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Rationality Review and the Politics of Public Health

Scott Burris

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RATIONALITY REVIEW AND THE POLITICS OF PUBLIC HEALTH

SCOTT BURRIS†

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I. INTRODUCTION

THE epidemic of HIV disease has brought about a revival of what may loosely be denominated "public health law," cases concerning state action taken in the name of preventing ill health or promoting good health. Sixty years of gradually diminishing interest in the subject rather abruptly came to an end, and for the past several years commentators and courts have been working out the working out of public health issues in the world of modern law and medicine.

Public health cases take a variety of legal forms.[1] In the age

† Staff Attorney, AIDS & Civil Liberties Project, American Civil Liberties Union of Pennsylvania; Lecturer in Law, University of Pennsylvania Law School; J.D. Yale Law School (1987); B.A. Washington University in St. Louis (1980). The author wishes to thank Susan Carle, Harlon Dalton, Sarah Barringer Gordon, Sung-Hey Lee, A. Brigid A. Rentoul, William Rubinstein and Doreena Wong for their assistance in the preparation of this essay.

1. "Public health cases" have never fallen into a neat doctrinal package. Challenges to such preventative measures as compulsory vaccination, water fluoridation and diagnostic testing, for example, have been grounded in the substantive due process clause, *see, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11 (1905), the free exercise clause, *see, e.g.*, State *ex rel.* Dunham v. Board of Educ., 154 Ohio

of AIDS, developments in both constitutional and statutory law have contributed to an abundance of doctrinal riches. The Constitution protects a broader spectrum of rights than it did when the leading health cases were decided at the turn of the century.[2] Moreover, it is no longer the only source of limitations on the states' police power to protect public health. With the passage of federal statutes dedicated to eliminating discrimination on the basis of handicap, notably section 504 of the Rehabilitation Act of 1973, a whole new set of limitations was placed on those acting in the name of public health, including state and local governments.[3] Cases that once would have been understood as involv-

St. 469, 96 N.E.2d 413, *cert. denied*, 341 U.S. 915 (1951), the fourth amendment, *see, e.g.*, Glover v. Eastern Neb. Community Office of Retardation, 686 F. Supp. 243 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir. 1989), and the equal protection clause, *see, e.g.*, Zucht v. King, 260 U.S. 174 (1922), not to mention more prosaic claims of improper delegation or ultra vires action, *see, e.g.*, Shuringa v. City of Chicago, 30 Ill. 2d 504, 198 N.E.2d 326 (1964), *cert. denied*, 379 U.S. 964 (1965).

Recent decisions relating to the admission to school of children with HIV have turned on the Rehabilitation Act, *see, e.g.*, Doe v. Belleville Pub. School Dist. No. 118, 672 F. Supp. 342 (S.D. Ill. 1987), the Education for All Handicapped Children Act, *see, e.g.*, Martinez v. School Bd., 861 F.2d 1502 (11th Cir. 1988); White v. Western School Corp., No. IP 85-1192-C (S.D. Ind. Aug. 23, 1985), and state administrative law, *see, e.g.*, Board of Educ. v. Cooperman, 209 N.J. Super. 174, 507 A.2d 253 (1986), *modified*, 105 N.J. 587, 523 A.2d 655 (1987). Procedurally, public health cases have arisen as counterclaims in state-initiated proceedings, *see, e.g.*, Board of Educ. v. Maas, 56 N.J. Super. 245, 152 A.2d 394 (1959), *aff'd*, 31 N.J. 537, 158 A.2d 330, *cert. denied*, 363 U.S. 843 (1960), as requests for an injunction against state action, *see, e.g.*, Paduano v. City of New York, 45 Misc. 2d 718, 257 N.Y.S.2d 531 (Sup. Ct.), *aff'd*, 24 A.D.2d 437, 260 N.Y.S.2d 831 (1965), *aff'd*, 17 N.Y.2d 875, 218 N.E.2d 339, 271 N.Y.S.2d 305 (1966), *cert. denied*, 385 U.S. 1026 (1967), as suits for the writ of habeas corpus, *see, e.g.*, Varholy v. Sweat, 153 Fla. 571, 15 So. 2d 267 (1943), as employment discrimination suits, *see, e.g.*, Chalk v. United States Dist. Court, 840 F.2d 701 (9th Cir. 1988), as tax-payer actions, *see, e.g.*, Kraus v. City of Cleveland, 55 Ohio Op. 6, 116 N.E.2d 779 (C.P. 1953), *aff'd*, 55 Ohio Op. 36, 121 N.E.2d 311 (Ct. App. 1954), *aff'd*, 163 Ohio St. 559, 127 N.E.2d 609 (1955), *appeal dismissed*, 351 U.S. 935 (1956), and as defenses in criminal proceedings, *see, e.g.*, *Jacobson*, 197 U.S. 11.

In all these cases, certain obvious definitional criteria are met: the state, in the name of improving public health, has taken action that has aggrieved someone sufficiently to confer standing to oppose the action in court. This "definition" is intentionally tautological. These cases are about public health not because they meet an external standard, or because they are carried out by health officials, but because they are justified with reference to, and actually define, the public health.

2. For example, the right of medical privacy, *see* Whalen v. Roe, 429 U.S. 589 (1977), has been raised in challenges to a variety of health actions. *See, e.g.*, Doe v. Coughlin, 697 F. Supp. 1234 (N.D.N.Y. 1988) (granting preliminary injunction, on privacy grounds, against involuntary transfer of HIV-positive inmates into separate prison dormitory).

3. *See* Rehabilation Act of 1973, 29 U.S.C.A. § 794 (West 1985 & Supp. 1989). The Supreme Court resisted application of the Rehabilitation Act to state governments in Atascadero State Hosp. v. Scanlon, 473 U.S. 234 (1985)

ing state action to protect the public health are now viewed, under the Rehabilitation Act, as cases about the rights of the handicapped.[4] And not just that: they became cases in which state health actions are unabashedly evaluated by objective medical criteria, and in which key policy questions, such as the level of acceptable risk, are taken out of state hands. Similarly, the 1966 holding that blood tests ordered by the government were subject to the fourth amendment[5] created the possibility that case identification through diagnostic testing, an increasingly common public health practice, would fall under yet another legal standard entailing close scrutiny of the medical bases of the state's decision.[6]

There appears to be little doubt that judicial review of health actions under the "new" public health law of the Rehabilitation Act and the fourth amendment, as well as the fourteenth amendment cases in which heightened scrutiny will apply,[7] will entail a specific examination of the medical benefits and social costs of public health actions. But in the confusion of the developing public health law, there remains the important question of the appropriate standard of review of constitutional challenges to public health actions which do not trigger heightened scrutiny.

Two distinct points of view have developed. Following one view, which is derived from careful reading of past public health decisions relating to communicable disease control, courts require health actions to have reasonable medical support and a

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(eleventh amendment bars application of Rehabilitation Act to states), but Congress subsequently overruled *Atascadero* with the enactment of 42 U.S.C. § 2000d-7 (1982 & Supp. V 1987).

4. This development was quietly announced in 1979 in Judge Newman's fine opinion in New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644 (2d Cir. 1979).

5. Schmerber v. California, 384 U.S. 757 (1966).

6. For an introductory description of common public health actions, see Gostin, *Traditional Public Health Strategies*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 47 (H. Dalton, S. Burris & the Yale AIDS Law Project eds. 1987).

7. The application of heightened scrutiny in public health cases has been well-covered in the literature. *See, e.g.*, Gray, *The Parameters of Mandatory Public Health Measures and the AIDS Epidemic*, 20 SUFFOLK U.L. REV. 505 (1986); Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine* 14 HOFSTRA L. REV. 53 (1985); Note, *Reportability of Exposure to the AIDS Virus: An Equal Protection Analysis*, 7 CARDOZO L. REV. 1103 (1986); Note, *Preventing the Spread of AIDS by Restricting Sexual Conduct in Gay Bathhouses: A Constitutional Analysis*, 15 GOLDEN GATE U.L. REV. 301 (1985) [hereinafter Note, *Preventing the Spread*]; Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274 (1986) [hereinafter Note, *Constitutional Rights*]; Comment, *AIDS—A New Reason to Regulate Homosexuality?*, 11 J. CONTEMP. L. 315, 333-38 (1985); *see also* Sullivan & Field, *AIDS and the Coercive Power of the State*, 23 HARV. C.R.-C.L. L. REV. 139 (1988).

public health value that outweighs their cost to individuals. These substantive limitations will be applied openly or covertly by courts without regard to the standard of review normally deemed appropriate to the specific legal claim.

A second view begins in general constitutional law, applying the rational basis test and principles of deference to state political decisions regarding the exercise of the police power. Following this view, courts reviewing constitutional challenges to health actions will, in the absence of any factor triggering a heightened standard of review, use the same test in health cases as in any other challenge under the equal protection or substantive due process clauses.

Each of these views has virtue, but neither provides a sufficient account of both practice and doctrine. There is undoubtedly a tendency in public health cases to look more closely at the actual utility of state actions than is the practice with other kinds of legislative decisions. But whether this is a product of cultural factors (*e.g.*, the attitudes of judges towards health matters), or of superannuated legal doctrines, the fact remains that such an approach lacks a clearly stated doctrinal justification. The Supreme Court, in an important footnote in *School Board v. Arline*,[8] has indicated a preference for the first view, and has perhaps hinted at a proper test, but has not provided a clear explanation of the legal basis for that view.

Each of these views of judicial review treats medical science in general and public health practice in particular as objective sources of neutral standards. Before examining judicial review in action, this essay therefore criticizes the idea of public health as an apolitical science. Indeed, the construction of a vision of public health—as scientific, political, or some hybrid—is a threshold act of enormous importance to any judicial review.

An examination of several prominent public health cases—under the fourth amendment and the Rehabilitation Act as well as the fourteenth amendment—illustrates the apparent impossibility of holding to a purely political vision of public health decisions. Almost invariably there is an appeal to the authority and neutrality of medicine. This, in turn, raises two basic questions about rationality review in public health. The first, which is answered here, is what test is to be applied: a health measure cannot be rationally related to a legitimate state interest unless it has a ra-

8. 480 U.S. 273, 286 n.15 (1987).

tional medical basis. This is a sensible test that does not impair the ability of states to protect public health, but a second question remains: how does this test fit into the framework of general constitutional law? The Court constructed the house of equal protection scrutiny, and it can alter it. A rational medical basis test may be accommodated as heightened scrutiny, or, as this essay suggests, focused scrutiny, or it may be applied without justification at all, but that is simply a matter of the Court's power. The question this essay restates is: why medicine and not, for example, Judge Posner's economic interpretation of law? We are left with a better sense of what courts are to do, and, one hopes, a greater understanding of the judicial reliance on medicine, but the old hard questions about rationality review remain.

II. TWO VIEWS AND FOOTNOTE FIFTEEN

Initial attempts to derive from past public health cases rules for the disposition of modern cases about AIDS focused more on practice than doctrine,[9] leading to the development of what I shall label the "behavioral" view of rationality review.[10] From the obvious fact that the actual value of a public health action did not vary according to the legal theory under which it was attacked, flowed the not unreasonable (though not necessarily acknowledged) assumption that certain basic criteria would and should be applied by courts in review. A substantive, medically-based test was obviously being applied in modern cases under the Rehabilitation Act, but commentators found similar values in past constitutional public health cases. The ad hoc committee on AIDS of the American Bar Association, for example, has summarized these limitations as follows:

> Despite . . . deference to public health decisions, the early public health cases laid down certain substantive limitations on public health powers: (1) the true purpose of the legislation must be public health, not a disguised form of prejudice; (2) there must be some discernable public health necessity supported by scientific evidence or expertise; (3) the control measure itself

9. *See* Current Topics in Law and Policy, *Fear Itself: AIDS, Herpes and Public Health Decisions*, 3 YALE L. & POL'Y REV. 479 (1985) (authored by Scott Burris) [hereinafter Burris, *Fear Itself*].

10. The label is used only because proponents of this view have concentrated on what courts do, rather than upon their legal explanations for their conduct. No reference to behavioralism is intended.

> must not pose a significant health risk; and (4) there must be a reasonable relationship between the measure adopted and the objective of reducing the spread of infectious disease.[11]

Few would dispute that these are minimal requirements any court ought to demand of a public health action. Fewer still would argue that they were not, at one time, requirements that had a basis in law. What remains unexplained is the assertion that these kind of limitations "still survive, and should apply in a contemporary judicial analysis."[12] The behavioral view provides a good account of what courts tend to do in health cases, without explaining why that conduct is doctrinally appropriate today.

The alternative view, which I shall label the "doctrinal" one, is considerably more hard-headed about post-*Lochner* rationality review. It suggests that courts will not distinguish between challenges to health measures and attacks on other state political decisions.[13] Assuming no aspect of a health action triggered a higher level of review, and that a court would find reducing the spread of HIV a proper purpose,[14] we may expect courts to apply a test that asks only whether there exists some conceivable explanation of the state's conduct that can be coherently stated with reference to some state of the world.[15] This is not to say that

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11. ABA AIDS COORDINATING COMM., AIDS: THE LEGAL ISSUES 52-53 (Aug. 1988) (discussion draft) (citing Gostin & Curran, *Legal Control Measures for AIDS: Reporting Requirements, Surveillance, Quarantine, and Regulation of Public Meeting Places*, 77 AM. J. PUB. HEALTH 214 (1987)); *accord* Burris, *Fear Itself*, *supra* note 9, at 496. A leading proponent of this view has been Lawrence Gostin. *See, e.g.*, Gostin, *supra* note 6, at 52-53; *see also* Gostin, *The Future of Public Health Law*, 12 AM. J. L. & MED. 461, 465-68 (1987).

12. Gostin, *supra* note 11, at 468.

13. Professor Merritt's article is the definitive expression of this account. Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U. L. REV. 739 (1986); *see* Note, *Constitutional Rights*, *supra* note 7; *see also* Kushnar, *Substantive Equal Protection: The Rehnquist Court and the Fourth Tier of Judicial Review*, 53 MO. L. REV. 423, 449-50 (1988) ("Government classifications established . . . seeking to protect the public health, such as in the case of quarantine . . . laws, . . . are accorded maximum deference under the rational basis test.").

14. *See* Note, *Constitutional Rights*, *supra* note 7, at 1280.

15. Kadrmas v. Dickinson Pub. Schools, 108 S. Ct. 2481, 2489-90 (1988) (Anyone "challenging the legislative judgment must convince us 'that the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the governmental decisionmaker.' ") (quoting Vance v. Bradley, 440 U.S. 93, 111 (1979)). *See also* Bowen v. Owens, 476 U.S. 340, 348 (1986); Spece, *AIDS: Due Process, Equal Protection, and the Right to Treatment*, 4 ISSUES L. MED. 283, 286-88 (1988) (summarizing due process and equal protection analysis in health law context). *See generally* 2 L. ROTUNDA, J. NOWAK & J. YOUNG, TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE AND PROCEDURE § 18.3,

courts in health cases will not go about defining rationality in precisely the manner described by the behavioralists. Arguably, something like that happened in the case of *City of Cleburne v. Cleburne Living Center*.[16] But the problem of justifying dentures for a standard designed to be toothless is not for the doctrinalist to solve. The doctrinal view simply suggests that the barriers to substantive review built into the rational basis test will not deliberately be lifted in health cases.

Neither the behavioral nor the doctrinal view provides a satisfactory account of both law and practice. Under the behavioral view, we would expect a court applying the rational basis test to engage in substantive, context-specific scrutiny of a challenged health measure, a serious departure from doctrinal propriety. Yet the doctrinal view, which would treat communicable disease control in the same manner as, say, the regulation of street vendors,[17] does not address the gravitational force of the new public health law, and does not recognize the degree to which courts in traditional public health cases have in fact tested the specific rationality of challenged health measures.[18] The behavioral view thus provides the best account of what actually happens in health cases, while the doctrinal view jibes with the legal rules that, without more, one would expect to apply.[19]

The Supreme Court appears now to have indicated a prefer-

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at 330 (1986) (discussing rationality review); L. TRIBE, AMERICAN CONSTITUTIONAL LAW §§ 16-2 to -3 (2d ed. 1988) (same).

16. 473 U.S. 432 (1985) (invalidating, as applied under minimal scrutiny, zoning ordinance requiring special use permit for group home for mentally retarded); *see* Merritt, *supra* note 13, at 783; *see also* Gostin, *supra* note 11, at 471 (discussing *Cleburne*-style rational basis testing in health cases). *Cleburne* stands as the prime example of what Professor Tribe calls "covertly heightened scrutiny"—penetrating judicial examination cloaked in the rhetoric of extreme deference. *See* L. TRIBE, *supra* note 15, § 16-3, at 1443-44.

An alternative view to Professor Tribe's is that *Cleburne* openly requires some enhancement (or, as I shall characterize it, focusing) of scrutiny. And, indeed, one court of appeals has read *Cleburne* as specific justification for "a more searching inquiry" in cases involving physical or mental handicaps. Brennan v. Stewart, 834 F.2d 1248, 1259 (5th Cir. 1988).

17. *See* City of New Orleans v. Dukes, 427 U.S. 297 (1976).

18. This is not to say that courts never apply a standard rational basis test in health cases, but only that it is rare. For a particularly troubling example of rationality review, see Doe v. Coughlin, 71 N.Y.2d 48, 518 N.E.2d 536, 523 N.Y.S.2d 782 (1987) (denial of conjugal visits to inmate with AIDS), *cert. denied*, 109 S. Ct. 196 (1988). *See also* New York Soc'y of Surgeons v. Axelrod, 200 N.Y.L. J. No. 96, at 29 (Sup. Ct. 1988) (rejecting plaintiff's attempt to force state health official to declare HIV a transmissible disease).

19. One need not believe that legal rules are determinate in order to take the equal protection doctrine seriously. A judge's desire to follow the rules, or her belief that she is doing so, invests the rules with enough determinacy to

ence for the behavioral view, without addressing the questions raised by the doctrinal account. In *School Board v. Arline*,[20] the Court held that contagious diseases could be handicaps under section 504 of the Rehabilitation Act, which prohibits discrimination against the handicapped in programs or activities receiving federal funds. As I will discuss in more detail,[21] scrutiny under the Act is close, based on the congressional mandate that decisions limiting the access of the handicapped to the amenities of modern life rest on valid medical considerations, rather than abstract fears or prejudice.

Because the Act applies to state health decisions that once were subject only to constitutional challenges, some argued that extending the Act to cover communicable diseases would conflict with traditional state prerogatives to address health threats under the police power.[22] Several states, joining California's amicus brief, disagreed, contending among other things that most health actions do not involve discrimination (*e.g.*, uniform school vaccination requirements), or were already substantially limited by the Constitution (*e.g.*, quarantine).[23] The brief, which had adopted the behavioral account,[24] concluded that little, if any, conflict would arise between review under the statute and under the Constitution:

> [A]llowing a cause of action to be maintained does not mean that exclusions based on demonstrable and supportable medical concerns will not ultimately be upheld. It simply subjects such decision [sic] to scrutiny and allows those which are not or cannot be supported to be set aside. If Section 504 were invoked to preclude ac-

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attract the attention of an attorney whose success in a constitutional health case is contingent upon a judge's willingness to examine the medical facts.

20. 480 U.S. 273 (1987).

21. *See infra* notes 47-65 and accompanying text.

22. *See, e.g.*, Brief for the United States as Amicus Curiae at 16-17, School Bd. v. Arline, 480 U.S. 273 (1987) (No. 85-1277).

23. Brief of the State of California joined by Maryland, Michigan, Minnesota, New Jersey, New York and Wisconsin as Amici Curiae at 25-28, School Bd. v. Arline, 480 U.S. 273 (1987) (No. 85-1277).

24. The amici wrote:

> Generally speaking, [public health actions] have been upheld where public health officials can demonstrate a public health necessity, that is, the existence of a public health problem and at least a rational and demonstrable relationship, based on medical evidence, between the means chosen and the problem. Where individual liberty is restrained, the least restrictive alternative must also be chosen.

Id. at 28 (citing Burris, *Fear Itself*, *supra* note 9, at 488-95).

> tions by health officials which were based on irrational, uninformed or medically unsupportable distinctions, the public interest would be furthered not hindered.[25]

The Court agreed with California:

> Construing section 504 not to exclude those with contagious diseases [from its protection] will complement rather than complicate state efforts to enforce public health laws. . . . [C]ourts may reasonably be expected normally to defer to the judgments of public health officials in determining whether an individual is otherwise qualified unless those judgments are medically unsupportable. Conforming employment decisions with medically reasonable judgments can hardly be thought to threaten the States' regulation of communicable diseases.[26]

That sounds right, which is one of the chief virtues of the behavioral account. Public health decisions are substantially medical in character and ought to be made on a *medically* rational basis. Certainly, too, there would be little to be said for an approach that found a health action to be based on irrational prejudice under the Rehabilitation Act but rationally related to a legitimate state interest for constitutional purposes. But, as the doctrinal view makes clear, decisions being reviewed under the rational basis test have been required only to be *constitutionally* rational, a species of rationality having more to do with logic than experience. This theory of review, designed to respect the prerogatives of state decisionmakers to take action on any not patently illegitimate basis, theoretically does not require any consideration of medical facts at all.

In previous opinions under the Act, at least two courts of appeals had perceived a conflict between the kind of review appropriate under the Act and the rational basis test.[27] In a 1983 case, the Third Circuit allowed that officials

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25. *Id.* at 29.

26. *Arline*, 480 U.S. at 286 n.15. The Court went on: "Indeed, because the Act requires employers to respond rationally to those handicapped by a contagious disease, the Act will assist local health officials by helping remove an important obstacle to preventing the spread of infectious disease: the individual's reluctance to report his or her condition." *Id.*

27. *See* Strathie v. Department of Transp., 716 F.2d 227, 231 (3d Cir. 1983); New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644, 648-49 (2d Cir. 1979).

> surely are entitled to some measure of judicial deference . . . by reason of their experience with and knowledge of the program in question. On the other hand, broad judicial deference resembling that associated with the 'rational basis' test would substantially undermine Congress' intent in enacting section 504 that stereotypes or generalizations not deny access to federally-funded programs.[28]

In suggesting that there not only is no serious conflict between the standards applicable under the Act and the Constitution, but also that constitutional scrutiny is coextensive with the close analysis of the Act, Justice Brennan at a stroke adopted the behavioral position in toto, and, in the process, identified a substantive requirement of medical reasonableness in a class of decisions which, at least in theory, were previously subject only to a general test of hypothetical rationality.

III. THE HEALTH DECISION: AS IS, AND AS SEEN

Underlying the behavioral and doctrinal accounts are fundamentally different constructions of what the public health case concerns. At the core of the behavioral account of public health review is the recognition that these cases, whether under the fourteenth amendment, the fourth amendment, or the Rehabilitation Act, are all *about* the same sort of thing—the adoption of a measure to protect public health. Implicit are the notions that it matters how well the particular measure will serve the goal of protecting public health; that its adequacy will be the chief issue in a legal challenge; and that this issue will be decided principally as a matter of medical judgment. A doctrinalist, however, is bound to the view that any serious consideration of the actual value of a health measure is inappropriate in modern rational basis review. A decision to exercise the police power to protect the public health is an essential act of state sovereignty, involving important political choices. Unless it is utterly arbitrary and irrational, the court has no role to play. The deferential standard of review keeps the federal courts out of the business of second-guessing these legislative determinations by presuming their correctness and accepting virtually any logical justification in their support. The health case is not about the value of a health measure, but the state's unhindered political freedom.

28. *Strathie*, 716 F.2d at 231 (footnotes and citations omitted).

The behavioral account is baldly anti-majoritarian. The doctrinal view partakes of the tautology inherent in modern rationality review. Both avoid their theoretical extremes by appealing to science as an objective measure. The behavioralists treat medicine as apolitical. The doctrinalists will use medical science as the neutral tool for justifying a decision that an action is arbitrary and irrational. While I confess that I can come up with no better standard, the heavy burden science bears in both accounts of judicial review makes it worth our while to consider briefly the nature of the decisions being reviewed and how these decisions are or may be conceived of by courts.

Public health is the science of organizing social resources against medical threats to the population. Public health decisions are virtually always rooted in the science of medicine. They refer to diseases whose natural history is or has been the subject of medical study, to complex diagnostic or treatment technologies, and to highly informed professional speculation in areas of experiment or pure uncertainty.

Although rooted in medical science, the science of public health operates in the translation of medical facts, assumptions and educated guesses into programs that promote physical well-being on a broad scale. Its practice, therefore, requires expertise not just in disease, but also in social responses to disease. In the AIDS epidemic, for example, developing a program of antibody testing required public health officials both to quantify the accuracy of the available testing procedures, and to assess how various testing regimes—anonymous, confidential, or mandatory—would be received among those whose testing would be of benefit to public health.[29] Yet, even if decisions of that sort are not "technical" or "scientific" in a narrow sense, there are meaningful differences between such decisions as made by lay people and those that are informed by professional values of objectivity, quantification, neutrality, and the careful delineation of uncertainty.

As a cultural matter, our mistrust of experts coexists with a belief in the miraculous power of science to cure the sick and protect the healthy. Decisions can credibly be assigned to "experts" working within a scientific model on the basis of their supposed

29. *See, e.g.*, R. BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES 104-23 (1989); Letter to the Editor, *Mandatory Reporting of HIV Testing Would Deter Men from Being Tested*, 261 J. A.M.A. 1275 (1989); W. Johnson, F. Sy & K. Jackson, The Impact of Mandatory Reporting of HIV Seropositive Persons in South Carolina (June 12, 1988) (unpublished paper presented at IV International Conference on AIDS, Stockholm).

neutrality: trained public health professionals, it is thought, avoid decisions based on social, racial or interest group passions in favor of quantifiable, utilitarian, "objective" goals and considerations.

Yet, despite its kindly aura of white-coated technocracy, "public health" is a highly political construct. In the broadest sense, public health decisions are "political" in that the very understanding of a health problem, even if addressed in the terms of science, is infused with value judgments. Public health, like illness, can be a metaphor.[30] For instance, the perceived seriousness of a threat is frequently a function of the social subgroup the disease threatens, a phenomenon of which AIDS has provided a prime example. It took the federal government quite a bit longer to recognize the HIV epidemic as a health emergency than to grasp the seriousness of Legionnaire's Disease, largely because of the perception of AIDS as a "gay plague."[31] As AIDS becomes a

30. *See generally* S. SONTAG, AIDS AND ITS METAPHORS (1988) (discussing social construction of AIDS through verbal imagery). Allen Brandt has described one instance in the historical record of a disease whose natural history was adjusted in order to accommodate social needs: unwilling to implicate the middle class in fornication, doctors identified pens, doorknobs, drinking cups and toilet seats as vectors for the transmission of syphilis. An entire variety of the disease, *venereal insontium*—venereal disease of the innocent—was invented. "The distinction between venereal disease and venereal insontium, of course, had the effect of dividing victims: some deserved attention, sympathy, and medical support, others did not. By determining how the infection was obtained, doctors separated victims into the 'innocent' and the 'guilty.' " Brandt, *A Historical Perspective*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 37, 38 (H. Dalton, S. Burris & the Yale AIDS Law Project eds. 1987); *see* S. SONTAG, *supra*, at 53-55; *see also* Musto, *Quarantine and the Problem of AIDS*, 64 MILBANK Q. 97, 108 (Supp. 1 1986).

> The fear of a disease . . . arises not just from a reflection of the physiological effects of a pathogen, but from a consideration of the kind of person and habits which are thought to cause or predispose one to the disease. Likewise, quarantine is a response not only to the actual mode of transmission, but also to a popular demand to establish a boundary between the kind of person so diseased and the respectable people who hope to remain healthy.

Id.

31. R. SHILTS, AND THE BAND PLAYED ON 101, 109-10, 143-44, 186 (1987). Shilts describes one measure of the fiscal response to AIDS, derived from a Congressional Research Service comparative report:

> The report found that in 1982, the National Institutes of Health's research on Toxic Shock Syndrome, a mystery that had by then been solved, amounted to $36,100 per death. NIH Legionnaire's spending in the most recent fiscal year amounted to $34,841 per death. By contrast, the health institute had spent about $3,225 per AIDS death in fiscal 1981 and $8,991 in fiscal 1982. By NIH calculations, the life of a gay man was worth about one-quarter that of a member of the American Legion.

Id. at 186.

disease of the urban underclass, a further decay in the general level of urgency is detectable.[32]

Medical decision makers are as prone as anyone else to biases based on race, class and other characteristics. Moreover, the medical culture has its own imperatives, and may overvalue, for example, physicians' interests in professional autonomy to the detriment of the public interest in informed consent and control of private medical information. In any event, simply deciding whether or not to act against a health problem, much less selecting from among remedial options, inevitably requires essentially political judgments about the allocation of social resources, the importance of human lives and human rights, and the relative costs of different kinds of physical and emotional suffering.

Health officials, for instance, must assess the degree of danger posed by a health threat, but there is no objective scale for weighting the identified costs. While it may be possible to predict the death toll of one disease and the prevalence of another, there is no equation for comparing them in seriousness. Is a disease that kills ten people per year a more serious health problem than one that cripples one hundred? The possible effects of a proposed remedy—swine flu vaccine, for example—may be uncertain. On what "scientific" basis does a health professional elect to proceed with a large scale program despite the risk to those vaccinated? Similarly, a health measure such as pre-marital testing for HIV might be compared to an education and intervention program targeted at drug abusers through the use of a cost-benefit analysis, but the decision that various remedies should be analyzed according to the amount of money spent per life saved presupposes a political decision that all lives are equally valuable. Among the relevant "costs" of a remedy will often be its impact on individual rights. By what measure does a scientist compare the intrusiveness of a blood test with a .002% reduction in mortality?

Even among those who agree on the general seriousness of a disease such as AIDS, identifying specific threats against which to take action reflects prior choices of values or methodologies. Health decisions, after all, are not always made by health officials. Many traditional public health tools, such as compulsory contact

32. In *Illness as Metaphor*, Susan Sontag described the mental process by which social fear of a serious disease was addressed by stigmatizing those who contracted it. S. SONTAG, ILLNESS AS METAPHOR (1978). Conceiving of AIDS as a punishment for drug use, poverty, or being a minority, creates a zone of safety for the "general population" in which indifference to the epidemic can prosper.

tracing or pre-marital screening, are disfavored by public health experts, but have lost none of their lustre in the eyes of the general public and its legislators.[33] Prostitutes have not been found to be major vectors for HIV transmission in the United States, and so have received relatively less attention as a target for public health intervention than gay men and IV drug abusers.[34] Among many legislators, however, prostitutes, as archetypal "incorrigible" disease transmitters, have been regarded as a major public health threat, either because of an unsupported belief that they constitute a significant reservoir of infection or the conclusion that even a small amount of new AIDS attributable to prostitutes is unacceptable and ought to be prevented.[35]

Normal political rules are fully applicable in the area of public health. Public health measures may be enacted for no other reason than to satisfy a well-organized interest group. Exemplary are provisions requiring the notification of ambulance workers and other emergency medical personnel that an individual they have already cared for has HIV disease.[36] Measures may be passed purely because of their symbolic value. Pre-marital

33. The potential for conflict between lay and professional approaches to disease control has never been greater. Arguably, the AIDS epidemic begins a new era in public health practice, with its emphasis on cooperation rather than confrontation between public health authorities and those affected by a communicable disease. *See generally* R. BAYER, *supra* note 29 (describing political and social aspects of public health effort against AIDS). Before the development of the germ theory of disease transmission, public health practice was, at best, "crudely empirical," W. MCNEIL, PLAGUES AND PEOPLES 209 (1976), based on identifying and in some manner isolating the sick. *See* Musto, *supra* note 30, at 97. This approach to disease continues to be attractive to a large number of people, if not a majority. *See generally* Blendon & Donelan, *Discrimination Against People with AIDS: The Public's Perspective*, 319 NEW ENG. J. MED. 1022 (1988) (reporting poll results).

34. Rosenberg & Weiner, *Prostitutes and AIDS: A Public Health Priority?*, 78 AM. J. PUB. HEALTH 418 (1988); Seidlin, Krasinski, Bebenroth *et al.*, *Prevalence of HIV Infection in New York Call Girls*, 1 J. AIDS 150 (1988).

35. *See, e.g.*, ILL. ANN. STAT. ch. 38, para. 1005-5-3(g) (Smith-Hurd 1982 & Supp. 1988); R.I. GEN. LAWS § 11-34-10 (1981 & Supp. 1988); S.C. CODE ANN. § 16-15-255 (Law Co-op. 1985 & Supp. 1988), WASH. REV. CODE ANN. § 70.24.340(3) (Supp. 1989). *See generally* Gostin, *Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States*, 261 J. A.M.A. 1621 (1989) (summarizing state law). This is consistent with the historical pattern: in the great move against venereal diseases in the period of the First World War, thousands of prostitutes (but few johns) were detained and quarantined on the pure presumption that they were diseased. Brandt, *supra* note 30, at 40-41.

36. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1797.188 (West 1979 & Supp. 1989); ILL. ANN. STAT. ch. 111½, para. 147.08 (Smith-Hurd 1988); R.I. GEN. LAWS § 23-28. 36-3 (Supp. 1988). *See generally* Gostin, *supra* note 35 (summarizing state laws).

screening for HIV antibodies is an example. Notwithstanding the fact that screening would do little against the overall epidemic except divert scarce resources from more effective measures,[37] its potential for identifying "innocent" people (like unwitting female partners of secretly bisexual or drug-abusing males), and its symbolic placement of AIDS in the same class as other sexually transmitted diseases, created a strong base of political support.[38]

Obviously, there is a considerable overlap between the medical and political elements of public health decisions. There are good reasons for placing these decisions in the hands of those who have been trained to make them, and for requiring, as would the behavioralist, that health decisions make medical sense. But giving a decision to a technician does not make it a technical one. Ultimately, there is no absolute distinction between the medical and the political in health decisions. Instead, the concepts represent different ways of understanding the same phenomena, and choosing one or the other is an act of privileging, not of description. In this sense, the most important step in the review of public health decisions is deciding whether they should be characterized as "political," "medical" or a hybrid of both. In the remainder of this part, I will offer three simple models of the health decision available to courts.[39]

Those who view the public health decision as entirely committed to the political branches of government would be expected to adopt what we may call a classic "legislative" view. According to this account, decisions are formed in a melting pot of horse-

37. *See* R. BAYER, *supra* note 29, at 145-46. The high cost of identifying cases through pre-marital screening had fueled a trend to ending pre-marital screening for venereal disease. Gostin, *supra* note 6, at 56.

38. As Ron Bayer described it:

> That . . . premarital screening would target populations with very low levels of HIV infection, and that the pattern of premarital sexual relations in the United States made it unlikely that uninfected partners could be protected by screening that occurred just prior to marriage mattered less to the proponents of such a policy than the symbolic significance of attempting to take any measure necessary to protect the uninfected. The vision of women at the mercy of men who either wittingly or not could infect them and the specter of infants born with AIDS as the result of such unions—both of which had informed antivenereal campaigns of the 1930s and 1940s—provided the impetus behind calls for HIV antibody screening prior to marriage.

R. BAYER, *supra* note 29, at 145.

39. Much of the following is derived from Rodgers, *Judicial Review of Risk Assessments: The Role of Decision Theory in Unscrambling the Benzene Decision*, 11 ENVTL. L. 301 (1981). *See also* Diver, *Policymaking Paradigms in Administrative Law*, 95 HARV. L. REV. 393 (1981) (analyzing judicial models of administrative decisionmaking).

trading, compromise, interest-group pressure, political symbolism, parliamentary maneuvering, expertise, ignorance and sleep deprivation—in other words, anything may go into the decision as long as the outcome is not blatantly discriminatory or unmistakably out of touch with reality. Under this view, one might openly conceive of a health decision as having nothing to do with the "real" medical facts, assuming such animals exist. A problem might be targeted for action because it appears to pose a serious risk to health or because it affects a powerful community, like emergency medical workers. A remedy might be chosen because it is medically effective, or because it has considerable political symbolism, like pre-marital testing. Problems are identified, remedies evaluated (or not) and actions selected by the rules of normal political practice. Thinking about decisions medically, or conforming selections to medical advice, is entirely optional (which is not to say that legislators will not claim that their political decisions are based on medical imperatives). In a legislative model, leaving aside the antidiscrimination principle, there are no independent substantive limitations enforceable through judicial review. As long as a health decision is justifiable on some ground, there is no need to show that the decision was made in reliance upon or in conformity with medical judgment.

At the other extreme is the "scientific" model, in which health decisions are conceived of as highly technical, based as much as possible upon objective medical evidence, and carried out within a professional methodology in which the action ultimately selected is closely correlated with the underlying medical facts. A decision of this sort "to a large degree depend[s] upon the identification of alternatives, the projection of consequences, and the conscious selection of a 'best' decision."[40] Such a decision is based on "hard" data, on cost-benefit analysis, and on risk analysis. This model of the decision finds objectivity and other scientific values not merely in the technical nature of the issues addressed, but also in the process in which they are addressed. Political and other non-technical considerations are not necessarily excluded from consideration. If considered, however, they are objectified as much as possible and, of course, they are considered within a deliberately non-political process. This is arguably, the model of section 504.[41]

40. Rodgers, *supra* note 39, at 310; *cf.* Diver, *supra* note 39, at 396-97 (describing model of "comprehensive rationality").

41. *See infra* notes 47-65 and accompanying text.

The inevitable middle-ground is occupied by a hybrid model, which delineates decisions resolvable on medical grounds and those better decided politically. The essential characteristic of this model in the public health sphere is the explicit recognition of a relationship of limitation between the political and medical worldviews. The nature of these limitations is a variable, an arbitrary but essential premise. Thus, in one version of the hybrid decision model, the political places limitations on the medical (*e.g.*, public health officials are empowered to take such action as their professional training dictates, subject to living within a budget); or the opposite may be the case (*e.g.*, politicians may choose public health actions on any ground they like, but may only choose from among those actions that are medically justifiable). This, I think, is the model suggested in the behavioral account of rationality review.[42]

We can see, even from this brief discussion, that what public health "is" has no necessary connection to the style of its depiction for purposes of judicial review. In describing health decisions, we make fundamental choices about diseases and disease control. As we look at the cases that follow, these rough models will help us see those choices being made.

IV. CASES

For the behavioralist, the rationality of a challenged health action depends on whether it is, in fact, medically reasonable in public health terms. The appropriate standard of review, whether it comes from law or a judge's cultural attitudes, is at least a hybrid, if not entirely scientific one. For the doctrinalist, the issue is simply whether the state can provide any coherent explanation for what is seen as a legislative decision. In this part, I examine

42. *See infra* notes 155-56 and accompanying text. If we ultimately accept the view that the line between the political and the medical is artificial, then, of course, we must hold that all that is ever happening in the world is some variation of the hybrid model. One could well argue, for example, that standard rational relationship review adopts a hybrid model, with the minimal necessity of a logical connection between means and ends constituting a limitation on the political. This misses the point, however, because the key issue on review of a decision on any model is not the existence of a limitation (which inheres in the very idea of judicial review) but the nature of that limitation. Moreover, it is well to note that there is no requirement in the legal system that the formal model of the decision being reviewed bear any relationship to the actual decision-making process, so that the fact that all health decisions are ultimately composed of both medical and political elements does not compel the judicial use of a hybrid model.

the scientific model selected in *School Board v. Arline*[43] and *Glover v. Eastern Nebraska Community Office of Retardation*,[44] two cases of the new public health law, and compare those choices with the model used in *Jacobson v. Massachusetts*[45] and *City of New York v. New Saint Mark's Baths*,[46] a pair of traditional public health cases. While this will not tell us what courts ought to do, it will give us a clearer way of talking about what they do do.

A. *All Science by Law*

School Board v. Arline began with the decision of a local school board to fire a teacher with chronic tuberculosis. Although the Supreme Court majority did not mention it, the board claimed that its decision fulfilled, as the court of appeals put it, an "overriding duty to protect the public from contagious diseases."[47] The teacher, Gene Arline, sought relief under section 504 of the Rehabilitation Act,[48] which proscribes discrimination on the basis of handicap against people who are "otherwise qualified" to participate in a federally-funded program or activity, or who would be qualified if the discriminator made a reasonable accommodation to the person's special needs.[49] Two questions were addressed: whether the Act applied to people with contagious

43. 480 U.S. 273 (1987).

44. 686 F. Supp. 243 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir. 1989).

45. 197 U.S. 11 (1905).

46. 130 Misc. 2d 911, 497 N.Y.S.2d 979 (Sup. Ct. 1986).

47. Arline v. School Bd., 772 F.2d 759, 761 (11th Cir. 1985), *aff'd*, 480 U.S. 273 (1987); *cf.* New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644, 648 (2d Cir. 1979) (discussing inherent conflict between requirements of Act and traditional authority of school officials to protect students' health).

48. 29 U.S.C. § 794 (1982).

49. As in any discrimination case, the burden of proof ultimately rests with the plaintiff. She must prove: (1) that she is handicapped as that is defined by the Act; (2) that she is otherwise qualified for participation in the program or activity; (3) that she is being excluded solely because of her handicap; and (4) that the program or activity receives federal funds. Doe v. New York Univ., 666 F.2d 761, 774-75 (2d Cir. 1981). The order of proof is usually thought to track that of Title VII cases, *see, e.g.*, Norcross v. Snead, 755 F.2d 113, 116-17 (8th Cir. 1985), although reasonable accomodation to the unique qualities of § 504 has sometimes been made. *See Doe*, 666 F.2d at 776-77. If a person is not otherwise qualified, the court must also determine that no "reasonable accommodation" would make the person so. *See, e.g.*, Martinez v. School Bd., 861 F.2d 1502, 1506 (11th Cir. 1988). An accommodation of the handicap is "reasonable" so long as it does not impose "undue financial and administrative burdens," Southeastern Community College v. Davis, 442 U.S. 397, 412 (1979), or require "a fundamental alteration in the nature of the program." *Id.* at 410; *see generally* 45 C.F.R. § 84.12(c) (1988) (listing relevant factors for determining reasonableness of accommodation).

diseases at all, and, if so, what standards were appropriate to determine whether such a person was "otherwise qualified."

The Court held as to the first question that there was no doubt that contagious diseases could be handicaps under the Act. Indeed, the methods and purposes of the Act made its application to contagious diseases particularly apt. The goal of section 504, the Court explained, was to "protect[] handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear."[50] Noting that Congress had found "that society's accumulated myths and fears about disease are as handicapping as are the physical limitations that flow from actual impairment,"[51] the Court observed that "[f]ew aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness."[52] The Act, therefore, required federal grantees—and judges—to "replace . . . reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments."[53]

One's sense that the Court was adopting (or discerning) a "scientific" model of the health decision is enhanced by the Court's test for determining whether an individual handicapped by a contagious disease is "otherwise qualified." Having decided, literally in passing, that the Act does not allow discriminatory health actions unless the target poses at least a significant risk to the public health[54] (an important point to which I will return at length in Part V), the Court instructed the district judge on remand to determine himself whether Gene Arline posed such a threat. The Court emphasized that an individualized medical inquiry and findings of fact were necessary "if § 504 is to achieve its goal,"[55] and, quoting verbatim from the amicus brief of the

50. *Arline*, 480 U.S. at 287.

51. *Id.* at 284.

52. *Id.*

53. *Id.* at 284-85. Congress ratified *Arline*'s explanation of congressional intent in the Civil Rights Restoration Act. Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, § 9, 102 Stat. 28, 31-32 (1988) (codified as amended at 29 U.S.C.A. § 706(8)(c) (West Supp. 1989)).

54. *See Arline*, 480 U.S. at 287 n.16; *accord* Chalk v. United States Dist. Court, 840 F.2d 701, 707-08 (9th Cir. 1988); Martinez v. School Bd., 861 F.2d 1502, 1506 (11th Cir. 1988). This had obviously been the view of earlier cases. *See, e.g.*, New York State Ass'n for Retarded Children v. Casey, 612 F.2d 644 (2d Cir. 1979); Kampmeier v. Nyquist, 553 F.2d 296 (2d Cir. 1977); District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986); *see also* Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health and Civil Liberties*, 49 OHIO ST. L.J. 1017, 1020-21 (1987) (concept of significant risk "well recognized" in public health law).

55. *Arline*, 480 U.S. at 287.

American Medical Association (A.M.A.), it instructed the district court that the risk assessment should be derived from

> [findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.[56]

"In making these findings," Justice Brennan added, "courts should normally defer to the reasonable medical judgments of public health officials."[57]

As interpreted by the Court, the Act imposes upon the judiciary an obligation to employ a scientific model of the health decision, which in turn requires states to justify health decisions covered by the Act on a strictly medical basis.[58] The inquiry is designed to find the "right" medical conclusion, with the assumption being that trained health professionals are the ones to make it. The judge is supposed to use the same criteria as the A.M.A. would, minimizing the problems inherent in her lack of medical training by maximizing her deference to health professionals. Non-medical considerations are either to be excluded or folded into the "scientific" model.[59]

Arline is deferential to public health officials, but in a new and interesting way. Notwithstanding the Court's view that deference

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56. *Id.* at 288 (quoting Brief of American Medical Association as Amicus Curiae at 19, School Bd. v. Arline, 480 U.S. 273 (1987) (No. 85-1277)).

57. *Id.*; *accord Chalk*, 840 F.2d at 708.

58. *See Arline*, 480 U.S. at 287. The Court also noted:

> The fact that *some* persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act *all* persons with actual or perceived contagious diseases. Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were 'otherwise qualified.' Rather, they would be vulnerable to discrimination on the basis of mythology—precisely the type of injury Congress sought to prevent.

Id. at 285 (emphasis in original).

59. Beyond the scope of this article but well worth keeping in mind is the problem of prior findings of medical fact being treated as binding precedent by courts even after the facts have changed. For an excellent discussion of this problem, see Pine, *Speculation and Reality: The Role of Facts in Judicial Protection of Fundamental Rights*, 136 U. PA. L. REV. 655 (1988).

to health officials all but eliminates any potential for conflict between the Act and traditional public health law, the fit is not nearly so neat. In adopting a "scientific" model of the decision, the Court has moved its deference from the selection of policy, where it principally resides in constitutional cases, to the assessment of case-specific facts. This entails a drastic reduction in the range of decisions to which a court will defer. Rarely in a health case is there a dispute about the natural history of health threat; even in AIDS cases, disputes of fact have not gotten past the dubious question of uncertainty—whether or not there are as yet unidentified routes of transmission.[60] In practice, given the precision of medicine, the case will turn on policy decisions made with reference to essentially undisputed facts.[61] The real dispute between Arline and her employers did not concern the duration, transmission, and severity of tuberculosis—questions upon which a medical consensus could be readily achieved—but was over the acceptability of whatever level of risk she was determined to present.[62] This is a question that does not become medical merely

60. *See, e.g., Chalk*, 840 F.2d at 707; Ray v. School Dist., 666 F. Supp. 1524, 1530, 1535 (M.D. Fla. 1987).

61. Under the *Arline* approach, health officials become technical advisors providing raw material for the judicial policy-implementation process. This distinction between doctors as technicians and doctors as policy-makers had already been recognized in an early line of decisions dealing with school rules preventing children with various physical impairments from playing sports. In rejecting doctors' *conclusions* about whether the children should be allowed to participate, courts differentiated between physicians' philosophical judgments about the value of playing sports and their assessments of the actual risk of the children's doing so. *See, e.g.*, Grube v. Bethlehem Area School Dist., 550 F. Supp. 418, 423 (E.D. Pa. 1982).

This distinction was also at work in *Arline*. Justice Rehnquist, dissenting, pointed out that the school officials who had initiated Arline's termination had relied on a private doctor's medical advice. 480 U.S. at 291 n.3 (Rehnquist, J., dissenting). The majority ignored this, going so far as to state that the case did not present the question of whether a court should defer to the medical opinion of a private doctor. *Id.* at 288 & n.18. Clearly, the question was not deemed presented because the physician made findings of law-policy—"philosophical" judgments—rather than findings of fact. In *Chalk*, a similar AIDS case following *Arline*, the converse situation arose. A teacher was barred from the classroom despite the school board's doctor's recommendation that he be cleared for normal duty. *Chalk*, 840 F.2d at 703-04. The court of appeals did not order his reinstatement in deference to the physician's conclusion, but instead evaluated the medical evidence itself and applied the *Arline* test. *Id.* at 705-09.

62. This is particularly true in Rehabilitation Act cases, where the plaintiff has to prove what in another public health case he might well be disputing: that he has a communicable disease serious enough to limit him in one or more major life activities. *See* 45 C.F.R. § 84.3(j)(2) (1988) (defining "handicapped person" for purpose of Rehabilitation Act). On remand in *Arline*, for example, there was virtually no dispute on any of the medical issues involved in the "otherwise qualified" analysis. Arline v. School Bd., 692 F. Supp. 1286 (M.D. Fla. 1988).

because it is placed in medical hands. Yet, this basic policy decision has already been made: the Act requires that a teacher may not be prevented from pursuing her career unless she presents a significant risk as measured by medical standards.[63]

Under the Rehabilitation Act the notion of the state's police power to protect the public health being an essential attribute of state political sovereignty disappears. In *Arline*, the Court reconceptualized the state's interest in preventing the spread of disease—generally regarded as the archetypal "compelling state interest" withstanding the strictest level of scrutiny[64]—as a "legitimate concern[]" about "avoiding exposing others to significant health and safety risks."[65] Undoubtedly this is a sensible characterization of the state's public health role, one that would be shared by the vast majority of reasonable public health officials. Obviously, too, it furthers the remedial intent of the Rehabilitation Act. It is, in any event, within Congress' authority to impose such a requirement upon the states. But one cannot say, without more, that this creates no conflict with the state's authority to make public health decisions as previously limited only by the Constitution.

B. *All Science by Choice*

The *Glover*[66] case arose out of the decision of the governing board of the defendant Eastern Nebraska Community Human Services Agency (ENHSA), a state agency providing residential care for the developmentally disabled, to address a perceived risk of transmission of communicable diseases from staff to clients. After one employee died of AIDS, and two clients tested positive (falsely, it turned out) for HIV antibodies,[67] the board voted to require employees in positions involving extensive client contact to undergo testing for Human Immunodeficiency Virus (HIV), hepatitis B virus (HBV) and tuberculosis (TB).[68] The testing was challenged as an unreasonable search and seizure.

63. For a more detailed discussion of risk issues, see *infra* notes 130-54 and accompanying text.

64. *See* Note, *Constitutional Rights*, *supra* note 7, at 1280; *see also* Doe v. Coughlin, 71 N.Y.2d 48, 56, 518 N.E.2d 536, 541-42, 523 N.Y.S.2d 782, 788 (1987) (state interest obviously "substantial"), *cert. denied*, 109 S. Ct. 196 (1988).

65. *Arline*, 480 U.S. at 287.

66. Glover v. Eastern Neb. Community Office of Retardation, 686 F. Supp. 243 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir. 1989).

67. *Id.* at 247.

68. *Id.* at 245. The regulation also required employees to inform their employer of any knowledge or suspicion they might have of their own infection with

The Supreme Court has said that "the over-riding function of the Fourth Amendment [is] to protect personal privacy and dignity against unwarranted intrusion by the state."[69] A search is required to be "reasonable under all the circumstances,"[70] the test focusing on whether the search was "justified at its inception" and whether, as actually conducted, it was "reasonably related in scope to the circumstances which justified the interference in the first place."[71] This all reduces to a balancing of competing interests, in which the state's obligation and authority to protect the public health becomes an "interest" to be weighed against the cost of the intrusion on individual rights.[72]

The leitmotif of the analysis is "reasonableness," a quality which, like obscenity, the judge knows when she sees. Although balancing of this kind arose out of a judicial desire to objectify the decision-making process,[73] there is no clear definition of what constitutes reasonableness, especially in an untried area like HIV testing. A rough cost-benefit analysis generally provides a framework, but the problem of weighting the inputs renders any objectivity in the process rather tenuous.[74] (Although there is no "least restrictive means" requirement under the fourth amendment, "a factor relevant to the inquiry into the reasonableness of the search . . . would be whether less intrusive but equally effective means to the same goal are available."[75]) Unlike the Rehabilitation Act, however, nothing in the text or history of the fourth amendment suggests that "reasonableness" was specifically in-

a communicable disease, and to submit the records of any hospitalization of treatment they underwent for such diseases. *Id.*

69. Winston v. Lee, 470 U.S. 753, 760 (1985) (quoting Schmerber v. California, 384 U.S. 757, 767 (1966)).

70. O'Connor v. Ortega, 480 U.S. 709, 725-26 (1987).

71. New Jersey v. T.L.O., 469 U.S. 325, 341 (1985). The *Glover* court took for granted that neither a warrant, probable cause, nor individualized suspicion was required for this kind of testing scheme. It is not clear whether this flowed from a prescient guess concerning the Supreme Court's drug testing cases, *see* Skinner v. Railway Labor Executives' Ass'n, 109 S. Ct. 1402, 1413-21 (1989); National Treasury Employees Union v. Von Raab, 109 S. Ct. 1384, 1390-98 (1989), or from the view that the testing so clearly failed the reasonableness test that it was unnecessary to reach these more difficult questions.

72. *O'Connor*, 480 U.S. at 721; *accord Skinner*, 109 S. Ct. at 1414; *Glover*, 686 F. Supp. at 250.

73. Aleinikoff, *Constitutional Law in the Age of Balancing*, 96 YALE L.J. 943, 958-63 (1987).

74. *Id.* at 974-76. *See generally* C. DUCAT, MODES OF CONSTITUTIONAL INTERPRETATION 116-92 (1978) (discussing balancing).

75. Transport Workers' Union, Local Union 234 v. Southeastern Pa. Transp. Auth., 863 F.2d 1110, 1120-21 (3d Cir. 1988), *vacated*, 109 S. Ct. 3208 (1989).

tended to require the judicial use of a scientific model of the health decision. Indeed, the recent Supreme Court drug-testing cases suggest that, at least in the realm of the administrative search, fourth amendment "reasonableness" may be virtually identical to the "rational basis" of the fifth and fourteenth amendments.[76]

The *Glover* court's evidentiary inquiry focused on the essential facts of AIDS and its transmission, the uses and limitations of HIV testing in general, and the prevalence of biting, scratching, and sexual and drug abuse in ENHSA facilities. There appears to have been no serious dispute about the epidemiology of HIV and HBV disease,[77] or the lack of a vaccine against the former and the existence and availability to ENHSA of a vaccine against the latter.[78] Most important, there was essentially no dispute about the nature of the risk posed by HIV in the ENHSA facilities. The defendants' case turned on the reasonableness of conducting highly intrusive searches as a means of preventing the highly unlikely occurrence of a catastrophic event.

The court was determined to root its decision in medical soil, deferring whenever possible in its factfinding to the opinions of public health officials. It found, for example, that "the medically indicated reasons for HIV testing" were to help make a diagnosis in the course of "the medical workup of a patient who may be infected"; to determine prevalence in an epidemiological investigation; and as part of a program of risk-reduction counseling and behavioral modification among high risk group members. "Testing in isolation as provided in [ENHSA]'s policy," the court found, "does not serve these purposes."[79] Of course, a number of states have chosen to use the test for reasons outside this list, notably in the mandatory testing of people arrested or convicted of sex crimes and prostitution.[80] There was no serious discussion of why ENHSA was not entitled to use the test for a valid purpose not contemplated by doctors.

The court also discussed the evidence presented on risk levels and risk reduction techniques among health care workers, an analogous risk group to the plaintiffs:

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76. *See Skinner*, 109 S. Ct. 1402; *Von Raab*, 109 S. Ct. 1384.

77. The plaintiffs did not challenge the TB policy. *Glover*, 686 F. Supp. at 244 n.1.

78. *Id.* at 246-47.

79. *Id.* at 248.

80. *See supra* notes 34-35.

> These recommendations and guidelines do not include, nor is there any evidence that health care workers . . . are routinely screening for the presence of HIV. That these recommendations and guidelines are apparently effective is evidenced by the fact that health care workers, although theoretically at a higher risk than the general public, have few reported incidents of HIV transmission as a result of their jobs.[81]

The court did not explain why, in selecting the manner and mode of its public health effort at ENHSA, the state was limited only to those prophylactic measures approved by the CDC.

Based on its finding, expressed in a manner allowing no appellate inference of uncertainty, that the risk of transmission at the facility was "minuscule, trivial, extremely low, extraordinarily low, theoretical, and approach[ing] zero,"[82] the court held that

81. *Glover*, 686 F. Supp. at 249. The court's view of the evidence is also interesting in the way it shows a willingness to consider the consistency and coherence of the state's behavior in examining the reasonableness of the state's analysis of the seriousness of the problem and its selection of a remedy. The court found that ENHSA's rationale for selecting the positions for which testing would be a requirement was that the positions involved extensive client contact. It noted that the evidence showed that staff members in non-tested positions had also been bitten or scratched by clients. Moreover, although the state had relied rather heavily on the fact that an employee actually died of AIDS, ENHSA had not followed up by testing clients who had been involved in biting or scratching incidents with the employee, or otherwise informing them or their guardians of a possible risk. *Id.* at 248-49.

Normally the fact that a state addresses only one part of problem, or is otherwise inconsistent or incomplete in its action, is not something that goes to the validity of the action. *See, e.g.*, Dandridge v. Williams, 397 U.S. 471, 487 (1970); Skinner v. Oklahoma *ex rel.* Williamson 316 U.S. 535, 540 (1942). There is some precedent in health cases, however, for *Glover*'s approach. In *New York State Ass'n for Retarded Children v. Carey*, Judge Newman sidestepped the general rule by distinguishing a measure allocating benefits from a measure designed to prevent a specific threat of significant harm. In *Carey*, which concerned an effort to limit school attendance of children with HBV, the court found the

> lack of any evidence that a serious possibility of transmission existed . . . [was] underscored by the [School] Board's own failure to make any comprehensive plan based on its own assessment of the situation. Specifically, the Board made no effort to identify all the children in the public schools, or even all the retarded children in the public schools, who might be carriers of hepatitis B. Instead, it merely tested the 450 children who happened to be in classrooms that included known hepatitis B carriers, a policy that casts doubt on the Board's sense of how critical the problem was. . . . [Such an approach,] if not necessarily impermissible, at least suggests that the Board did not regard its own evidence of risk as particularly convincing.

Carey, 612 F.2d 644, 650 (2d Cir. 1979); *see also* Jew Ho v. Williamson, 103 F. 10 (C.C.N.D. Cal. 1900) (invalidating quarantine applied only to ethnic Chinese homes and not to adjoining European dwellings).

82. *Glover*, 686 F. Supp. at 251.

the testing was not justified at its inception. Implicitly adopting a significant-risk standard, it stated that "from a medical viewpoint, this policy is not necessary to protect clients from any medical risks."[83] Having elected sub rosa to evaluate risk against a medical scale, the court did not weight heavily "testimony . . . that there can be no guarantee that the [ENHSA] clients could not possibly contract the AIDS virus, and thus the policy is necessary because of the devastating consequences of the disease."[84] The defendants, the court explained, were "simply asking this Court to approve their policy because it is better to be safe than sorry."[85] Although it did not hold that the state was never entitled to take action aimed at eliminating all risk of transmission, the court weighted the state's interest in achieving that risk level in terms of its marginal medical benefit; that quantum of medical benefit being virtually nil, the testing's benefits did not outweigh the high cost to individual rights.[86]

The essence of *Glover's* holding, like *Arline's*, is that the state cannot do what millions of people elect to do every day: avoid risks subjectively identified as unacceptable. It cannot elect to be safe rather than sorry. The state is limited to addressing risks found to be significant in a medical analysis, at least where the prophylactic has a cost in human rights, no matter how unpalatable lesser risks might be to decision-makers and the public. Just as in *Arline*, the court's discussion of risk did not address the political component of public health actions. As in *Arline*, the court did not consider that deference to reasonable medical judgment is only deference to the state if the state was making a medical judgment in the first place. Unlike *Arline*, however, the court was not obeying a congressional policy decision. In section 504, Con-

83. *Id.* at 249. The court came to the same conclusion with respect to testing for HBV, adding that even if there were evidence of a significant risk, HBV testing would be unjustified because of the availability of immunization and effective treatment. *Id.* at 251.

84. *Id.*

85. *Id.* Ironically, the court found that ENHSA's "philosophy recognizes the dignity of risk, thus permitting its clients to live life with all its inherent risks, as they live in a community setting." *Id.* at 245.

86. *Id.* at 251 ("[T]he Executive Director . . . stated that his paramount concern was to 'protect clients at all cost.' This approach is impermissible for 'at all cost' in this case includes the violation of plaintiffs' constitutional rights."). Of course, the case could have gone off quite differently had the court decided that, for example, workers providing care for retarded people do not have a reasonable expectation of privacy in their medical condition. *See, e.g.*, Policeman's Benevolent Ass'n, Local 318 v. Township of Washington, 850 F.2d 133 (3d Cir. 1988), *cert. denied*, 109 S. Ct. 1637 (1989); Shoemaker v. Handel, 795 F.2d 1136 (3d Cir.), *cert. denied*, 479 U.S. 986 (1986).

gress decided that health decisions covered by the Act should be made on a medically reasonable basis. In *Glover*, the court found the same restriction in the text of the Constitution. Thus the court established that the judicially-crafted standard of reasonableness places substantive medical limitations on state health policy prerogatives.[87] The notable thing about *Glover*, then, is not that the court closely scrutinized the testing program—in a fourth amendment case, after all, the burden is on the state to persuade the court that its testing is reasonable[88]—but that reasonableness was defined exclusively in medical terms, the problem being the state's failure to arrive at the correct medical answer. The district court unselfconsciously used, and the court of appeals without discussion adopted, a purely scientific model of the health decision.

C. *Some Science for Some Reason*

Given the sweep of section 504's coverage, and the frequency with which case-identification measures involve blood testing, a substantial proportion of health cases in the age of AIDS will be decided on grounds other than the fourteenth amendment. That it is the rule, or practice, in these "new" public health cases to treat the health decision as a medical one, and to require a rea-

87. It is worth noting that the explicit or implicit adoption of a significant risk standard under § 504 and the fourth amendment is quite like judicial reasoning about health decisions under other statutory/regulatory regimes. In the well-known benzene case, Industrial Union Dep't, AFL-CIO v. American Petroleum Inst., 448 U.S. 607 (1980), the Court was faced with an OSHA decision to require the lowest occupational level of exposure to benzene, a carcinogen, that was technologically and economically possible. *Id.* at 613. The Court, noting that the decision to require the lowest possible level of exposure was not based on any finding that

> leukemia has ever been caused by exposure to 10 ppm of benzene and that it will *not* be caused by exposure to 1 ppm, but rather on a series of assumptions indicating that some leukemias might result from exposure to 10 ppm and that the number of cases might be reduced by reducing the exposure level to 1 ppm,

invalidated the standard. *Id.* at 634. The plurality explained that the Act presupposed the OSHA, before setting an exposure standard, would make a finding that such a standard was necessary to make the workplace safe. *Id.* at 642. But, the plurality further noted

> safe is not the equivalent of 'risk-free.' There are many activities that we engage in every day—such as driving a car or even breathing city air—that entail some risk of accident or material health impairment; nevertheless, few people would consider these activities 'unsafe.' Similarly, a workplace can hardly be considered 'unsafe' unless it threatens the workers with a significant risk of harm.

Id.

88. *See, e.g.*, New Jersey v. T.L.O., 469 U.S. 325, 341-42 (1985).

sonable medical basis for state action, does not compel the conclusion that such behavior is proper in "traditional" challenges claiming denial of equal protection or substantive due process. On the contrary, even accepting the foregoing account of public health review under other legal regimes, the doctrinalist would find no basis for departure from the generally-applied rules of fourteenth amendment rationality review.

Traditional public health law undoubtedly states a rule of extreme deference compatible with the loosest examples of rational basis scrutiny in contemporary constitutional law. On the level of rhetoric at least, courts use a legislative model of the decision, with the emphasis on the state's political freedom to do its protective duty in whatever way it sees fit. In practice, however, traditional health decisions, both past and present, focus far more than contemporary minimum scrutiny doctrine would allow on the actual medical validity of the challenged health action in the specific context in which it has been applied.[89] While a complete account of public health law, much less a revisionist one, has yet to be written, close readings of the classic traditional public health case, *Jacobson v. Massachusetts*,[90] and a contemporary case, *City of New York v. New Saint Mark's Baths*,[91] suggest that a hybrid model is used, under which specific scrutiny of health actions' medical bases frequently limits legislative prerogatives.

On a casual reading, *Jacobson* appears to embody pure deference to legislative health decisions. Mr. Jacobson was a citizen of Cambridge, charged criminally for refusing to submit to a general smallpox vaccination program ordered by the town board of health.[92] As part of his defense, he offered to prove that vaccination was both ineffective and dangerous as a public health measure.[93] The state trial court and the Supreme Judicial Court of Massachusetts both rejected his proffer. In its affirmance, the United States Supreme Court eliminated any lingering doubt about the state's general authority to act in the name of public health, setting forth a vision of a virtually unlimited police power that trumped individual rights to the full extent necessary to protect the public. No person, the Court explained, had a right to endanger the community.

89. For authorities analyzing actual practice in health cases, see *supra* note 11.

90. 197 U.S. 11 (1905).

91. 130 Misc. 2d 911, 497 N.Y.S.2d 979 (Sup. Ct. 1986).

92. *Jacobson*, 197 U.S. at 13.

93. *Id.* at 36.

Public health was recognized as an essential duty of local government, whose exercise was subject to only limited judicial check. Moreover, discretion in selecting the manner and mode of such action appeared to be reserved entirely to the People, to be exercised on whatever basis they chose. The Court declared the right of the people to adopt such health measures as were held by common belief to be effective, adding that "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."[94]

On a closer reading, recognizing the degree to which the decision reflects turn-of-the-century legal and cultural norms, its deference appears less complete. *Jacobson*, it must be recalled, was a product of the *Lochner* Court; its deferential language must be read in light of the Court's willingness to engage in close scrutiny of the actual value of vaccination as a health measure.[95] In fact, the Court's reliance on the People's right to choose vaccination as a health measure actually had more to do with the overwhelming social consensus that vaccination was medically valuable than a view that the medical bona fides of a health action were irrelevant.

Jacobson's principal ground for appeal was the trial court's decision not even to admit his evidence against vaccination. This decision, however, was not based on the view that the value of vaccination was irrelevant to Jacobson's defense. The Supreme Judicial Court of Massachusetts, in a portion of its opinion quoted by the United States Supreme Court, explained that the proffers, even accepted as true, would not change the results: the trial judge would merely have had to instruct the jury to consider this testimony along with "facts of common knowledge," including that

> for nearly a century *most of the members of the medical profession* have regarded vaccination as a preventative of small-

94. *Id.* at 35 (quoting Viemeister v. White, 179 N.Y. 235, 240, 72 N.E. 97, 99 (1904)).

95. Lochner v. New York, 198 U.S. 45 (1905). *See* Karst, *Vaccination*, in 4 ENCYCLOPEDIA OF THE AMERICAN CONSTITUTION 1953, 1953 (L. Levy, K. Karst & D. Mahoney eds. 1986) ("For the majority who found a violation of substantive due process in *Lochner's* sixty-hour limit on bakers' weekly work but validated compulsory vaccination, the difference surely was that they saw vaccination as a soundly based health requirement." (emphasis omitted)). *See also* Tribe, *Substantive Due Process*, in 4 ENCYCLOPEDIA OF THE AMERICAN CONSTITUTION 1798, 1798-99 (1986) (discussing *Lochner*).

> pox; that, while they have recognized the possibility of injury to an individual from carelessness in the performance of it, or even in a conceivable case without carelessness, they generally have considered the risk of such injury too small to be seriously weighed as against the benefits coming from the discreet and proper use of the preventative; and that not only the medical profession and the people generally have for a long time entertained these opinions, but legislatures and courts have acted upon them with general unanimity. *If the defendant had been permitted to introduce such expert testimony as he had in support of these general propositions, it could not have changed the results.*[96]

In a similar vein the Supreme Court said:

> [Jacobson's] offers in the main seem to have had no purpose except to state the general theory of those of the medical profession who attach little or no value to vaccination as a means of preventing smallpox or who think that vaccination causes other disease of the body. What everybody knows the court must know, and therefore the state court judicially knew, as this court knows, that an opposite theory accords with the common belief *and is maintained by high medical authority.*[97]

Jacobson was not based on the irrelevance of medical facts but on the overwhelming medical support for smallpox vaccination. Indeed, the value of vaccination was so firmly established that the Court was able to judicially notice it. In more than two pages of footnotes, the Court cited encyclopedia articles, government reports, case decisions and international legislation for the proposition that vaccination was widely accepted as a valuable public health tool against smallpox.[98] A rule that the people may do anything they like against disease without reference to medical evidence is far broader than was needed to decide the case, and certainly would not have required the Court even to discuss, much

96. *Jacobson*, 197 U.S. at 23-24 (quoting Commonwealth v. Pear, 183 Mass. 242, 246-47, 66 N.E. 719, 721 (1903), *aff'd*, 197 U.S. 11 (1905)) (emphasis added).

97. *Id.* at 30 (emphasis added).

98. *Id.* at 31-34 n.1.

less judicially notice,[99] any medical evidence at all.[100]

Any interpretation of *Jacobson* discerning categorical deference is also undermined by its attention to the particular facts of the defendant's case. Indeed, Jacobson's essential tactical mistake, as the Court itself hinted, was his failure to sufficiently particularize his attack. The Court identified several factual claims not made by Jacobson that might have compelled a different outcome, including whether or not smallpox actually posed a current threat to the town and the suggestion that the law would be unconstitutional if applied to a person who could prove actual likelihood of harm to himself.

Under the doctrinal view of minimum scrutiny of health actions, *Jacobson*'s willingness to consider the actual medical reasonableness of a health measure would now be incorrect, but it was proper under the doctrinal regime within which the *Jacobson* Court was operating. The Court's decision drew on the idea that the exercise of the police power is grounded in "the principle of self-defense, of paramount necessity."[101] In the latter part of the nineteenth century, the concept of necessity[102] was a linchpin of a definitional analysis of the police power.[103] For example, in an Illinois case invalidating vaccination where there was no evidence that the disease was present, the court said:

> The power to compel vaccination . . . can be derived from no other source than the general police power of the state, and can be justified upon no other ground than

99. Extensive use of judicial notice and exclusion of defendant's proffers was undoubtedly a questionable way to gather evidence. While the perceived gap between lay and professional competence has, if anything, widened, the misuse of judicial notice remains a problem. *See* Davis, *"There is a Book Out . . . ": An Analysis of Judicial Absorption of Legislative Facts*, 100 HARV. L. REV. 1539 (1987). One does not quite know what to make of a decision that relied for its medical facts, as did one otherwise fine AIDS decision, on *Reader's Digest*. *See* Ray v. School Dist., 666 F. Supp. 1524, 1530 (M.D. Fla. 1987).

100. It is also important to recognize that *Jacobson* came at a time when the perceived gap between the physician's and lay person's understanding of disease and disease prevention was still narrow. *See* Burris, *Fear Itself*, *supra* note 9, at 485-86.

101. *Jacobson*, 197 U.S. at 27; *see* Reznick, *Empiricism and the Principle of Conditions in the Evolution of the Police Power: A Model for Definitional Scrutiny*, 1978 WASH. U.L.Q. 1, 51-53 (discussing *Jacobson*).

102. Or, as it has recently been called, the theory of "conditions." Reznick, *supra* note 101, at 2.

103. *See* E. FREUND, THE POLICE POWER: PUBLIC POLICY AND CONSTITUTIONAL RIGHTS (1904) (leading treatise on police power); Reznick, *supra* note 101. *See generally* L. TRIBE, *supra* note 15, §§ 8-1 to -4 (discussing constitutional model of implied limits on government).

> as a necessary means of preserving the public health. Without the necessity, or reasonable grounds upon which to conclude that such necessity exists, the power does not exist.[104]

This approach reflects the view that an exercise of state power could not be reviewed for matters of degree. As Professor Ernst Freund, a leading commentator quoted in *Jacobson*, explained:

> The earlier attitude . . . seems to have been that if it was acknowledged that a condition consisted for legislative action, the legislature was sole and conclusive judge (under specific constitutional limitations) to what degree its power could be exercised. So it was said in Brown v. Maryland: "Questions of power do not depend upon the degree to which it may be exercised. If it may be exercised at all, it must be exercised at the will of those in whose hands it is placed."[105]

By the time of *Jacobson*, however, this view had been tempered to the extent that, in addition to considering whether "a condition exist[s] which justifies any legislative action,"[106] a court was also thought to be empowered to consider the proportionality of the exercise of the authority in relation to the condition which justified it.[107]

This theory that exercise of the police power was contingent upon the actual necessity for action suggests the importance of *Jacobson*'s sua sponte notation of the absence of a claim that smallpox was not prevalent in Cambridge,[108] and explains this otherwise curious passage in which it elaborates upon the concept:

> Smallpox being prevalent and increasing at Cambridge, the court would usurp the functions of another branch of government if it adjudged, as a matter of law, that the mode adopted under sanction of the State, to protect the people at large, was arbitrary and not justified by the necessities of the case. We say necessities of the case, because it might be that an acknowledged power of a local

104. Potts v. Breen, 167 Ill. 67, 74, 47 N.E. 81, 84 (1897).

105. E. FREUND, *supra* note 103, § 53, at 58 (quoting Brown v. Maryland, 12 U.S. (1 Wheat.) 419, 439 (1827)).

106. *Id.* § 63, at 60.

107. *Id.* § 63, at 60-61.

108. *Jacobson*, 197 U.S. at 27.

> community to protect itself against an epidemic threatening the safety of all, might be exercised in particular circumstances and in reference to particular persons in such an arbitrary, unreasonable manner, or might go so far beyond what was reasonably required for the safety of the public, as to authorize or compel the courts to interfere for the protection of such persons.[109]

The rule of *Jacobson* is not one of categorical deference to a state's political decisions, or even its medical determinations, regardless of evidence tending to falsify them. Rather, *Jacobson* held that the commitment of health decisions to the political branches entitles the state to proceed unimpeded with necessary actions bearing a reasonable medical relation to a demonstrable health threat. This rule obviously does not contemplate the state acting in a manner that is not medically justifiable, no matter how politically compelling the action might be. It therefore imposes a medical limitation on the state's health power, indicating the Court's adoption of a hybrid, rather than purely legislative, model of the health decision.

The question is, then, precisely how much of *Jacobson* remains viable?[110] *Lochner* is gone, and with it the approach to judicial review upon which *Jacobson* rested. Arguably, the idea that a public health measure must be supported by medical evidence, while eminently reasonable, derogates from the broad freedom of action currently accorded states under the rational basis test.[111]

109. *Id.* at 28; *see, e.g.*, State v. Rackowski, 86 Conn. 677, 680, 86 A. 606, 608 (1913) (police power's "origin rests in necessity"); *cf.* People *ex rel.* Barmore v. Robertson, 302 Ill. 422, 433, 134 N.E. 815, 819 (1922) ("health regulations are all sustained on the law of necessity, and when the necessity ceases the right to enforce the regulations ceases"); *In re* Smith, 146 N.Y. 68, 73, 40 N.E. 497, 498 (1895) (if police power is exercised, "it must appear very clearly and satisfactorily, not only that [the right to act] has been conferred by the law, but also that in its exercise the facts were present which justified it").

110. Its specific suggestion that the decision might have gone the other way had there been no evidence of an actual smallpox epidemic in Cambridge was obviated by the decision 18 years later in Zucht v. King, 260 U.S. 174 (1922), that vaccination could be required even in the absence of an immediate threat of epidemic.

111. Naturally, a pure legislative model of the decision is difficult to maintain given the obvious medical quality of at least some aspects of the public health decision. As Professor Davis has observed in the context of administrative law, there is a meaningful difference between rules grounded primarily in policy preferences—such as tax rules—and those which depend for their reasonableness on facts—such as a decision of the Consumer Products Safety Commission to ban a toy as dangerous. 1 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 6:13, at 510-13 (2d ed. 1978). The acceptance of medicine as a science, referring to a universe of verifiable facts, has contributed to the willingness of courts

Does not a judicial decision that it is not better to be safe than sorry ultimately commit the sin of *Lochner*, with the Centers for Disease Control's (CDC) opinions on appropriate health measures replacing "Mr. Herbert Spencer's *Social Statics*"?[112] The doctrine of necessity, seeking a limitation on state action in the nature of the police power itself, rather than primarily in the affirmative protections of state and federal constitutions, is, to say the least, out of fashion.

Yet even if its doctrinal basis has eroded, *Jacobson*'s approach has continued to be the model for health cases. The language of necessity appears in public health decisions into the modern era.[113] Moreover, public health cases continue to focus on the

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to intrude in health matters. I suspect that public health cases often appear to judges to involve matters more verifiable than challenges to more general social or economic legislation. *See, e.g.*, Turkington, *Constitutional Limitations on Tort Reform: Have the State Courts Placed Insurmountable Obstacles in the Path of Legislative Responses to the Perceived Liability Insurance Crisis?*, 32 VILL. L. REV. 1299, 1310-13 (1987) (discussing lack of meaningful review of tort reform decisions under rational basis test). The epidemiology of most diseases is now well understood. The manner of transmission of all but three percent of AIDS cases has been investigated and identified with reasonable certainty by a highly respected, professionally impeccable agency of the federal government charged with precisely that task. *See* Centers for Disease Control, HIV/AIDS Surveillance Report 8 (Feb. 1989). The issue is the subject of countless scientific papers by leading researchers and clinicians. *See* Editorial, *Heterosexual Transmission of Human Immunodeficiency Virus*, 260 J. A.M.A. 1943 (1988); Special Initiative on AIDS, American Public Health Association, *Casual Contact and the Risk of HIV Infection*, (July 1988). Claims that there might be some other way we do not know about, while perhaps not laughable, are certainly not colorable. Lifson, *Do Alternate Modes of Transmission of Human Immunodeficiency Virus Exist?*, 259 J. A.M.A. 1353 (1988). Even the efficacy of various prophylactic measures, while perhaps less so, are nevertheless fairly verifiable, either because they have been directly studied in connection with other diseases (*e.g.*, pre-marital testing for disease) or because so much is known about the transmission of the disease and the remedy (using condoms—we know the disease is spread sexually, we know how often condoms leak). Even issues dependent on behavior—will people use the condoms, what will addicts do with free needles—have been or can be studied. The availability of such information militates against judicial deference to post hoc or a priori, state claims about the fit between means and ends.

112. *See* Williamson v. Lee Optical, 348 U.S. 483, 488 (1955) (discussing deferential review); Lochner v. New York, 198 U.S. 45, 75 (1905) (Holmes, J., dissenting).

113. *See, e.g.*, Schuringa v. City of Chicago, 30 Ill. 2d 504, 509, 198 N.E.2d 326, 329 (1964) ("a police measure, to be beyond the pale of constitutional infirmity, must bear a reasonable relation to the public health or other purposes sought to be served, the means being reasonably necessary and suitable for the accomplishment of such purpose"), *cert. denied*, 379 U.S. 964 (1965); Moyant v. Borough of Paramus, 30 N.J. 528, 544, 154 A.2d 9, 17 (1959) ("[w]here the police power has been granted to a municipal corporation, it is elementary that it can be exercised only in those areas where regulation is needful for the common good"); *see also* Gostin, *supra* note 11, at 480-81 (discussing concept of necessity in modern cases).

facts specific to a particular action in the context in which the attack has arisen. Cases in which courts have essentially refused to attend medical evidence,[114] or have upheld laws based on "health" claims supported only by transparent generalizations,[115] have been a minority. The common practice, even in opinions claiming that the existence of doubt or alternatives is irrelevant, is to gather and weigh carefully often voluminous amounts of factual evidence.[116] Under this view, *Arline*'s insistence on deference to the views of reasonable public health officials is part of a long tradition in public health cases.

We see this in one of the few recent health cases decided on constitutional grounds,[117] *City of New York v. New Saint Mark's Baths*.[118] *Saint Mark's* was a suit by New York City health authorities to close down a gay bathhouse under the city's Nuisance Abatement Law. Public health officials were sharply divided

114. *See, e.g.*, Kirk v. Wyman, 83 S.C. 372, 65 S.E. 387 (1909) (upholding quarantine of non-contagious leper).

115. *See, e.g.*, Mayor of Baltimore v. Fairfield Improvement Co., 87 Md. 352, 365, 39 A. 1081, 1084 (1898) (enjoining placement of leper with family in developing neighborhood because of general fear it would provoke and because of the risk of contagion, and rejecting "mere scientific asseveration and conjecture" that disease not readily transmitted).

116. *See, e.g.*, *Schuringa*, 30 Ill. 2d at 507, 198 N.E.2d at 328 (matter referred to master, who held "prolonged hearings" and considered "a voluminous record"); Attaya v. Town of Gonzales, 192 So. 2d 188 (La. Ct. App. 1966) (record included numerous depositions and "a considerable volume" of scientific information and studies); Paduano v. City of New York, 45 Misc. 2d 718, 724, 257 N.Y.S.2d 531, 538 (Sup. Ct.) (900-page record plus mass of documentary evidence), *aff'd*, 24 A.D.2d 437, 260 N.Y.S.2d 831 (1965), *aff'd*, 17 N.Y.2d 875, 218 N.E.2d 339, 211 N.Y.S.2d 305 (1966), *cert. denied*, 385 U.S. 1026 (1967); Kraus v. City of Cleveland, 55 Ohio Op. 6, 116 N.E.2d 779 (C.P. 1953) (trail, extensive affidavits and 275 pages of congressional hearing testimony), *aff'd*, 55 Ohio Op. 36, 121 N.E.2d 311 (Ct. App. 1954), *aff'd*, 163 Ohio St. 559, 127 N.E.2d 609 (1955), *appeal dismissed*, 351 U.S. 935 (1956); *see also* Graybeal v. McNevin, 439 S.W.2d 323 (Ky. 1969); Chapman v. City of Shreveport, 225 La. 859, 74 So. 2d 142, *appeal dismissed*, 348 U.S. 892 (1954); *cf.* Huffman v. District of Columbia, 39 A.2d 558 (D.C. Mun. Ct. App. 1944) (upholding laws and regulations aimed at controlling communicable disease as having "a direct relation as a means" to legitimate end, but reversing appellant's conviction of refusing to submit to an exam because of lack of evidence that she was infected, refusal of trial court to allow scientific evidence of her health, and lack of emergency to justify summary action).

117. *See, e.g.*, Doe v. Coughlin, 71 N.Y.2d 48, 518 N.E.2d 536, 523 N.Y.S.2d 782 (1987) (denial of conjugal visits to inmate with AIDS), *cert. denied*, 109 S. Ct. 196 (1988); California v. Three 3 MCS, Inc., No. C685816 slip. op. (Cal. Super. Ct. Aug. 30, 1988) (challenge to closing of bathhouse); California *ex rel.* Agnost v. Owen, No. 830 321 (Cal. Super. Ct. Nov. 30, 1984) (same); *cf.* New York Soc'y of Surgeons v. Axelrod, 200 N.Y.L. J. No. 96, at 29 (Sup. Ct. 1988) (rejecting plaintiff's attempt to force state health official to declare HIV a transmissible disease).

118. 130 Misc. 2d 911, 497 N.Y.S.2d 979 (Sup. Ct. 1986).

about whether or not closing bathhouses was a good idea. It was likely that high-risk behavior would merely move somewhere else, and the baths at least offered an opportunity for reaching and educating those most at risk.[119] Rights of association and privacy were implicated by closure; and the symbolic importance of the baths in the gay liberation movement, with the correlative threat to gay cooperation with public health efforts posed by closure, raised the potential cost of action even when measured in purely public health terms.[120] On the other hand, there were reasonable public health officials who were prepared to assert that closing the baths would probably reduce overall transmission, and it was incontestable and uncontested that unsafe sex acts were occurring in the baths that would not occur there if the baths were closed.[121]

New York City's health commissioner had long been among the most vocal opponents of bathhouse closure, but political pressure at the state level eventually led to a change of mind, if not of heart.[122] New York City health department investigators were sent into the baths to confirm that sexual activities of a kind likely to spread HIV were occurring, whereupon the city sought an order for closure, citing a new state regulation declaring facilities where such unsafe sex was taking place to be nuisances.[123] The city was opposed by the defendant owners, bolstered by a group of intervening patrons, all asserting rights of privacy and freedom of association.

At the outset of its opinion, the court spoke of the state's "compelling state interest," which sweeps away the defendants' and intervenors' rights of privacy and free association, "provided, as here, it is also shown that the remedy adopted is the least intru-

119. *See* R. BAYER, *supra* note 29, at 65-66.

120. *See generally* R. BAYER, *supra* note 29; R. SHILTS, *supra* note 31; Burris, *Fear Itself*, *supra* note 9, at 508-14. Similar arguments against closure were presented in other bathhouse cases. They did not prove convincing in the Los Angeles case, California v. Three 3 MCS, Inc., No. C685816 slip. op. (Cal. Sup. Ct. Aug. 30, 1988). In the San Francisco case, however, where the trial judge recognized a privacy interest, these arguments helped secure an order allowing the baths to remain open with certain limitations and modifications. California *ex rel.* Agnost v. Owen, No. 830 321 (Cal. Super. Ct. Nov. 30, 1984); *see also* Note, *Constitutional Rights*, *supra* note 7, at 1284-86 (discussing review of bathhouse closures). For a general discussion of the bathhouse issue, see Note, *Preventing the Spread*, *supra* note 7.

121. Some political leaders, like Diane Feinstein of San Francisco, regarded it as a basic duty of government to prevent specific acts of transmission occurring in facilities it licensed. *See* R. BAYER, *supra* note 29, at 31-38.

122. *Id.* at 54-64.

123. *Saint Mark's*, 130 Misc. 2d at 914, 497 N.Y.S.2d at 981.

sive reasonably available."[124] Having concluded that even if strict scrutiny applied, the state had made the requisite factual showing to justify closure, the court spent several paragraphs explaining why the defendants and intervenors probably did not have any rights that would trigger heightened scrutiny after all (because the baths were commercial, because the intervenors were not prevented from having sex elsewhere, because sexual activity is not a protected associational right).[125] Finally, the court completed its reversion to deference by dredging up the hoary maxim that "[i]t 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, an illusory pretense."[126]

Notwithstanding its "total scrutiny" approach,[127] *Saint Mark's* is actually a good representative of a traditional health decision, and the mark of its affinity is none other than its supposed resolve not to scrutinize the state's chosen measure beyond the point of determining that it bore a medically rational relationship to the legitimate goal of protecting public health. The court's "refusal" to decide the scientific merits, exactly as in *Jacobson* before it, reflects the view that it could not invalidate the health department's action if the defendant-intervenors showed no more than a dispute about the best way to reduce dangerous sexual activity. But, of course, to determine that the evidence did no more than show that scientific uncertainty existed, the court had necessarily to scrutinize the medical evidence. Indeed, the court did not merely determine that the challengers had done no more than cast doubt on the value of closure, but found that the scientific evidence "demonstrate[d] the inadequacy of self-policing procedures by the St. Mark's attendant staff, and the futility of any less intrusive

124. *Id.* at 916, 497 N.Y.S.2d at 982.

125. *Id.* at 917, 497 N.Y.S.2d at 982-83.

126. *Id.* at 917, 497 N.Y.S.2d at 983 (quoting Chiropractic Ass'n of New York v. Hilleboe, 12 N.Y.2d 109, 114, 187 N.E.2d 756, 757, 237 N.Y.S.2d 289, 291 (1962); Williams v. Mayor of Baltimore, 289 U.S. 36, 42 (1933)).

127. Other bathhouse decisions have found it difficult to pin down a level of scrutiny. *See, e.g.*, California v. Three 3 MCS, Inc., No. C685816 slip. op. (Cal. Sup. Ct. Aug. 30, 1988). In a similar case brought by the city against a heterosexual sex resort, a New York judge applied the New York derivative of the four-pronged test enunciated in United States v. O'Brien, 391 U.S. 367 (1968), on incidental restrictions aimed at expressive activities protected by the first amendment. City of New York v. Big Apple Spa, 130 Misc. 2d 920, 497 N.Y.S.2d 988 (Sup. Ct. 1986).

solution to the problem other than closure."[128]

In practice, then, the court's decision was deeply rooted in the specific factual context of the particular health action, focusing on the evidence of what was actually occurring and of the efficacy of closure. While there were differences in opinion between reasonable public health officials, the court at each evidentiary turn required the city to have at least some such support in its corner.[129] This goes far beyond the normal rational basis test, which should have required only the recital of a plausible connection between closing a place of public accommodation and preventing disease. It is particularly notable that nonmedical policy elements, such as the social value of a strong message in favor of "conventional" sexual proclivities, were not mentioned. In *Saint Mark's*, as in the Rehabilitation Act cases like *Arline* or *Glover*'s fourth amendment analysis, the factual inquiry is uniformly focused on the medical bases for action.

V. THE RULE OF MEDICAL RATIONALITY

It should be clear that few courts in traditional health cases have ever applied the legislative model of health decisions that would best fit the doctrinal account of review. Requiring a health decision to be medically supportable itself places a limit on the state's political freedom, narrowing the universe of justifications

128. *Saint Mark's*, 130 Misc. 2d at 915, 497 N.Y.S.2d at 982.

129. This approach to review was used much more consciously in a Los Angeles bathhouse case:

> It is quite clear that Defendants' [i.e., the opponents of closures] experts disagree with Plaintiff's experts and that, within the community devoted to AIDS prevention and control, there is in fact a split of opinion as to whether it helps to close gay bathhouses. As observed by the [*St. Mark's*] court . . . it is not the function of the courts to determine which scientific view is correct when deciding whether the police power has been properly exercised. The evidence supporting the Plaintiffs' view is substantial and persuasive and the fact that others might not agree is simply not dispositive of the issue before me.
>
> . . . .
>
> I appreciate the expertise and opinions of LAMBDA Legal Defense and Education Fund and I understand that it is the view of Amicus as well as . . . Defendants that bathhouses do not accelerate the spread of AIDS. I do not attempt . . . to decide this question; from the evidence before me, this fact is not yet proven. What *is* proven, however, is that high risk sexual activities in an environment conducive to multiple, anonymous intimate contacts does [sic] facilitate the spread of HIV. In the manner in which Mac's is being operated, these conditions are being met.

California v. Three 3 MCS, Inc., No. C685816, slip op. at 8-9 (Cal. Sup. Ct. Aug. 30, 1988).

available to it under a rational basis test. So far, the behavioralists are correct.

Granting that courts, for some collection of reasons, place medical limitations on state health actions, it remains to delineate the nature of such limitations. Are we seeing the use of a scientific model, or a hybrid? Is the fourteenth amendment standard the same as section 504's? It is at this point that the *Arline* footnote becomes decisive. A hypothetical case turning on the analysis of a public health risk illuminates the standard of medical reasonableness suggested in *Arline*'s footnote fifteen.

A. *Risk: One Problem in Health Politics*

The analysis of risk epitomizes the metaphorical meeting of medicine and politics. Particular risk can be assessed probabilistically based on past events with a high degree of precision. The quantified likelihood of an event occurring, however, is but a small factor in the average person's subjective assessment of the chances of a bad event, and, if anything, an even smaller factor in the decision to accept the risk. Although they can be disguised as technical determinations relying on objective decision making, at bottom the assessment and acceptance of risks—whether from the chemical that makes apples redder, the fuels that make the globe warmer, or the virus that causes AIDS—involve fundamental social choices.[130] A judicial decision to place medical limits on the public health decision, while not necessarily requiring the state to make its choice about risk in a scientific manner, does at least require that the decision, however achieved, be justifiable in scientific terms.[131] This places a real limitation on state policy freedom, a limitation grounded in a cultural or political choice to see risk in scientific terms. However sensible this may be—and I think it is very sensible—we are left with the problem of how to fit this requirement into the modern rational basis approach.

130. *See, e.g.*, R. BAYER, *supra* note 29, at 167-68 (discussing "essentially political character" of decisions with respect to risk and compulsory screening for HIV).

131. One may roughly identify two ways in which a court's scientific model can be concretized, both of which are suggested in the *Arline* case. One, of course, is to require that the decision be made by scientists. This suggests an emphasis, on review, on whether the process has conformed with acceptable professional norms. *Cf.* Ethyl Corp. v. EPA, 541 F.2d 1, 66-67 (D.C. Cir.) (Bazelon, J., concurring), *cert. denied*, 426 U.S. 941 (1976). The other is to require that the decision actually represent a scientifically supportable approach. The emphasis on review in this kind of approach would focus on the substance of the decision and the evidence in its support. *Cf.* Industrial Union Dep't, AFL-CIO v. Hodgson, 499 F.2d 467, 473-76 (D.C. Cir. 1974).

1. *Assessing Risk*

A scientific approach to risk depends on quantification and comparison, while lay risk assessment tends to be impressionistic.[132] For example, current statistics indicate that heart attacks kill five times as many people as lung cancer,[133] yet the slow, painful death of cancer may strike many people as a far greater threat.[134] Objective comparison of the likelihood of an event occurring may suggest that a risk is "significant" or "minimal," but such characterizations are relative and, therefore, dependent on subjective individual experience of risk.[135] Events with serious or horrible consequences, or about which one frequently hears, seem more likely to occur than they actually are. Risks to which one is personally exposed may seem more likely to occur than risks to which one is not.[136]

Even agreed-upon risk assessments do not necessarily lead to agreed-upon results, because risk assessment is distinguishable from risk acceptability.[137] Parents who fully understand that the chance of HIV transmission from teacher to child is one in a mil-

132. Of course, like public health decisions, risk assessments do contain determinations that are not dictated by the numbers alone. *See, e.g.*, Davis, *The "Shotgun Wedding" of Science and Law: Risk Assessment and Judicial Review*, 10 COLUM. J. ENVTL. L. 67, 99 (1985) ("[T]he choice of a margin of safety—which is a component of risk assessments—is also a keenly political question. Science alone cannot rationalize a regulatory standard which is a 10th, 100th or 1000th of the level at which no effect has been observed.").

133. *Death Rate Declines Except for Mortality Related to Smoking*, N.Y. Times, April 2, 1989, § 1, at 12, col. 6.

134. S. SONTAG, *supra* note 30, at 38 ("Cancer is more feared than heart diseases, although someone who has had a coronary is more likely to die of heart disease in the next few years than someone who has cancer is likely to die of cancer.").

135. *See* Gerbert, Maguire, Badner, Altman & Stone, *Why Fear Persists: Health Care Professionals and AIDS*, 260 J. A.M.A. 3481 (1988).

136. *See, e.g.*, Kasper, *Perceptions of Risk and Their Effects in Decision Making*, in SOCIETAL RISK ASSESSMENT 71 (1980); Ratzan & Schneiderman, *AIDS, Autopsies, and Abandonment*, 260 J. A.M.A. 3466, 3466 (1988) ("Authorities note that 'response to losses is more extreme than response to gains' and that 'low probabilities are overweighted, moderate and high probabilities are underweighted, and the latter effect is more pronounced than the former.") (quoting Tversky & Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 SCIENCE 453 (1981)). Susan Sontag has written:

> In contrast to the soft death imputed to tuberculosis, AIDS, like cancer, leads to a hard death. The metaphorized illnesses that haunt the collective imagination are all hard deaths, or envisaged as such. Being deadly is not in itself enough to produce terror. It is not even necessary, as in the puzzling case of leprosy, perhaps the most stigmatized of all diseases, although rarely fatal and extremely difficult to transmit.

S. Sontag, *supra* note 30, at 38-41.

137. Ratzan & Schneiderman, *supra* note 136, at 3466.

lion still may refuse to expose their child to the risk of being the unlucky one.[138] Despite an understanding that everything in life entails risk, and that the difference between the risk of harm coming to the chid in the classroom with and without the teacher with HIV is infinitesimal, the parent may attach great value to the marginal difference in safety, if only because it is attainable. Indeed, the very recognition that life is pervaded by risks may inordinantly enhance the subjective value of avoiding risks perceived to be unnecessary and controllable. Moreover, risks are generally proffered as costs of a greater benefit, whose perceived value frequently depends on an individual or social decision that it is not better to be safe than sorry. If the parent attaches little or no value to the nondiscrimination principle, what does he gain in return for exposing his child to any additional risk from a schoolmate with HIV?

2. *Cases of Risk*

Risk has been a particularly important issue in the several cases dealing with HIV in schools.[139] Given the CDC's convincing account of the epidemiology of AIDS, however, it has not really been the assessment of the risk in a school setting that has been at the heart of the dispute, but rather its acceptability (either in terms of its absolute dimension or the degree to which the CDC is not "100 percent sure" of its assessment). An exemplary case is *Chalk v. United States District Court Central District of California*,[140] in which a teacher, Vincent Chalk, sought redress under the Rehabilitation Act when he was reassigned by local school authorities from his teaching job because he had AIDS.

The only medical evidence submitted by the defendants to justify their decision was a deposition from another case, stating the proposition that "there is a possibility, small though it is, that there are vectors of transmission as yet not clearly defined."[141]

138. Burris, *Fear Itself*, *supra* note 9, at 500; *see* Blendon & Donelan, *supra* note 33, at 1024 (reporting "paradox" that while only 10% of parents believe child can contract HIV from classroom contact, 33% would withdraw child from school).

139. *See, e.g.*, Martinez v. School Bd., 861 F.2d 1502 (11th Cir. 1988); Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376 (D.C. Cal. 1986). *See generally* Kass, *School Children with AIDS*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 66 (H. Dalton, S. Burris & the Yale AIDS Law Project eds. 1987); Cooper, *AIDS Law: The Impact of AIDS on American Schools and Prisons*, 1987 ANN. SURV. AM. L. 117.

140. 840 F.2d 701 (9th Cir. 1988).

141. *Id.* at 707.

By contrast, Chalk's position that the risk he posed was low was supported by "more than 100 articles from prestigious medical journals and the declarations of five experts on AIDS, including two public health officials."[142] The trial court applied the *Arline* "otherwise qualified" test, focusing in particular on the probability of transmission and the severity of the risk. The evidence fairly compelled the conclusion that the risk of transmission of HIV from Chalk to his students was "minimal." The court also found, however, that the results of such a transmission would be "catastrophic."[143] Because of the severity of the consequences, and in the belief that "we do not know enough about AIDS to be completely certain" in the assessment of either the means or probability of transmission,[144] the court upheld that school authorities' action.

The court of appeals chided the district court for placing an "impossible" burden on the teacher. "Little in science can be proved with complete certainty,"[145] it stated, making clear the panel's view that the Rehabilitation Act (per *Arline*) set forth a significant-risk standard that supplanted any lower risk standard preferred by a state in a section 504 case.[146] Given the extremely low risk of transmission, and therefore despite the grave and permanent consequences of transmission, the court found that Chalk did not present a significant risk and was consequently "otherwise qualified" to carry out his classroom duties.

Clearly, the court of appeals had the better of the district court in interpreting the Rehabilitation Act. *Arline* suggests that, in the absence of a significant risk of *transmission*, the severity of the consequences will not make a risk "significant."[147] Just as clearly, this view of risk privileges quantified risk assessment over subjective evaluation of risk acceptability. The school authorities, after all, believed there was a "significant risk," not as a scientist would use the term, but as the district court did: a low probability that a child would be infected with a frightening, fatal disease. Moreover, that risk could be avoided at what was perceived as a

142. *Id.* at 706. The court also relied, in considering the likelihood of his ultimately prevailing on the merits, on the outcomes in school cases like *Atascadero*, 662 F. Supp. 376, and New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644 (2d Cir. 1979). *Chalk*, 840 F.2d at 708.

143. *Chalk*, 840 F.2d at 707.

144. *Id.*

145. *Id.*

146. *Id.* at 707-08; *accord* Martinez v. School Bd., 861 F.2d 1502, 1506 (11th Cir. 1988).

147. *See Arline*, 480 U.S. at 287 & n.16.

relatively low cost: one person's professional (and even personal) well-being was viewed as an acceptable price to pay to avoid exposing children to HIV, and the stress of a negative public reaction to that risk.[148]

Imagine, however, that Vincent Chalk had worked part time at his public school, and part time at a private academy receiving no federal funds. Imagine further that a state health law barred teachers with communicable diseases from the classroom. Chalk, dismissed, can seek reinstatement in his public school position under the Rehabilitation Act, but can reclaim his private school job only by showing that the state's health law fails the rational basis test.[149] Assume that Chalk is found to present a less-than-significant risk of HIV transmission, and therefore, cannot be discriminated against by his federally-funded employer.[150] The *Arline* footnote suggests that his constitutional challenge should turn out no differently. In the absence of evidence suggesting a significant risk, there could hardly be a reasonable medical basis for the action. Yet that analysis begs the question.

Under a rational basis analysis applying a legislative model of the decision, the question would be whether there was any state of the world in which the legislature could have believed a law barring teachers with communicable diseases would have the de-

148. The court of appeals' decision reflected the view that the school authorities' approach to risk had been precluded by Congress when it adopted a scientific model of the health decision. It is interesting to note, however, that this is not the way the court discussed the issue. Justifying its decision, it did not speak of the authority of Congress to choose a medical standard, such as significant risk, over a political one, such as avoidance of very low risks with very serious consequences. Instead, it spoke of the rarity of certain proof in science, as if setting a standard for safety that could not be met by medical proof was inherently irrational. The court spoke, that is, not from without the scientific model but from within.

149. *See* Merritt, *supra* note 13, at 765-74; *cf.* Note, *Constitutional Rights*, *supra* note 7, at 1289-90 (suggesting, rather tepidly, that heightened scrutiny might be applied). The hypothetical assumes that the state does not have its own antidiscrimination law covering HIV. As California's *Arline* amicus brief explained, the decision of states to bind themselves by such statutes is itself persuasive evidence that they did not see extending the antidiscrimination principle to cover people with communicable diseases as a threat to their ability to protect the public health. Brief of the State of California joined by Maryland, Michigan, Minnesota, New Jersey, New York and Wisconsin as Amici Curiae at 26, School Bd. v. Arline, 480 U.S. 273 (1987) (No. 85-1277).

150. At least as to the federally-funded public school, the case would present a preemption issue which we may assume would be decided against the application of the state health law in a manner inconsistent with the Rehabilitation Act. It could, similarly, be argued that the state law in and of itself constituted handicap discrimination, and that the state could not enforce the requirement even in a school not receiving federal funds.

sired protective effect. Several come readily to mind. Some diseases, like measles or mumps, might be more readily communicated. There is also the remote possibility that teachers and students will have sex, or even share drugs. There would be ample room in this analysis to uphold the firing of a teacher with AIDS without any serious reference to *reasonable* medical evidence of the specific likelihood of Chalk's transmitting the particular virus under these particular circumstances.[151] Indeed, even were the court to employ the kind of close, context-specific analysis expected under the behavioral account of traditional health cases, a requirement of significant risk, as in the *Glover* decision, assumes away the state's best argument: If the state's claim is the right to prevent children being exposed to any level of catastrophic risk, why need it show that the risk is significantly likely to occur?[152]

Certainly, few would question that a court decision barring Chalk from his private school job because he presented some theoretical risk of transmission but allowing him back into the public school classroom because he presented a less-than-significant risk would be bizarre. Indeed, to bar him from the private school would be bizarre even without the counterpoint. The state's claim of a prerogative to apply a no-risk standard sounds very much like the kind of archaic and groundless attitudes "based on the irrational fear" of contagion,[153] the "discrimination on the basis of mythology"[154] that the Supreme Court condemned in *Ar-*

151. In Doe v. Coughlin, 71 N.Y.2d 48, 518 N.E.2d 536, 523 N.Y.S.2d 782 (1987), *cert. denied*, 109 S. Ct. 196 (1988), the New York Court of Appeals upheld the constitutionality of barring inmates with AIDS from participating in a conjugal visit program. Among the decidedly speculative harms it accepted in finding rationality, the plurality opinion included the possibility that subsequent spouses and children of a conjugal visitor infected with AIDS would also become infected.

152. *See* Merritt, *supra* note 13, at 758-60 (discussing this issue in context of school admission). The recent decision in *Von Raab*, in which the Court found reasonable a customs service drug-testing program, presents an analogous situation: although there was no proof that customs employees were or were not likely to be compromised in their work because of drug use, the Court upheld the testing in reliance upon the potentially fatal consequences of such abuse. National Treasury Employees Union v. Von Raab, 109 S. Ct. 1384, 1395 (1989). The Court stated:

> The mere circumstances that all but a few of the employees tested are entirely innocent of wrongdoing does not impugn the program's validity. . . . Where, as here, the possible harm against which the Government seeks to guard is substantial, the need to prevent its occurrence furnishes an ample justification for reasonable searches calculated to advance the Government's goal.

Id.; *see id.* at 1398-99 (Scalia, J., dissenting).

153. *Arline*, 480 U.S. at 284.

154. *Id.* at 285.

line. The essence of this "irrationality" is the rejection of scientific values and knowledge: it is acting in the belief that something demonstrably unlikely to occur will take place because of the fit of such an occurrence within a mythic plotline. No plot is more effective in its inevitability than that the leper infects, that all lepers are degenerate, or that identifying and isolating all the lepers will keep the rest of us safe from harm. The Court was talking about this kind of irrationality in a section 504 case, but its language is by no means limited by that. This was not "irrationality" or "mythology" or "reflexive reactions" for purposes of section 504 only. This was irrationality made actionable under section 504.

Nevertheless, the decision to fire the hypothetical Chalk is bizarre only if one starts with the view that risk is properly assessed in a scientific way. A decision to readmit him is only the proper result if one concedes that a court is empowered to impose its view of substantive rationality upon the state. The choice between a lay risk assessment focusing on consequences and a scientific risk regime giving more weight to likelihood of occurrence in a given setting is ultimately a political one. The political decision to evaluate risk in a scientific rather than lay manner has been attributed under section 504 to Congress. What is the source of that policy under the Constitution? Given that the handicapped do not appear to fit within the Court's definition of a suspect or quasi-suspect class, and that employment is not a fundamental right, why should not the state be allowed to fire a teacher with AIDS?

I am decidedly not suggesting that the state be allowed under the Constitution to place serious impediments in the career paths of people who pose no serious risk to anyone. On the contrary, unless footnote fifteen is inadvertent error, there seems not way to avoid a conclusion that the Court intends to prevent such measures under the rational basis test as well as under section 504. I am suggesting that courts will rarely, if ever, judge health actions by any but medical standards, and, consequently, will already have abandoned the pure deference captured in the legislative model of the health decision. To that extent, the behavioralists have it right. Leaving aside the question of how this behavior fits in with general constitutional law, then, the final task of this essay is to offer a clearer, more coherent description of the proper test, with some thoughts about its practical application.

B. *The "Rational Medical Basis" Test*

Arline's footnote fifteen sets forth a requirement that health actions be supportable by the "medically reasonable judgments" of health officials, to whom courts are to defer.[155] In this is the core of what can best be described as a "rational medical basis test." This is not so much a heightened as it is a focused standard of review, using a hybrid model of the decision under which state political freedom to abridge constitutional rights in matters of public health is limited by a requirement of medical reasonableness. What follows is a preliminary account of the test.

The test itself is readily described. It places a medical limitation on state policymaking that has two distinct components. The first, a requirement that the decision be *medically* justified, precludes all manner of other possible explanations for a health measure, from preserving social morale to saving money. Whatever explanations are offered of the means and ends of the measure must be medical ones. But the requirement does more than limit the universe of justifications: the Court's specification that the medical judgment be "reasonable" precludes the kind of logical but far-fetched claims that would be enough to sustain an action under the rational basis test. The substance of the *Arline* approach has been well described in the behavioral account of rationality review, which, as discussed above, demonstrates that courts in public health cases have tended to consider the actual necessity of a measure, its likely effectiveness, its costs to individuals in relation to its benefits, and the existence of other equally effective, less costly alternatives.

It would be inaccurate, however, to categorize this as heightened scrutiny.[156] To begin with, it does not shift the burden of justification to the state. The state does not need to prove that it is right, but only to produce a reasonable medical judgment suggesting that it is not wrong.[157] A challenger carries her burden only if she can show that the health measure in question is not

155. *Id.* at 286 n.15.

156. This is a distinction that eluded the Fifth Circuit in Brennan v. Stewart, 834 F.2d 1248 (5th Cir. 1988), which is the decision that has come the closest to fulfilling the doctrinal potential of *Cleburne*. In *Brennan* the court described its "rational basis" scrutiny of government decision based on mental or physical handicaps as "somewhat closer than usual." *Id.* at 1258.

157. It is particularly noteworthy that in most of the health cases discussed here—*Arline*, *Glover*, *Chalk*—the health decision at issue was taken, not by a health official, but by a person or entity with some incidental duty to protect public health, but no particular public health expertise.

medically reasonable under the actual conditions in which it is applied.[158] Mere disagreement between medical authorities, or uncertainty as to the value of the chosen action, will not be enough.

Moreover, it remains a deferential standard: the court must defer to the judgment of health officials "unless those judgments are medically unsupportable."[159] While the requirement of medical reasonableness already constitutes a substantial limitation on the state's freedom to act, the requirement does not change the nature of the constitutional inquiry. In the rational basis health case, the court does not sit to choose or require the "best solution," but only to guarantee that the challenged state action has enough of a medical basis to be reasonable in public health terms. While deference to health officials tends to cut against the state in cases where the action at issue resulted from the decision of non-health personnel (for example, a school board), in cases like *Saint Mark's*, where the action was initiated by the health department, the rule of deference will make the measure very difficult, if not impossible, to defeat.[160]

Finally, the test does not intrude on the *process* by which the action is chosen. The decision to implement a particular measure does not have to have been made on a medical basis, nor must non-medical factors have been excluded. Rather, the test demands only that however the decision was made, and on whatever otherwise allowable basis, it be medically supportable.[161] This

158. Although this essay cannot undertake to describe the elements of medical rationality, there appear to be many ways in which a health action could be shown to be unreasonable: for example, there might exist an alternative that was considerably more effective and without a serious cost to individual rights; or it might be that the measure selected has a substantial cost to the persons against whom it will be applied, but has been rejected as without public health value by the vast majority of responsible public health officials. For a discussion of the proper criteria for health action, see generally Gostin, *supra* note 11.

159. *Arline*, 480 U.S. at 286 n.15.

160. Deference has the potential for being the joker in the deck of public health law. Its role has frequently been overestimated in past health cases, which, for the most part, have dealt with just two medically unimpeachable measures, vaccination and water fluoridation. In modern cases, it may well pose a problem of local versus national standards. It is not at all clear what courts will do when and if a local health department adopts a measure unavoidably in conflict with the recommendations of national health officials such as the Centers for Disease Control.

161. It is in this way distinguishable from the apparently "scientific" model of § 504. Using a hybrid model, the court will not consider how the decision was made, or even whether the medical justifications being offered to support a health measure were actually considered by the legislators or health officials who promulgated it, so long as there is in fact a reasonable medical basis for the measure. By contrast, the analysis under § 504 involves, it would appear, a de

test focuses more narrowly on the challenged measure and the state's justification, but it does not heighten generally the state's burden. It is not strict in theory, and will also not be fatal in fact.[162]

Such a test proceeds, it must also be said, upon a proper estimation of the state's interest in health actions. In *Arline*, the State of California argued, and the Supreme Court agreed, that the states have no interest in health measures which are not, in fact, reasonably likely to secure a medical benefit. Indeed, the amici wrote that "[i]f Section 504 were invoked to preclude actions by public health officials which were based on irrational, uninformed or medically unsupportable distinctions, the public interest would be furthered not hindered."[163] Implicit in this view, and in the treatment of health cases on a more or less medical basis throughout public health law, are the notions that the medical reasonableness of a health measure is an objective characteristic courts are capable of identifying on the basis of medical evidence, and that doing so does not interfere with the fulfillment of legitimate state interests.

The states undoubtedly do have a substantial interest in being able to take necessary action in the absence of complete or uncontradictable knowledge. Public health officials charged with preventing ill health must often proceed despite uncertainty about the nature of a threat or the efficacy of a remedy, and will normally elect to err on the side of caution.[164] This test accommodates that interest. Because the state need only produce reasonable medical support for its measure, the test privileges the state to proceed with health actions in areas of uncertainty. Under this test, indeed, political freedom asserts itself most prominently as a means of resolving medical uncertainty.[165]

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novo decision-making process in the courts, in which actual health officials will recreate the decision considering only the medical issues.

162. *See* Gunther, *Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1 (1972).

163. Brief of the State of California joined by Maryland, Michigan, Minnesota, New Jersey, New York and Wisconsin as Amici Curiae at 29, School Bd. v. Arline, 480 U.S. 273 (1987) (No. 85-1277).

164. *See* Gostin, *supra* note 11, at 489 ("Public health is based on the assumption that it is preferable to provide maximum protection against the spread of infectious disease. It is best that any risk of error be on the side of a . . . more cautious approach.").

165. The use of deference as a means of resolving medical uncertainty is rather common. In cases of setting safe exposure levels to dangerous substances, for example, the government must ground its findings of significant risk in substantial medical evidence, but "is not required to support its finding . . .

This has been a schematic introduction to the test derivable from *Arline* and the constitutional health cases of the past. While this discussion only begins to suggest the complexities of implementing, much less justifying, such a test, it suggests that the Court's nascent approach places a limitation on state prerogatives that will prevent irrational and punitive health measures without compromising the state's essential authority to protect public health.

VI. CONCLUSION

The great wrongs of the HIV epidemic will not arise so much in obviously irrational acts as in the steady procession of measures—pre-marital screening, prostitute testing, segregation of HIV-positive prison inmates, mandatory testing of hospital patients—which "make sense" to the People precisely because they comport with deeply held ideas about disease and disease control as traditionally practiced. Each of these is unreasonable to some degree in public health terms because of the high ratio of costs to benefits, and because the threat addressed is of a low order of magnitude in relation to other vectors of HIV transmission. They are unreasonable, that is, because they are predicated on the belief that something unlikely to occur is likely to occur, because its occurrence comports with a pre-existing impression of the world. In reviewing actions of this kind under the rational basis test, the willingness of courts to seriously address their medical reasonableness will be decisive.

There has been a tendency to think of public health cases as striking the balance between individual rights and public welfare. This essay has suggested that, at least for lawyers, the prime issue is delineating the freedom of the People to identify what is good public health policy and to select the means by which to achieve it. We enter the second decade of the HIV epidemic with several

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with anything approaching scientific certainty." Industrial Union Dep't v. American Petroleum Inst., 448 U.S. 607, 656 (1980) (plurality opinion); *accord* Forging Indus. Ass'n v. Secretary of Labor, 773 F.2d 1436, 1443 (4th Cir. 1985). Similarly, an employer taking action to protect employee health (to make out a business necessity defense), in part "carries its burden by showing that the body of opinion believing that significant risk exists is so considerable 'that an informed employer could not responsibly fail to act on the assumption that this opinion might be the accurate one.' " Hayes v. Shelby Memorial Hosp., 726 F.2d 1543, 1548 (11th Cir. 1984) (quoting Wright v. Olin Corp., 697 F.2d 1172, 1191 (4th Cir. 1982); *see also* Perritt, *Negotiated Rulemaking Before Federal Agencies: Evaluation of Recommendations by the Administrative Conference of the United States*, 74 GEO. L.J. 1625 (1986).

alternative legal devices for answering this basis question—the Rehabilitation Act, the fourth amendment and traditional public health law. In *Arline*, the Supreme Court suggested that the answers derived from these different regimes would be congruent.

Whether the Court is correct will depend on how well its signals are read. I have suggested that the practice of traditional health decisions, and the understated instruction of *Arline*'s footnote fifteen, is to require, even under the most deferential standard of review, that any health actions have a rational medical relationship to the goal of protecting public health. I have provided a formulation of the proper test, in order that constitutional protection would not, in Professor Tribe's words, "be left to the manipulable discretion of judges operating with multiple standards of review all masquerading as 'minimum rationality.' "[166] Nevertheless, the rational basis review of health decisions remains part of the larger confusion of three-tiered scrutiny, and one must be appropriately cautious in expecting the Court to carve out any explicit exceptions to its beleaguered rules of review.

In the end, the degree to which courts will overturn quietly hysterical health decisions will depend on their willingness to engage in sophisticated cultural and medical analysis and explanation, a willingness one cannot pretend to believe will be generous. Nevertheless, we already have a more promising starting point than perhaps we anticipated: mere logic will not be enough to justify a health measure even under minimal constitutional scrutiny. Taking *Arline* seriously, we may challenge courts to demand some reasonable medical basis for a health action, and to reject actions that proceed primarily from reflexive mythology. But ultimately, if we are to take health law and the *Arline* footnote seriously, we are left with unanswered questions of the most fundamental nature. "Conform . . . decisions with medically reasonable judgments"[167] is the passing answer. Will courts apply the test?

166. L. TRIBE, *supra* note 15, § 16-3, at 1445.
167. *Arline*, 480 U.S. at 286 n.15.