

MECHANISMS OF LEGAL EFFECT: LAW AND SOCIETY APPROACHES

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Summary

“Law and society” is the term for scholarship using a variety of social science methods to study law and legal institutions. The unique contribution of this approach is its focus on meaning-making as a mechanism of legal effect. A foundational assumption is the need to focus on law in action rather than solely on law on the books. The latter (“law on the books”) refers to the institutionalized doctrine of legal codes and judicial opinions; the former (“law in action”) shows how law operates in practice. Key law and society concepts, including legal consciousness, law as legality, organizational legalization, and organizational politics, elaborate how law operates in action through meaning-making. Meaning-making may involve an overt politics of contested meanings or the exercise of covert power, and is an avenue both for establishing power and for resisting authority. Meaning-making happens both within the formal legal system, for example, through administrative and court enforcement, and outside formal law, for example, through construction of compliance by regulated organizations. Each of these meaning-making processes influences the other.

The concept of legal consciousness highlights how ordinary people construct legal meanings. The same individuals attribute multiple – and often contradictory – meanings to law in their everyday lives. The various meanings and their interrelationships form a cultural repertoire available to be drawn on variably in different situations. To the extent that either formal law or broader concepts of legality transform social status or identity, or create new social categories or other types of cultural meanings, law and society scholars refer to law’s “constitutive” effects – that is, law’s power to make, and make sense of, the social world. Intriguingly, recent research holds open the possibility that, even to the extent persons respond to current marginalization with the hope that fair and just law might improve things in future, rather than with legal cynicism, they may experience better mental health (Upenieks, Sendriou, Levi, & Hagan, 2021).

Law and society research on law and organizations also emphasizes meaning-making. Organizations that are not part of the formal legal system may enact and implement internally sets of law-like organizational rules, structures, and procedures that define and effect the rights and responsibilities of actors within the organization. From the managerial perspective, a “legalized” workplace, emphasizing formalized rules and due process grievance procedures, ensures smooth operation of the business.

To be of maximal utility for research linking law and public health, research on the legalization of organizational fields external to the formal legal system must be brought together with understanding how *internal* organizational politics may affect meaning attribution within single organizations. Similarly, one must consider how variation between organizations in internal organizational politics and consequent meaning attribution may reverberate back to influence organizational structures, policies, and practices across the broader organizational field.

Law and society research can further inquiry into how law operates as or upon social determinants of health. The “fundamental cause” framework of social epidemiology is consistent with the law and society tradition’s focus on meaning-making as a central mechanism by which law affects individual and aggregate health outcomes. And it is consistent with a law and society approach to the question of how law, inequality, and public health interrelate. Any law that affects economic or social inequality also is likely to affect mean aggregate public health as well as dispersion in health outcomes within the population.

Learning Objectives

- Identify and discuss key concepts in the law and society approach.
- Explain the way law influences public health through meaning-making, organizational politics, and “fundamental causes.” Give concrete examples.
- Identify two ways in which the law and society approach dramatically expands the research agenda for law and public health research.

“Law and society” is the name given to scholarship using a wide variety of social science perspectives and methods to study law and legal institutions (Friedman, 2005). Many such approaches, including law and economics, law and psychology, and criminology, are tied loosely together through the interdisciplinary Law and Society Association (LSA). Sociologists of law founded the LSA in 1964, and sociological preoccupations with law and inequality, the politics of law, and the workings of legal culture and institutions and their effects remain central to the law and society tradition (Edelman & Stryker, 2005; Friedman, 2005; Scheingold, 2004; Silbey, 2002; Stryker, 2007). This chapter shows how theory and methods yielding insight into these core issues likewise improve our understanding of how law can diminish or improve public health. The chapter first explores key concepts and mechanisms of legal effect emphasized by law and society researchers, highlighting methodological strategies appropriate for leveraging these concepts in public health research. Second, it develops the potentially far-reaching implications of the law and society approach for policy interventions dealing with “fundamental causes” of variation in health outcomes (Burris, Kawachi, & Sarat, 2002; Link & Phelan, 1995; Lutfey & Freese, 2005).

Concepts, Methods, and Mechanisms

Law and society researchers recognize that, as assumed by economists and criminologists emphasizing deterrence, law affects social action by shaping the instrumental costs and benefits of alternative behaviors. The unique contribution of the law and society approach, however, is to suggest mechanisms of legal effect emphasizing *meaning-making*. Key law and society concepts including legal consciousness, law as legality, organizational legalization, organizational politics and the difference between law “on the books” and “law in action” all implicate meaning-making (Edelman & Stryker, 2005; Stryker, 2007). Meaning-making may involve either an overt politics of contested meanings or the exercise of covert power, and it is an avenue for establishing both power and resistance (Edelman & Stryker, 2005; Ewick & Silbey, 1998).

LEGAL CONSCIOUSNESS AND LEGALITY

From its beginnings, law and society research distinguished between law's meanings and practices as understood, experienced, and enacted by lawyers, judges, and other actors within legal institutions (legal culture) and those meanings and practices as understood and experienced by ordinary citizens (popular legal culture) (Friedman, 1989). Research on legal consciousness derives from interest in the latter. Scholars such as Tom Tyler (1990) investigated through survey research how attitudes about procedural and distributive justice, and support for and sense of internalized obligation to obey legal authorities, shaped obedience to law (see Chapter 6). But scholars of legal consciousness, including Austin Sarat (1990), Sally Merry (1990), and Patricia Ewick and Susan Silbey (1998) went in a somewhat different direction. They used the term *legal consciousness* to highlight how ordinary people, in interaction with each other as well as with formal legal authorities, constructed, experienced, and enacted legal meanings. Using qualitative data gathering and analytic techniques including observation, in-depth interviewing, and detailed narrative and interpretive accounts, they showed that citizen understandings of law were complex and often contradictory.

For example, Sarat (1990) conducted field research in a local welfare office and found that “the welfare poor understood that law and legal services are deeply implicated in the welfare system and are highly politicized” (p. 374). At the same time that the welfare poor experienced fear and uncertainty in the face of the welfare bureaucracy, many of them also expressed hope that (at least partly because of law) their needs would be met. Welfare bureaucrats might be seen as embodying mindless technical rule-following or as agents of need based, substantive justice.

On the basis of in-depth, face-to-face interviews with more than a hundred people in four New Jersey counties, Ewick and Silbey (1998) found three types of everyday legal consciousness that together worked to produce what these researchers labeled “law as legality.” Where “*before the law*” legal consciousness was marked by awe at law as a “serious and hallowed space . . . removed from ordinary affairs by its objectivity,” “*with the law*” legal consciousness saw the legal arena as a game and law as a resource to be mobilized strategically (pp. 47–48). “*Against the law*” legal consciousness was marked by a “sense of being caught within the law or being up against the law” and trying to “forge moments of respite from the power of law” (p. 48). The same individuals attributed multiple – and often contradictory – meanings to law in their everyday lives. The various meanings and their interrelationships formed a cultural repertoire available to be drawn on variably within and across persons and situations. The very concept of *legality* blurred the boundary between meanings attributed to law by formal legal actors and those by actors outside the formal legal system, and between

formal law and the “law like” meanings that worked in and through other institutions, including the economy, education, religion, health and medicine, and the family. Ewick and Silbey argued that the very plurality and contradictory character of legal consciousness helped explain the power of law and the durability of legal institutions.

Building on Ewick and Silbey’s explication of legality, Kathleen Hull (2003) found that many same-sex couples denied a formal legal right to marry held commitment ceremonies combining religious ritual and broader cultural enactments of the wedding ceremony as an alternative source of legality. The point of the commitment ceremony was to assert that they were “normal,” just like heterosexuals, and to transform their social status and identities from that of single individuals to that of members of a married couple. In this case, even though the formal law did *not* recognize or endorse the identity and status transformation, enactment of the commitment ritual and the meanings attached to it by the community of participants ensured that “social roles and statuses . . . relationships . . . obligations, prerogatives, and responsibilities . . . [and] identities and behaviors” nonetheless bore an “imprint of law” (Ewick & Silbey, 1998, p. 20).

Given that commitment rituals enhance social support for the primary relationship recognized and symbolized therein and that social support typically is positively related to health (for example, Lakey, 2010; Uchino, 2009), such rituals may well have unintended positive consequences for the physical and mental well-being of people who celebrate them. Indeed, we might go further and hypothesize that as formal law recognizes and validates same-sex marriage, the health of gay men and lesbians improves, whether or not they chose to get married (Burris, 1998a). Perceptions and experiences of marginalization and discrimination are associated with greater stress and feelings of insecurity (Schnittker & McLeod, 2005). By “caus[ing] wear and tear on the cardiovascular, endocrine, immunologic and metabolic systems,” experiencing chronic stress increases the long-term risk of maladies including hypertension, obesity, diabetes, depression, asthma, and infections (Burris et al., 2002, p. 513). By reducing perceptions and experiences of marginalization, then, the removal of federal legislation defining marriage as between a man and a woman, the further diffusion of state laws validating same-sex marriage, and a Supreme Court decision affirming the right of gays and lesbians to marry just like anyone else may be expected to improve aggregate health outcomes among gays and lesbians, as indeed seems to be happening (Tuller, 2017).

Figure 4.1 provides a causal diagram capturing this particular hypothesized process, and any similar process through which formal law or enactment of legality makes meaning that affects social status or identity, which in turn affects mental and physical health. For the sake

of simplicity, this diagram does not include the more proximate risk and protective factors, including social support and chronic stress, that may mediate between status and identity transformation and individual and group-level health outcomes.

To the extent that either formal law or broader concepts of legality do transform social status or identity or create new social categories or other types of cultural meanings, law and society scholars refer to law’s “constitutive” power or effects – that is, law’s power to make, and make sense of, the social world (Edelman & Stryker, 2005; Scheingold, 2004). Research on disability by David Engel and Frank Munger (2003) illustrates the promise of concepts such as legality, legal consciousness, and the constitutive power of law for research on law and public health. Where much research on the efficacy of the Americans with Disabilities Act of 1990 investigated quantitatively the statute’s impact on employment outcomes of the disabled, Engel and Munger focused instead on the impact of the ADA as a vehicle for individual identity transformation. Using a narrative, life history approach, they did in-depth interviews with 60 people with diverse learning and physical disabilities. They found that the rights granted by the ADA “had a powerful effect on many of the interviewees by fostering their self-image as capable and potentially successful employees” (Stein, 2004, p. 1156, discussing Engel & Munger, 2003). However, for the ADA to enhance self-image and well-being, the disabled had to understand the rights it bestowed and that their previous exclusion from employment had been a rights violation.

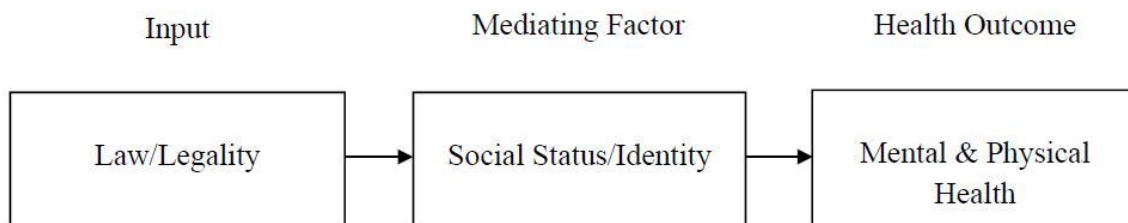


Figure 4.1. How Formal Law and Legality Influence Health.

Engel and Munger were not researching law and health outcomes per se. But their study, like Hull’s similar study of law and same-sex couples, encourages broader investigation of potential public health consequences of law-promoted status and identity change. At the same time, it shows that the meanings individuals draw from any particular health-related law in everyday life will be contingent upon their prior life roles, experiences, and understandings. So, for example, the ADA and other disabilities-related law can be expected to shape images of

disabilities and of the disabled somewhat differently for the disabled themselves, their family members, employers, and health care providers (see Engel & Munger, 1996; Stein, 2004).

ORGANIZATIONAL LEGALIZATION

Using different methods, including surveys of organizations and various statistical modeling techniques, law and society research on law and organizations also emphasizes meaning-making as a key mechanism of legal effect. The concept of organizational legalization drew from seminal work on industrial justice by Philip Selznick and colleagues (1969) and focused initially on the due process grievance procedures that American firms adopted in response to post-World War II legislation and judicial rulings governing the workplace and social welfare (Dobbin & Sutton, 1998; Sutton, Dobbin, Meyer, & Scott, 1994). Organizational legalization signals that organizations *not* part of the formal legal system – for example, schools, workplaces, doctors’ offices, hospitals and clinics, insurance companies, health maintenance organizations, pharmacies, day care centers, churches, and synagogues and mosques – may operate in a formal-rational way. That is, they enact and implement internally sets of “law-like” organizational rules, structures, and procedures that define and effect the rights and responsibilities of actors within the organization to each other and to the organization itself (Edelman & Stryker, 2005). Examining processes and effects of organizational legalization in response to state regulatory laws including labor, pension, employment, occupational safety, environmental, tax, insurance, information technology, health privacy and security, and family leave law has become a cottage industry (for example, Dobbin, 2009; Dobbin & Sutton, 1998; Edelman 2016; Edelman, Krieger, Eliason, Albiston, & Mellema, 2011; Kalev, Dobbin, & Kelly, 2006; Suchman, 2010).

Some of this research is qualitative, including field research and in-depth interviews attempting to assess directly the attribution and transformation of legal meaning by organizational actors, including affirmative action officers, human resource personnel, and medical professionals (Edelman, Erlanger, & Lande, 1993; Suchman, 2010). One research project observed privacy and security policy planning meetings and training sessions, toured numerous hospital clinics and wards with the hospital privacy officer, and interviewed hospital decision makers and selected front-line doctors and nurses to glean how the 1996 Health Insurance Portability and Accountability Act (HIPAA)’s security and privacy provisions were understood and were reshaping hospital practices (Suchman, 2010). This field study of a single 500-bed teaching hospital was accompanied by a survey of 320 hospitals using a multilevel stratified random sampling design that captured variations in governing state and federal law. Suchman (2010) assumed that HIPAA would affect both costs and quality of health care, and that these in turn would affect health. However, it would be impossible to say

what direction these health effects would take or how large they would be without first understanding how organizational actors, meanings, and practices shaped on-the-ground implementation of HIPAA.

Figure 4.2 diagrams the causal logic of this argument, in which upstream change in regulatory law affects organization-level meaning attribution. This in turn affects organization-level policies and practices, which affect interaction among medical professionals and between medical professionals and patients. These interactions affect the quality of health care provided and ultimately the health of individual patients. Suchman's field research and in-depth interviews provide empirical evidence on the first causal link only. In the full multilevel process theorized, law's effect on organizational policies and practices is mediated by (that is, works through) organization-level meaning attribution. Interaction patterns within the organization then mediate between organization-level policies and practices and health care quality.

While Suchman examined meaning-making empirically, much research on organizational legalization examines some relationship between formal legal change and organizational outcomes, while *hypothesizing* but not directly *testing* a mediating meaning-attribution process suggested by other literature. So, for example, Edelman (1992) collected survey data on organizations and then used event history analysis to model the diffusion of affirmative action policies and offices through organizational fields, as a consequence of enactment of Title VII (the employment title) of the Civil Rights Act of 1964 and of Executive Order 11246 requiring government contractors to undertake affirmative action. By 2010, Suchman had used his field research at one hospital to help him design appropriate organization-level survey questions for quantitative research that would assess systematically how a more representative sample of hospitals responded to HIPAA. To the extent that compliance with HIPAA is construed to impede efficient communication among the often-decentralized collection of doctors with different specializations, treatment clinics, and diagnostic laboratories, one can imagine that the continuity and quality of care could be affected unintentionally and adversely, increasing patient risks of mortality or sustained morbidity.

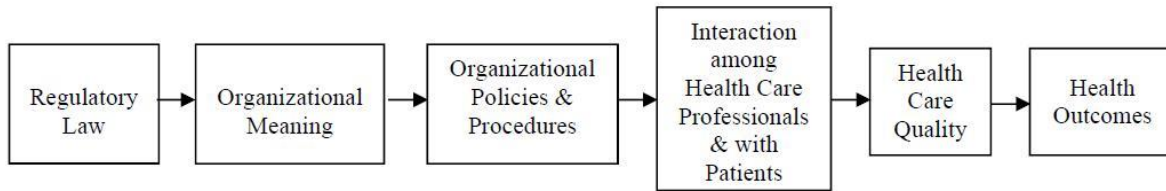


Figure 4.2. How Upstream Change in Regulatory Law Ultimately Affects Health.

With respect to Title VII, Edelman (1992) argued that managers and human resource professionals would assimilate new federal legislation and executive orders into their prior understanding of what constituted good business practice. From the managerial perspective, a “legalized” workplace, emphasizing formalized rules and due process grievance procedures, would ensure smooth operation of the business and employee productivity. Thus, managers and human resource professionals constructed strategies of compliance that involved adding affirmative action rules and offices to other aspects of formalization within their organizations.

Much other research on organization-level meaning attribution also emphasizes this type of process, typically dubbed “managerialization” (Edelman, 1992). However, other research shows that it is not just personnel managers and human resource professionals, but also other kinds of professionals, including scientific-technical staff, who use positions in organizations as well as in their professional networks and associations to promote interpretations of regulatory law that are consistent with their professional norms, values, and identities, and also with their professional interests in expanding their authority, influence, and status (Dobbin, 2009; Kelly, Moen, & Tranby, 2011; Stryker, Docka-Filipek, & Wald, 2011). One would expect health care professionals in diverse organizational settings to be no different. And while Edelman (1992) presumed that elite meaning-making reflected covert power, others have shown how meaning-making also results from interest-based strategic action and from overt organizational and professional conflicts over the meaning of law within organizations and organizational fields, including health care (Dobbin, 2009; Kellogg, 2011; Pedriana & Stryker, 2004; Scott, Ruef, Mendel, & Caronna, 2000; Stryker, 2000).

FROM ORGANIZATIONAL LEGALIZATION TO ORGANIZATIONAL POLITICS

To be of maximal utility for research linking law and public health, research on the legalization of organizational fields *external* to the formal legal system must be brought together with understanding of how *internal* organizational politics may affect meaning

attribution within single organizations. Similarly, one must consider how variation *between* organizations in internal organizational politics and consequent meaning attribution may reverberate back to influence organizational structures, policies, and practices across the broader organizational field (Kellogg, 2011; Scott et al., 2000; Stryker, 1994, 2000).

Different professions train their members according to their own sets of professional norms and practices. Examining how the introduction of scientific technical expertise into the legal system influenced formal legal decisions and the legitimacy of law, Stryker (1994, 2000) showed that legal and scientific meanings, norms, and practices often competed to provide alternative solutions to legal issues. Parties engaged in adversarial litigation could mobilize each set of meanings, norms, and practices as resources to influence judges to rule in their favor. She termed this situation one of “competing institutional logics of law and science.” More recently, she has shown how political processes of mobilization, counter-mobilization, and conflict among the competing institutional logics of law and science helped shape judicial doctrine interpreting Title VII of the 1964 Civil Rights Act (Stryker et al., 2011).

Carol Heimer (1999) showed that a similar kind of competing institutional logics analysis is fruitfully applied to health law research. She used comparative ethnographic research to study medical decision making in the neonatal intensive care units (NICUs) of two teaching hospitals in Illinois in the late 1980s and early 1990s. She showed that formal law “gain[ed] influence by working through internal organizational processes,” and that decision making in NICUs was influenced by three separate sets of meanings, norms, and practices – those pertaining to the often-competing institutions of law, medicine, and family (p. 17).

As Heimer’s study shows, the quantity of law that could potentially affect medical treatment and infant health outcomes in the NICU is fairly mindboggling. The civil law of torts operates through insurance companies, accreditation bodies, rules about standards of care, quality assurance monitoring, incident reports, hospital risk managers, hospital legal counsel, and medical malpractice litigation. Regulatory law governing medical practice operates through “consent procedures in hospitals and coordination with state officials when consent is not given by families, rules about DNR (do not resuscitate) orders, inspections, record keeping, [and] review committees [with] much overlap with mechanisms and agents of civil law” (Heimer, 1999, p. 47). Baby Doe regulations, outlawing discrimination against infants who are handicapped, and child abuse regulations that prohibit being neglectful of infants who are handicapped, exemplify the category of “fiscal law – regulations about expenditure of state and federal monies” and influence infant health outcomes in the NICU through such means as withdrawal of funds, ethics committees, infant care review committees, and hotlines (Heimer, 1999, p. 47). Meanwhile, such criminal laws as those

against murder and manslaughter, child abuse, and child neglect also impinge on the NICU to help protect infant patients from harm; one way they do so, for example, is through custody hearings for abusive parents.

However, Heimer found wide variability of legal penetration into the day-to-day practice of medicine in NICUs. What legitimated NICUs in the eyes of government regulators and funders was often not the same as what legitimated them to the parents of infants and professional bodies such as the American Academy of Pediatrics. Government regulatory agents were on site in NICUs very infrequently, whereas medical professionals were on site all the time. Parents mobilizing law to affect their child's treatment were, in the famous language of Marc Galanter (1974), typically "one shot players" against the "repeat player" medical professionals who had been in similar decision-making situations many times before.

Unsurprisingly, Heimer found that, although "[f]amilies, the state and hospital staff members all claim[ed] the right to make decisions about infants in NICUs, and each trie[d] to influence both individual decisions and decision making procedures . . . laws end[ed] up mainly being used for the purposes of the repeat players in hospital settings – physicians rather than parents or agents of the state" (1999, pp. 61–62). Those laws that hospital staff found less useful had much less effect. The ways that law could penetrate the NICU varied depending on the type of law and the skills possessed by those interested in using it in the medical setting, but the impact of law diminished "where legal and other institutions work[ed] at cross purposes, as when families or physicians resisted judicial intrusion" (Heimer, 1999, p. 59).

Themes of law, power, and resistance as they pertain to public health likewise are emphasized in Katherine Kellogg's (2011) field research on the impact of regulatory change restricting work hours by hospital residents. From the outside, regulating residents' working hours seems like a no-brainer. Indeed, patients' rights and residents' rights groups pushed for limiting resident work hours because residents were "overworked, sleep deprived and unduly stressed. The result [was] damage to their well-being, to medical education, to patient care, and to the entire profession" (Kellogg, 2011, p. 2, quoting commentary in the *New England Journal of Medicine*). New York passed the Bell Regulation, limiting work hours for residents to 80 per week, with no reduction in pay, rather than the 100 to 120 hours per week typically worked. Though the Bell Regulation failed to go national, the American Council for Graduate Medical Education (ACGME) did enact a similar nation-wide regulation on hours worked.

Despite the new regulation's worthy goal of improving health outcomes for patients and residents, Kellogg found such substantial resistance to reform by defenders of the status quo

within the surgical units of three teaching hospitals that two of the hospitals successfully resisted changing residents' work hours. She reported that "changing the daily work practices targeted by this regulation proved difficult because it required challenging long-standing beliefs, roles, and authority relations" (Kellogg, 2011, p. 8). Those residents with the highest status in the surgical world maintained high commitment to the "Iron Man" identity forged through weekends spent on continuous call from Friday morning until Monday night. They pushed to maintain the traditional practices buttressing their status and identity in the surgical world, and many truly believed the traditional practices were best for medical training and for patients. Reformers inside surgical units in hospitals tended to come from among those who were just starting out as interns and had not yet grasped the rules of the surgical world; female residents, who were excluded from adopting the Iron Man label; residents who did not intend to make a career path of general surgery; and male residents who were especially patient-centered or who wanted to take on more responsibilities outside the hospital.

Administrators in all three hospitals planned similar compliance programs, and for a few months, change processes were similar across all three hospitals. However, over the two-and-a-half-year duration of the study, "members acted quite differently in each hospital and outcomes diverged radically" (Kellogg, 2011, p. 8). In two of the three hospitals, reformers were able to build coalitions across work conditions to promote the reduction in resident work hours, but in one of the hospitals, reformers did not achieve this key step to successful change. In only one of the two hospitals that mobilized an initial broad-based internal constituency for change could that constituency be sustained through repeated attempts to divide and undermine it by defenders of the status quo.

In short, explaining which of the three hospitals embraced the change mandated by the work hours regulation, and explaining how and why implementing the change failed in two of the hospitals, required Kellogg to examine how external legal pressures reverberated into an internal politics of contested meaning in the everyday life of the hospitals. Kellogg (2011) devotes much of her book to charting the relevant actors, resources, strategies, and tactics involved in promoting or resisting work hours change in the three hospitals, and to showing what factors accounted for differences in hospital change processes and outcomes. Kellogg's own interest is in change in health care delivery, rather than in the causal link between health care delivery and health outcomes for residents and patients. However, her research exemplifies mechanisms of legal effect that operate through an everyday politics of contested meanings. These mechanisms are likely to influence on-the-ground policies and practices in many different organizational settings for health care delivery.

Figure 4.3 diagrams the more general process through which enactment of new health-related formal law sets off an internal organizational politics of contested meaning in health care organizations. As Kellogg’s research shows, such internal organizational politics are not likely to be resolved uniformly. The paths and resolutions of internal organizational politics are likely to vary systematically depending upon exogenous variability in types and distributions of actors inside organizations and their resources, including the organization-level status and power structure prior to the advent of the new law. Different organization-level political resolutions in turn are likely to have different effects on organization-level health practices, and these in turn will affect the health of persons treated in each health care organization.

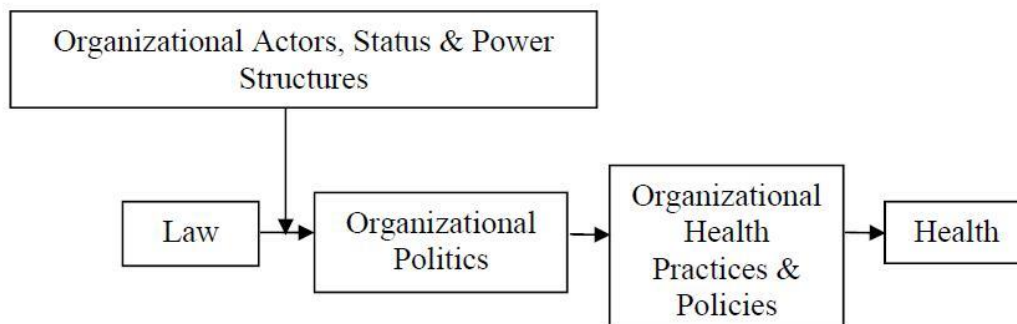


Figure 4.3. Process by Which New Health-Related Law Influences Health Through Organizational Politics.

As in Figure 4.2, the horizontal arrows in Figure 4.3 signal that law has its effects on health *through* organization-level practices (that is, these practices mediate law’s impact on health). However, unlike in Figure 4.2, law has its effects on organization-level health practices through internal organizational politics, and law’s impact on organizational politics is itself *moderated* by variability in extant within-organization actors, status, and power structures that preexisted the law. In other words, just as each additional year of education may produce *different* returns in income depending upon sex or race, law may produce a *different* set of within-organization political processes and outcomes depending on the between-organization variability in actors, status, and power structures inside organizations.

To retain focus on the causal meaning of moderate versus mediate, Figure 4.3 does not depict an added complexity often characterizing legal effects through meaning attribution: that a politics of contested meanings may take place simultaneously in single organizations and at the level of the organizational field. The two are interrelated. Field-level activity

influences individual organizations. But interaction internal to key individual organizations, including those that are “first movers” in constructing compliance with law, feeds back to influence the entire field (Stryker, 1994, 2000). Aggregate health outcomes for some population of individuals receiving health care across a population of health care organizations (say all surgical hospitals, for example) will depend heavily on which of a set of multiple organization-level policies and practices resulting from organizational meanings attributed through organizational politics come to dominate the organizational field.

LAW ON THE BOOKS AND LAW IN ACTION

Whether highlighting the concept of legal consciousness, legality, organizational legalization, or organizational politics, we have seen that one-way law operates in action is through meaning-making outside the formal legal system. As does Kellogg’s (2011) study, many studies of law in action illuminate sizeable gaps between statutes, directives, regulations, executive orders and judicial opinions, and how compliance with them is constructed (or not) by regulated organizations. But law in action research also focuses on gaps that emerge within the formal legal system itself. Legislative law must be implemented and enforced through meaning-making by other formal legal actors including administrative agencies, courts, police, prosecutors, and prisons. Such further meaning-making will be consequential for the public health impact of all health-related legislation.

Shep Melnick’s (1983) qualitative analysis of air pollution control standard setting and enforcement in US appellate and trial courts illustrates the import of formal legal meaning-making for public health. He showed that the adversarial, narrow, and reactive processes through which US pollution control takes place paradoxically led courts to extend the scope of Environmental Protection Agency (EPA) programs but diminish EPA resources to achieve pollution control. Appellate judges upheld stringent general anti-pollution standards set by the EPA, but the standards still had to be enforced in any particular situation through lawsuits heard in the first instance in federal district court. In such individual enforcement actions, trial judges typically engaged in equity-balancing, considering both the standards’ potential health benefits and their potential economic costs to local businesses being sued. Over time, the US judiciary collectively made it clear that while general anti-pollution standard-setting itself allowed little role for such equity balancing, equity balancing could play a role in judicial decisions about how those general standards should apply in any particular case. Judicial interpretation of antipollution law, then, has been complex, and public health gains potentially achieved through strict standard setting may have been partially undermined through a case-by-case, equity-balancing enforcement of those standards.

Similarly, writing about water pollution control, Peter Yeager (1990) combined interpretive analysis of evolving legal doctrine with quantitative modeling of pollution charges, violations, and sanctions to show how the culture and politics of enforcement limited federal water pollution control law from substantially improving public health. Because enforcers attributed moral ambivalence rather than unqualified harm to the conduct they regulated, they adopted a more technical, less aggressive orientation to compliance rather than a possible more punitive approach. Yeager argues that in so doing, enforcers may have lessened the positive public health impact of federal clean water legislation.

Yeager also found that large corporations that were the largest polluters had the most financial and technical resources to combat the EPA in administrative enforcement. Larger companies had more access to administrative hearings than did smaller companies, and these hearings often changed pollution control requirements in favor of regulated companies. Bigger polluters thus ended up with fewer legal violations than smaller polluters. The EPA sometimes avoided going after the largest polluters because the agency knew it could win more easily in court against resource-poor smaller companies. In Yeager's estimation, the overt politics of contested meaning that played itself out through administrative and judicial enforcement, and also the more covert power of administrative enforcers to decide on targets for enforcement, ended up reproducing the very public health problems that motivated federal anti-pollution legislation in the first place.

Figure 4.4 combines the insights afforded by the different strands of research on law in action — the one focusing on formal legal actors and the other focusing on actors in organizations outside formal law — to depict a causal process linking law to public health through multiple and mutually influencing pathways of meaning construction.

As shown in Figure 4.4, health-related legislation is likely to set off parallel meaning construction among organizations both in the formal legal arena and outside of it. Relevant organizations outside formal law include health care providers, employing organizations, insurers, schools, churches, and families. Indeed, substantial law and society research shows that meaning-making by organizations outside the formal legal system is influenced not only by legislation but also by variation over time in interpretation and enforcement by administrative agencies and courts (Dobbin, 2009; Pedriana & Abraham, 2006; Pedriana & Stryker, 2004). At the same time, if meaning-making with respect to health-related legislation resembles meaning-making with respect to Title VII, agencies and courts interpreting and enforcing the legislation likewise will be influenced by how the organizations they are regulating construct compliance (see Edelman, Krieger, Eliason, Albiston, & Mellema, 2011,

and Edelman, 2016, on judicial deference to the policies, structures, and practices put in place by business organizations constructing compliance with Title VII).

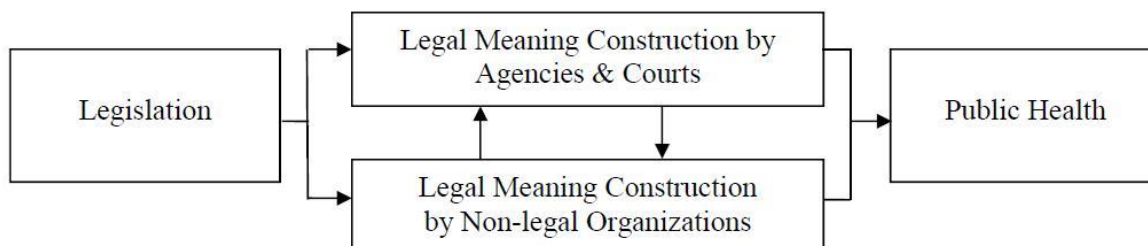


Figure 4.4. How Law Is Linked to Health Through Multiple Pathways of Meaning-Making.

Consistent with this added complexity, Figure 4.4 illustrates that the impact of legislation on public health works through the combination of formal legal meaning-making and the making of broader, culturally infused legal meanings by regulated organizations. The two-way vertical causal arrows in Figure 4.4 are meant to signal that the “combined” meaning attribution process that intervenes and mediates between law and public health involves a two-way street between formal legal actors and regulated actors external to the legal system.

Law, Inequality, and Health

Within the literature on the social determinants of health, one important line of research focuses on describing and explaining health disparities based on socioeconomic status (SES) (Lutfey & Freese, 2005). Findings of health gradients by income, education, and occupational prestige are commonplace, as is the knowledge that inadequate economic resources tend to translate into less and less good health care; poorer health-related education and information networks; poorer diet and lifestyle; and greater exposure to environmental toxins, crime, and violence (Burris et al., 2002; Graham, 2004; House, Kessler, & Herzog, 1990; Link & Phelan, 1995; Schnittker & McLeod, 2005).

In 1995, Bruce Link and Jo Phelan proposed that socioeconomic status be considered a “fundamental cause” of variability in individual health outcomes. By this they did *not* mean that the virtually ubiquitous positive association between SES and health (higher SES is associated with better health) invariably worked through the same mediating causal pathway. They meant instead, as Lutfey and Freese (2005) wrote, that

some *meta-mechanism(s)* is [or are] responsible for how specific and varied mechanisms are continuously generated over historical time in such a way that the direction of the

enduring association is observed. . . . If an explanatory variable is a fundamental cause of an outcome, then the association cannot be successfully reduced to [any one] set of more proximate, intervening causes because the association *persists* even while the relative influence of various proximate mechanisms *changes* [Lutfey & Freese, 2005, pp. 1327–1328, emphasis in original].

Karen Lutfey and Jeremy Freese investigated and built on the notion of SES as a fundamental cause of health with respect to one narrowly defined health domain: treatment of diabetes. The starting points of their research were the oft-replicated findings showing that incidence of and complications and mortality from diabetes are inversely associated with SES in the United States and other developed countries. The researchers hypothesized that in-depth qualitative, comparative research could illuminate multiple potential mediating mechanisms through which these statistical associations could work. They conducted a comparative ethnography of diabetes treatment in two endocrinology clinics, one of which treated a mostly white, middle- and upper-class population, the other of which served a mostly minority, working-class, and under-insured population. They did indeed identify a multiplicity of interconnected mediating mechanisms that would tend to reproduce poorer health outcomes among lower-SES, relative to higher-SES, diabetics. Some of these mechanisms operated at the clinic level, at which Lutfey and Freese found systematic differences in continuity of care, in-clinic educational resources, and the division of labor among doctors. These differences worked to advantage patients treated at the clinic disproportionately serving those of high SES. Other mechanisms included “differences in external constraints on potential [treatment] regimens [and] those manifesting as [between patient] differences in patient motivation . . . and [apparent] patient cognitive capabilities” (Lutfey & Freese, 2005, p. 1338).

Each of these factors in turn could matter for health outcomes for multiple reasons. For example, the high continuity of care characterizing the clinic disproportionately serving a high-SES population allowed the doctors in that clinic to have better information about the patient prior to the medical interview and to get better information during the medical interview process. Because these doctors knew that they would be able to follow up personally on individual cases, they felt free to recommend more aggressive treatment regimens that provided greater control over patients’ glucose levels and so had a better chance of improving patients’ longer-term health outcomes than did less aggressive treatments. Meanwhile, in the low-continuity-of-care clinic disproportionately serving a low-SES population, doctors had trouble acquiring basic information about patients, learning about patient habits, and identifying connections between patient habits and diabetes management. Treatment under a low-continuity-of-care regime was predicated on the assumption that all subsequent doctors

who saw the patient would have the same problems. This favored a more conservative treatment regimen that provided weaker control over glucose levels, and in turn increased the risk of long-term complications (Lutfey & Freese, 2005).

The point here is not to provide a detailed accounting of all the pathways mediating between SES and health outcomes as identified in the research of Lutfey and Freese. Rather, it is to highlight just how many alternative mechanisms might contribute to the association between SES and health, and to point out that, as any one such mechanism is eliminated, another might emerge in its place, reproducing the positive association between SES and health.

This does *not* mean that addressing fundamental causes of health disparities is futile. Instead it suggests that when possible, one might want to tackle the fundamental cause itself, rather than tackling only the mediating mechanisms. If variability in the fundamental cause – in this case SES – is reduced, health disparities likewise will be reduced and probably through multiple specific pathways. One also could consider putting in place potential intervening or mediating factors that would operate as countervailing or compensatory mechanisms, reducing the more typical effect of the fundamental cause (see Lutfey & Freese, 2005).

Law provides a vehicle for both kinds of interventions. With respect to tackling directly the fundamental cause itself, if, for example, tax law were used to narrow individual-level variability in income and wealth, there would be less such variability available to act as a fundamental cause of health disparities. Instead, however, in the United States tax law has been moving in the opposite direction. Since 1981, federal tax law has increased, rather than decreased, economic inequality, and tax law may likewise have contributed to reproducing substantial wealth inequality between blacks and whites (Burris et al., 2002).

Meanwhile, where law establishes universal health insurance, this would operate in countervailing or compensatory fashion to undermine at least one of the pathways through which individual-level disparities in SES translate into individual-level health disparities. Thus, *other things equal*, the historical lack of universal health insurance in the United States (Quadagno, 2005) should make for greater health disparities associated with SES in the United States than in countries providing universal health insurance.

In *The Spirit Level*, Richard Wilkinson and Kate Pickett (2009) encourage thinking about law and fundamental causes of health—indeed about law and the social determinants of health more generally—at the aggregate level as well as in terms of individual-level health disparities. The *Spirit Level* is reminiscent of Emile Durkheim’s *Suicide* ([1897] 1951) in

mining different types and levels of data to converge repeatedly on the same argument. For Wilkinson and Pickett, as for Durkheim, the type and character of our social environments have profound social-psychological implications, shaping each individual's mental and physical health. Like law and society researchers, Wilkinson and Pickett also highlight the roles of status, identity, and meaning-making as mediating mechanisms, in this case between economic inequality and health, rather than between law and health.

Wilkinson and Pickett argue that aggregate levels of economic inequality are associated with aggregate levels of public health through inequality's effects on social inclusion or exclusion, social status, and friendship. Increased inequality removes opportunities and inclinations for protective social interactions involving reciprocity, mutuality, sharing, social obligation, trust, recognition, and understanding of the other and others' needs. Conversely, increased inequality exacerbates status-driven comparison processes; competition and hostility; and an incapacity to perceive obligations, to trust, take the role of the other, to involve oneself in the community, and to perceive things in terms of the community good. Increased inequality aggravates individual insecurities, the emotions of pride and shame, low self-esteem, and low sense of efficacy or high sense of grandiosity and self-aggrandizement. In short, Wilkinson and Pickett hypothesize that aggregate economic inequality relates to aggregate public health through meaning attribution embedded in situational opportunities and constraints and the nature of social interaction. These processes include socialization, behavioral experiences and attributions, individual and collective identity processes, status processes, and comparison processes.

Though the argument and evidence in *The Spirit Level* focus explicitly on economic inequality, the basic argument, by logical implication, also should apply to other social determinants of health, including race. This is so because the theorized pathways of *mediation* through meaning attribution, whether through self and identity processes, status and comparison processes, or other meaning attribution processes, flow from the "social fact" of aggregate inequality levels, whether social or economic. There is, in fact, substantial research to show that health disparities are based on race, as well as on socioeconomic status (Burris et al., 2002; Schnittker & McLeod, 2005; Williams & Collins, 1995). Much, though not all, such research shows that race differences in health persist after controlling for socioeconomic status (Schnittker & McLeod, 2005).

The Spirit Level has been criticized for methodological shortcomings and has been something of a lightning rod for contending ideologies (Snowdon, 2010). Whatever one's judgment about such controversies, however, the book's underlying social scientific argument

is powerful. It also is consistent with the law and society tradition’s focus on meaning-making as a central mechanism by which law affects individual and aggregate health outcomes. And it is consistent with a law and society approach to the question of how law, inequality, and public health interrelate.

Above all, and paralleling the implications of SES as a fundamental cause of individual-level health disparities, Wilkinson and Pickett’s theoretical argument suggests that *any* law that exacerbates or mitigates economic or social inequality is likely to enhance or conversely shrink dispersion in individual health outcomes within the population, while also affecting mean aggregate health. Figure 4.5 illustrates this causal argument.

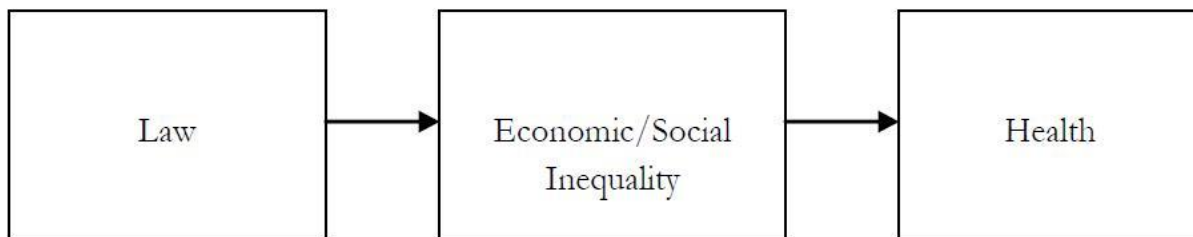


Figure 4.5. Law Affects Health Through Inequality.

Laws that explicitly are health related and laws that apparently have nothing to do with health (for example, tax law) will have consequences for health, through their consequences for inequality. Law will have such consequences whether or not these are intended and whether or not these are recognized by lawmakers or the general public, as long as the law in question affects economic or social inequality. For simplicity, Figure 4.5 omits the many and varied mediating pathways by which inequality is known to affect health-relevant environments and behaviors and health outcomes. Guided by Figure 4.5, it only makes sense that public health effects be factored into debates over both the tax and spending sides of fiscal policy, as well as over environmental law, occupational safety and health law, disabilities law, health privacy and security law, and any law pertaining to health care, health insurance, and other health benefits.

Conclusion

The law and society tradition lays fertile ground for research on law and public health, and especially for research focused on mechanisms of legal effect emphasizing meaning-making.

This chapter has shown that law affects health through meaning-making at the levels of both the individual and the organization. Likewise, it has shown that meaning-making promoted by law can operate covertly or through an overt politics of contesting meanings. It also has shown that law promotes meaning-making within the formal legal system and outside of it. The two meaning-making processes mediating between law and public health (that is, the one within the formal legal system and the other outside of it) are interrelated systematically. Each influences the other in a recursive causal fashion. Each of the various concepts emphasized within the law and society tradition, including legal consciousness, organizational legalization, and organizational politics, are associated with particular types of meaning-making at the individual level, the organizational level, or both. All of these core law and society concepts are derived from the traditional law and society concern with how law works “in action.” As shown in Figures 4.1 to 4.5, all meaning-making processes elaborated in this chapter generate theoretical hypotheses and guide associated empirical research that links legal inputs to health outcomes.

This chapter also shows that a diversity of qualitative and quantitative methods is useful for research on law and public health framed within the law and society tradition. This is all to the good because it allows all the research design and analytic methods traditionally used in the social and behavioral sciences of health to make appropriate contributions to theory building and theory testing in the field of law and public health. Ideally, research teams are formed in which qualitative and quantitative researchers work in tandem to elucidate the various paths of meaning-making mediating between law and public health. As this chapter has shown, numerous law and society scholars whose work has been foundational use qualitative methods for grounded theorizing about legal meaning-making. But other law and society scholars have used various statistical modeling techniques to test hypotheses consistent with particular pathways of meaning-making. And, as illustrated by research on the social psychology of identity formation and its consequences, including consequences for health, it is possible to develop and test identity and other meaning-making processes quantitatively (for example, Stryker & Serpe, 1982; Thoits, 1986). Consistent with the proposed causal processes outlined in this chapter, various types of multilevel and dynamic modeling also can be useful.

In addition to its core emphasis on meaning-making, the law and society tradition stands out among diverse approaches to law and public health by broadening the concept of law so that it includes both formal law and law as legality. The latter concept especially calls for an appreciation of the ways beyond the most obvious that law can be “imprinted” on everyday life, whether at the level of individuals or of organizations, through cultural meanings and

practices far beyond the formal legal system itself. That law truly may be “all over” – as in Austin Sarat’s famous phrase (1990) – in the production of public health is a boon to research linking law and health. It is so in two far-reaching ways. First, armed with the law and society tradition’s insight that the law-like rulemaking by organizations outside the formal legal system is, in fact, a form of law as legality, research on law and public health can expand its focus to the health implications of virtually all organization-level rulemaking, whether such rulemaking occurs in direct response to change in that organization’s formal legal environment or not.

An example of this type of fruitful organization-based research is that of Phyllis Moen and Erin Kelly (Kelly et al., 2011; Moen, Kelly, Huang, & Tranby, 2011). The researchers took advantage of a natural experiment undertaken at the Twin Cities metropolitan headquarters of Best Buy, a Fortune 500 retail company, to study the impact of an organization-level policy initiative intended to create a new norm of flexibility about where and when employees worked (Kelly et al., 2011). Treating those participating early in the initiative as the intervention or treatment group, and those who continued prior work practices for a longer time period as the comparison group, the researchers collected pre- and post-intervention survey data and combined their survey research with qualitative observational study and interviews. Selection problems inherent in the design were lessened because employees themselves did *not* select in or out of participating in the policy initiative earlier versus later. Instead, unit supervisors committed to the initiative earlier versus later depending on factors that should have been unrelated to employee health outcomes (Kelly et al., 2011; Moen et al., 2011).

While Moen and Kelly did not frame their research within the law and society tradition, their findings nonetheless are consistent with that tradition’s emphasis on meaning-making as a central pathway by which law affects health. Employees participating in the policy initiative experienced reduced work-family conflict and enhanced sense of control over their schedules (Kelly et al., 2011, p. 265). Hypothesizing that variation in work-family conflict and schedule control reflected broader notions of variations in job strain and stress, the researchers also found that employees participating in the policy initiative slept more, exercised more, saw a doctor more when they were ill, and refrained more from coming to work when ill than did employees who did not participate in the initiative. The policy effects were mediated in part by the meaning-making inherent in perceiving negative spillovers between work and home and in perceiving schedule control (Moen et al., 2011).

The second way that the law and society tradition dramatically expands research on law and public health stems from the insight that any law affecting economic and social inequality is also likely to affect public health. Here, the mechanism of legal effect is through inequality as a mediating “fundamental cause” of health disparities. Inequality itself then influences health through a multiplicity of resource and meaning-making mechanisms such as those signaled by Link and Phelan (1995, 2005), Lutfey and Freese (2005), and Wilkinson and Pickett (2009). In short, law and public health researchers are encouraged to consider how many laws apparently unrelated to health may nonetheless have substantial public health effects. Indeed, those who are concerned about public health might want to promote considerations of health impact, akin to analogous considerations of environmental impact, across a wide swath of public policy making.

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