1984

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Current Topics in Law and Policy

Fear Itself: AIDS, Herpes and Public Health Decisions

We should use this as a model and not make the same mistakes again. Because plagues most certainly will happen again. Man is a biological system, and we are always going to be attacked by infectious disease.

—Dr. Marcus Conant, AIDS researcher, on San Francisco's handling of the AIDS epidemic.1

I. Introduction

States have the authority to exercise their police power to protect public health. The law upon which this authority rests has been well settled for decades.2 The leading case, Jacobson v Massachusetts,3 was decided in 1905; since that time, neither its language nor its approach has been explicitly updated,4 despite a medical revolution that has substantially changed the manner in which society confronts disease.5 Recent controversies involving two diseases, Acquired Immunodeficiency Syndrome (AIDS) and herpes suggest the urgency of clarifying the law governing state health actions under the police power.

The late nineteenth century discovery that infectious diseases are transmitted by infectious agents such as viruses and bacteria revolutionized medicine.6 The germ theory of disease was the basis for the development of precise diagnostic and curative techniques, changing the responses of doctors and public health officials to dis-

4. See infra notes 48-50 and accompanying text.
6. G. ROSEN, supra note 5, at 294-5, 314.
ease. When *Jacobson* was decided this theory was still neither completely explicated nor universally accepted, even in the medical community. *Jacobson* and its companion cases reflected a judicial belief that common sense was at least as important as medical expertise in assessing medical risks and selecting public health responses. There were very few things that doctors could do to hinder the spread of disease, and the things they could do — vaccinate and quarantine — were based on simple and accessible premises that the public could apply as well as physicians.

Medicine today is firmly established as a science, whose practitioners possess special expertise largely inaccessible to the layman. Through application of this expertise, most of the diseases that terrorized mankind at the time of *Jacobson* have been all but eliminated as public health threats in the United States. The dramatic, large-scale use of public health measures such as quarantine and adult vaccination is now rarely justified by medical necessity. The modern battle against disease is fought through research, public education and improved individual treatment. This change has two major implications. First, medical expertise has become a prerequisite to accurate assessment of public health threats and responses. Common sense no longer provides an adequate measure of the necessity or efficacy of a given health action. Second, medical approaches to public health problems conflict with public demands in more and more instances. While it is obvious that medical knowledge has changed vastly in the past century, there is little to suggest that basic human responses to disease have changed at all. People are still afraid of both disease and the sick.

Public health officials are left in an awkward position. On the one
Public Health Decisions

hand, there may be clear public pressure for responses that are medically inappropriate. On the other hand, there is legal language which does not clearly state the criteria under which decisions are to be made. This comment seeks to clarify the law governing state action in assessing and responding to public health threats and considers how the law acts to reconcile divergent scientific and lay views of disease control. Section I examines the evolution of the law governing the health power and explains the legal criteria for evaluating state action. Court decisions in police power cases have required a sufficient medical basis for state action, but without providing legal language to make this requirement explicit. Language recognizing this requirement is found in health cases decided under Federal statutes. This precedent should apply to police power cases. Sections II and III analyze recent cases involving the public school attendance of children with herpes, and the continued operation of homosexual bathhouses allegedly contributing to the spread of AIDS in San Francisco. In both cases, the expert medical evaluations which should be the necessary justification for any state health action were either ignored, or tainted with extraneous political judgements. The wrong decisions were reached, for the wrong reasons, in the wrong ways. The comment concludes that the problems raised in these cases are generic to public health law, and may only be prevented in the future by a clarification of the premises and standards for public health judgments.

I. The Power to Protect the Public Health

A. The Public Health Decision: An Analytic Model

In reviewing state health actions under the police power, courts ask whether the action addressed a problem the solution of which was a legitimate state purpose, and whether the action was reasonably related to achieving that purpose. Where fundamental individual rights are compromised, courts apply a stricter standard of review, requiring both a compelling state interest and a showing that the chosen action was the least restrictive means of achieving it. Of course, problems arise as soon as one attempts to assign meaning to words like "legitimate," "rational," "compelling" and "restrictive." In public health law, these terms must be defined to allow only those measures which are medically necessary or justified. Courts have recognized this, and moved, either explicitly or

12. AIDS — A New Reason to Regulate Homosexuality, supra note 2, at 332.
implicitly, to adopt a model of public health decisions which allows them to reflect current medical opinion while disregarding extraneous public demands.\textsuperscript{13}

Public health decisions may be understood analytically as having two parts: first, an assessment of the risk posed by a disease and, second, a choice of response. Risk assessment is a purely objective, medical question; it is an analysis both of the severity of a disease and the manner and likelihood of its transmission — a usually fatal but non-contagious disease such as leukemia presents an altogether different kind of public health risk from a highly contagious but rarely dangerous disease such as chicken pox. Simply put, the risk assessment tells us if there is a problem, and, if there is, charts its boundaries. The choice of a response incorporates both medical and non-medical factors. In this phase, the health official initially measures possible responses against a medical standard of efficacy. She may also engage in a cost/benefit analysis, in social and political as well as economic terms; in fact, virtually any factor that may properly be considered by an administrator may be considered in the response phase. The initial medical measurement, however, limits her choice in that she may not select for non-medical reasons a response which is more restrictive of individual rights than one of equal or greater medical efficacy, or one which has no medical value. The response phase simply tells us what to do about the medically defined problem.\textsuperscript{14}

This model of the health official's decision process mirrors in a prospective form the retrospective analysis of the reviewing court. It provides a means of defining the terms used in the judicial analysis. A state has a legitimate or compelling interest in a particular health action when a medical risk assessment has established the existence of a public health problem. To the extent that objectivity is possible, this is an objective assessment, based solely on medical and epidemiological data interpreted according to accepted scientific principles. No regard is given in this phase to the problems attendant upon attempting to address the necessity. The response choice is reasonably related to the state's goal when it is a medically

\textsuperscript{13} See infra text accompanying notes 39-74.
\textsuperscript{14} Morgenstern, supra note 7, at 547, offers a three stage risk assessment analysis consisting of scientific evaluation of the problem, scientific choice of an effective method for measurement of the problem, and correlation of the results with designated government program options; it is from these options that the political choice of response is made. This model's thrust is identical to that of the model described here — that a distinction must be made between scientific and non-scientific elements of the public health decision.
Public Health Decisions

sound response to the risk as assessed. It is the least restrictive means if it is the medically-justified response that entails the least infringement on individual rights. The most medically sound response is justified even if another response is less restrictive, less costly or less controversial. At trial, the state must prove that its risk assessment is justified by the medical evidence. The state's response to a proven medical risk, however, is presumed valid unless those attacking it prove it to be medically unjustified, or more restrictive than another choice of comparable medical effectiveness.\(^{15}\)

Because the health law may often be applied in controversial cases, it is important to recognize that this analysis is not a method of eliminating doubt, but of apportioning uncertainty. It is not the nature of scientific evaluations to be one hundred percent certain. Where no action is taken, the costs of a mistake — and fear of a continuing threat, unrelieved by action — are borne by the public. If action is taken, the costs of a mistake are borne by those whose rights are compromised. Because uncertainty is inevitable, courts must bear in mind that protecting one group from its costs simply transfers those costs to another. The health law may be understood as regulating the placement of this burden.

In the cases to be examined here, it is possible to trace the relatively rapid disenchantment of the courts with a lay or common sense view of increasingly complex medical problems, with a consequent increase in dependence on a medically-based form of analysis. The cases to be considered fall into three groups. The early cases find the courts, at the end of the last great era of fundamental theoretical disagreement in the medical community, just beginning to accept medicine as a science. The second group, beginning in the

\(^{15}\) Other discussions of the health power have referred to it as a constitutional balancing test, as in Equal Protection or Due Process decisions, which is both true and misleading. Damme, supra note 10, at 804; Comment, An Evaluation of Immunization Regulations in Light of Religious Objections and the Developing Right of Privacy, 4 DAYTON L. REV. 401,410. A balancing is built in to the review of decisions in the least restrictive means analysis; moreover, in general in the response phase, the cost in individual rights will tend to be considered as an element of the broader impact of possible responses. But the legitimate or compelling state purpose — necessity — is established in the risk assessment without reference to response and attendant abridgement of individual rights. It is a threshold test asking only if there is a credible risk to public health. Obviously, subjectivity and prospective weighting may creep into the choice of the threshold, see, e.g., Kasper, Perceptions of Risk and Their Effects in Decision Making, in SOCIETAL RISK ASSESSMENT 71 (1980), but, in principle, the test involves a comparison between the medical assessment of risk, and the strength of the medical evidence that supports it. Once that assessment is accepted by a court, and the necessity of action to protect the public is established, the state action may abridge any individual right so long as it is a medically effective and least restrictive means to the end of protecting the public from danger and is not arbitrarily and capriciously enforced. See infra note 200 and accompanying text.
second decade of this century and continuing to the present day, shows courts adopting medical risk assessment and response standards demanded by rapid expansion of medical knowledge, but without updating legal language to reflect the new requirement. Courts did not explicitly state these standards because most police power cases that arose in the past fifty years presented individuals protesting, often for religious reasons, steps which were both generally accepted by the public and supported by the preponderance of medical evidence. Courts simply did not see the challenging sorts of cases that arise where lay and medical approaches to disease diverge drastically. It is these cases — those in which great public fear exerts pressure on decision-makers for health measures which are not supported by medical necessity — which require for their resolution a clear explication of the language of the law. Examples are found in the third group of health cases. Decided, in the absence of dynamic police power litigation, under other law, these cases yield an explicit statement of the fundamental role of medical risk assessment and response choice in public health actions.

B. The Early Cases

The standard for the exercise of the police power in health is expressed in the leading Supreme Court case on the subject, *Jacobson v Massachusetts.* *Jacobson* arose from the refusal of a Cambridge man to follow an order of the town Board of Health requiring vaccination against smallpox. The risk of smallpox transmission was established by uncontraverted evidence that smallpox was prevalent and increasing in the community. *Jacobson* joined battle on the issue of whether vaccination was an effective response, asserting that vaccination was not medically justified and offering medical evidence to that effect. In the Court's opinion, however, *Jacobson* was merely stating a general theory, held by some in the medical profession, of the inefficacy and danger of vaccination. The Court rejected this claim: "What everybody knows the court must know, and therefore this court knows, that an opposite theory accords with the common belief and is maintained by high medical authority." The Court could not adjudge the regulation inappropriate and still "attach any value whatever to the knowledge which . . . is common to all civilized peoples touching smallpox and the methods most usu-

16. See infra note 48 and accompanying text.
17. 197 U.S. 11 (1905).
18. Id. at 27-28.
19. Id. at 30.
ally employed to eradicate that disease . . . .”20

Jacobson is characterized by an equipoise in the perceived value of medical knowledge and common sense in assessing and coping with medical risk. Every reference in the opinion to “the matured opinions of medical men” is coupled with recourse to “the experience of mankind.”21 The Court quoted a contemporary New York case, Viemeister v. White,22 which recognized that the effectiveness of vaccination was disputed by some lay and medical people, but pointed out that:

[Vaccination] is accepted by the mass of the people, as well as by most members of the medical profession. . . .

The fact that the belief is not universal is not controlling, for there is scarcely any kind of belief that is accepted by everyone. The possibility that the belief may be wrong, and that science may yet show it to be wrong, is not conclusive; for the legislature has the right to pass laws which, according to the common belief of the people, are adapted to prevent the spread of contagious diseases. . . . While we do not decide, and cannot decide, that vaccination is a preventive of smallpox, we take judicial notice of the fact that this is the common belief of the people of the State, and with this fact as a foundation, we hold that the statute in question is a health law, enacted in a reasonable and proper exercise of the police power.23 (emphasis added)

Jacobson reflects tension between the emerging medical understanding of disease and the lay view.24 The case came at the end of five decades of steady advances in the capacity of medical science to prevent and control disease.25 Even the most enlightened laymen, however, were aware that the continuing efforts to understand the etiology of disease were marked by fundamental and often bitter theoretical conflicts; where science presented such marked alternatives,26 it was natural for laymen to feel qualified to choose among them. Jacobson suggests that in situations in which the uncertainty about the nature and contagion of a disease is equal in the public and medical minds, the most reasonable solution in a democratic society is to allow the majoritarian organs of government to resolve

20. Id. at 28.
21. Id. at 30-31, 37.
22. 179 N.Y. 235, 72 N.E. 97 (1904).
23. 197 U.S. at 34-5 (quoting Viemeister v. White, 179 N.Y. 235, 72 N.E. 97 (1904)).
24. Typical of this tension was the Court’s placing of the principal medical evidence in a four page footnote. 197 U.S. at 31 n.1. An in-depth review of the contemporary medical knowledge was thought relevant, but not central.
25. See supra notes 4-8 and accompanying text.
26. C. Winslow, supra note 8, at 363-66. For a glimpse at the state of knowledge in 1910, see id. at 370.
that uncertainty according to their informed views of necessity.\textsuperscript{27} Jacobson, then, looked forward in requiring an assessment of medical risk and response, but it looked backward in not leaving medical judgments exclusively to medical experts.

\textit{Jacobson} upheld the broad power of the state to identify and address public health problems.\textsuperscript{28} The analysis of the propriety of this particular application of the power was closely linked to the general legitimacy of state action. Because the Court decided the case in terms of the general legitimacy of the police power, and did not establish a medical standard for action in particular cases, \textit{Jacobson} failed to answer the central question before courts in modern public health cases: is the application of the health power valid \textit{in this case}?\textsuperscript{29} This question, naturally enough, was first posed in those cases in which the court rejected a specific state action while accepting the state's general power. It was in the effort to protect individual rights without infringing upon state prerogatives that an emphasis on medical evaluation first appeared.

In the 1895 case of \textit{In Re Smith},\textsuperscript{30} the New York Court of Appeals began its opinion by pointing out that in any evaluation of a health regulation:

\begin{quote}
[I]t must appear very clearly and satisfactorily, not only that it [the power to take the particular act] has been conferred by the law, but also that in its exercise the facts were present which justified it. The validity of the law is not so much called in question as the right to enforce its provisions is. (emphasis added)\textsuperscript{31}
\end{quote}

In holding that county health officials could not quarantine two haulers who had refused vaccination simply because their business brought them in and out of areas where smallpox was epidemic, the court required a showing "if they are not actually 'infected' with disease, that they have been 'exposed' to it, and that the conditions actually exist for a communication of contagion . . . ."(emphasis added)\textsuperscript{32} In short, a valid grant of authority did not relieve the health commissioner of his obligation to make a medical evaluation of the risk and choose a medically sound response.\textsuperscript{33}

\begin{footnotes}
\item[27.] 197 U.S. at 30-31.
\item[28.] \textit{Id.} at 37-38.
\item[29.] See also State ex rel Freeman v. Zimmerman, 86 Minn. 354, 90 N.W. 783 (1902); Blue v. Beach, 155 Ind. 121, 56 N.E. 89 (1900).
\item[30.] 146 N.Y. 68, 40 N.E. 497 (1895).
\item[31.] \textit{Id.} at 73, 40 N.E. at 498.
\item[32.] \textit{Id.} at 76, 40 N.E. at 499.
\item[33.] \textit{Id.} See also Pierce v. Dillingham, 203 Ill. 148, 67 N.E. 846 (1903).
\end{footnotes}
The 1900 case of *Jeu Ho v. Williamson*,\(^{34}\) places even greater emphasis on medical criteria in evaluating state action. San Francisco's health officials found nine fatal cases of what they diagnosed as bubonic plague in a primarily Chinese neighborhood of the city. They quarantined some ten thousand Asians in a twelve-square block area. The plaintiff sought an injunction against the quarantine on two grounds. First, he disputed the diagnosis, offering the testimony of medical specialists whose expertise in the plague far surpassed that of the city's doctors. Second, conceding the existence of the epidemic *arguendo*, he asserted that the quarantine was improperly and ineffectively enforced: instead of quarantining the houses and contacts of the plague victims, the entire neighborhood was closed down; additionally, the boundary was shifted on a house by house basis in order not to quarantine whites who lived along the border.\(^{35}\)

Relying on medical evidence, the court held that the quarantine as enforced was a violation of the Equal Protection Clause of the Fourteenth Amendment not only because it was clearly applied in a discriminatory fashion, but also because its scale was not reasonably related to the goal of preventing plague as judged by normal medical standards.\(^{36}\) The Court did not, however, foreclose a quarantine of the homes and contacts of the nine who had died. Although it observed that the best evidence suggested there had probably never been any plague, it deferred to the health department's assessment of risk and declined to offer a judicial opinion on the question, this being one that "courts... are disposed to leave to boards of health to determine upon such evidence as their professional skill deems satisfactory." (emphasis added)\(^{37}\) An acceptance of a lay or common sense assessment of the risk played no role in the Court's decision. In both *Smith* and *Jeu Ho*, it is possible to detect the first glimmerings of judicial recognition that health decisions were becoming too complex and too prone to abuse to be made without reference to objective medical standards.\(^{38}\)

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\(34\). 103 F. 10 (9th Cir. 1900).

\(35\). Id. at 12,13.

\(36\). Id. at 21-24.

\(37\). Id. at 26.

\(38\). There were contemporary decisions in which courts maintained a very limited view of medical evidence. See, e.g., *Potts v. Breen*, 167 Ill. 67, 47 N.E. 81 (1897) (vaccination regulation invalid because the state had not shown the presence or danger of a smallpox epidemic). One should note that even in *Jacobson* the vaccination question was still decided in the context of an actual epidemic. Comment, *supra* note 15, at 405. It was another fifteen to twenty years before courts were prepared to interpret vaccination as a preventive measure. *See infra* note 47 and accompanying text.
C. The Implicit Acceptance of Medical Standards

In the first twenty years of this century, medical science began to present a united professional front as the discoveries of the late nineteenth century produced dramatic results.\footnote{G. Rosen, supra note 5, at 294.} There was an enhancement of the perceived authority of medical pronouncements.\footnote{See, e.g., Id. at 493-4; C. Winslow, supra note 8, at 379-80.} Courts gave less weight to the lay perception of disease, and more to medical evaluations of risk and response. The general legitimacy of the state’s police power was no longer a sufficient basis for action in the absence of a specific medical justification.

In 1913, \textit{Board of Health of Covington v. Kollman}\footnote{156 Ky. 351, 160 S.W. 1052 (1913).} upheld sanitary milk bottling rules despite plaintiff’s claim that the measures did not prevent disease. The court discounted the plaintiff’s suggestion that scientific theories were too unreliable and changeable to serve as a basis of fair law:

> In matters affecting the public health it is the part of reason and common sense to adopt the best scientific thought of the age in which we live. If research and investigation lead to other accepted theories, then we must adopt them. Were the rule otherwise, both the courts and the Legislature would be without a competent guide. Viewing the matter in the light of the accepted theories of science at the present time, [this] regulation . . . is neither unreasonable nor oppressive.\footnote{Id. at 352, 160 S.W. at 1054.}

The court was aware not only of the rapid development in medical science, but also that common sense alone would no longer serve as a “competent guide” in adjudicating the appropriateness of particular health actions that compromised important individual rights.\footnote{See also Crayton v. Larabee, 220 N.Y. 493, 503, 116 N.E. 355, 358 (1917). This was by no means a clear and conscious trend. In the same year, the Supreme Court of Errors of Connecticut, holding that an officer must have reasonable grounds to believe in the infection of a person quarantined and observing that the origin of the police power “rests in necessity,” still noted that “[c]ommon knowledge tells us that contagious diseases may be spread by those who have been exposed.” State v. Raczkowski, 86 Conn. 677, 681, 86 A. 606, 608 (1913).}

By 1922, in \textit{People ex rel Barmore v. Robertson},\footnote{302 Ill. 422, 134 N.E. 815 (1922).} the Illinois Supreme Court understood: “Public health measures have long been recognized and used, but the science of public health is of recent origin, and with the advances of the science, methods have greatly altered.”\footnote{Id. at 426, 134 N.E. at 817.} Not only in its dicta, but also in its holding, the court manifested a confidence in and reliance on medical evidence. Barmore was a boarding-house keeper who, laboratory analysis showed, was a
carrier of typhoid. A lay view of contagion might have resulted in a conclusion that Barmore was not contagious: her husband did not have typhoid, and none of her boarders who developed the disease did so while living in her house. The court, however, relied on laboratory evidence of her infection in upholding a quarantine.\textsuperscript{46} The \textit{Barmore} decision reflected the same growing appreciation of scientific methodology and preventive medicine as \textit{Zucht v. King}.\textsuperscript{47} There, the Supreme Court upheld an ordinance that set vaccination as a prerequisite for school attendance without regard to the actual or imminent presence of an epidemic. \textit{Jacobson}'s requirement of both an assessment of risk and an evaluation of response survived; its belief in the equality of lay and medical evaluations did not. Both \textit{Zucht} and \textit{Barmore} suggest a major step in judicial conceptualization of the role of public health actions. Doctors were now fighting disease on a broad scale, moving to deal effectively with diseases whose presence was not even recognized by the public. In judging such actions, courts found doctors' expertise indispensible.

Since \textit{Zucht}, there has been little change in the implementation of health law under the police power. A medical assessment of risk and response is required, but the requirement is still most often stated in the language of \textit{Jacobson}. The authority of the state to protect the public health has achieved virtually unanimous political, legal and social acceptance.\textsuperscript{48} Supported by this acceptance, the

\textsuperscript{46} Id. at 433-434, 134 N.E. at 819-820.
\textsuperscript{47} 260 U.S. 174 (1922).
\textsuperscript{48} There have been few attempts to attack the power to make or delegate such measures on a broader basis, and such arguments have been dismissed with only a cursory recital of the state's well established authority. See Mack v. Board of Education, 1 Ohio App. 2d 143, 204 N.E. 2d 86 (1963) (upholding power of school boards to require vaccination); Allen v. Ingalls, 182 Ark. 991, 35 S.W. 2d 1099 (1931) (emergency not necessary to justify immunization); Pierce v. Board of Education of City of Fulton, 219 N.Y.S. 2d 519 (1961) (presence of smallpox in school district not necessary to validity of vaccination requirement). The trend towards broad acceptance of government power to act in matters of health was bolstered in the 1930's by the removal of the Due Process barriers which had severely limited federal health action. Morgenstern, \textit{supra} note 7, at 543-44.

Most litigation has come in response to technologically novel measures or particular actions that seemed arbitrary or capricious. There have been cases involving water fluoridation, \textit{e.g.}, Beck v. City Council of Beverly Hills, 30 Cal. App. 3d 112, 106 Cal. Rptr. 163 (1973); zoning laws based on sanitary considerations, \textit{e.g.}, People v. Johnson, 129 Cal. App. 2d 1, 277 P.2d 45 (1955); and disease reporting requirements, \textit{e.g.}, Schuman v. New York City Health and Hospitals Corp., 44 A.D.2d 482, 355 N.Y.S.2d 781, aff'd, 38 N.Y.2d 234, 342 N.E.2d 501, 379 N.Y.S.2d 702 (1974).

Perhaps the most common kind of case has involved the assertion of religious or other ideological objections to the mandatory school vaccination requirements that exist in every state. Morgenstern, \textit{supra} note 7, at 543. These are not attacks on vaccination as a principle, but attempts to secure an individual exemption. Davis v. State, 294 Md. 370, 451 A.2d 107 (1982); Maier v. Besser, 73 Misc. 2d 241, 341 N.Y.S.2d 411 (1972); Board
medical standard, though not explicitly stated by courts, has generally been applied in public health cases. Only recently have problems arisen which require a clearer statement of the health law.

D. The Explicit Adoption of Medical Standards

Perhaps because the law with respect to police actions has appeared so settled, litigants seeking to challenge state health measures have relied on other grounds for a cause of action. These include recent Federal statutes granting special protections or entitlements, such as the Rehabilitation Act of 1973 and the Education for All Handicapped Children Act (EAHC),49 and newly developed


There have also been, throughout this period, attempts to limit the state's power on due process grounds. Rather than attacking the risk assessment or even the response on a medical basis, such cases frequently have turned on the procedures used in implementing the response. They often have involved habeas corpus petitions by individuals quarantined or forcibly examined for venereal disease or tuberculosis. See, e.g., In Re Halko, 246 Cal. App. 2d 553, 54 Cal. Rptr. 661 (1966); People v. Strautz, 386 Ill. 360, 54 N.E.2d 441 (1944). These cases arose from the more systematic use of quarantine, which was no longer applied to everyone suffering from TB or VD, but only to those who were not perceived to be capable of conforming their behavior to prevent transmission. Thus, due process for them meant a fair chance to argue that they were, in fact, able to police themselves. Because the health law is justified by necessity, even where the plaintiff wins, he often loses. So for example, in In Re Halko, a man quarantined for TB was granted a writ of habeas corpus on the ground that he had not been adequately represented by counsel at his quarantine hearing; the court also, however, ordered him confined for sixty days, in which time California could proceed to quarantine him with due process. Thus it is clear that though due process was important, the risk the plaintiff was believed to pose was, as a practical matter, decisive.

Finally, some health actions have been overturned simply because they reflect moral, rather than medical, imperatives. See, e.g., State v. Saunders, 75 N.J. 200, 381 A.2d 333 (1977) (anti-fornication statute not justified by declared goal of preventing venereal disease).

49. See e.g., infra notes 51-54, 71 and accompanying text. The Education for All Handicapped Children Act of 1975, 20 U.S.C. §§1405-1420 [hereinafter EAHC], mandates the provision of a "free, appropriate public education" to handicapped children by recipients of federal education funding; section 504 of the Rehabilitation Act of 1973, 20 U.S.C. §794 [hereinafter Rehabilitation Act], provides that "[n]o otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . ."

Recently, several courts have interpreted these federal statutes as foreclosing plaintiffs from the remedies traditionally available under the law governing state police actions. For example, in August, 1985, Ryan White, a hemophiliac with AIDS, sought a preliminary injunction ordering his local school board to reverse its decision to bar him. White claimed that the school board's action violated his rights under the EAHC, the Rehabilitation Act, the Civil Rights Act, 28 U.S.C. §1983 (1982), and the Due Process and Equal Protection clauses of the United States Constitution. White v. Western School Corp., No IP 85-1192-C, slip op. at 2 (S.D. Ind. August 16, 1985). The Federal District Court refused White relief, saying that the EAHC provided White with his exclusive remedy,
Public Health Decisions

Constitutional protections, such as the right of privacy. Thus, important decisions involving the same issues as the classic health action cases have been decided without explicit reference to the police power. While formally decided under different law, these cases confront the problems that arise when health risks must be assessed and responses chosen where medical and lay perceptions of a health problem diverge. In these cases, courts have explicitly applied strict rules of medical evidence in testing the validity of state health actions. Both because the issues are identical, and because there is available only after proceeding through the four levels of state hearings required by the EAH. \( \text{Id. at 4.} \)

The court based its ruling on Smith v. Robinson, 104 S.Ct. 3457 (1984). That case was brought by parents of a child with cerebral palsy "and a variety of physical and emotional handicaps," \( \text{Id. at 3461,} \) caught in a fight over what state agency would fund his special education. While the grounds of the parents' action in Smith were the same as those in White, the specific issue before the Court was under which of several Federal statutes, if any, attorneys' fees could be recovered. The Court held:

Congress intended the EHA to be the exclusive avenue through which a plaintiff may assert an equal protection claim to a publicly financed special education. The EHA is a comprehensive scheme set up by Congress to aid the States in complying with their constitutional obligations to provide public education for handicapped children. Both the provisions of the statute and its legislative history indicate that Congress intended handicapped children with constitutional claims to a free appropriate education to pursue those claims through the carefully tailored administrative and judicial mechanism set out in the statute. \( \text{Id. at 3468.} \) The accuracy of this assessment will not be addressed here, but its applicability to White is readily disputed. Even the legislative history cited by the Court in Smith suggests that Congress was addressing the problem of children with handicaps not receiving the special assistance they needed in order to get access to an appropriate education. \( \text{Id. at 3468-3470.} \) While it has been possible, as White itself indicates, to argue that people with AIDS are handicapped within the meaning of these statutes, the situation is the converse of the usual contemplated by the EHA. Instead of a school board refusing to take the action required to secure to a handicapped child the means of getting an education, the board in White acted to bar the child: in the usual case, the child cannot get the appropriate education without state action — in the AIDS case, the child could not get the appropriate education because of state action. It is stretching reason to regard an action to bar a child deemed a public health threat as simply a placement issue under the EHA.

Before the passage of the federal statutes, a plaintiff such as White would have had a federal cause of action by virtue of the state's assertion of its police power. It is not claimed anywhere in Smith that Congress intended to foreclose this longstanding remedy. Moreover, it cannot be said that remedies available under the EHA are equivalent to those available under the law governing police actions. The law of police actions contemplates swift adjudication of the legality of a state's emergency infringement of individual rights while the EHA was designed to encourage deliberate, and often drawn out, consideration of educational placement alternatives. A state should not be able, simply by labeling an object of state health action as a "special" child within the coverage of the EHA, to prevent the swift vindication of its federal rights. For a child with AIDS who wants a last brief chance to lead a normal life, the foreclosure of the availability of a preliminary injunction based on the likelihood that he will prevail, the traditional police action remedy, is often dispositive of the merits.

50. See infra notes 197-198 and accompanying text.
frequently implicit reference to the police power, these precedents should be applied in police power cases.

Typical of these recent decisions is a line of cases involving the admission into regular schools of children who are carriers of Hepatitis B, a serious viral disease. In one of these cases, New York State Association for Retarded Children, Inc. V. Carey, the School Board of the City of New York attempted to bar some fifty retarded children infected with hepatitis B from school attendance. This failed in the District Court. The Board then moved to segregate the children within the school. The Board's actions were sparked by a false alarm of hepatitis infection of a teacher. In the haste and panic of its reaction, the Board selected a severely flawed response; the flaws were decisive in the Court of Appeals' affirmance of the District Court's rejection of the segregation plan. First, the Board, which had been unable to formulate a plan in cooperation with the Health Department, failed to show that its own assessment of the risk justified a response that so severely compromised the children's educational rights. The weight of the medical evidence suggested that the children could safely attend regular classes with the adoption of a few, minimally restrictive precautions. Second, the Board made a mistake akin to that of the city of San Francisco in : if the Board's assessment of the risk were accepted, then its response was medically inadequate since it made no effort to identify and isolate all hepatitis B carriers in the school system. To the Court, this approach "at least suggest[ed] that the Board did not regard its own

51. The hepatitis B virus is transmitted in blood and other body fluids; casual contact does not spread the disease. THE MERCK MANUAL 837-838 (R. Berkow 14th ed. 1982) [hereinafter MERCK].
53. 466 F.Supp. 486-7. The court wrote:

Instead of following the New York City Department of Health's Guidelines or the less restrictive procedures advocated by the United States Public Health Service or the [New York State Office of Mental Retardation and Developmental Disabilities], the Board of Education adopted the present course of action which none of the medical experts countenance.

Id. at 484-485.
54. Id. at 492-3. Many of the children had previously been residents of Willowbrook State Hospital, but were now in community homes under a Federal consent decree. The District Court found that the Board's action violated the Willowbrook consent decree, the EAHHC and the Rehabilitation Act as well as the Due Process and Equal Protection clauses of the Fourteenth Amendment. This action was ultimately decided, however, only under the EAHHC. 612 F.2d at 649.
55. 612 F.2d 647.
56. 466 F.Supp. 492.
57. 612 F.2d at 647-648.
58. Id. at 650-51.
Public Health Decisions

evidence of risk as particularly convincing.” 59

In selecting standards for its review, the Court of Appeals was clearly guided by the need to establish a medical justification for the Board’s action. 60 The court rejected the Board’s contention that the District Court erred in conducting an inquiry into the adequacy of the Board’s own fact-finding, which, the Board claimed, should have been judged solely for rationality, with the deference due to a legitimate exercise of the state’s power. The court recognized that no such deference to the Board’s version of the facts was justified where the facts would be practically dispositive of important rights or entitlements — where, in other words, it was the facts themselves that were at issue. While finding that close, highly technical calls would go to the qualified administrators, the court did not hesitate to intervene when the overwhelming weight of the medical evidence went against the state’s action. 62 This decision suggests a very important role for courts in evaluating health actions. Because action can only be premised upon necessity, courts may insist upon satisfying themselves through expert medical testimony that risks have been accurately assessed. Because responses that infringe upon basic rights cannot be more restrictive than is medically necessary to address the relevant risks, courts may themselves measure responses against a medical standard.

The choice of medical standards does not always represent an escape from uncertainty and the risk of incorrect decisions. Rather, it represents a recognition that medical expertise offers the most objective and coherent standard available for dealing with uncertainty. In fact, medical standards as evidentiary tools are most important precisely when knowledge is most limited. LaRocca v. Dalsheim, 63 the first case directly involving AIDS to come to trial, 64 offers a model for medical risk assessment in a judicial setting. A group of prisoners at a New York state prison brought a class action to enjoin the state from enforcing policies which they believed promoted the

59. Id. at 650.
60. The court interpreted the EAHC to require that government agencies and other recipients of federal funds must establish a substantial justification for their actions. Id. at 649-50. In refusing to accept the state’s demand for a deferential standard of review, the court here, as in Community High School District 155 v. Denz, 124 Ill. App. 3d 129, 463 N.E.2d 998 (1984), was depending less on the Supremacy clause than on the failure of officials to sustain a burden of medical proof.
61. 612 F.2d at 648-49.
62. Id. at 650. A similar result was reached in Community High School District 155, supra note 60.
63. 120 Misc.2d 697, 467 N.Y.S.2d 302 (1983).
spread of AIDS within the prison. (Thus, the inmates were not acting against a health action, but, as private health officers, one might say, seeking to establish quarantine, isolation and mandatory examination.) The judge was acutely aware of the context of fear in which this litigation was occurring, and discussed public and inmate anxiety at some length. "Much of the apprehensiveness exists because no one is completely sure how AIDS is spread, and no one has conclusive answers as to the relationship between contact and risk." This fear and uncertainty made it vital for the court to "evaluate the risks by examining the known features of AIDS as measured against the existing conditions" at the prison. Such a measurement would, the judge recognized, provide certainty only "to the extent that current scientific knowledge allows . . . ." In testing the necessity of action, the court properly recognized that the nature of medical knowledge made both finality and certainty impossible and inappropriate, and concluded:

The scientific knowledge . . . with regard to AIDS may be expected to change, with each new medical advance. In a month, a practice accepted today may be discarded in favor of a new approach. . . . In a matter of time, the ailment may be conquered, or inhibited by tactics which are as yet unfathomed. The court cannot suitably act as an administrative body on an on-going basis. The more practical solution is to dismiss the action . . . with leave to renew the proceeding . . . upon a claim that the State has acted improperly.

This candid acceptance of inevitable uncertainty should be a model for courts in similar situations. Uncertainty can rarely be avoided. Responses that purport to avoid it are likely to have an impact more comforting than real; worse, in accepting comfort as a legitimate goal, such responses may be overbroad and place an unacceptable burden on disease victims.

The principle purpose of the health law is to protect public health, but, as the cases above demonstrate, the health law is structured to protect individual rights as well by requiring all actions to meet a test of medical necessity. This is to be seen in a line of cases decided under the Rehabilitation Act of 1973, involving the participation of handicapped students in interscholastic sports. In fact sit-
Public Health Decisions

uations free of the distortions that come with fear and associated political pressures, the courts explicitly held that the states may not infringe upon individual rights in the name of health on any basis less than valid medical necessity, however well-intentioned or sensible the action might be from a common sense point of view.\textsuperscript{72}

The strongest case in this line is \textit{Grube v. South Bethlehem Area School District}.\textsuperscript{73} Several physicians, none of whom possessed any special expertise in sports medicine, decided that a student with one kidney should be barred from the football team. The boy and his family consulted a sports medicine expert, who helped the student procure special protective pads and testified at the trial that there was no record of anyone suffering a serious kidney injury playing football. In holding for the student, the court stated that neither philosophical judgments nor generalized medical concerns could replace specialized medical knowledge:

The evidence is clear that [none of the school’s physicians] had any facts which would permit them to make a medical evaluation of the existence of a risk. In an understandable abundance of caution, all three eventually concluded that the safest course was to say that Richard could not play. I conclude that the opinion of these three doctors cannot serve as a substantial justification for the district’s actions where their decision lacks a medical basis.\textsuperscript{74}

E. Summary

The cases examined demonstrate the courts’ consistent move-

\textsuperscript{72} In the first of these cases, Kampmeier v. Nyquist, 533 F.2d 296 (2d Cir. 1977), a school was held to have properly excluded visually impaired children from sports participation on the basis of unrefuted medical testimony that such participation would be dangerous. The need to refute medical testimony with experts of one’s own did not, apparently, go unnoticed by future litigants. Wright v. Columbia University, 520 F.Supp. 799 (E.D. Pa. 1981), involved another visually impaired student who wished to play football. The court differentiated the case from \textit{Kampmeier} because Wright presented evidence on his own behalf from a highly competent ophthalmologist.

\textit{Poole v. South Plainfield Board of Education}, 490 F.Supp. 948 (D. N.J. 1980), concerned a student barred from wrestling because he had only one kidney. The student presented medical evidence showing the chance of injury to be slight, and the court found that the school’s physicians’ objections were based more on their assessment of the worth of sports than of medical risk. One school doctor was quoted as writing:

It is in the best interest of the students to bar them from contact sports despite the wrath of both students and parents. How can you justify and explain to the student who has one kidney and the other destroyed that his death or lifelong attachment to a kidney machine was worth the ‘glory’.\textit{Id.} at 952. As a later decision explained, “It was apparent to the court that both the school system and the Board itself were making a philosophical and not a medical judgement.” \textit{Grube v. Bethlehem Area School District}, 530 F.Supp. 418, 423 (E.D. Pa. 1982).

\textsuperscript{73} 530 F.Supp. 418 (E.D. Pa. 1982).

\textsuperscript{74} \textit{Id.} at 424.
ment towards adopting medical criteria for assessing public health risks and responses. As the general legitimacy of state health action has receded as an issue in police power cases, the language of "rational relations" and "least restrictive means" has come to be defined by medical criteria. The holdings of later police power cases make clear the state's obligation to medically justify individual health actions. This approach is explicit in modern cases decided under Federal statutes, such as Carey, LaRocca and Grube.

The appropriate standard for state action is clear: a state health action is justified even if it infringes on individual rights if, 1) a medical risk assessment has defined the health threat and its dimensions; and 2) the chosen response is the least restrictive medically appropriate means of dealing with the risk. As the cases above show, the standard has been applied and has worked. Recent cases involving two sexually transmitted diseases, AIDS and herpes, have suggested, however, that, because police power cases have left the standard implicit, it is frequently misapplied or ignored. The danger of an implicit standard is that courts will not recognize it, particularly when under pressure from a frightened public. In such cases, it may be tempting to reconcile opposing demands by "making a philosophical and not a medical judgment." Succumbing to this temptation, however, may create more problems than it solves.

II. Herpes Goes to School

Sexually transmitted diseases seem to be particularly frightening to the public. But granting that, herpes still seems an unlikely cause for fear. To begin with, most people already have it: eighty to ninety-five percent of Americans carry one of the four principle viruses of the herpes family, only one of which is usually sexually transmitted. Apparently, fear of genital herpes and general confusion about the herpes viral family have led to the stigma of sexual transmission spreading to all the herpes viruses.

The three forms of herpes not associated with sexual transmission are herpes Zoster, Cytomegalovirus (CMV) and Epstein-Barr virus.

75. Id. at 423.
77. The Ordeal of the Herpes Kids, Time 57 (Jan. 21, 1985) [hereinafter Ordeal].
78. Merck, supra note 51, at 200, 1629; but see infra notes 87-89 and accompanying text.
79. N.Y. Times, Jan. 12, 1985, §1, at 6, col.1; In Iowa, A Herpes Expert Confronts a Fearful Community, People 71 (Jan. 28, 1985) [hereinafter Iowa].
Herpes Zoster is the virus responsible for chicken pox and shingles. CMV is a flu-like disease that infects 60 to 90 percent of all Americans by adulthood. Its symptoms are so mild that it frequently remains undiagnosed and is dangerous only to very young infants and fetuses, or those with suppressed immune systems (for example, AIDS sufferers). EBV is principally encountered as the virus which causes infectious mononucleosis; it has also been linked to two cancers, Burkitt's lymphoma and nasopharyngeal carcinoma, but it is suspected that additional factors in the environment or the victim are necessary for the cancers to develop.

The most familiar virus in the herpes family is herpes simplex, which occurs in two forms. Both are characterized by lesions, similar to mosquito bites, that may appear anywhere on the body. Simplex I is particularly associated with common cold sores, and its lesions usually appear above the waist. Simplex II usually produces lesions below the waist. Simplex II is also the usual cause of genital herpes, but genital herpes is nothing more than either simplex virus present in the genital area. Simplex II is the usual cause largely because of its tendency to appear below the waist. It is possible, however, for Simplex I to pass from the lips to the genitalia, or for Simplex II to make the same trip in reverse. The symptomatic lesions of both simplex strains appear intermittently, usually with decreasing frequency and severity as the patient ages. Nearly fifty percent of all children have been infected with one of the simplex viruses by the age of five, and as many as seventy-five percent of all adults carry it.
Herpes simplex is rarely dangerous. The notable exceptions occur when the virus is contracted by an infant less than six weeks old or by a sufferer of excema.\textsuperscript{92} In infants, whose undeveloped immune systems are not able to control the disease, the effects can be traumatic and the disease is frequently fatal.\textsuperscript{93} If the virus takes hold in the eyes, it may eventually cause blindness.\textsuperscript{94} Genital herpes has been associated with an increased risk of cervical cancer.\textsuperscript{95} There is also a major risk of transmission to children during birth.\textsuperscript{96} For both sexes, genital herpes may have severe psychological effects, both because of the stigma attendant upon an incurable "venereal disease,"\textsuperscript{97} and because the disease's general symptoms of malaise may be triggered and compounded by stress and weariness.\textsuperscript{98} Estimates of the number of genital herpes cases in America range from five to twenty million.\textsuperscript{99}

Simplex is not easily spread. The virus has to pass from an active lesion to a new host through a mucus membrane, broken skin or an open sore.\textsuperscript{100} Salivary transmission through coughing, biting or sneezing may be possible,\textsuperscript{101} but is unusual: casual contact provides little opportunity for transmission.\textsuperscript{102} Intimate, and in particular sexual contact, is about the only common activity likely to spread herpes simplex. In the context of day to day social intercourse, there is no such thing as a herpes epidemic.\textsuperscript{103}

Early in 1985 three cases arose in which limitations were placed on the school attendance of children infected with various forms of herpes. The cases, in Pasadena, Maryland, Council Bluffs, Iowa, and Sacramento, California, played out roughly the same scenario.\textsuperscript{104} This comment will focus on the Council Bluffs case. Baby

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\textsuperscript{92} MERCK, supra note 51, at 200-201, 1805.
\textsuperscript{93} Id. at 1805-06.
\textsuperscript{94} Id. at 1994.
\textsuperscript{95} Id. at 1629-30.
\textsuperscript{96} Id. at 1805.
\textsuperscript{98} MERCK, supra note 51, at 200-201.
\textsuperscript{100} MERCK, supra note 51, at 200-201; Are Schools Dangerous to Kids' Health? U.S. NEWS AND WORLD REPORT 83 (Feb. 11, 1985); Washington Post, Jan. 10, 1985, at C7, col. 5.
\textsuperscript{101} N.Y. Times, supra note 79.
\textsuperscript{102} Ordeal, supra note 77.
\textsuperscript{103} Council Bluffs, slip op. at 3-4; MERCK, supra note 51, at 200-201; N.Y. Times, supra note 79.
\textsuperscript{104} Ordeal, supra note 77.
Public Health Decisions

Jane Doe's mother had arranged for her child to be admitted to a special pre-school program organized under the EAHC. Like many children whose infancy was marred by herpes, Baby Doe also suffered from a learning disability which qualified her for special pre-school education to prepare her for regular school. Apparently Baby Doe contracted herpes shortly after birth from a cold sore on her mother's lips. There was no evidence that either mother or child had genital herpes. Having survived to school age, Baby Doe was over the worst of her disease. Her primary remaining symptom was lesions that appeared at about five month intervals in one of three places: her forearm, the outside thigh of one leg, or her hands. Other than their unusual location, her lesions were indistinguishable from ordinary cold sores, and no more infectious.

Initially, school officials had no difficulty admitting Baby Doe. They understood that highly unusual contact would be required for a child to transmit herpes. Such contact could be forestalled by a minimal increase in teacher awareness. There had been no special concern about so mild, widespread and uncontagious a disease. Officials may have been aware of the general fear of genital herpes, but it was regarded as irrelevant: genital herpes is a serious disease, but it is not transmitted in pre-school classrooms by children who do not have it. Initially, school officials' assessment of risk conformed to available medical information, and their response — a slight increase in teacher watchfulness — was medically sound.

Baby Doe's troubles began when news of her admission reached the public. Teachers first sounded the alarm. The reaction was

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105. Council Bluffs, slip op. at 4-5; see also supra note 77.
106. N.Y. Times, supra note 79.
107. Iowa, supra note 79.
108. Council Bluffs, slip op. at 2.
109. N.Y. Times, supra note 79.
110. Council Bluffs, slip op. at 2.
111. N.Y. Times, supra note 79; Iowa, supra note 79.
112. Des Moines Register, Nov. 17, 1984, at 38, col. 1. In the Maryland case, the Superintendent of Schools planned on "taking the same precautions you would for any common disease that is nonquarantinable." The only conditions he planned to place on Johny Bigley's attendance were those routine for disease spread by contact with sores (such as chicken pox): open sores were to be covered, or when, by reason of location, they could not be covered, the child would be sent home for the duration of the outbreak. According to the Superintendent, this policy was, in fact, already applicable to cold sores. Washington Post, Jan. 3, 1985, at C3, col. 1.
113. Council Bluffs, slip op. at 2.
114. N.Y. Times, supra note 79.
stunning: "herpes" was a cry that created hysteria. Boycotts were threatened, and the teachers' union filed suit to bar the child from school. Based on an exaggerated fear of genital herpes, compounded by ignorance of the different forms of herpes, and magnified by a gross over-evaluation of the risk of transmission by casual contact, teachers and parents were sure they and their children were in real and imminent danger. Neither the outcry by experts across the country against this fear and its effects on the children with herpes, nor the educational efforts of local health officials were able to calm the parents and teachers. Public health officials were faced with the divergence between lay and medical thinking in its purest form. Medical scientists assessed the risk of substantial harm from the herpes children as extremely low. Some even pointed out that childhood infection with herpes was normally far milder than when the virus was contracted in adulthood. As the public affairs director of the Centers for Disease Control (CDC) put it, "[The controversy] is built on a true foundation — the children do have herpes. But it's all so colored by fears and misinformation." The public's ignorance of herpes played a large role in its reaction, but so did doctors' inability to guarantee that no child would ever become seriously ill with a herpes infection contracted in school. Doctors could only say that the probability of such an occurrence was very low. The public, however, evaluated the risk less in terms of probability than possibility. As one mother in Maryland put it, "We're scared that [our son] will be the one-in-a-million child that will come down with something that will harm him." Such a risk assessment would justify virtually any restriction on the victim, no matter how small the empirical increase in security it provided — even if that security were purely psychological. The most effective

116. Iowa, supra note 79.
117. Des Moines Register, Nov. 17, 1984, at 3, col. 1; Washington Post, Jan. 8, 1985, at B1, col. 1; Ordeal, supra note 77. In Maryland, teachers were so worried about contagion that they demanded a lifetime job guarantee for teachers infected in the line of duty, and indemnification for teachers sued because of classroom transmission. Washington Post, Jan. 5, 1985, at B3, col. 1.
118. N.Y. Times, supra note 79; Ordeal, supra note 77. Judge O'Brien's repeated dismissal of the issue of genital herpes in the Council Bluffs case demonstrates how concerned he was with the public's anxieties. He correctly stated, "a teacher would have to somehow have physical contact with the herpes virus on the teacher's genitals before the teacher could get genital herpes. . . ." Council Bluffs, slip op. at 2,3.
119. Iowa, supra note 79; Ordeal, supra note 77.
120. Ordeal, supra note 77.
121. N.Y. Times, supra note 79.
response under such an analysis is one which assures no contact at all, namely total isolation of the diseased child.

Such was the goal of the Council Bluffs Education Association when it sought a preliminary injunction against Baby Doe's enrollment from the Federal District Court. After a two-day hearing, Judge Donald O'Brien issued a decision allowing the child to enroll but ordering that Baby Doe's mother must examine her for lesions and/or fever every morning and take her child to school personally; she was not to ride the school bus. Before mingling with other children at school, Baby Doe was required to be examined again for lesions and fever by both her mother and the school nurse or his designee. If lesions were present at any stage, Baby Doe was to remain at home until they healed. This was to apply to all children with herpetic lesions, including cold sores. Each child in the class had to be examined daily for lesions. "All this is to be done as discreetly as possible and without any fanfare." In the other herpes cases, the results were remarkably similar. In Maryland, county Judge Eugene Lerner, following Judge O'Brien, required a daily nurse check, and barred the child, Johny Bigley, from the school bus. He followed the local school's original plan by not barring Johny if his lesions could be covered, and somehow thought up the idea of having Johny wear a one-piece jumpsuit when he had lesions on his back. Any lesions on his hands, however, coverable or not, would require Johny to stay home. Then, because Johny might get lesions on his "diaper area," the judge ordered that the boy's diapers be changed in a separate room, not used by children, by an official wearing a disposable gown and gloves. Finally, Johny was to have a designated set of playthings reserved for his sole use, to be disinfected at the end of each day. In Sacramento, where the child in question had CMV, school officials agreed to equip restrooms "with more soap and towels to decrease the risk of spreading the disease, keep other children from touching the boy's food and tray, and minimize his playground contact with other children." There are obvious problems with these orders. One is hard put to

124. Council Bluffs, slip op. at 1.
125. In addition to extensive medical testimony, there was evidence that exclusion from the classroom would substantially harm Baby Doe's intellectual and social development. Moreover, the placement of the child in the classroom was in full conformity with the requirements of the EAHCP and Iowa's parallel State Plan. Id. at 4-5.
126. Id. at 7-8.
128. First Day of Herpes Check Turns Up Nothing, United Press International, Jan. 16,
envision a nurse examining a classroom full of preschoolers for herpes lesions "discretely . . . and without any fanfare." In Iowa, children with the common cold sore, who have been trooping off to school as long as there have been schools, are now to be barred from school not because people are afraid of cold sores, but to justify the exclusion of a child whose sores, while not on the lip, are of the same viral type, and, where they are covered by clothing, probably less transmissible. In Sacramento, a child's playground contact with other children is to be "minimized" despite the fact that his disease is so common that his classmates' chances of getting it are virtually unaffected by the restriction. In Maryland, Johny Bigley is required to wear a special playsuit. In both Maryland and Iowa, children who may get lesions as rarely as once in a school year are barred permanently from riding the school bus. None of these precautions is more than marginally justified by the medical facts, if at all. But these problems should not obscure more fundamental errors in the decisions.

These cases are examples of the health decision-making process breaking down both in the evaluation of risk and the selection of response. Judge O'Brien's opinion in the Council Bluffs case recognizes that the risk of herpes transmission had been assessed as very slight, justifying only the most minimal limitations, if any, on Baby Doe's attendance:

One of the doctors who testified stated that he had written the guidelines on how to handle herpes children . . . and that, while he had written the guidelines recommending that any child with herpes who had active lesions should remain out of school until the lesions healed, he personally felt that was a very conservative statement and that if he had a child in the same class, he would not object if the child with active herpes lesions stayed in the class if said lesions were covered.

The physicians who were called upon to make the risk assessment, the simple determination of the problem posed by Baby Doe's herpes in the school setting, failed, however, to exclude the public's frightened reaction from consideration. Judge O'Brien in turn failed to demand an untainted risk assessment. The improper

129. See supra notes 92-103 and accompanying text.
130. Canadian Pediatric Society, supra note 82; Prevalence, supra note 82.
131. See supra notes 109-114 and accompanying text.
132. Council Bluffs, slip op. at 3.
133. An assessment may be tested, as in Carey, by weighing opposing evidence, see supra notes 60-62 and accompanying text, but the task was even easier here, given the
Public Health Decisions

mixing of medical and public assessments of risk, which rendered the resulting assessment useless as a standard by which all could debate the more open question of response, is clear in this passage of the opinion:

The physician who had inspected Baby Jane Doe on two or three occasions said that her history showed that she had these lesions periodically and that they were active for about four days. He further recommended that she should be kept out of school during that period even though there is no real reason to isolate Baby Jane Doe on a scientific basis, but that it is desirable on a social basis because possible contact with herpes or the mention of it usually creates such an emotional situation as to require that the child be segregated based only on social considerations. (emphasis added)

Here is a judge adopting the political advice of a physician testifying as a medical expert. This is precisely the kind of mistake the strict requirement of a purely medical risk assessment is supposed to prevent. If there was no medical basis for isolating Baby Doe when her lesions were active but could be covered, there was no legal basis for doing so. If there was no adequate showing of necessity on the basis of a proper risk assessment, responses should not even have been considered. The herpes cases are simply the Grube case recast in a tougher setting; doctors, under pressure, begin to substitute "philosophy" or, in this case, "sociology," for medical data in their judgments. The only difference is that here the courts allowed it.

It may be that some precautions were justified, but it is not possible to evaluate responses with a tainted and virtually standardless risk assessment. As a result, the courts' decisions were not only wrong as law — they also failed to deal effectively with the public health problem. The courts saddled school officials and themselves with the enforcement of excessive regulations that are burdensome, hard to justify and bad precedent. Ironically, public anxiety was not significantly reduced; decisions such as this validate the public perception of crisis. Worst of all, the children and their parents were injured by potentially stigmatizing, costly, and educationally damaging restrictions. Had the courts in these cases applied the proper standards — had, for example, Judge O'Brien excluded im-

explicit presence of impermissible factors in the assessment. See infra note 134 and accompanying text.

134. Council Bluffs, slip op. at 4 (emphasis added).

135. In Maryland and Iowa City, boycotts continued for weeks after the decision, and some parents were speaking of moving their children to new schools or the entire family to new school districts. Teachers Check School Kids for Herpes, United Press International, Jan. 15, 1985 (press release available on NEXIS); First Day of Herpes Check Turns Up Nothing, United Press International, Jan. 16, 1985 (press release available on NEXIS).
proper medical testimony on the social wisdom of isolating Baby Jane Doe, and based his decision on a strictly medical risk assessment as the courts did in Carey or Grube — the law would have been far better served. Health officials would have had a firm basis for adopting more limited and practical responses without decreasing the actual amount of protection to Baby Doe's classmates, and public fears would have been far more sensibly addressed. An authoritative body following strict rules of evidence would have publicly evaluated the risk as minimal and scrutinized the state's responses. The courts' orders treated fear as the problem to be eliminated, rather than as a key complicating factor. As a result, their decisions mischaracterized or inadequately responded to the medical problem, undermining the purposes for which the engine of public health was started. Common sense, which has at least this role in medical questions, tells us that the results of the herpes suits would be silly were it not for the cost to the victims. These costs, however, point out the injustice of public health law incorrectly applied — victims of disease were burdened and mistreated out of all proportion to the health threat they posed.

III. The Battle of the Bathhouses

The disease now known as Acquired Immunodeficiency Syndrome was first identified as a distinct medical entity in 1981.136 AIDS' symptoms are other diseases; it kills by proxy.137 It now appears that AIDS itself is caused by a virus138 which undermines the immune system, leaving the body biologically defenseless against disease.139 The prognosis for an AIDS patient is grim; the disease

136. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES: U.S. PUBLIC HEALTH SERVICE, FACTS ABOUT AIDS 1 (1985) [hereinafter FACTS]. At first, AIDS was simply referred to as "Kaposi's sarcoma and opportunistic infections in previously healthy persons." Then, as both its immune system suppression and its disproportionate impact on gays were noted, many adopted the acronym "GRID", for "Gay-related immune deficiency." "AIDS" was finally adopted in 1982, as the broader dimensions of the disease became clearer. Update on Kaposi's Sarcoma and Opportunistic Infections in Previously Healthy Persons, 31 MORBIDITY AND MORTALITY WEEKLY REPORT 294 (1982); Black, The Plague Years, ROLLING STONE 48, 117 (Mar. 28, 1985).

137. FACTS, supra note 136, at 1.


139. Council on Scientific Affairs, supra note 138; Batchelor, AIDS: A Public Health and Psychological Emergency, 39 AM. PSYCHOLOGIST 1279, 1280 (1984). The virus affects cellular organs called T-lymphocytes, which take the form of either helper T cells or suppressor T cells. Helper T cells work with other immune cells to fight bacterial and viral invaders. Suppressor T cells regulate other cells in this fight. In AIDS patients, the
Public Health Decisions

appears to be uniformly fatal. About half of the reported victims have already died.\footnote{140}

While there remains much to learn about AIDS, physicians are confident that their general knowledge of viral infection informs their understanding of AIDS’ spread. According to Dr. Mervyn Silverman, San Francisco’s former health director, “even though we don’t have all the answers, the disease didn’t come from outer space. We know about disease processes.”\footnote{141} AIDS is often compared to hepatitis B, whose etiology is well understood.\footnote{142} In the same way as Hepatitis B,\footnote{143} AIDS is spread by transfer of bodily fluids, principally semen and blood.\footnote{144} Both may occur in the course of homosexual, and also heterosexual, sex,\footnote{145} in the sharing of hypodermic needles\footnote{146} or during blood transfusions.\footnote{147} In addition, mothers may pass the disease to their children at birth.\footnote{148} Some sort of intimate contact is probably always necessary to spread the disease: salivary and other forms of casual or airborne transmission are regarded as highly unlikely.\footnote{149}

number of helper T cells is seriously reduced. Council on Scientific Affairs, supra note 138, at 2037. The two most common diseases that afflict the AIDS victim are Kaposi’s sarcoma, a rare form of cancer, and \textit{pneumocystis carinii} pneumonia. Instead of, or in addition to these, many victims suffer and even die from an array of opportunistic infections which are rarely serious in the general population. Facts, supra note 136, at 1. For example, forms of herpes such as CVM, Simplex and Epstein-Barr, are common, and commonly fatal, in AIDS patients. Update on Kaposi’s Sarcoma, supra note 136; Update on Acquired Immune Deficiency Syndrome (AIDS) — United States, 32 Morbidity and Mortality Weekly Report 465,466 (1983). New research suggests that the virus may directly act upon the brain, causing severe dementia in a substantial percentage of cases. Battling AIDS, TIME 68 (April 29, 1985).


\footnote{141. Epidemic of Fear, supra note 1, §2 (The World), at 13.}


\footnote{143. See supra note 51.}

\footnote{144. Batchelor, supra note 139, at 1279.}

\footnote{145. Council on Scientific Affairs, supra note 138, at 2041.}

\footnote{146. Facts, supra note 136, at 1.}

\footnote{147. Boston Globe, April 17, 1985, at 14, col. 1.}

\footnote{148. Council on Scientific Affairs, supra note 138, at 2040-41.}

\footnote{149. Battling AIDS, supra note 139. Studies have detected the virus in the saliva and tears of AIDS carriers, but transmission via either fluid is thought to be highly unlikely, since the virus cannot enter a host body except through broken skin or mucous membranes. AIDS: The Saliva Scare, Newsweek 103 (Oct. 22, 1984); AIDS Update, 3 Connecticut Epidemiologist 19,20 (1985); N.Y. Times, Aug. 17, 1985, at 6, col. 4. Even before the virus was discovered, the CDC regarded airborne spread as a highly unlikely possibility. Acquired Immunodeficiency Syndrome (AIDS) Update — United States, 32 Morbidity and Mortality Weekly Report 309, 310-11 (1983).}

Originally, the disease was confined to members of four high risk groups: sexually active gay men, intravenous (IV) drug abusers, hemophiliacs and recent Haitian immigrants. Id. Haitians were removed from the list. N.Y. Times, April 10, 1985, at A13.
Two elements particularly complicate the task of monitoring and preventing the spread of AIDS. The first is the long incubation period of the disease, which is at least six months but may be thirty-six months or even longer. This results both in a long lag time in the reporting of cases, and a long period of time in which an infectious victim may be sexually active without any indication, to himself or his partners, that he has the disease. The second is the existence of a related syndrome referred to as either pre-AIDS, AIDS Related Complex (ARC) or lymphadenopathy. Its symptoms are less severe than AIDS, and it is more likely a successful defeat of AIDS than an early stage. Nevertheless, it is equally incurable, and its victims may carry and transmit the AIDS virus to others, less able to fight it off. By the end of July, 1985, there had been over 12,000 reported cases of AIDS, and it is feared that both AIDS and ARC are spreading fast. The CDC expects the number of cases to double in 1985 alone, and AIDS caseload of forty to one hundred thousand patients is not unlikely in the next few years.

col. 1. Hemophiliacs, it was quickly understood, probably picked up the virus from transfusions of contaminated blood, and were at high risk only because of the frequency with which they required transfusions. Council on Scientific Affairs, supra note 138, at 2041; Update: Acquired Immunodeficiency Syndrome in Persons with Hemophilia, 33 Morbidity and Mortality Weekly Report 589, 590-91 (1984). There are now many confirmed cases of transmission to non-hemophiliacs via infected blood. Boston Globe, supra note 147. Heterosexual transmission is becoming a serious problem among prostitutes and sexual partners of IV drug abusers. Battling AIDS, supra note 139; San Francisco Chronicle, Nov. 14, 1984, at 4, col. 1.

There is little question that AIDS is not an intrinsically male disease — one third of France's victims are women, San Francisco Chronicle, Jan. 5, 1985, at 10, col. 1, as are forty percent of Belgium's as compared with seven percent in the United States. Council on Scientific Affairs, supra note 138, at 2037-38. A San Francisco health official has urged that promiscuous heterosexuals be designated an AIDS risk group in that city. Wall St. J., Apr. 18, 1985, at 22, col. 3.

151. Id. at 2037; N.Y. Times, May 16, 1985, at A19, col. 1.
152. San Francisco Chronicle, Dec. 9, 1984, at B1, col. 5. Some researchers believe that as many as 20% of ARC victims will go on to develop AIDS. AIDS: A Growing Threat, Time 40, 42 (Aug. 12, 1985).
154. A 1985 report commissioned by the National Institutes of Health (NIH) estimated that more than four hundred thousand people may have been infected with the AIDS virus. The Waterbury Republican, Feb. 21, 1985, at C12, col. 2. Not all of these people will get the disease, but in limited follow-up studies for periods ranging from one to five years, 4 to 19 per cent of those exposed were found to have developed AIDS. Only two months later, a new estimate of one million infected Americans emerged from a CDC AIDS conference. Battling AIDS, supra note 139. Based on the NIH study, this figure suggests that as many as 190,000 new cases of AIDS could arise in the next several years.

506
Public Health Decisions

CDC and state health department guidelines for hospitals and schools presented with AIDS patients, developed by and large outside the glare of publicity, make it clear that a few simple precautions serve to all but eliminate any risk of transmission. Since AIDS is transmitted via body fluids, the guidelines primarily cover treatment of blood and open sores. In general, they are the same precautions, for example wearing gloves when handling patient blood, taken for any patient who has a blood-transmissible disease such as hepatitis. That these guidelines are effective is shown by the lack of AIDS cases in medical personnel in direct contact with AIDS patients, including those who have been accidentally stuck by needles used on AIDS patients. AIDS, despite its severe effects and the mystery it retains, is controllable, and virulent primarily under identifiable and avoidable circumstances. AIDS is a severe problem, but it is not a modern version of the Black Death.

The public response to AIDS has changed as its incidence has spread beyond the initial high risk groups. At first, those members of the public who did not belong to any of the high risk groups tended not to fear AIDS. It was a “Gay Plague.” As AIDS has begun to spread to heterosexuals through blood products, however, both public attention and public fear have increased. While AIDS is far rarer than herpes, far rarer than even genital herpes, its high mortality rate makes it as real and serious a public health threat as herpes is an overreaction. Enough is known about AIDS to assess it as a major public health risk. But, as responses are considered, uncertainty as to the disease’s etiology may be magnified in lay minds; health officials, in turn, may be unwilling to choose medically justified responses which ask the public to accept too much scientific uncertainty. When one considers how difficult it proved for officials and courts to adhere to strictly medical standards in the case of herpes, one can readily imagine even greater difficulty in

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155. Precautions for Health-Care Workers and Allied Professionals, supra note 142, at 19-21.
156. Id.
158. Black, supra note 136, at 121.
160. See supra notes 77, 99, 152 and accompanying text.
anti-AIDS health actions. 162

AIDS struck San Francisco hard. Proportionally, the city has the highest gay population in the country, and, proportional to its population, the highest rate of AIDS. 163 By early 1984, new cases of AIDS were being reported at the rate of one or two a day. 164 As the mechanism of sexual transmission became clear, it was hard for many people to ignore the bathhouses, cinemas and book stores that served as sexual meeting places for the city's gays. 165 The bathhouses had a special meaning for San Francisco's gays. 166 They were an important part of a brave new world in which a sexuality that had been hidden could thrive openly and proudly. They were among the most visible manifestations of gay power and freedom in San Francisco. 167 To some extent the term "bathhouse" is a misnomer; the "baths" were really a hybrid of restaurants, gymnasiums, cinemas and bars. But they were designed, built and promoted as sexual pleasure domes. They offered individuals the opportunity and special equipment necessary for frequent, anonymous sexual encounters, often involving many men at once. 168 While this kind of sex was arguably evidence of gay liberation, many people, both gay and straight, were convinced that it was also spreading death by AIDS, and began to consider ways to close the bathhouses. 169

In contrast to the herpes children, gays in San Francisco were a self-conscious and politically organized minority able to assert their

162. Public information is regarded as essential in the battle against AIDS and fear of AIDS. In its guidelines for hospital AIDS management, for example, the American Hospital Association deals with the fear produced by AIDS and the risk this poses to adequate medical care for the victim. Some hospitals have been severely disrupted by the arrival of AIDS patients, with other patients, service personnel and even doctors boycotting. "Intensive efforts at education and crisis intervention by skilled, knowledgeable [sic], and respected hospital personnel are perhaps the most useful activities to ensure that a hospital continues to function adequately when an AIDS patient is present." American Hospital Association, A Hospitalwide Approach to AIDS 3 (Dec. 1984) (released by State of New York, Department of Health, Office of Public Health).

The magnitude of the public information problem is suggested by a poll which found that, "About half the American people believe AIDS can be transmitted through casual contact despite what Federal scientists say is overwhelming evidence to the contrary." N.Y. Times, Sept. 12, 1985, at B11, col. 1; and see Results of a Gallup Poll on Acquired Immune deficiency Syndrome — New York City, United States, 1983, 34 MORBIDITY AND MORTALITY WEEKLY REPORT 513 (1985).

168. Id.
169. See supra note 165 and accompanying text.
Public Health Decisions

rights in the political as well as the judicial arena. Gays were already encumbered or threatened by many legal and social restrictions, and they scrutinized health action against AIDS in that light.\textsuperscript{170} There was, in fact, considerable resistance on the part of many gay leaders and political organizations to any action against the bathhouses. For these parties, the symbolism of the baths, and, perhaps even more importantly, the negative implications of any public limitations on the gay life and privacy, outweighed the risk of AIDS transmission.\textsuperscript{171} On an intuitive level, gays suspected the motives of those who claimed to have their safety at heart. As one psychologist wrote, "'gay men are now asked to appraise in a positive and trusting manner the same recommendations for behavioral change that were only recently offered for transparently negative reasons.'"\textsuperscript{172} A San Francisco gay political leader put it differently: "'[Checking on bathhouse sex] reminds us of the way things were when vice cops spied on toilets. There is a very strong reaction to this.'"\textsuperscript{173} Many gays were understandably afraid that AIDS might be used as a pretext for oppression and discrimination.\textsuperscript{174}

Proponents of closure, including Mayor Diane Feinstein, gay City Supervisor Harry Britt and most physicians involved in treating and researching AIDS in San Francisco, were cautious. They believed that the bathhouses were spreading AIDS and should close, but wanted to avoid government action that might be perceived as antigay.\textsuperscript{175} Resources were directed towards public education efforts, in the hope that the danger posed by the bathhouses would be amelo-

\textsuperscript{171} Wall St. J., Feb. 8, 1985, at 23, col. 4.
\textsuperscript{172} Joseph, supra note 170, at 1300.
\textsuperscript{173} L.A. Times, supra note 164, at 30, col. 1.
\textsuperscript{174} There have been indications that some state governments are using the spectre of AIDS as a public health justification for reviving moribund sodomy laws. \textit{AIDS — A New Reason to Regulate Homosexuality}, supra note 2. Although these attempts have not always been successful, see, e.g., Baker v. Wade, No. CA 3-79-1434-R, slip op. (N.D. Tex. Apr. 3, 1984), supplementing, 533 F. Supp. 1121 (N.D. Tex. 1982), appeal dismissed, 743 F. 2d 236 (5th Cir. 1982), there have been numerous cases of job and housing discrimination against gays as both actual and potential victims of AIDS. Flaherty, \textit{A Legal Emergency Brewing Over AIDS}, Nat'l L. J., July 9, 1984, at 1, 44; Comment, supra note 64.

Recently, Colorado's Health Department decided to begin a list of all people who test positive for the AIDS virus. N.Y. Times, Aug. 24, 1985, at 24, col. 1. The Defense Department has announced that it will screen all new recruits for AIDS, which some gay activists regard as "a surrogate marker to identify gays." \textit{Trying to Lock Out AIDS}, Newsweek 65 (Sept. 16, 1985). There are some neutral justifications for screening — for example the high cost of treating AIDS victims — but there are also legitimate concerns about the reliability and possible misuse of the test data, as well as widespread adoption of such screening in the private sector. \textit{Id.}; N.Y. Times, Aug. 31, 1985, at 1, col. 4.
\textsuperscript{175} See supra note 165; Wall St. J., Feb. 8, 1985, at 23, col. 4.
rated through either greater indulgence in safe gay sex (sex, that is, in which transmission of infectious bodily fluids is avoided by the use of condoms and abstention from oral sex) or the closing of bathhouses for want of patrons.176 There was a decline in bathhouse patronage after the initial AIDS scare in the summer of 1983, and some bathhouses did close, but by early 1984, attendance, and AIDS, were on the rise.177

The figure at the center of the bathhouse debate was Dr. Mervyn Silverman, city health commissioner. Though he regarded AIDS as the most serious public health problem he had ever faced, he initially doubted the effectiveness and legality of closing the bathhouses.178 The nature of the parties and the disease involved in the bathhouse controversy made the issue extremely sensitive. While Silverman, as a public health official, was required to make a decision based on medical grounds, that does not mean he was barred from an awareness of the political realities. Had he developed a medically justified plan with broad community support and participation, he might have avoided significant political and legal opposition. Similarly, better efforts to produce a consensus plan might have led to effective voluntary action by the concerned parties. In the year preceding his decision to close the bathhouses, however, Silverman, unsure of his position, managed to alienate virtually everyone.

The starting point in the controversy over closure was the reluctance of anyone to do anything. The impasse was broken in March, 1984, when a gay activist named Larry Littlejohn announced a petition drive to place a proposition on the November ballot that would have forced the city to close the bathhouses.179 Gay leaders recognized that such a proposition might develop into a potentially disastrous referendum on homosexuality; an administrative closing for health reasons was by far the lesser evil.180 Within forty-eight hours of Littlejohn's announcement, Silverman was presented with a letter signed by dozens of gay leaders urging him to close the bathhouses.181 The city attorney assured Silverman he had the legal au-

178. San Francisco Chronicle, supra note 164; Politics and the Bathhouses, supra note 165, at 15.
Public Health Decisions

Authority to close the bathhouses. Closure was supported by the Mayor, the straight political leadership and the medical community. Silverman called a news conference at which, he said, a closing order would be announced, but at the very last minute he changed his mind, claiming medical and legal doubts. This was probably the last chance for action supported by all the key parties. In the general reaction of outrage, the fragile coalition splintered.

Two weeks later, Silverman banned sexual activity in the bathhouses. His position was now that dangerous bathhouse sex was contributing to the spread of AIDS, but that available medical evidence might not be enough to justify closure to a court. In order to obtain the means to enforce the ban, he spent the next several months trying to have the authority to license the bathhouses shifted from the police department to the health department. Dissatisfaction with his performance and the impending arrival of the 1984 democratic convention combined to kill his proposal in committee. By August, it was clear that his ban had accomplished nothing, while squandering great amounts of human and political energy.

Silverman's next move was an undercover investigation, which, to no one's surprise, revealed that unsafe sexual activity conducive to the spread of AIDS was continuing in the bathhouses. On October 9, 1984, convinced that AIDS was being spread in the bathhouses, convinced that he finally had the medical evidence to prove it, and willing to rely on his own power under the state health code, Silverman ordered the closing of fourteen establishments where investigators had observed unsafe sex. Upon the refusal of

182. Id.
183. Id.; San Francisco Chronicle, supra note 180.
184. San Francisco Chronicle, Mar. 31, 1984, at 1, col. 2. At this time, the City Attorney still maintained that Silverman had it in his power to close the bathhouses, but, a few days later, he retreated from that position. San Francisco Chronicle, Apr. 5, 1984, at 2, col. 5.
191. Id.; L.A. Times, Oct. 10, 1984, at 1, col. 3.
several owners to obey his order, Silverman sought an injunction in the Superior Court.\textsuperscript{194}

After a long ride in the political arena, the decision to close the bathhouses was now to be decided in a court, under the health law.\textsuperscript{195} The court had to make two determinations: risk — was bathhouse sex contributing to the spread of AIDS — and response — was closing the bathhouses the least restrictive, medically effective solution. No one seriously disputed that AIDS was being spread in the bathhouse.\textsuperscript{196} Battle was joined on the second question. The city argued that closure was a justifiable response to the risk of AIDS transmission in the bathhouses because of the severity of the risk and the failure of less drastic, voluntary measures.\textsuperscript{197} The bathhouse owners replied with two arguments. First, they asserted that the constitutional privacy doctrine prohibited any regulation of activities in private bathhouse cubicles. Second, they maintained that, given both the nature of the risk and the importance of the privacy rights involved, closure was too extreme a means to regulate activity in the open areas of the bathhouses. Instead, they suggested a plan to ban high risk sex in public areas, with enforcement insured by improved lighting, employee monitoring of patrons, and random health department checks. They also offered to pass out “I like safe sex” stickers to patrons.\textsuperscript{198}

The owners’ privacy argument was intended to trigger a strict scrutiny of the city’s action, and to convince the judge that the cost to individual rights of closing the bathhouses was greater than the benefit to society.\textsuperscript{199} Such a cost/benefit analysis, however, is inappropriate except as a measure of the restrictiveness of the response. Jacobson states that individual rights may be abridged where neces-

\textsuperscript{194} A temporary restraining order was issued, closing the bathhouses, but, because of First Amendment protections, not the bookstores and cinemas. N.Y. Times, Nov. 29, 1984, at A26, col. 1. The bookstores and theaters were, however, ordered to prevent sex in public areas. L.A. Times, Oct. 16, 1984, at 20, col. 1.

\textsuperscript{195} The issue before the court was whether or not to issue a preliminary injunction closing the bathhouses pending a full trial. California ex rel. Agnost v. Owen, No. 830 321, slip op. (Cal. Super. Ct. Nov. 30, 1984).


\textsuperscript{197} San Francisco Chronicle, Dec. 21, 1984, at 2, col. 1; L.A. Times, \textit{supra} note 164.


Public Health Decisions

sary to protect the public. The risk of transmission having been established, privacy became simply another right the state might sweep away.

The owners' alternative response asserted the medical inadequacy and excessive restrictiveness of closure. As in Carey, the rights asserted were important enough for the court to undertake its own fact-finding; but, also as in Carey, the court could overturn the city's action only upon a showing by a preponderance of the evidence that it was not medically justified. The owners bore the burden of showing not only that their proposal was reasonable and might work, but also that it was both less restrictive and more medically appropriate that the city's. The owners attempted to meet this burden with two arguments. First, the owners claimed that closure did not address the real problem, which was not bathhouses, but dangerous sexual activity, which would continue with or without bathhouses. This was the position taken by public health officials in other AIDS-beset cities, and was premised on a view that bathhouse patrons represented a sexual hard-core who would continue their activity even if the bathhouses closed. The owners' second claim followed from this, though with less than convincing logic: bathhouses, as the loci of unsafe sex, presented an ideal forum for educating those most in need of education, a forum that would be lost if the activity was diffused throughout the community. Obviously, the two arguments together required the court to accept that bathhouse patrons are at the same time incorrigible and educable. Nevertheless, neither argument can be dismissed out of hand.

The city, however, had strong medical backing and legitimate counter-arguments. In all likelihood, closure would have re-

200. The Court wrote that "[u]pon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members." 197 U.S. 11, 27. Steps that might infringe upon individual rights were justified by the principle that liberty, "does not impart an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good." 197 U.S. 11, 26.
201. New York State Association for Retarded Children, Inc. v Carey, 612 F.2d 644 (2d Cir. 1979).
202. See supra notes 60-62 and accompanying text.
204. L.A. Times, supra note 164, at 1; Wall St. J., supra note 171.
206. San Francisco Chronicle, Oct. 12, 1984, at 2, col. 5; id. Oct. 10, 1984, at 1, col. 1; id. Sept. 5, 1984, at 6, col. 4. It is clear, as the CDC has written, that, "In the absence of an available vaccine or specific therapy for the treatment of AIDS, broad-scale preven-
duced dangerous activity. An informal health department survey conducted before closure found that forty-seven percent of patrons questioned would not alter their activity if the bathhouses closed, but that thirty-five percent would either reduce or eliminate the activity altogether.\(^{207}\) It was not necessary that the city completely stop unsafe sex; stopping unsafe sex only in facilities it licensed and over which it could reasonably exercise control was a legitimate city goal. Furthermore, while some indices suggested that education campaigns had successfully reduced the level of unsafe sex in San Francisco, these efforts had not been concentrated in bathhouses and were, presumably, least successful among men who still frequented them.\(^{208}\) Finally, a major element in evaluating the medical effectiveness of the two responses was enforceability. The city claimed that a voluntary or owner-policed system would not work.\(^{209}\) It was questionable whether owners would be willing or able effectively to supervise the sex acts of consenting adult customers.\(^{210}\) Certainly, the task posed far more problems than checking a classroom of pre-schoolers for herpes lesions. Given these counterarguments, the owners failed to meet their burden of proof. They, like the plaintiff in Jacobson, merely asserted that some people disagreed with what the city chose to do. They failed to attack the risk assessment, or convincingly show, as in Carey, that the response was neither medically effective nor least restrictive.

Nevertheless, Judge Roy L. Wonder’s decision lifted the restraining order and allowed the bathhouses to operate under the following restrictions.\(^{211}\) The owners were required to hire for every twenty patrons one monitor, whose job would be to check sexual activity every ten minutes and eject patrons engaging in unsafe

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207. L.A. Times, supra note 164, at 1.

208. Id. at 30-31. The long incubation period of AIDS makes calculation of the impact of any program difficult, but one indicator was the incidence of rectal gonorrhea, a disease almost exclusively confined to homosexuals. In the two years before the closing, it declined 75 percent in San Francisco. Id. For comparison, New York reported a 59 percent decrease between 1979 and 1983. Declining Rates of Rectal and Pharyngeal Gonorrhea Among Males — New York City, 33 Morbidity and Mortality Weekly Report 295, 295-97 (1984).

209. See supra notes 196-197 and accompanying text.

210. San Francisco Chronicle, Dec. 21, 1984, at 2, col. 1; id. Nov. 30, 1984, at 70, col. 1. It was also recognized that owner policing of consensual sex raised substantial privacy problems of its own.

Public Health Decisions

sex. (Unsafe sex was to be defined not by the health department, but by the San Francisco AIDS Foundation, a private, gay-based organization.) The doors of individual cubicles and rooms were to be removed (mooting the privacy issue). Finally, owners were required to assist in efforts to educate patrons.212

Wonder's decision was a careful compromise, right down to the selection of the AIDS Foundation as the arbiter of safe sex. The problem is that the court was not asked to construct a compromise; it was asked to apply the health law. In allowing any regulation, the court accepted that the transmission of AIDS in the bathhouses was a danger to public health. It accepted, that is, the city's medical assessment of the risk. That done, the only task properly remaining for the court was an examination of the chosen response according to the standards set forth in this comment. In this case, where so much hinged upon the most practical way to regulate specific sexual behavior in a specific setting, medical standards were of relatively little help in selecting a response. There was a consequent increase in the importance of questions of enforcement, privacy rights, and economic impact.213 One could argue that the judge took all these into consideration in fashioning a remedy, but this argument fails to deal with one basic element of the legal analysis: deference to the judgment of the health official. Deference does not replace medical evidence or foreclose judicial fact-finding, but where the medical evidence on either side is equal, it does leave the decision to the responsible health official. While there was merit in the owners' arguments, they were not strong enough to overcome the presumption of appropriateness attached to the action of the city's health officer. Silverman was not required to prove that those who argued against closure were wrong. His burden was properly met by reasonable medical evidence of risk and efficacy of response. The best way to stop dangerous sex in the bathhouses was certainly a close call, one that perhaps would better have been settled politically long

212. Id. at 2.3. A month later, Judge Wonder, in response to enforcement problems, modified his decision to give Silverman the final word on the definition of unsafe sex. San Francisco Chronicle, Dec. 21, 1984, at 2, col. 1.

213. Thus, for example, the attorney for the owners was left room to complain, "The primary problem with the order is it requires private police forces and requires that doors be removed so there's no private place patrons can go. A lot of people don't want to have sex in front of other people." San Francisco Chronicle, Nov. 29, 1984, at 1, col. 5. Of course, this was precisely the point; the order clearly recognized that the sex needed to be regulated, the question was, how? This question, the court's compromise inadequately answered.

515
before it reached Judge Wonder. Once in the courts, however, close calls should go to health officials.

This was a hard case. The medical knowledge upon which decision-makers drew was less sure than that available to the courts in the hepatitis or even the herpes cases. One's tendency in a hard case may be to be more sympathetic to those whose basic rights are being threatened, and to soften the impact of the health law accordingly. This may be misguided. The bathhouse decision distorted the health law decision-making process. Although the distortion erred in favor of gay rights, that is hardly likely to be the usual outcome. As the herpes cases show, the losers when political pressures taint the assessment of risk or the choice of response are usually the victims of the disease. As AIDS continues to spread, in heterosexual consciousness if not heterosexual bodies, there may be pressure for measures far worse than the closing of bathhouses — quarantine, closing of bars, or even mandatory examination and registration. Such steps may not be medically justified, but whether they are allowed or not will depend upon courts' insistence upon medical evaluations when applying the law. In the bathhouse case, the risk was undisputed. There was no ideal way to respond to it; there was not even a uniformly acceptable compromise. The court had to apportion the burden of uncertainty, in the manner prescribed by law. While it was not totally satisfactory, the response of closure should have been accepted or rejected on the issue of whether the owners had met their burden of proof. Not only is this the law, it is the only way to preserve the protections against abuse of individual rights that the health law provides.

IV. Conclusion

The state's police power to protect the public health is premised on a medical assessment of risk, and guided in the choice of response to that risk by a requirement that any step taken be the least restrictive medically justified method of alleviating the problem. Officials charged with selecting a response may, of course, consider economic, social and political factors in selecting among medically justified responses (including the choice to take no action), but they can no more choose a medically unjustified response than they

214. For examples of proposed measures against AIDS, see AIDS — A New Reason to Regulate Homosexuality, supra note 2, at 340-43; An Act Concerning Quarantine Measures and the Reporting of Accidental Poisonings to the University of Connecticut Health Center, Pub. Act. No. 84-336. See also supra note 174.
should be able to respond to a health risk that is politically but not medically defined. It is not the purpose of the health law to balance the burden of disease against the loss of individual rights. Rather, the health law governs state actions when individual rights must be abridged for the common good. In risk assessment, it sets a threshold test of the necessity of any action, which, in requiring a substantial medical showing, allows no action if there is no actual threat to public health. In the response analysis, individual rights are protected by the least restrictive means test, but otherwise fall before a medically sound state action. Thus, in enforcing valid restrictions on the few, the law also protects individuals from arbitrary and capricious exercises of state power which respond only to the fears of the general public.

The law was improperly applied in the herpes and AIDS cases discussed in this comment. The results neither protected public health nor preserved individual rights against unnecessary intrusions. The task of determining whether actual risks justify particular responses is generic to the health law, and can only be adequately carried out using the best possible medical information, strictly applied. Cases raising the same issues will continue to arise. Currently, for example, communities across the nation are facing the question of whether or not to allow children with AIDS or ARC to attend public schools. Many of these cases will probably be decided in court, in an atmosphere of extreme public anxiety. Courts must not suc-

215. As of September 2, 1985, there had been 165 reported cases of AIDS in children under age thirteen; 113 of the children had died. There were 61 reported cases in children between thirteen and nineteen. N.Y. Times, Sept. 8, 1985, at 1, col. 2. A slightly greater number of children may be in the early stages of the disease, and as many as 2400 children may have ARC. N.Y. Times, July 1, 1985, at 1, col. 3.

Using the model described in this comment to consider the admission of one of these children to school, the decision-maker first would have to assess the medical risks posed by children with AIDS. The CDC and state and local health departments in such heavily affected states as Connecticut, New Jersey, New York and California, have all concluded that children with AIDS or ARC may safely attend school in most cases. N.Y. Times, Sept. 8, 1985, at 1, col. 2; AIDS Update, supra note 149, at 19; N.Y. Times, July 1, 1985, at A1, col. 3, B10, col. 1; San Francisco Chronicle, Sept. 13, 1985, at 1, col. 1. As the Connecticut Guidelines put it, "The kinds of closer contact that can occur in school (sharing of foods, kissing, wrestling) were not assessed to be significant risks. . . ." AIDS Update, supra note 149, at 20. The principal risks posed by AIDS in school arise from bleeding, incontinence or open sores which expose children and teachers to infectious body fluids. The use of gloves, band-aids and common sense readily alleviate these risks. Id. Only uncoverable sores, a tendency to bite or mouth, or chronic incontinence or bleeding coupled with poor habits of personal hygiene would justify exclusion or segregation, and that would have to be decided on a case by case basis. Id. (The consensus among medical experts is that AIDS is very close to Hepatitis B in degree and manner of contagion. As has been seen, children with Hepatitis B have generally been admitted to school in a non-segregated fashion. See supra note 62 and accompanying text.) Thus, the mere presence of children with AIDS in the schools does not create a
cumb to the pressure of public fear in cases such as these. They must allow only those actions that are required by objective medical evaluations. This may be unpopular, but it is right, and it is the law.

—Scott Burris

health risk which would justify their blanket exclusion or segregation. A court test of a decision allowing AIDS children to attend school would certainly be the occasion for the introduction of contrary medical evidence. Some AIDS researchers do question the safety of mainstreaming AIDS victims. See N.Y. Times, Sept 14, 1985, at 27, col. 1. However, even in the face of the general uncertainty about AIDS, the complainors would have to show that the state's assessment did not conform to the available knowledge and norms of medical and epidemiological practice.

Based on this assessment, an adequate response would have several elements: at the least, it would involve a case by case determination of whether the child is one of those whose behavior creates a greater risk. If so, it would have to be decided whether this risk could be controlled within the school setting, or whether an alternative placement would be required; if not, it would have to be decided who needed to know the child's identity, and what steps could be taken to reassure and inform staff, parents and other students.

Several communities were faced with this issue as school resumed in the fall of 1985. Their responses have varied. In Swansea, Massachusetts, a hemophiliac teenager with AIDS was admitted, and, while there have been some protests, many in the community have gone out of their way to express their support for the decision and their sympathy with his plight. N.Y. Times, Sept. 8, 1985, at 1, col. 2. New York City adopted the consensus risk assessment and set up a panel to make case by case evaluations. The panel consists of both medical and non-medical personnel. It has, to date, considered four cases. One child was admitted to school; two were to receive special education in the hospitals in which they were confined; and one child, who was well enough to go to school but whose identity had been accidently revealed, was asked to accept home tutoring "because of the potential social discrimination to which the student could be subjected." N.Y. Times, Sept. 8, 1985, at 1, col. 2. Events in Swansea suggest that such discrimination is avoidable, but it remains unclear whether New York would have taken the risk of normal admission if the child's parents had insisted.

Elsewhere, the results have been less promising. In Florida, Connecticut, California, New Jersey and Indiana, children have been refused admission. Superintendent John Dow of New Haven, CT, justified his decision by saying, "There is extreme concern and fear. It may not be right, but it's real." Id. The Ryan White case in Indiana is even more unsettling, because of what appears to be a cynical sense on the part of school officials and their lawyers that time is on their side. See supra note 49.

In the case of children with AIDS going to school, the law places the burden of uncertainty on the public. Health and school officials may and should educate the public about the true nature of the risk, but they may not exclude all children with AIDS merely to ease public fears. The issue is complex, but it can also be simply put, as it was recently by New York's Mayor Koch: "This child is no danger — no danger — to other children. You can panic if you want to, but I hope you won't." N.Y. Times, Sept. 9, 1985, at B3, col. 4.