The AIDS Epidemic and Gay Bathhouses: A Constitutional Analysis

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Abstract. Some legal scholars propose that the right of privacy articulated by the United States Supreme Court should be extended to protect homosexual activity. In light of the advent of AIDS, should that extension include constitutional protection for homosexual men who frequent gay bathhouses? The author argues that although the government has the power to close the baths in the name of public health, it should not do so without careful and conscious balancing against the privacy rights infringed upon by its actions. Balancing the tension between public health policy and individual rights applies not only to the specific situation of the baths, but also to insurance companies' aim to test all single, young, male life and health policy applicants for exposure to the putative AIDS virus; to potential health department releases of names of those testing antibody-positive for HTLV-III; to the military's rumored plans to discharge all personnel suspected of having AIDS; and to school districts seeking to exclude children with AIDS.

In October 1984, the public-health director of San Francisco, Dr. Mervyn Silverman, moved to close nine gay bathhouses and clubs. San Francisco health officials said these establishments "encouraged the type of promiscuous sexual activity that spreads [acquired immunodeficiency syndrome (AIDS)]." After two months of closure, a superior court ordered reopening on the condition that sexual activities would be policed by the bathhouse management.1

The action taken by Dr. Silverman inspired death threats towards him and led to his resignation.2 More importantly, the closures ignited debate within the homosexual and heterosexual communities concerning the interrelation of AIDS as a public-health concern and the civil rights and public image of homosexual men, who as a risk group have the highest incidence rate of AIDS in the United States to date.

1 I would like to express my thanks to Jon Howard, M.D., S.M., Assistant Professor, Department of Community and Environmental Medicine at the University of California, Irvine Medical School for arguing with me and for his invaluable help. Besides his main career interest, occupation-related diseases and health hazards, Dr. Howard is a member of the state of California AIDS Task Force, Consulting Medical Director of the Gay and Lesbian Community Services Center in Los Angeles, and Medical Director of the Los Angeles County Department of Health Services' AIDS Prevention Project. Thanks, too, must go to each of my anonymous gay information sources.

In this paper I will examine the constitutional implications of gay-bathhouse closures motivated by the public-health goal of limiting the spread of AIDS.

Because of the time frame and scope of my exploration, I have of necessity made the assumption that the anecdotal information I have gathered about homosexual men and their varied lifestyles is basically accurate. The biggest gaps in facts involve gay lifestyles. As Darrow et al. noted in the American Journal of Public Health, "All samples of gay men are seriously flawed because no one knows the magnitude or basic characteristics of the homosexual population in the United States." Naturally, source confidentiality and stigma remain problems for information gathering and documentation; further, although homosexual activity between consenting adults is legal in California, it remains illegal in most jurisdictions. With these caveats in mind, then, the exploration begins.

Bathhouses

The consensus among my sources was that gay bathhouses are the sites for a broad continuum of social and sexual activities. This is consistent with historical development of public baths and spas. Other than refreshment and conversation, interaction includes mere fantasizing and watching, hand-holding and caressing, hugging, fondling, simultaneous and mutual masturbation, oral/genital intercourse, and anal intercourse.

Anecdotal accounts from early AIDS patients told of their own great number of partners; a few of my sources opined that bathhouses cater to those seeking multiple, anonymous sexual encounters. Others presented the view that patrons often know one another socially prior to meeting at the baths.

Psychologist Walter Batchelor has written that "all gay men are presumed to be extremely promiscuous; all gay male sexuality is presumed to involve ejaculation and the transmission of semen from one partner to another; all gay men are presumed to engage in anal intercourse. . . ." From Batchelor's conclusions and my own research, I understand that these presumptions are true for an unidentifiable minority of the gay male population.

Bathhouse owners have catered to more sexually adventurous and active patrons by providing private rooms with lockable doors and dim lighting for intimate encounters. And, obviously, men seeking large numbers of partners might want to patronize baths because they could expect to find other like-intended people there.

A recent study conducted by Dr. John L. Martin of the Columbia University School of Public Health presents new facts about bathhouse frequenters. Dr. Martin interviewed 700 homosexual men; of a sampling of 100, 40 frequented the baths before learning of AIDS, with an average of 32 partners there a year. In the last year, only 16 have visited the baths, with an average of 7 partners each.

Most gay men do not frequent the baths at all. They may be sexually inactive, monogamous, or only moderately active. Further, many other places exist for homosexual men to meet one another, such as through personal advertisements or
mutual friends; at work and parties; in bars, restaurants, public restrooms, locker rooms, social clubs, gyms and spas; and by street pick-ups. Homosexual men undoubtedly meet their sexual partners in at least as many ways and places as heterosexual men do.

AIDS

For surveillance purposes, the Centers for Disease Control (CDC) in Atlanta, Georgia, defines AIDS as "a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in a person who has no known cause of underlying cellular immunodeficiency, or any other underlying reduced resistance reported to be associated with that disease." Stated simply, the syndrome is manifested by a weakening of the individual's natural immune system, thereby making the patient subject to numerous "opportunistic infections." Although physicians may treat these infections as they appear with some success, no treatment or cure has yet been discovered to correct the underlying immunodeficiency. Consequently, the patient gradually loses strength and eventually succumbs to one or more of the opportunistic infections.

Symptoms of AIDS include fever, drenching night sweats, weight loss, malaise, unexplained generalized lymphadenopathy (swollen lymph glands), coughing or shortness of breath, and skin lesions; any individual may display one or all of these symptoms. Because all of these symptoms may appear in other diseases, AIDS is not easily recognizable. Many blood tests, X rays and examinations may be necessary to make a positive diagnosis.

Further complicating detection and diagnosis is the existence of a syndrome referred to as ARC (AIDS-related complex). ARC patients may experience chronic lymphadenopathy, immunological abnormalities, and other nonspecific symptoms such as weakness and fatigue. ARC is now considered by some to be a milder form of AIDS. Although no precise estimate can now be made of the proportion of ARC patients that become AIDS patients, 19 percent have been reported to evolve to the full-blown syndrome after 15 to 30 months.

As is clear from the preceding paragraphs, and according to Dr. James W. Curran of the CDC, "Persons at risk of transmitting AIDS may be difficult to identify. It is likely that persons in whom 'definite' AIDS eventually develops have been infected for a prolonged period before the diagnosis is made, since investigations of transfusion-associated AIDS indicate that the period between transfusion and diagnosis ranges from one to four years (mean, two years)."

Recent reports, coming out of an international AIDS conference held 15–17 April 1985, revealed that the incubation period for AIDS may be as long as 14.2 years, with a mean incubation period of 5.5 years. This combination of difficult identification and long incubation period makes it almost impossible to know whether a person has AIDS, will get it, or is in a carrier state.

Despite its constellation of symptoms and long incubation period, AIDS is not entirely ubiquitous. Researchers have isolated a likely causal agent necessary for
catching AIDS called “human T-cell lymphotropic virus” (HTLV-III) or “lymphadenopathy-associated virus” (LAV).16 Although the HTLV-III retrovirus has not been definitely proven to be the single etiologic agent of AIDS, all available current evidence strongly supports its causal role.17 Other environmental, genetic, and infectious factors may also be needed for an individual to contract AIDS; in short, HTLV-III is necessary, but perhaps not sufficient to produce the syndrome.

Clearly, it is hoped that only some people infected with HTLV-III will develop overt AIDS. Nevertheless, it has been extrapolated that an extremely large number of Americans—from 500,000 to 1 million—have already been exposed to HTLV-III, of which number a definite but unknown subset will progress to AIDS.18 AIDS is most frequently transmitted through intimate sexual contact, followed in frequency by the intravenous drug-user practice of sharing needles, and then by the transfusion of blood and blood products; there is no evidence of transmission via casual skin contact or airborne spread via respiratory droplets.19 The extent of intimate sexual contact needed to transmit the virus from one partner to another is unknown.20

One may contrast this indeterminate incubation period and transmission via blood, blood products, and mucosal secretions to development of more familiar diseases such as the common cold and influenza. The latter diseases are caused by viruses which are spread easily, via airborne respiratory droplets; they produce disease rapidly, in under 24 hours; and they generally do not result in death for young, otherwise healthy, patients. The prognosis for AIDS patients, alluded to above, is dismal. Those who contract AIDS have a mortality rate of greater than 80 percent within two years of diagnosis.21 To date, there are no reports of an AIDS patient’s immune deficiency being corrected.

In the United States, more than 70 percent of AIDS patients have been homosexual or bisexual males. Increased incidence occurs in three “high-risk” population groups here: (1) homosexual and bisexual men with multiple partners; (2) past or present users of intravenous (IV) drugs; and (3) hemophiliacs.22 Nearly 90 percent of patients have been 20 to 49 years old. They have included members of all primary racial and ethnic groups and have been of both sexes.23 Despite prevalence of AIDS among homosexual men, heterosexuals with no other risk factors have contracted AIDS; heterosexual transmission is responsible for less than 5 percent of the total AIDS cases in the United States.24 In Europe and central Africa, however, AIDS is primarily a disease of heterosexuals of both sexes who have many partners.25

Even if AIDS does not follow the current trend towards more widespread infection of the heterosexual population, infection among the high-risk group of homosexual males alone means AIDS affects a large subset of the American people. Using Kinsey’s historical estimate that 10 percent of the adult male population is homosexual, on the basis of 159 million adult Americans, there are about 8 million adult homosexual men in the United States.26 The economic and human loss potential is simply staggering.
No vaccine for AIDS yet appears feasible even on the horizon, although a blood test to help detect HTLV-III exposure was licensed by the Food and Drug Administration as of March 1985. The blood test establishes fairly accurately whether one has been exposed to HTLV-III, the putative infectious agent of AIDS, by detecting whether the blood contains an antibody to HTLV-III. Such a test does not necessarily show whether the person's blood still has the virus in it, whether the person will contract AIDS or ARC, or whether the person can or will transmit AIDS. Thus, it is a troublesome test, as it seems to create as many problems as it solves; for example, what does a positive test result mean to an individual—or a negative one?

Freedom of intimate association

The United States Supreme Court articulated a right to privacy, in the sense of freedom from governmental interference, in the 1965 case of Griswold v. Connecticut. Griswold held that state law could not constitutionally forbid the use of contraceptives within the marital relationship. Seven years later, Eisenstadt v. Baird extended this freedom to govern one's intimacy to unmarried couples. There is some question about how far courts will go in extending the privacy right. Because privacy needs frequently coincide with sexual activity, courts hesitate to extend full privacy rights beyond entrenched, rigid conceptions of who "deserves" privacy in interpersonal, especially sexual, association. One prominent constitutional law scholar suggests extension of current privacy rights; after summarizing his ideas, I will apply them to bathhouse patrons.

Professor Kenneth Karst wrote an article called "The Freedom of Intimate Association," describing a constitutional area "dealing with marriage and divorce, family relationships, the choice whether to procreate, and various forms of intimate association outside the traditional family structure." Ideally, the degree to which this freedom of association elevates judicial scrutiny in a constitutional analysis depends on the degree to which one's intimate association corresponds to or fulfills values necessary for development of a sense of individuality.

Intimate association is "a close and familiar personal relationship with another that is in some significant way comparable to a marriage or family relationship," with a shared sense of being more than a collection of individuals. It includes close friendship with or without shared living quarters, blood ties, sexual intimacy, or a formal relationship. People who exercise their freedom of intimate association gain to a varying degree the benefit of these values: society (shared physical presence, whether fleeting or regular), self-identification, caring and commitment, and intimacy. According to Karst's hypothesis, the more one's intimate relationship fulfills these values, the higher the level of scrutiny a court should apply to any governmental burdening of the relationship.

All of these values clearly accrue to monogamous homosexual relationships, for they are closest in nature of association to Karst's model of heterosexual mar-
riage. Steady couples of any stripe associate with one another to gain stability and a frame of reference for sharing affection and for experiencing life together. But how much do the stated values properly accrue in casual bathhouse encounters? Can the resulting elevation of scrutiny suffice to override public-health concerns about AIDS?

To determine the level of judicial scrutiny bathhouse patrons would receive under Professor Karst's scheme, we must engage in the analysis presented below.

Freedom of association and the bathhouse

Society. The first value, society, is the opportunity to enjoy the company of certain other people. Various states have tried to limit gay association by revoking the alcoholic-beverage licenses of bars frequented by homosexuals. Statutes outlawing licensure to gay bars had been held justifiable as the states' "tight control over the liquor business mandated maintenance of accepted (sic) standards of public decency." But prosecutors and alcoholic-beverage commissions apparently have not utilized the alcohol-license route of late to limit gays' association; after the late 1960s, cases concerning gay bars disappeared from the court reporters. New Jersey, New York, and California courts now agree that "to revoke a license under liquor regulation statutes, something more must be shown than mere status of the bar owner's patrons as homosexual." This reflects an attitude accepting associational rights for gays, but that acceptance is grudging at best.

Unfortunately, the Supreme Court has shied away from cases dealing with homosexuality and the right of gays to each other's society. In Texas A&M University v. Gay Student Services, the court would not hear arguments concerning a gay student group seeking to meet on the campus of a state-funded university. Lower courts and commentators are still waiting for abandonment of the court's extraordinary delicacy and hesitation concerning gay issues.

Although one cannot predict the outcome of a court challenge on the issue, it is certainly arguable that bathhouse socializing does fulfill Karst's value of society for patrons.

Self-identification. This value relates to one's sense of self and role individuation. "Some kind of answer to the question, Where do I belong?, is necessary for the question, Who am I?" Just as one identifies politically by forming groups, one creates a psycho-sexual self-image by associating with people sharing similar needs and similar modes of fulfilling those needs.

For homosexuals, this is something of a paradox. Their very act of self-identification—coming out of the closet—has for many resulted in stigmatization, and in loss of rights such as employment. Homosexual people frequently must conceal their sexual self-identity and preferences to retain their jobs and their places in the larger community.

As far as the bathhouse patrons are concerned, the value of self-identification is manifestly strong. Individuals do patronize the baths in affirmation of their gay
identity. Harder questions arise, however, in matching the latter two Karst values to bath patrons.

_Caring and commitment_. The monogamous homosexual relationship is “in some significant way comparable to marriage.”46 No state in the union has recognized homosexual marriage, however, despite several challenges to marriage statutes on associational, free exercise of religion, and equal-protection grounds.47 Casual intimate contact is directly opposite to marriage. Professor Karst nonetheless recognizes a justification for extending constitutional protection to casual intimate associations because “they may ripen into durable intimate associations. Indeed, the value of commitment is fully realizable only in an atmosphere of freedom to choose whether a particular association will be fleeting or enduring.”48 But what if an intimate sexual contact is not meant to be anything more than casual or fleeting? The caring and commitment values are antithetical to anonymous and nonexclusive sexual encounters.

The heterosexual marriage model breaks down in the free-circulating bathhouse.49 For an individual with multiple partners, intimate satisfaction does not derive from caring for and commitment to any one sexual partner, but from the extended stimulation of a succession of partners over the space of an evening, a weekend, or a year. One could say that widely-circulating gays have caring and committed relationships with a large circle of people. Thus, they share their intimacy with a limited segment of society, fellow homosexual males. Better, one may arguably apply the value of society and self-identification to lifestyle; although caring, commitment, and intimacy values exist, they are not directed towards any individual, but rather towards a way of life shared with a subset of the gay population.

However psychologically fitting a fiction that explanation may be, it strains credibility to say a commitment includes privacy when it involves a group of hundreds or thousands of people over the course of a lifetime.50 This is not to judge whether such activity should occur, for the fact is that it does; it is rather to acknowledge that constitutional protections of privacy as embodied in _Griswold_ and its progeny will unlikely be extended by any living court to this activity if that court depends on the value of caring and commitment as a pillar of its reasoning.51

Professor Laurence Tribe argues eloquently “that no unconventional form of consensual human sexuality can be excluded from the protected sphere solely on the ground that it is thought by the majority not to draw on the historically deepest wellsprings of human emotions and instincts.”52 Tribe has a good argument for strict scrutiny, but without terrible distortion of Karst’s theory, the caring and commitment value cannot be met by multiple-partner bathhouse relationships.

**Intimacy.** Intimacy encompasses both privacy in the sense of limited flow of information about oneself, and also “close and endearing association between peo-
ple.” The second is more important for intimate association, but the first is also needed.53

As discussed in the preceding section, it is virtually impossible for a sexually-prodigious person to know all the individuals he engages in sexual intimacy as whole people;54 such knowledge is antithetical to highly casual, anonymous encounters. Also, such a person cannot realistically expect intimate information shared with, say, 300 people to remain secret or private.55 This value, then, does not accrue in the case of the targeted customers of the baths.

**Intimate association freedom for bathhouse patrons**

The four values embodied in the freedom of intimate association translate well to people who relate to one another in exclusive or at least long-lasting relationships. However, the Karst model, based as it is on heterosexual marriage or familial relationships, is not a very close fit for gay-bathhouse frequenters—especially for the gay man with many partners,56 because it requires intimate knowledge of a partner and at least the potential for long-term caring and commitment.

It is essential to note that the presumptive right recommended in Karst’s freedom of intimate association, like any other right, may be abridged, but only after “a serious search for justification by the state for any significant impairment of its values.”57 How a court might weigh the state’s public-health concerns against these associational values follows.

**Constitutional balancing**

No right guaranteed by the Constitution is absolute. Even a fundamental right like freedom of speech may be abridged if the state can prove overriding governmental interest.58

Because the Supreme Court has not provided much guidance in the area of homosexual rights, I think it appropriate to test public-health concerns against those rights on all three levels of scrutiny articulated by the court: (1) “rational relation” of state action limiting individual freedom to a legitimate governmental interest, the lowest level of scrutiny; (2) action necessary to achieve an important or substantial state interest, mid-level or elevated scrutiny; and (3) action necessary to accomplish a compelling state interest, strict scrutiny.59 The Supreme Court has generally applied strict scrutiny in cases involving fundamental rights explicit or implicit in the Constitution,60 or discrimination against suspect classes of individuals.61 It has applied mid-level scrutiny to equal protection cases involving gender and illegitimacy;62 the rational-relation test applies to all other state action.

**Rational relation or low-level scrutiny.** Under the rational-relation test there exists a presumption that state action is constitutional. In the instance of bathhouse closure, as in all applications of the test, that action must be rationally related to a legitimate governmental interest. Traditionally, states have “police power” to
protect the health and welfare of their citizens, as exercised through criminal law enforcement, motor vehicle registration, and controls on the sale and distribution of alcoholic beverages. 65

For the state, the health and welfare of citizens are legitimate state interests. A 1905 Supreme Court case, *Jacobson v. Massachusetts*, 66 upheld a Cambridge city ordinance requiring smallpox vaccination for all residents, stating that "[the court] has distinctly recognized the authority of a state to enact quarantine laws and 'health laws of every description.' . . . According to settled principles, the police powers of a state must be held to embrace, at least, such reasonable regulations established . . . [to] protect the public health and public safety." 67 The court would be compelled under this authority to interfere only if the state exercised its power to control an epidemic in an "arbitrary, unreasonable manner, or . . . [one going] so far beyond what was reasonably required for the safety of the public." 68

Courts generally uphold legislation under this standard of review. For example, a Virginia federal district court in *Doe v. Commonwealth's Attorney* would not grant declaratory or injunctive relief to bar enforcement or threatened enforcement of the state's criminal sodomy statute against gays, despite the fact that the state did not introduce any evidence as to the interests furthered by the law. 69 If a court can make that decision — and not be overturned on appeal — with no showing of state interest, it is clear that the addition of a sexually-transmitted fatal disease on the state's side of the equation can only hurt those seeking to repeal sodomy statutes or to enforce any gay rights.

Gay baths that come under regulation obviously do not operate openly, or at all, in states that ban homosexual behavior. Nevertheless, even in socially-liberal states like California, New York, Florida, or New Jersey, the magnitude of AIDS itself makes meeting the mere rationality test elementary for the state.

By closing down the gay baths, the San Francisco Health Department sought to further the governmental interest of limiting the rapid spread of a fatal disease. Since 70 percent of AIDS patients are homosexual or bisexual men, and since the disease is most frequently communicated through the exchange of semen and blood, it is rational to suppose that closing baths will deter the activities which spread the syndrome. Since regulation of the class of people and activity is at least rationally related to the end sought, the court will probably uphold it.

**Mid-level or intermediate scrutiny.** Because their activity fulfills some but not all of Ken Karst's intimate association values, bathhouse patrons would likely receive mid-level scrutiny from a court that accepted Karst's sliding scale of judicial scrutiny. 70 Is the closing of gay baths and clubs necessary to achieve an important or substantial state interest?

Undoubtedly, preservation of life, prevention of a deadly epidemic, and avoidance of astronomical health care expenditures are substantial, important state interests. Likewise, preservation of the values of self-identification and society remains key to gays patronizing bathhouses. The balance probably favors the state,
but it is important to examine whether the means of legislation or other state action are sufficiently well adapted to accomplish its ends. An earlier mid-level-scrutiny case should provide guidance.

In *Craig v. Boren*, a mid-level-scrutiny gender-discrimination case, the Supreme Court measured the relationship between means used and ends sought, finding it too tenuous to constitute a "substantial relation."69 The case involved a challenge to an Oklahoma statute forbidding the sale of supposedly nonintoxicating "3.2" beer to males under 21 and females under 18. Despite statistical proof of higher arrest rates for drunken driving among 18- to 20-year-old males than for that among females, the court rejected the means–end correlation as insufficient justification for discriminatory treatment on the following bases: (1) maleness could not serve as a proxy for drinking and driving because the arrest rate represented only a small percentage of those 18- to 20-year-old males; (2) regulation of a supposedly nonintoxicating beverage should not affect intoxication rates; and (3) the statute regulated sale, but not consumption.70

The state could easily get experts to testify that bathhouse closure would have some effect on the control of AIDS, and that that result alone justifies the means. One physician I interviewed expressed this commonly-held health view: The bathhouse is a place where intimate sexual interaction goes on. Since we know that multiple semen exchanges enhance a person’s chances of getting AIDS, it is better to close the bathhouses down and thereby make it harder for rapid, multiple sexual contacts to be made. It is better to slow down circulation in the high-risk group by closing the baths than to single out and further stigmatize the infected individual.71

That opinion, with its clear empathy towards the individual patient, glosses over the right to intimate expression and association of those who are not AIDS patients. Considering the great variety of activity apart from oral and anal intercourse—the modes of sexual contact most likely to put one in danger of contracting AIDS—that takes place in the baths, sweeping closure as recommended by this physician would be, in a word, overbroad. By using the *Craig v. Boren* criteria of equal protection, we can determine whether a court would agree with the physician’s assessment that closure would be for the best.

First, if contraction of AIDS is what state action seeks to control, can bathhouse attendance serve as a proxy for contraction of AIDS? In *Craig*, because only about 2 percent of the males in the targeted age bracket were arrested under drunk driving laws, Justice Stevens stated in his concurrence that the challenged statute would "unlikely . . . have a significant effect on that 2 percent or on the law-abiding 98 percent. But even assuming some such slight benefit, it does not seem to me that the state can be justified in visiting the sins of the 2 percent on the 98 percent."72

Currently, less than 0.2 percent of homosexual men have AIDS,73 a smaller number than the drunk-driving males arrested in *Craig*. Using the same reasoning Justice Stevens applied in *Craig*, it is unreasonable to "visit the sins" of the minority on 99 percent of homosexual men. Thus one can argue that bathhouse closure is overinclusive regulation.
In Craig, the second objection of the Court centered on regulation of the wrong activity, for supposedly nonintoxicating beverages will not get males or females drunk enough to endanger others on the road. 74 Although the supposition is somewhat arguable, only minor rephrasing makes the objection applicable to the bathhouse-closure case. Restrictions on bathhouses interfere with noninfectious behavior that occurs there—regulation of the wrong activity—and will therefore have no effect on the infection of individuals engaging in “safe sex.” 75 But just as consumption of enough 3.2 beer will increase the risk of intoxication, enough intimate sexual contacts with high-risk individuals will increase the chance of an effective contact, i.e., one that results in AIDS.

The third problem with the statute in Craig was that it regulated sale, but not consumption. Bathhouse closures are likewise overbroad in that they limit location, but not occurrence, of behavior. As noted in the first section of this paper, many other outlets exist for gays—and all AIDS carriers, for that matter—to meet sexual partners.

Assuming that the Columbia University School of Public Health study is a fair sampling of homosexual activity, approximately 16 percent of the gay population now frequents the baths. This figure represents a far larger portion of the gay community than those who have AIDS; this is a strike against homosexuals arguing for equal protection under Craig, as visiting the sins of 16 percent on the 84 percent remaining seems much less drastic than visiting the sins of 0.2 percent on 99.8 percent. Obviously, although drunk driving creates a hazard that may result in death, AIDS absolutely means death for 80 percent of its victims within two years of diagnosis.

It remains uncertain how persuasive courts would find these arguments for keeping bathhouses open; clearly, the San Francisco superior court that issued the injunction against gay-bathhouse closures understood the health department’s action as overinclusive. I think another court could as easily conclude that factual evidence of the danger of AIDS could justify continued closure of the baths. It might just require the implementation of strict judicial scrutiny to overcome such a strong asserted state interest.

Strict scrutiny. Judicial review of bathhouse closures could be elevated to strict scrutiny two ways, by implicating a fundamental right or by finding homosexuals a suspect class.

The Supreme Court has not provided any guidance in reference to extension of the right of privacy to consensual, extramarital, adult sexual relations. 76 In a 1982 case, Baker v. Wade, 77 a federal district court in Texas found that this lack of guidance from the Supreme Court allowed it to consider whether the Constitution permits the use of a state statute to prohibit private, consensual, homosexual conduct. 78 The Texas statute in question prohibited “oral and anal sodomy” between homosexuals but not between heterosexuals. 79 The court found no legitimate state interest in the prohibition, even in the claim that homosexual sodomy was dis-
tasteful, "a practice . . . abhorred in western civilization and [one that has] . . . long inspired an almost universal phobic response."\textsuperscript{80}

The \textit{Baker} court held for the gay plaintiff on equal-protection ground, tested by the rational-relation standard.\textsuperscript{81} By describing the privacy rights of homosexuals in its analysis, the \textit{Baker} court laid the legal analytical groundwork to apply strict scrutiny in a future case; it did not use fundamental privacy rights to elevate scrutiny, but could have done so.

Likewise, the \textit{Baker} court did not decide the suspect class issue.\textsuperscript{82} But Professor Tribe has argued convincingly that homosexuals do have the necessary characteristics of a suspect class, inasmuch as "the history of homosexuality has been largely a history of disapproval and disgrace; indeed, it would not be wholly implausible to suggest, on just this basis, that homosexuals form virtually a discrete and insular minority."\textsuperscript{83} An individual's homosexuality, he notes, is usually irrelevant and it ordinarily originates in conditions beyond that person's control; these facts bolster the argument for treating homosexuality as a suspect classification.\textsuperscript{84} Further, denial of rights because of public distaste and disapproval "would turn on its head the axiom of heightened judicial solicitude for despised groups and their characteristic activities."\textsuperscript{85}

Assuming that fundamental privacy rights and suspect-class considerations apply, how would the strict-scrutiny balance weigh out? Regulation "may be justified only by a compelling state interest and must be narrowly drawn to express only the legitimate state interests at stake."\textsuperscript{86}

There is no question that the state has a compelling interest in controlling the spread of infectious disease.\textsuperscript{87} AIDS, because it is painful, expensive to treat, psychologically isolating, and eventually fatal, presents a unique epidemic, one that is probably compelling enough a public-health emergency to outweigh even fundamental rights.

The problem with AIDS is to find sufficiently narrow yet effective means to prevent spread of the syndrome. Quarantine, because of the lengthy incubation of the disease and the difficulty in identifying carriers and the infected, is not practicable; if it were, perhaps its enforcement could be a suitably narrow means to the end of containment at present levels of infection.\textsuperscript{88}

Another approach would be criminalization of anal intercourse without the use of a condom. In a sense, such a regulation would force homosexual men to behave like heterosexual women, who must use contraceptives if they wish to avoid pregnancy (although the consequences are vastly different). Criminalization would be much more privacy-invasive and stigmatizing than bathhouse closure itself. Practically speaking, criminalization of homosexual acts has never caused them to disappear, because "sex, next to hunger and thirst, is the most powerful drive that human beings experience," and it would be unrealistic to think that such laws will force total abstinence.\textsuperscript{89} Criminalization of sodomy would be an overbroad solution, too, in that it would affect monogamous homosexuals and heterosexual couples, who are not at serious risk for AIDS. Enforcement, because of its dif-
ficulty, would likely be arbitrary at best. Further, since AIDS affects sexually-active heterosexuals, the criminalization of unsafe gay sex would also be under-inclusive, and probably fatally so.

As to bathhouse closures as a means of controlling the spread of AIDS, the overinclusiveness problems explained in the mid-level-scrutiny section above still apply. Not all bathhouse patrons engage in high-risk infection-promoting activities. Closure would therefore violate the first amendment associational and privacy rights of those who go there to socialize. Second, because of myriad alternative locations for fulfilling sexual desires, it is questionable whether bathhouse closure would actually deter those intent on engaging in "unsafe sex" as frequently as they would like.

Nevertheless, the overbreadth of bathhouse closure is probably incremental. Gays may continue to associate while fully clothed in bars and clubs even if the state closes the baths. A court facing a deadly public-health epidemic could easily conclude that closure of bathhouses would further the substantial state interest of limiting AIDS without causing the constitutional problems inherent in outlawing anal intercourse or homosexuality. Considering that death by AIDS weighs heavily in favor of radical state action, the associational rights of a minority of gays would unlikely outweigh public-health needs, even under strict scrutiny of the state action.

Conclusion

AIDS is a confounding disease not only because of its lengthy and uncertain incubation period, but also because its primary means of spreading has been through intimate sexual contact. AIDS has come to the limelight just as homosexual men have started to gain greater acceptance than ever before; yet, ironically, it is precisely the free-wheeling sexual activity of the gay-liberation movement that makes gays the major American carriers and victims of AIDS.

The state cannot stand idly by as its citizens fail to protect one another against AIDS. The government has a great stake in public health; for those unsympathetic to the plight of AIDS victims, that stake may be understood as a huge financial burden. Further, should self-interest alone motivate heterosexuals, it should once again be noted that no one is immune to AIDS—in fact, many of the unsympathetic may have already contracted it.

Public education should continue in earnest. Admittedly, even careful publicity generates new waves of homophobia—"they gave it to us"—and panic. The gay community has become confused, divided, and panicky as well. Deaths of friends have brought about sobriety and in some cases depression. As a result, gays have radically curbed their sexual activity. This is evidenced by New York City Health Department reports of an 80-percent decline in venereal disease among homosexual men over the last two years.

Nevertheless, bathhouses remain open, and they can serve an important educational purpose as gay social-gathering places. Better lighting and open doors
may encourage "safe sex," but dissemination of health-care pamphlets, support-
group information, and condoms would probably do more to increase peer pressure
against "unsafe sex."44 Regulation, if it occurs, should extend to heterosexual
bathhouses as well. Research continues to identify the causes and possible cures
of AIDS, and to develop effective treatment. Before we discover a medical solution
for AIDS, it will surely threaten more than the civil liberties of a few thousand
people. It will be tempting for public-health officials and courts to forget the rights
of infected people, yet individual rights must not be ignored or glossed over as
we meet the scientific challenges ahead.

Notes
1. Los Angeles Times, 12 December 1984, part I, p. 1. The superior court judge was Judge Roy
Wonder.
   Despite difficulties, researchers do attempt to estimate the magnitude of the population:
   "[Using] Kinsey's historical estimate that 10 percent of the adult male population are homo-
   sexual, then on the basis of the estimate of 159 million persons in the United States aged 18
   and older, there are approximately 8 million homosexual men in the United States." S. H.
5. This entire section derives from discussions with a sampling of homosexual men residing in Los
   Angeles and with men and women well acquainted with various California gay communities.
   I refer to them as my sources.
6. It should be noted that bathhouses have existed for centuries. They occurred in early Egyptian
   palaces, and achieved great popularity during the Roman Empire. Bathing rituals for health and
   religious rites have developed along with social- and athletic-club functions. Since the Industrial
   Revolution three main types of public baths have been constructed: 1) public swimming pools
   with adjacent showers; 2) public swimming pools with steam, massage, and rest rooms; and 3)
   medicinal springs baths with treatment rooms, restaurants, card rooms, concert and dance halls.
   and extensive gardens (e.g., Bath, England). Encyclopaedia Britannica 3 (1972 ed.), pp. 275-
   77.
   of the American Medical Association (JAMA) 252 (19 October 1984): 2037-43. CDC researchers
   came upon AIDS in 1981 when coincidental trends recorded in CDC's weekly Morbidity and
   Mortality Reports presented rare cancer, Kaposi's sarcoma, and pneumonia, PCP or pneumo-
   cystis carinii pneumonia, in otherwise healthy, young gay men. Such diseases had not appeared
   before in a young population except as the result of intentional, iatrogenic immunosuppression,
   as for organ transplant. A suppressed immune system under that condition is of greater benefit
   than risk because it prevents the body from rejecting the transplanted organ.
   A fine history of the AIDS discovery appeared on public television's NOVA program on 12
   February 1985. Transcripts are available singly for $4.00 from NOVA, AIDS: Chapter One,
   Box 322, Boston, MA 02134.


15. "Dr. William Blattner, a key AIDS researcher with the National Center Institute, said the syndrome's long incubation period was concealing the heterosexual cases that are quietly incubating in the nation, much as the AIDS virus was widespread in the gay community long before AIDS was discovered." *San Francisco Chronicle*, 18 April 1985, p. 4.


T-cells are white blood cells the human body uses in fighting disease. T-cells include "supressors" and "helpers," both of which are necessary for resistance to infection. AIDS greatly reduces the number of T-helper cells in the bloodstream, thus crippling the body's ability to utilize the T-suppressor cells.

17. T. C. Quinn, "Perspectives of the Future of AIDS," *JAMA* 253 (11 January 1985): 247–49. A retrovirus is one that contains RNA (single-stranded protein) rather than DNA (double-stranded) as its genetic material; a virus has DNA. Additionally, a retrovirus reads its own genetic code from right to left (reverse transcription process), whereas a virus reads its genetic code from left to right. In other words, a retrovirus is like a virus which reproduces differently. (Unfortunately, this paper cannot reach the scientific precision better met in medical journals and textbooks.)

18. *Arizona Republic*, 15 September 1985, p. AA3. The CDC estimates that 90 to 95 percent of those exposed will not develop full-blown AIDS.

19. Ammann et al., "Council Report," p. 2041. AIDS "seems to follow the same infectious pathway as hepatitis B [also prevalent among homosexual men], which is highly infective and can be recovered from saliva, but is not easily transmitted in saliva." Dr. Peter Drotman of CDC Task Force, as quoted in *Acute Care Medicine* (January 1985): 14 (emphasis in original).


21. Quinn, "Perspectives," p. 247. As reported in the *Los Angeles Times*, 4 April 1985, part 1, p. 2, "More than 500 San Franciscans have died of AIDS since . . . mid-1981. The city's Public Health Department said there had been 193 new cases of acquired immune deficiency syndrome and 103 deaths during the first three months of 1985. The department noted that this is nearly three times as many deaths and nearly double the number of new cases as occurred in the same period a year ago. San Francisco has the highest per capita AIDS rate of any city in the nation."

Actually, New York City had the highest per capita rate as of 15 April 1985, with 368.7 cases per million population; San Francisco had 346.1 per million. "CDC AIDS Weekly Surveillance Report," 15 April 1985.


24. Heterosexual transmission "has been documented in Haitians and in females who have had sexual contact with IV drug users, bisexual men, and rarely, hemophiliacs. . . . While it is not known whether [females] will be as efficient as homosexual men in transmitting the virus, the potential for extension of AIDS outside the present high-risk groups remains a real possibility." Quinn, "Perspectives," p. 248.

See *Los Angeles Times*, 12 December 1984, part 1, p. 1, which covered a press conference held by the San Francisco Department of Health; "Here in San Francisco, other surveys have established that there is a significant amount of sexual contact between gay men and women. One survey conducted for the San Francisco AIDS Foundation revealed that 21 percent of gay men said they had sexual relations with one or more women over the last five years. Another
survey by the City Health Department showed that 23 percent of the men who visited gay bathhouses listed themselves as something less than 'exclusively' homosexual..."


See San Francisco Chronicle, 18 April 1985, p. 4. A recent study by Dr. William Blattner of the National Cancer Institute indicates probable widespread latent AIDS virus in the American heterosexual population. Heterosexuals will eventually comprise a higher proportion of the AIDS caseload than homosexuals, according to Blattner. Also from the same source: A New York City Health Department study of nearly 300 sexually active heterosexual men showed a 3.4 percent infection rate with HTLV-III. None had used intravenous drugs, nor had any engaged in any homosexual contacts.


27. By way of encouraging gay men to take tests away from blood-donation sites, California legislators have passed a statute providing for alternative sites for HTLV-III antibody tests. The non-blood-bank sites may inform those tested that access to test results immediately, while blood-bank testing results may not be telephoned for one year.

28. "Some of the problems with the test are set forth by Alvin Novick. M.D., professor of biology at Yale University, New Haven, Conn.: "We do not yet know whether the presence of antibody to the AIDS agent correlates with the ability to transmit the agent to others, or with possible vulnerability to AIDS if accompanied by unknown environmental or host cofactors or by repeated exposure." M. F. Goldsmith, "Medical News: HTLV-III Testing of Donor Blood Iniminent: Complex Issues Remain," JAMA 253 (11 January 1985): 173–81.

"The test is absolutely unreliable as an indicator of whether you will get the disease," said Dr. Neil Schram, director of the L.A. Task Force of AIDS, Los Angeles Times, 18 February 1985, part II, p. 4, col. 1. An interesting twist, too, is the fact that when someone has full-blown AIDS, antibodies to HTLV-III will disappear entirely from the patient's blood.

29. The HTLV-III antibody test is a fascinating and complex subject, but one unfortunately beyond the scope of this paper. See Goldsmith, "Medical News," for one sophisticated discussion.


31. Ibid., p. 485.


34. Ibid., p. 625.

35. Ibid., p. 629.

36. Ibid., pp. 630–37. I recognize the truth to Professor Karst's cautionary note 30 (p. 630) that his is not an exclusive list of values. However, I have found them useful in applying his theories to this topic.


42. 105 S.Ct. 2369 (1985), rehearing denied. Ruling below, 737 F.2d 1317 (5th Cir. 1984).


45. Baker v. Wade, 533 F. Supp. 1121, n. 9. The discrimination problem is even worse for AIDS patients. Civil suits have been filed by various civil or gay-rights groups as well as private at-
torney representing clients with AIDS who have suffered discrimination at the hands of employers, landlords, and insurance companies. Arizona Republic, 15 September 1985, p. AA3.


48. Karst, “Freedom of Intimate Association,” p. 633. As Professor Karst adds in n. 44: “There is irony here, because casual sexual intimacy usually is the exact antithesis of the intimacy that involves caring. Yet if the freedom of intimate association is to extend to lasting, nonmarital relationships, the practical argument for protecting casual association becomes conclusive.”

49. I refer to widely-circulating, sexually-active patrons because as indicated above it is obvious that Karst’s model does apply to homosexual people with monogamous or few, select relationships. If selective or exclusive couples frequent bathhouses, their relationships clearly retain the same degree of caring and commitment as elsewhere.

50. Fully recognizing my heterosexual bias, I nonetheless think that “relationships,” homosexual or heterosexual, where people exchange no more than first name and bodily secretions can hardly qualify as “ripening into durable intimate associations.” On the other hand, should one use “privacy” in the sense of freedom to be left without governmental inference, anonymous sexual contacts may be viewed with greater tolerance.

“Caring for an intimate requires taking the trouble to know him and deal with him as a whole person, not just the occupant of a role. This fact alone limits the number of intimate associations one person can have at any one time, or even in a lifetime.” Karst, “Freedom of Intimate Association,” pp. 634–35.


52. Tribe, American Constitutional Law, p. 947 (emphasis in original).


54. See note 50.

55. This goes for heterosexuals as well. It is true, ironically, that one exchanges far less intimate information with casual sexual partners than with ongoing partners; thus anonymity itself preserves secrecy.

56. I would hesitate to estimate numerically how many partners it takes to make an individual fall into the commonly-used but pejorative category of “promiscuous.” That is why I do not use the term. For consideration of the infectious disease question, however, it is clear that increased number and frequency of sexual contacts have been linked with increased incidence of AIDS.

The early cases of AIDS occurred largely among widely-circulating gay men.


58. See, for example, Scales v. United States, 367 U.S. 203 (1961), where the Court upheld conviction for active, purposive membership in an organization engaged in illegal advocacy.

59. Additionally, to pass strict scrutiny, the interest must not be achievable by less restrictive means. The legislation or state action “must be narrowly drawn to express the [compelling] state interests at stake.” Dike v. School Board, 650 F.2d 783, 786-87 (5th Cir. 1981).

60. See, for example, Harper v. Virginia Board of Elections, 383 U.S. 663 (1966) (poll tax creates inequality in the right to vote, a fundamental right).

61. This includes race; see, Korematsumi v. United States, 323 U.S. 214 (1944) (ironically upholding law confining Japanese-Americans to camps during World War II).

62. See, for example, Craig v. Boren, 429 U.S. 190 (1976) (statute forbidding sales of 3.2 percent beer to males aged 18-21 but not females of same age unconstitutional; gender classifications must serve important governmental objectives and must be substantially related to achievement of those objectives).

63. See, for example, Murphy’s Tavern v. Davis, 70 N.J. Super. 87.

64. 197 U.S. 11 (1905).

65. Ibid., p. 25.
66. Ibid., p. 27. It should be noted that Kenneth Wing, author of *The Law and the Public's Health* (Ann Arbor, Mich.: Health Administration Press, 1985), suggests in his upcoming second edition, p. 25, that because of changes in constitutional analysis, the Jacobson case might not be decided the same way today.


68. See text accompanying notes 33–34.


70. Ibid., pp. 200–03.

71. Private conversation with Michael S. Rabin, M.D., in March 1985, while he was a researcher at the National Cancer Institute, National Institutes of Health.

72. *Craig v. Boren*, 429 U.S. 190, p. 214. (Stevens, J. J., concurring.) The 2 percent is only the number who are arrested; I think it fair to use as a parallel figure those who actually get AIDS. In both situations, there are many who engage in risky behavior but apparently do not get arrested or ill.

73. See text accompanying note 26. If homosexual and bisexual men remain at the current percentage levels of people contracting AIDS, 80,000 gay patients would mean over 114,000 total AIDS patients.

74. The *Craig* court objected to Oklahoma’s questionable statistic gathering and the state’s assumption that 3.2 percent beer is nonintoxicating. The Court would have liked some comparison between the effects of 3.2 percent beer and those of alcohol generally. *Craig v. Boren*, 429 U.S. 190, pp. 202–03.

75. Noninfectious behavior includes so-called “safe sex,” anal intercourse using condoms. This ideally prevents transmission of the disease through semen and the thin mucosal tissues of the anus.


77. Ibid.

78. Ibid., p. 1139.

79. Ibid., p. 1150.

80. Ibid., p. 1145. Apparently the defendants had read Leviticus but not Plato.

81. Ibid., p. 1144. See note 44.

82. Ibid.


84. Ibid.

85. Ibid., p. 946.


88. California public health officials have considered quarantine plans. “[Dr. James] Chin [chief of the state health department’s Infectious Disease Section] has asked for a legally enforceable quarantine policy as soon as possible.” The policy drafted involves “modified isolation,” with quarantine similar to home arrest for violators. R. Pagano. “Quarantine Considered for AIDS Victims,” *California Lawyer*, March 1984, p. 17.


90. Unlike curbs on heterosexual intercourse, where the tangible “product,” the fetus, either is carried to term or is aborted, curbs on homosexual intercourse could not be enforced without totalitarian patrols holding vigil at every place 8 million homosexual men could engage in intercourse. On the other hand, self-policing is increasingly prevalent in the gay community due to the fear of death. Few gays have not lost friends and acquaintances to AIDS. See *New York Times*, 22 September 1985, p. 1.

91. Further, there are obvious equal-protection questions regarding the closure of only homosexual, and not heterosexual, bathhouses. See *Baker v. Wade*, 533 F. Supp. 1121. This question becomes more urgent in light of recent discoveries concerning AIDS in the entire population. See *San Francisco Chronicle*, 18 April 1985, p. 4.
92. Sadly, this has already come to pass. California State Senator Ed Davis was approached by a religious group, the American Coalition for Traditional Values, asking Davis to refuse political support from gays in his U.S. Senate bid. The group's letter, signed by its chairman, the Rev. Tim LaHaye, "accused homosexuals of spreading the disease AIDS in their bathhouses and assailed homosexuals for violating 'traditional family values.'" Los Angeles Times, 16 April 1985, part 1, p. 3. Some Christian fundamentalists, including the Rev. Jerry Falwell, have declared that the disease is God's way of punishing homosexuals. Arizona Republic, 15 September 1985, p. AA3. See also "Fear of AIDS," Newsweek, 23 September 1985, pp. 18-25.


94. The bathhouses serve as excellent sites for dissemination of news and health information. Surely gays who frequent the baths are in need of information concerning AIDS and safe sexual practices.