal mechanisms for addressing this complexity and suggesting more comprehensive solutions. Still, a recurring limitation in the two case studies is the inability of the alternative approach to fully address the social complexity: When dealing with medical error, the enactment of "apology laws" that try to address the need to encourage communication and avoid litigation, does not answer the need of victims for recognition, and remains constricted within legal boundaries and one-sided acts. The incorporation of mediation in order to deal with medical mistakes conflict management does not always enable to transcend the adversarial culture. The prevailing legal culture is adversarial and mediation is coopted in a sense and becomes narrow and evaluative. When dealing with vaccination policy, the use of legal coercive measures does not address the grass root popular resistance to vaccination or its complex and varied nature, emerging from a variety of historical and sociological backgrounds. There is also no reference to more sophisticated and nuanced approaches to compliance as developed by ADR in the past decades. An obsolete rigid perspective of law is adopted as part of an advanced medical perspective. An integrative approach requires more dialogue and community building. It also calls for more hybrid legal-dispute resolution methods which use soft law, the shadow of the law, and mandatory schemes to encourage choice and participation. These said limitations result mainly from the dominance of the mainstream legal approach and from the fact that the shadow of law as a coercive formal system is still assumed as the core intersection between law and medicine. Therefore, our claim in this paper is that a comprehensive approach, which presents law as focusing on primary prevention through relationship building, and on altering the social conditions that produce

medical conflicts while digging deep into their source, will provide a more advanced form of social order for treating health care conflicts. Such a public health approach to law can be elaborated through the use of methodologies of Dispute System Design (DSD), or Therapeutic Jurisprudence, and through incorporation of basic principles of conflict resolution. Their study should be a central part of medical and legal education. Since the cause for the relative failure of alternative mechanisms to address contemporary public health problems lies in the marginality status of conflict resolution perspectives within the two professions, the solution should arrive through mainstreaming a public health perspective of law within health care conflicts. Such an approach should be developed through bottom-up clinical work, combined with theory building and conceptual development. Legal education based on prevention and a broad conflict resolution perspective combined with medical education based on a public health approach that relies on soft mechanisms combined with legal knowledge will enable to transform the process health care disputes and improve the intersection of law, medicine and contemporary communities.

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