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BOOK REVIEW

Sex, Fear, and Public Health Policy

John G. Culhane, J.D.*

Gay Bathhouses and Public Health Policy. Edited by William J. Woods & Diane Binson. New York: Harrington Park Press, 2003. Pp. 253.

Looking into the AIDS abyss in the mid-1980s, public health officials sometimes succumbed to the same impulses—notably, panic and scapegoating—that activated politicians, judges, and the public itself. Among the best-known results of these impulses were city-by-city efforts to shut down gay bathhouses. No one disputed that sexual activity went on in the bathhouses, but it was—and remains—unclear whether closing them would help stop the transmission of HIV, hinder that effort, or have no net effect. *Gay Bathhouses and Public Policy*,¹ a collection of essays on this topic, comes two decades after the hardest-fought bathhouse closure battles. William J. Woods and Diane Binson, the book's editors (and contributors), have skillfully amassed a group of works that provides a mix of historical depth, reportorial analysis, statistical research, and legal background to the battle over the bathhouses. The authors' stated purpose is to fill a void in knowledge, information, and understanding of the bathhouse question. The bathhouse wars are thereby given historical and cultural context that is perhaps only possible twenty years after these battles were conducted.

In this mission, the book succeeds. The volume, simultaneously published as two issues of the *Journal of Homosexuality*, collects legal, public health, and reportorial papers about the controversy over gay bathhouses and their role in the prevention or spread of HIV.

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1. GAY BATHHOUSES AND PUBLIC HEALTH POLICY (William J. Woods & Diane Binson eds., 2003) [hereinafter GAY BATHHOUSES].

Two of the essays foreground the discussion of HIV transmission in bathhouses. One deals with the history of gay bathhouses² while the other, the volume's most compelling read, provides a detailed account of the social, political, and legal battle to close the San Francisco bathhouses at the height of AIDS hysteria in 1984.³ Later in the book, this battle is brought back to life through reprints of two articles from a San Francisco gay monthly. These accounts, which first ran in 1984, were delivered by journalists whose news-gathering techniques included participation in the sexual culture they were describing—in the bathhouses⁴ and in other commercial settings in which sex between men took place.⁵ Indeed, the editors of *Gay Bathhouses* note that the “spark” for the book was the idea to simply reprint these two articles.⁶ But the volume expanded as noted above, and that expansion was broad enough to take in two final essays examining behaviors and interventions in bathhouses today, when the horror of certain death from AIDS has receded enough to enable sober discussion.

In its overall impact, *Gay Bathhouses and Public Policy* supports the conclusion that, although time and distance can impart rationality and depth to the discussion of charged public health issues, sensible solutions and approaches will remain elusive. Indeed, public health law and policy are replete with instances where initiatives that could save lives are swallowed whole by the scapegoating and sloganeering logic of politics. A commonly cited example of this phenomenon involves needle exchange programs: Despite clear and consistent evidence that such programs both reduce the incidence of disease transmission and provide good opportunities for addiction intervention and treatment,⁷ both Congress and the executive branch have refused to support their funding.⁸ Worse,

2. Allan Bérubé, *The History of Gay Bathhouses*, in GAY BATHHOUSES, *supra* note 1, at 33.

3. Christopher Disman, *The San Francisco Bathhouse Battles of 1984: Civil Liberties, AIDS Risk, and Shifts in Health Policy*, in GAY BATHHOUSES, *supra* note 1, at 71.

4. Michael Helquist & Rick Osmon, *Sex and the Baths: A Not-So-Secret Report*, in GAY BATHHOUSES, *supra* note 1, at 153.

5. Michael Helquist & Rick Osmon, *Beyond the Baths: The Other Sex Businesses*, in GAY BATHHOUSES, *supra* note 1, at 177.

6. William J. Woods & Diane Binson, *Public Health Policy and Gay Bathhouses*, in GAY BATHHOUSES, *supra* note 1, at 1, 7.

7. By this time, the effectiveness of well designed needle-exchange programs is beyond reasonable doubt. For an article citing a few of the many studies on this point, see *Needle-Exchange Programs Are Slowly Finding Greater Acceptance*, AIDS ALERT (Am. Health Consultants), June 1, 2002, at 69 [hereinafter *Needle-Exchange Programs*].

8. During the Clinton Administration, the Secretary of Health and Human Services

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they have often spun the tragedy of drug abuse into partisan gold by fretting about the signal of government acceptance that such programs supposedly send.⁹

The spin is “logical”—in a perverse sense—because the direct benefits of such public health programs most often go to minority groups: sexual, racial, and economic.¹⁰ It is, in the short run, cheaper and easier to blame the victims than to engage in the more complex task of selling a policy whose broader societal benefits, including lowered incidence and prevalence of serious diseases, will be realized only over the long term.

The needle exchange illustration shows that even in cases where the rational public health arguments all come down on one side, expediency is sometimes prioritized over good policy decisions. The bathhouse issue, by contrast, is *not* simple. Because our coarse political discourse does not handle nuance well, needed debate sputters and often stalls. Moreover, bringing difficult issues into the open risks their immediate conversion into politically expedient sound bites. But as the issues gain some distance from the eyes of political storms, activists and scholars become less reluctant to talk honestly about problems and limitations on all sides of a debate.

Through its aggregative approach, *Gay Bathhouses* implicitly makes this

did acknowledge the many benefits of such programs, but the Administration did not recommend funding them at the national level. Editorial, *Widen the War on AIDS*, L.A. TIMES, July 3, 1998, at B8. The message, shaped by political reality, was that such programs should be funded at the local level. Many cities do have such programs today, *see* Mike Chalmers, *Needle-Exchange Programs Urged for Wilmington*, NEWS J., Aug. 3, 2004, at A17, but the lack of a clear and consistent national commitment to the needle exchange initiative has left such programs without a strong rhetorical anchor; too often, this translates into a lack of funding. The Bush Administration opposes such programs, Nicole Foy, *Would Needle Exchanges Fly in S.A.?*, SAN ANTONIO EXPRESS-NEWS, May 13, 2004, at 1A, and Congress has gone so far as to ban funding for needle-exchange programs in the District of Columbia, Spencer S. Hsu, *Republicans Revive D.C. Voucher Plan*, WASH. POST, Nov. 17, 2003, at B1.

9. *See* Kathy Kiely, *AIDS Activists Storm Office*, DAILY NEWS (New York), July 21, 1998, at 16 (noting that many in Congress oppose needle-exchange programs because “they send the wrong signal”).

10. The benefits are often, but not always, most apparent to those at the margins. An important exception is the decades-old commitment to immunization of children against infectious diseases that once killed, injured, or seriously disabled millions. *See* John G. Culhane, *Tort, Compensation, and Two Kinds of Justice*, 55 RUTGERS L. REV. 1027, 1092 (2003). Other examples, such as the need for sanitation, are by now so much a part of the landscape that they are taken for granted in the absence of a crisis. Moreover, good public health outcomes ultimately redound to the benefit of all.

point about the value of perspective. Reading the essays in the order in which they were presented, I was able to appreciate fully the cumulative effect of this volume—part history, part ethnographic study, part political journal. Doing so allowed me to appreciate the book’s final line: “Given the solid position that bathhouses hold within gay sexual cultures, there is a compelling obligation to understand them and to use these unique environments to promote health and safety among their patrons.”¹¹ Yet the overall effect of this book is to produce a sense of the frustration born of complexity. Even though sober discussion has by now become possible, solutions remain elusive. The intractable difficulties of predicting and affecting human behavior—and then pursuing public health policies consistent with any conclusions reached—may be greatest where sexual desire and impulse collide with public disapproval and the reality of disease and mortality. No one intelligent and thoughtful enough to complete this sometimes disturbing collection of readings could wholly subscribe to either of the extreme positions that defined the bathhouse debate twenty years ago when the first signs of HIV infection heralded certain death. The harder question is always what to do in the face of such intractable uncertainty.

The polar positions are easy enough to state. Those who favored closing the bathhouses—including then-Mayor of San Francisco (and now U.S. Senator) Dianne Feinstein—simply took the position that the sexual practices carried on in the bathhouses led to the transmission of HIV, and the bathhouses must therefore be closed. Christopher Disman’s account of the San Francisco “bathhouse wars” is the book’s most compelling story. As he relentlessly establishes in *The San Francisco Bathhouse Battles of 1984: Civil Liberties, AIDS Risk, and Shifts in Health Policy*,¹² evidence that called into question the prevalence of “unsafe sex” in the bathhouses was not honestly assessed,¹³ nor was much thought given to the question of whether such practices would simply move elsewhere in the absence of these institutions.¹⁴ Indeed, the centripetal political forces were strong enough to effect the conversion of San Francisco’s Public Health Director, Dr. Mervyn Silverman, from a position opposing the closure of the bathhouses

11. Matt G. Mutchler, *Comparing Sexual Behavioral Patterns Between Two Bathhouses: Implications for HIV Prevention Intervention Policy*, in *GAY BATHHOUSES*, *supra* note 1, at 221, 240.

12. See Disman, *supra* note 3.

13. *Id.* at 90-91, 99.

14. *Id.* at 98.

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to one favoring it.¹⁵ Those familiar with the routine capitulation of the Centers for Disease Control and Prevention (CDC) to the executive and legislative branches of government will hardly find Silverman's change of heart surprising,¹⁶ but Disman's nuanced account makes clear that Silverman's conversion is not so easily or neatly explained. He may have honestly come to believe that the impossibility of regulating behavior within the bathhouses made closing them the only workable solution.

On the other side of the bathhouse debate is the following rote account of the role of these institutions and the projected effect of their forced closure: Bathhouses provide a safe space for the expression of gay sexuality that is otherwise consigned to such places as outdoor spaces and public restrooms.¹⁷ Since patrons are in a more welcoming and friendly place, they may be more receptive to interventions—such as condom use, other safe sex practices, and HIV testing—than would be possible, let alone practical, in less controlled settings.¹⁸ Without the bathhouses, the sexual conduct will simply disperse to the places it had been previously.¹⁹ HIV transmission will therefore increase and public health will suffer. This cluster of related arguments, while facially plausible, is difficult to prove or disprove empirically.

That said, the book's final essay, *Comparing Sexual Behavioral Patterns Between Two Bathhouses: Implications for HIV Prevention Intervention Policy*,²⁰ suggests that the “bathhouse means prevention” argument is no more convincing than its counterpart. Although one should not draw any solid conclusions from a short-term study of behavior in only two bathhouses—a caveat the authors themselves express²¹—it is impossible to tell the “bathhouses mean prevention story” with the same confidence after reading this essay. In fact, one of the bathhouses studied by this consortium of local and federal public health specialists could be

15. *Id.* at 79-109.

16. For example, the CDC has been known to buckle to political pressure in removing links to websites that right-wing organizations, such as Focus on the Family, find objectionable. See Online Policy Group, Action Alert: Urge CDC and USDA To Provide Same-Sex Info to Youth, at <http://www.onlinepolicy.org/action/cdcusdaalert.shtml> (last visited Sept. 13, 2004).

17. Bérubé, *supra* note 2, at 35-37.

18. See Freya Spielberg, *Designing an HIV Counseling and Testing Program for Bathhouses: The Seattle Experience with Strategies To Improve Acceptability*, in *GAY BATHHOUSES*, *supra* note 1, at 203.

19. Bérubé, *supra* note 2, at 49.

20. Mutchler, *supra* note 11, at 221.

21. *Id.* at 240.

characterized as a mecca for the transmission of infectious disease.²² In short, *Gay Bathhouses* makes clear that the two extreme accounts of the risks and benefits of bathhouses are too simple. The remainder of this Review focuses on the difficulty of the policy choices facing public health officials and judges, as well as the owners and patrons of the bathhouses. As with other tough public health issues, though, government usually has the last word.

Disman's account highlights Feinstein's position on the bathhouses, which was a matter of record: "My own opinion is that if this was a heterosexual problem, they would have been closed."²³ The connection this position bore to her purportedly negative attitudes towards matters of men's sexuality and sexual creativity is unclear,²⁴ but certainly many of those who favored closing the bathhouses were influenced by the "ick" factor—the equation of "distaste with immorality"²⁵—a tendency particularly prevalent in discussions about homosexual sex. And Feinstein certainly had plenty of cover from the gay community itself; as Disman reminds us, some gay activists feared that if the AIDS epidemic broke out widely in the heterosexual population, failure to close the bathhouses would make it easier to blame the gay "lifestyle."²⁶

Given the epidemiology of the disease and the undisputed higher risk that those engaging in anal as opposed to vaginal sex will contract it, blaming the gay community for the HIV epidemic was likely inevitable whatever the fate of the bathhouses. But because the bathhouses—which, according to Dr. Silverman's estimates, were frequented by only five to ten percent of the gay male community during the mid-1980s²⁷—are such powerful cultural and political signifiers, debates about public policy toward them assume a disproportionate significance. Yet the San Francisco debate simplified bathhouse culture in a way that ignored the bathhouses' important and beneficial role in the gay community. Under this view, it was

22. For a fuller discussion of the point, see *infra* notes 62-67 and accompanying text.

23. Disman, *supra* note 3, at 90 (quoting Larry Liebert & Hsu, *Feinstein Would Shut Bathhouses*, S.F. CHRON., Apr. 5, 1984).

24. See Disman, *supra* note 3, at 90.

25. Arielle Goldhammer, *A Case Against Consensual Crimes: Why the Law Should Stay Out of Pocketbooks, Bedrooms, and Medicine Cabinets*, 41 BRANDEIS L.J. 237, 241 (2002) (quoting Michael Nava & Robert Dawidoff, *Created Equal: Why Gay Rights Matter to America*, in TAKING SIDES: CLASHING VIEWS ON CONTROVERSIAL MORAL ISSUES 165, 170 (Stephen Satris ed., 6th ed. 1998)).

26. Disman, *supra* note 3, at 89 (discussing letter from gay author Frank Robinson to Public Health Director Silverman).

27. *Id.* at 77.

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all about sex.

Allan Bérubé's *The History of Gay Bathhouses*²⁸ provides a helpful corrective to this narrowing impulse. The origin of the gay bathhouse around a century ago (as the evolutionary offspring of Turkish baths, public baths, and spas) offered a nervous and nervy “contradict[ion to] these stigmas” of gays as criminally diseased sinners “and gave Gay Americans a sense of pride in themselves and their sexuality.”²⁹ Admittedly, the point about stigma is arguable; after all, acting in illicit places may reinforce the very stigma patrons are trying to overcome. Nonetheless, it is almost certainly true that the bathhouses were useful to gay men, at least when they were not being raided. As Bérubé notes, the bathhouses offered a sort of democratic camaraderie,³⁰ an important zone of privacy, and a relatively comfortable social environment. Each of these was valuable in a society that was many decades away from its still-grudging willingness to “see” gay people, but the bathhouses’ chief benefit was their safety: Compared to public parks, with their potential for injury and death, not to mention blackmail, the bathhouses must have seemed like home. Raids were always possible, but, depending on the bathhouse, these were less of a threat than the arrests for public sex that had been a constant fear.³¹ Bérubé notes that establishments catering to the “best citizens” were often left alone.³²

Further, the bathhouse culture was in a constant state of evolution. At least in the meccas of New York City and San Francisco, gay sexuality had taken hold in other commercial establishments in the years immediately

28. Bérubé, *supra* note 2.

29. *Id.* at 34.

30. Nakedness is democratic in one sense because class distinctions diminish or evaporate, but it substitutes a hierarchy of its own based on the relative beauty of bodies. This point is well articulated in PATRICK MOORE, *BEYOND SHAME* 32-33 (2004).

31. *Id.* at 37.

32. *Id.* The ever-present possibility of raids extended to all establishments frequented by gays, whether or not the patrons were actually looking for sex. *Id.* at 41 (noting that one goal of the periodic anti-bath and anti-bar campaigns included preventing gay men and women from having a place to socialize). For a literary account of the socializing, sex, and fear that were the lot of the gay underground in 1949, see ETHAN MORDDEN, *HOW LONG HAS THIS BEEN GOING ON?* 3-91 (1995). This fear of the gay “other” continues to influence every issue from gay marriage to judicial disputes about child custody and visitation. In one case, for example, a trial judge forbade a mother to “expose” her children to anyone “known by [her] to be lesbian”—whether or not this person had any sexual or romantic tie to the mother. *DeLong v. DeLong*, No. WD 52726, 1998 Mo. App. LEXIS 69, at *8 (Mo. Ct. App. Jan. 20, 1998), *superceded by* *J.A.D v. F.J.D.*, 978 S.W.2d 336 (Mo. 1998).

preceding the AIDS crisis.³³ Given the drift toward greater acceptance, Feinstein's crusade—which involved sending undercover officers to bathhouses and then misleadingly reporting what they had found³⁴—might not have caught fire in a less combustible situation. But AIDS was decimating the gay male population of San Francisco, and the ravaged wraiths awaiting death were a constant, terrible reminder of the disease's toll. While people were beginning to understand that different sexual behaviors carried different levels of risk,³⁵ lack of confidence in the science of transmission occluded the debate and enabled Silverman to complete his 180 degree turn, made official by this statement: “[A]ll sexual activity between individuals [is to] be eliminated in public facilities in San Francisco where the transmission of AIDS is likely to occur.”³⁶

This statement makes no sense on its face; the transmission of AIDS (more precisely, HIV) is “likely to occur” only in the presence of specific sexual conduct, so if *those* risks—certainly less than all sexual conduct—are eliminated, no transmission will occur. Silverman's proclamation can only be understood in a non-contradictory way by assuming that the bathhouses *themselves* are responsible for transmission. So by this time the public health community had gotten behind the reductive idea that bathhouses were all about sex and that *they* were the problem. Shortly after this statement, Silverman declared that the bathhouses were public nuisances³⁷ and ordered their closure. Thus was a difficult public health problem “solved” by fiat.

Nonetheless, Disman points out that the often-reported story that the San Francisco bathhouses were closed by court order is false. In fact, while the city was able to obtain a temporary restraining order forcing the

33. See MOORE, *supra* note 30 (discussing bathhouses, sex clubs, and dance clubs that permitted sexual conduct that flourished during this time).

34. Disman, *supra* note 3, at 106-07 (discussing Silverman's generic and outraged description of every imaginable and “unimaginable” sexual activity even though actual evidence was less dramatic).

35. See *id.* at 97 (noting that suggestions for baths “failed to mention AIDS-risk levels”).

36. *Id.* at 90.

37. States and cities have the authority to declare anything that injures or threatens the public health, safety, and welfare a public nuisance. See John G. Culhane & Jean Macchiaroli Eggen, *Defining a Proper Role for Public Nuisance Law in Municipal Suits Against Gun Sellers: Beyond Rhetoric and Expedience*, 52 S.C. L. REV. 287, 297 (2001). But the position must be defensible in a court of law; the city's public nuisance claim against the bathhouses was weak and only partially successful. See *infra* text accompanying notes 38-39. In fact, the bathhouses were *not* closed (except briefly) by the courts.

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bathhouses to close for fifteen days,³⁸ ultimately they were permitted to remain open under two sets of progressively more restrictive rules.³⁹ The story has been retold as ending with the court ordering the baths closed, in part because the city won the most important battle: the right to decide what counted as high-risk sex. But recall that Silverman's definition made no effort to distinguish between risk levels and left out sex between any pairing other than two males.

Although the bathhouse owners achieved only a limited legal victory—Pyrrhic by any measure, since the San Francisco bathhouses eventually closed under the unworkable constraints imposed⁴⁰—courts are typically even more deferential to governmental actions defined as public health measures. While the ability to second-guess public health decisions may be, in the words of one Australian observer “an extremely American process,”⁴¹ it is rarely invoked. Scott Burris, an accomplished law and public health scholar, makes the point matter-of-factly in his contribution, which surveys the bathhouse litigation from 1984 through 1995.⁴² While only eight such cases were reported during that period, Burris notes that the routine victories achieved by the public health community (seven of eight cases were winners, at least in substantial part) over the establishments they sought to close likely discouraged other potential litigants who closed without even trying to fight.⁴³

Judicial deference to public health officials, particularly in the case of epidemics (real or asserted) is not new to the bathhouse controversy. A staple case of any public health law course is the U.S. Supreme Court's decision in the century-old *Jacobson v. Massachusetts*,⁴⁴ in which a city ordinance requiring all adults to be vaccinated against smallpox because of

38. Disman, *supra* note 3, at 110.

39. *Id.* at 112-15. The first ruling “focused . . . on pragmatic ways to prohibit high-risk sex in the businesses.” *Id.* at 112. About a month later, a modified injunction placed final authority for defining high-risk sex with the director of the public health department. *Id.* at 114-15.

40. *See id.* at 116.

41. *Id.* at 113 (quoting Dennis Altman). The statement reflects a foreigner's incredulity at the American focus on individual rights. While such rhetoric frames judicial decisions that weigh policies by the public health authority against personal liberties, in practice courts are quite biased in favor of public health officials. *See infra* notes 48-58 and accompanying text.

42. Scott Burris, *Legal Aspects of Regulating Bathhouses: Cases From 1984 to 1995*, in GAY BATHHOUSES, *supra* note 1, at 131.

43. *Id.* at 134.

44. 197 U.S. 11 (1905).

increased prevalence of the disease was upheld against a liberty-based challenge.⁴⁵ While the court's deference to the public health authority's discretion was unsurprising—and is still good law⁴⁶—what is perhaps shocking to a rights-schooled reader is the Court's endorsement of this statement from a then-recent New York court decision, also involving smallpox vaccination: “A common belief, like common knowledge, does not require evidence to establish its existence, but may be acted upon without proof by the legislature and the courts. . . . [F]or what the people believe is for the common welfare must be accepted as tending to promote [it], whether it does . . . or not.”⁴⁷

Although few would likely support such an abdication today, statements endorsing broad discretion for those charged with protecting public health continue to be articulated, and the heat generated by the AIDS crisis precluded a more balanced judicial approach. Consider this language from one of Burris's cited bathhouse cases, again from New York: “It is not for the courts to determine which scientific view is correct in ruling upon whether the police power has been properly exercised. ‘The judicial function is exhausted with the discovery that the relation between means and end is not wholly vain and fanciful’”⁴⁸ As Burris points out, part of this mortifying deference has to do with “practical and doctrinal limitations on the role of courts.”⁴⁹ One of the most significant achievements of his contribution is the nuanced connection he draws between this modesty—which surely has some logic to recommend it, in view of the serious consequences of erring on the side of keeping the bathhouses open—and judicial attitudes about sex and the status of sexual outliers. Define the constitutional right implicated as limited to *private* sexual conduct, and bathhouse sex as *public* conduct, and the patrons disappear as rights holders. Even private peep shows have been defined, without analysis, as public.⁵⁰ A more fully articulated approach, such as one that might be derived from looking at the physical, social, and environmental aspects of the bathhouses—as suggested by Woods and

45. *Id.* at 37-39.

46. *See, e.g.,* Stenberg v. Carhart, 530 U.S. 914, 970-72 (2000) (Kennedy, J., dissenting) (citing *Jacobson* in late-term abortion case for proposition that legislative determinations of public health policy are determinative absent some indication of improper motive). As Burris asserts throughout his essay the balance of power remains with public health.

47. *Jacobson*, 197 U.S. at 35 (quoting *Viemeister v. White*, 72 N.E. 97, 97 (N.Y. 1904)).

48. *City of New York v. New Saint Mark's Baths*, 130 Misc. 2d 911, 917 (N.Y. Sup. Ct. 1986) (quoting *Williams v. Mayor of Baltimore*, 289 U.S. 36, 42 (1933)).

49. Burris, *supra* note 42, at 138.

50. *Id.* at 144.

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Binson in *A Theoretical Approach to Bathhouse Environments*⁵¹—is beyond the ken of most courts. They do not want to consider the possibility that bathhouse sex may be neither fully public nor private, nor do they want to second-guess the public health community's decisions about risk.

Why, though? Courts routinely make all kinds of difficult decisions and have brazenly gotten involved in everything from the management of prisons to the details of school busing.⁵² But straying from their comfort zone—legal analysis—requires a Herculean effort that courts take on only rarely and often reluctantly. Whether sex is public or private may be garbed as a question amenable to the kind of multi-factor balancing that makes courts comfortable, but the question taps into a deeper vein of disquiet. As Burris notes, the confluence of a public health crisis, societal squeamishness about sex—especially “non vanilla” sex—and the alloy created by fusing the stigma of gay identity to perceived public harm operates to keep courts mostly on the sidelines.⁵³

Rare exceptions prove the rule. In *Jew Ho v. Williamson*,⁵⁴ the attempt to quarantine a section of San Francisco to prevent the spread of bubonic plague was so clearly an act of discrimination that the public health charade was removed. The boundaries of the quarantine area zigzagged,⁵⁵ and it was enforced in a way likely to spread—rather than contain—the plague. Most significantly, it was enforced only against Chinese Americans.⁵⁶ Even here, the court was unwilling to second-guess the public health authority's finding that there was indeed plague (despite evidence to the contrary); it was only public health's inability to explain such counterproductive policies that could not be overlooked.⁵⁷ Usually, the cases are harder, so courts find it easier to defer to the public health authority's decisions. For example, the resurgent tuberculosis epidemic in the early 1990s led a trial judge in New Jersey to rule (in an unusually thoughtful and careful decision) that a man with infectious tuberculosis could be involuntarily confined if he refused to take medication that would

51. Diane Binson & William J. Woods, *A Theoretical Approach to Bathhouse Environments*, in *GAY BATHHOUSES*, *supra* note 1, at 23.

52. See Barbara E. Armacost, *Affirmative Duties, Systemic Harms, and the Due Process Clause*, 94 MICH. L. REV. 982, 1006-07 (1996) (citing these and other examples of cases where courts are criticized for operating beyond their institutional competence to resolve problems that are polycentric rather than binary).

53. Burris, *supra* note 42, at 137-39.

54. 103 F. 10 (N.D. Cal. 1900).

55. See *id.* at 23.

56. *Id.* at 23-24.

57. *Id.* at 26.

eliminate the risk to those with whom he came into contact.⁵⁸

Again, the bathhouse issue was and remains difficult. It remains impossible—even today—to know definitively what policy toward bathhouses will yield the best public health outcomes. With HIV now a chronic but manageable disease—at least in the United States and for people who have access to the best treatment—a more careful analysis may at last be possible. And it is in everyone’s interest to engage in this more challenging project. Seen as a group, patrons have their health interests at stake in the best policy; bathhouse owners have a financial stake in the outcome and cannot risk bringing the power of the public health community down on them; and the public health community has its already depleted moral authority to defend. Legal coercion is possible, but widely and correctly viewed as a last resort. Where public health authorities can get “buy-in” from all constituents, they can obviate expensive and ham-handed measures and can help repair the trust that governmental policies (not always, but sometimes, those of public health officials) have damaged—especially in minority communities.⁵⁹

One size probably will not fit all. On-site HIV testing appears to have promise as one compromise measure. Based on a successful HIV testing program in Seattle, Freya Spielberg and her co-authors offer useful suggestions for achieving better design for HIV testing at bathhouses.⁶⁰ The program faced, and largely overcame, obstacles involving: owner and patron reluctance (patrons eventually saw the availability of testing as a convenience, and owners became convinced the idea was sound); space limitation and training problems; and patrons’ frequent failure to return to pick up their results (an issue largely mitigated by the advent of tests that provide “while you wait” results).⁶¹ As the high number of HIV positive persons unaware of their status attests, any opportunity for such testing should not be squandered. But is the Seattle experience the authors describe transferable to other places?

The book’s final essay raises hard questions like these without

58. *City of Newark v. J.S.*, 652 A.2d 265 (N.J. Super. Ct. Law Div. 1993).

59. The most infamous example of public health’s own mistreatment of minority groups is the CDC-supported Tuskegee study of the course of syphilis infection in African-Americans, who were neither told of the study nor offered antibiotics from the early 1930s until 1972. See Allan M. Brandt, *Racism and Research: The Case of the Tuskegee Syphilis Study*, 8 HASTINGS CENTER REP. 21-29 (1978), reprinted in LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW AND ETHICS: A READER 312-19 (2002).

60. Spielberg, *supra* note 18, at 203.

61. *Id.* at 207, 209 (patron reluctance); *id.* at 208 (space/training limitations); *id.* at 211 (failure to pick up results); *id.* at 215-16 (new testing).

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answering them. The article is a needed counterweight to the relentless—and mostly justified—criticism of the public health community that lashes the rest of the volume together.

Standard wisdom has it that groups historically mistreated by governmental policy and its often-unfair application are the least likely to heed public health messages. In the HIV context, the demimonde of black men living on the “down low”—participating in a subculture marked by sex with other men, but also by having girlfriends or wives who are unaware of their partners’ conduct and the risk it creates for them⁶²—is often used as Exhibit A in the effort to illustrate the difficulty of reaching marginalized groups with public health messages. So one might expect that a study of two bathhouses, one frequented by young, mostly white men (Bathhouse “A”), and the other, by a more ethnically diverse mix with most of the patrons either African-American or Latino (Bathhouse “B”), would show greater condom use (a marker for trust in public health) among the first group.

In fact, just the opposite turned out to be the case. Bathhouse “A” patrons were likely to engage in even the riskiest behavior without using condoms, while those frequenting Bathhouse “B” “tended to state that they always use condoms for anal sex and none said that they . . . never used them.”⁶³ Other factors may help to explain this unexpected result: Bathhouse “A” residents were likelier to have used drugs such as ecstasy or crystal methamphetamine that can either increase sexual drive or cloud judgment; they tended to be younger, with more “beautiful” bodies, perhaps suggesting a perception of immortality.⁶⁴ The description of Bathhouse “B”—while it did mention alcohol use among some patrons—focused more on meeting “regular guys” and on watching erotic videos.⁶⁵ Oral sex was more prevalent than anal sex.⁶⁶ Interestingly, many patrons of Bathhouse B did fit the “down low” description, yet they avoided at least the riskiest conduct.⁶⁷

Despite the obvious limitations of such a small study, these findings do

62. See Benoit Denizet-Lewis, *Double Lives on the Down Low*, N.Y. TIMES, Aug. 3, 2003, at 6-28; see also JACOB LEVENSON, THE SECRET EPIDEMIC 54-55 (2004).

63. Mutchler, *supra* note 11, at 234.

64. *Id.* at 232-33.

65. *Id.* at 233-35.

66. *Id.* at 235.

67. The authors make the important point that oral sex, while posing a low risk for the transmission of HIV, does create a high risk of transmitting other STDs. Therefore, female partners of men on the “down low” are still in peril. *Id.* at 238.

suggest the need for further questioning of our assumptions about the best intervention and prevention policies. Their findings are a sobering warning against policies not steeped in careful attention to facts “on the ground.” Such a warning should be applied not only to bathhouse policy, but to public health issues generally.

Of course, sound public health policy is elusive. The needle-exchange example shows that even simple questions can receive the wrong answer. The bathhouse issue is more complex, so both sides can offer plausible arguments for their positions. As the public tried to absorb the unfolding horror of the AIDS crisis, rational arguments did not stand a chance of receiving a fair hearing, and it was inevitable that the advocates of prohibition would prevail. At times, the reader of *Gay Bathhouses* feels a sense of pessimism about the likelihood that good policy is even possible. That conclusion is perhaps too gloomy. Although time and reflection do not make the complexities of the issue disappear, the overall impression left by *Gay Bathhouses* is that good policy choices can eventually emerge.