

CONCLUSION

Punishing Disease

On March 13, 2016, Corey Rangel was pulled over in southwest Michigan for having a loud muffler.¹ A police officer cited Rangel for driving without corrective lenses and without an operating license; however, the more serious issue was that Rangel was driving after his curfew. Rangel was nine months into his probation for felony drug charges. His case was diverted to Cass County's Adult Drug Treatment Program. According to Rangel, his probation officer initially brushed off the altercation with police, indicating to him that he did not want to violate him for such a minor incident. This might have been the end of it—except that Rangel was different from other individuals under probation: he was HIV positive. Hours later, he received an ominous phone call from probation officials: Report to jail immediately. And bring your cell phone.

When Rangel reported to jail, he brought his cell phone as requested. Officials demanded that he hand over his phone and provide them with the password to access information in it. Over the next several days, what began with a traffic stop for a loud muffler spiraled into a serious investigation that threatened to put Rangel behind bars for years. Rangel told reporters that a few days after arriving in jail, a local police officer showed up to ask him a few questions: "He asked me whether or not I was disclosing to my sex partners. . . . I told him I was. And he said he was going to contact them and ask them—to see if our stories matched up."²

Police admit to going through Rangel's phone and finding digital photographs of Rangel engaged in sex with other men. They admit to

then calling several of his phone contacts hoping to discover whether they knew that Rangel was HIV positive. According to one of the men who received one of these calls, Nico, police made it clear what information they were after without ever actually using the term *HIV*. Nico told reporters that they asked “basically just, you know, about him, like making me come out and say, ‘You mean his status?’ you know. So, ‘About that,’ and I’m like, ‘Yeah, I know about it. He told me already.’”³

In effect, police were investigating Rangel for not disclosing his HIV status on the basis of nothing more than the fact that he was HIV positive. That investigation failed to yield any legally actionable information. A police representative told a reporter, “It could have been a crime. We have investigated, and we found nothing criminal happened. The criminal case has been closed.” But even though the investigation into his HIV-disclosure practices may have been closed, the saga had just begun for Rangel. Over the next several months, authorities moved to dismiss Rangel from the drug treatment court. At the hearing to consider his dismissal, the drug court coordinator, Dr. Barbara Howes, testified about what led her to conclude that Rangel was a danger to society. Although she denied being made aware of the sexual photos police found on Rangel’s phone, she said that she was aware of his HIV status. The prosecutor inquired, “Would you consider that to be a potential danger to the public?” “Yes,” she responded. The prosecutor then asked whether she believed his traffic violation—the reason the case came to court in the first place—made him a danger to the public. “Possibly,” she said. “If he was consuming drugs or alcohol.”⁴

Corey Rangel was ultimately dismissed from the drug treatment court, which had the effect of violating the terms of his probation on felony drug charges. He entered a plea of guilty to probation violation charges in front of the very same judge who in 2009 had sentenced Melissa G. to five months in jail for allowing a client’s nose to penetrate her vagina, Judge Michael E. Dodge (discussed in chapter 5). Judge Dodge sentenced Rangel to 36–240 months in prison.⁵

While this book focuses on the cases brought under HIV exposure and disclosure laws, cases like Corey Rangel’s demonstrate that these laws can have effects that extend far beyond the cases brought directly under them—in Rangel’s case, by prompting law enforcement to view him with suspicion. Would an HIV-negative person on probation cited for a traffic violation have his phone seized and sexual partners contacted? Clearly, Rangel was treated differently because of his HIV status and viewed as a threat to public safety, as Dr. Howes herself said.

was pulled over in southwest Michigan. A police officer cited Rangel for driving without an operating license; however, the officer was driving after his curfew. Rangel was charged with felony drug charges. His case went to the Intensive Drug Treatment Program. According to the court, Rangel initially brushed off the altercation but he did not want to violate him for having been the end of it—except that he had individuals under probation: he was charged with having received an ominous phone call from probation immediately. And bring your cell phone. Rangel brought his cell phone as requested. The officer searched his phone and provide them with information in it. Over the next several days, what started as a muffled investigation spiraled into a serious investigation. Rangel ended up behind bars for years. Rangel told the court that while in jail, a local police officer showed him a photo and asked me whether or not I was doing what he was doing. And he said he was going to see if our stories matched up.”²

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Although she did not cite Michigan's felony disclosure law, nonetheless a pall of criminality associated with being HIV-positive loomed over Rangel's case.

When gay and lesbian rights organizations fought for four decades to get states to repeal their anti-sodomy laws, they did so in part because those laws symbolically validated what so many Americans believed: that gay sex was a crime. Similarly, HIV exposure and disclosure laws reinforce the view that sex for HIV-positive people is a potentially criminal affair, leading law enforcement to view people living with the disease with suspicion. In Corey Rangel's case, that suspicion led police to seize his phone and investigate his sex life. Law enforcement did not wait for a person to come to them to report Rangel; he was presumed guilty from the start by virtue of his HIV status.

These views are reflected in stories told in chapter 3 by Michigan health officials tasked with monitoring and controlling HIV-positive people in their counties. While the state's felony HIV disclosure law makes clear that the only legal obligation required of people living with HIV is to disclose their status to sexual partners, the civil health-threat law granting health authorities the authority to surveil and control the behavior of people living with HIV was more open to interpretation. When asked to describe the surveillance practices employed to identify potential health-threat cases, some health officials conflated failing to disclose with failure to use a condom. For example, in some counties, testing positive for a sexually transmitted infection was reported to be a sufficient rationale for labeling someone a health threat—despite the fact that a positive test result for gonorrhea does not indicate whether a person disclosed his or her HIV status. Underlying these surveillance practices is the assumption that sex for HIV-positive people is necessarily dangerous.

At the heart of these assumptions are distinctions between "risky" and "safe" behaviors that are not particularly nuanced. For example, as chapter 5 described, as many as one in three Americans continue to believe that HIV can be transmitted by kissing. But can we blame them? In 1997, the Centers for Disease Control (CDC) published a report of a woman who acquired HIV from "deep kissing" with an HIV-positive man.⁶ The *New York Times* proclaimed that the case was the "first linked to kiss" but went on to reveal that both individuals had gum disease and that she had recently had oral surgery (a root canal). The report notes that the CDC "has long recommended against deeply kissing an infected individual and said that individuals who did should be tested."⁷ Was it really *kissing* that was the risk factor in this case—or

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the improbable scenario of both partners having gum disease and one recently having undergone a root canal? The obsession in public health practice to distinguish between "risky" and "safe" has made it a chal- lenge to effectively communicate about HIV risk to the American pub- lic. In the face of rare cases or theoretical possibilities, some doctors and public health experts feel ethically obligated to emphasize risk rather than safety.

This dichotomous view of risk is often coupled with a special focus on individual behaviors stripped of any contextual factors. That HIV has been labeled a sexually transmitted infection has exacerbated this issue: Health authorities carve up the sexual act into an array of who-put- what-into-wheres, which are often distinguished in black and white terms as either safe or not. This is more likely for diseases we consider to be sexually transmitted and to HIV in particular. Would the CDC put out a news release if a new Zika or flu infection was "linked" to grocery shopping or going to the gym? Although both individuals in the CDC release cited above had gum disease, the link promoted was not the rela- tively rare probability of two people kissing who both have gum disease but instead the altogether commonplace behavior of kissing. Intentional or not, the effect is to absurdly exaggerate the risk of commonplace behaviors in the minds of many readers. Context, in fact, matters.

Even a handful of the Michigan health officials who formed the backbone of their counties' HIV/AIDS programs struggled to accurately evaluate the risk of transmission in particular scenarios. In a survey completed by officials interviewed for chapter 3, each official was asked to assign a risk probability to various scenarios along a scale of factors of 10—from less than 1 in 100,000 to 1 in 1. In sixteen of the twenty scenarios given, health officials on average overestimated the risk of transmission—sometimes by more than a factor of 10. For example, they were asked to evaluate the average risk of transmission for an HIV-negative woman who has vaginal sex *without a condom* once with an HIV-positive man. CDC estimates this risk to be less than 1 in 1,000 on average—not taking into account the HIV-positive partner's viral load. Seventeen of twenty-five (68 percent) health officials rated the risk at least a factor of 10 greater: two rated it at 100 percent; six rated it at 1 in 10; and nine rated it at 1 in 100. On average, health officials also evaluated identical behaviors (for example, oral sex) as posing a greater risk in scenarios involving gay men than in those involving heterosexual couples. If trained professionals consistently overestimate the risk of transmission, it is no wonder that lay Americans and legal professionals

do the same. For most Americans, where there is sex, so too must there be its accompanying risk—and where there is risk, there is the potential for harm. This slippery syllogism facilitates efforts to punish disease.

Yet, despite the fact that risk is ubiquitous for all Americans, the label of “risky” is selectively applied to certain social contexts—most frequently those involving marginalized groups, stigmatized behaviors, or undesirable social locations. Those social contexts then become the battleground for disease control. As chapter 1 made clear, the most intrusive and coercive measures aimed at controlling risk have at times been historically reserved for marginalized populations. From Seattle’s Firland tuberculosis clinic-turned-detention center for poor alcoholics to the prison camps built in World War II to house sex workers suspected of spreading venereal disease, disease control efforts have turned punitive when they are driven by social bias.

This process of labeling and stigmatizing echoes the way America has historically dealt with other socially undesirable groups. For example, during the first few months of his presidency in 2017, President Donald J. Trump signed an executive order banning nationals from seven majority-Muslim countries from entering the United States for ninety days.⁸ While the president argued that the policy was necessary in the face of a growing threat of terrorism, CNN anchor Chris Cuomo rebuffed those claims on the air, arguing instead that the policy was driven by “phobias, not facts.”⁹ Cuomo’s argument echoes much of the evidence presented in this book; while authorities in both cases frequently invoke discourses of risk as a veneer to justify harsh and coercive measures, a closer inspection of the evidence reveals the fear, ignorance, and stigma lurking beneath the surface.

Although punitive disease control is not new, HIV stigma facilitated the rise of an unprecedented criminal justice response to infectious disease. To be sure, there have been attempts historically to criminalize diseases, primarily sexually transmitted infections like syphilis. However, never in American history have states been so systematically aggressive in using the criminal law to punish individuals because of their illness—and in many cases, the real offense does appear to be HIV-positive status. Although HIV disclosure and exposure laws are, at least in theory, premised on punishing behavior, these laws are often written so broadly that they can transform even a garden-variety lap dance at a strip club into a felony.

The criminalization fever has arrived, and recent developments suggest it may be contagious. In 2014, Iowa reconsidered its HIV-specific

ere there is sex, so too must there be risk, there is the potential for stigmatized efforts to punish disease. Ubiquitous for all Americans, the link to certain social contexts—most notably, stigmatized groups, stigmatized behaviors, and the social contexts then become the focus. As chapter 1 made clear, the most difficult at controlling risk have at times been stigmatized populations. From Seattle's detention center for poor alcoholics during World War II to house sex workers since—disease control efforts have turned on racial bias.

Stigmatizing echoes the way America has treated undesirable groups. For example, the Presidential Commission in 2017, President Donald Trump banning nationals from seven countries entering the United States for ninety days—that the policy was necessary in the face of terrorism, CNN anchor Chris Cuomo arguing instead that the policy was Trump's argument echoes much of the while authorities in both cases fre— a veneer to justify harsh and coercive— the evidence reveals the fear, ignore—the surface.

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criminal law after a widely reported case involving an HIV-positive gay man accused of having sex while wearing a condom yielded a twenty-five-year prison term and lifetime sex offender registration.¹⁰ After a statewide advocacy campaign, the Iowa legislature moved to reduce the penalties for cases involving low risk—a success that was widely heralded by advocates as a sign of “modernization.” Less discussed was the simultaneous move to add a bevy of other infectious diseases to the criminal law, including tuberculosis, hepatitis, and meningococcal disease. Indeed, left-leaning advocacy groups even celebrated this shift as a triumph over AIDS stigma. The state's LGBT rights organization, One Iowa, noted in a press release, “Rather than single out HIV, the law now includes other infectious diseases.”¹¹ Iowa's legislative reform came on the heels of a similar expansion in Tennessee, where the legislature voted to extend the state's HIV-specific criminal statute to individuals infected with hepatitis B or C.¹² These developments suggest that the logic of criminalizing diseases is spreading and becoming more deeply entrenched in American society.

THE CRIMINALIZATION OF SICKNESS: A CONCEPTUAL MAP

Chapter by chapter, this book has implicitly been informed by a conceptual model of the social contexts and social forces that ultimately led to the criminalization of HIV. In what follows, this model is made explicit by explaining how the pieces of the puzzle fit together at three levels: the cultural level, the criminal justice and policy level, and the event level.¹³ As depicted in box 1, cultural attitudes and biases that provide the backdrop for efforts to regulate HIV include three social phenomena—stigma, responsibility politics, and ignorance and fear. These three factors are mostly outside the control of any individual person or organization but nonetheless have played a pivotal role in facilitating criminalization efforts at the criminalization and policy level. They act as resources for the institutions, authorities, and stakeholders that make up the second level to draw on in their efforts to promote or enact criminalization. For example, politicians have drawn on stigmatizing views of homosexuality and played on public fears of HIV to drum up support for new HIV-specific criminal laws. Finally, the third level consists of triggering events—sensationally reported arrests and ambitious politicians—that ignite efforts to criminalize HIV. While imperfect, this conceptual map illustrates the relationships between the different kinds

Box 1. Conceptual Map of Criminalization

1. Cultural Level
 - a. Stigma
 - b. Responsibility politics
 - c. Ignorance and fear
2. Criminal Justice and Policy Level
 - a. Crime policy
 - b. Complainants, law enforcement, and public health
 - c. State governments
3. Event Level
 - a. Moral entrepreneurs
 - b. Sensationally reported crimes
 - c. Interest group lobbying

of social phenomena identified as driving criminalization throughout this book.¹⁴

1. *The Cultural Level*

a. Stigma. Throughout the book, stigma—against not just HIV but also gay men and sex workers—has repeatedly reared its hoary head to drive efforts to criminalize HIV. As chapter 4 illustrated, early efforts to criminalize HIV were fueled by antigay and antiprostitution biases; there was considerable anxiety that HIV could bleed over from “high-risk groups” into the “general population”—a rhetorical othering that is characteristic of stigmatizing campaigns. In the case of prostitution, stigma against sex workers prompted police in states across the country to pressure lawmakers to enact a rapid succession of felony, HIV-specific prostitution laws. That HIV was steeped in homophobia and social anxieties around sex from the start made it prime fodder for lawmakers looking for new problems to punish.

b. Responsibility politics. This book has argued that the way we conceptualize disease has implications for how it is socially regulated. From the outset, conservative Americans blamed HIV-positive people for contracting the disease. But as chapter 2 revealed, in popular discourse HIV-positive people were nonetheless often discussed as “AIDS victims.” This changed over time, especially when treatment was intro-

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duced in the mid-1990s. Suddenly, people were *living* with HIV and thus deemed responsible for taking care of themselves. Public health responded by shifting resources away from campaigns telling HIV-negative people to use a condom and toward telling HIV-positive people not to infect their partners—a trend that has reinforced the idea that people living with HIV carry the greater share of the responsibility for managing the epidemic. The responsibility has often been conceptualized as belonging to the individual person living with the disease (for example, “HIV stops with me”) rather than something shared between people. As chapter 2 argued, characterizing HIV-positive people as individually responsible for preventing HIV transmission complements criminalization by implicitly assigning blame and victimhood—a characteristic feature of the criminal justice system.

Notably, pre-exposure prophylaxis (PrEP) threatens to reorganize these politics. (As discussed in chapter 2, PrEP is a strategy for preventing HIV in which an HIV-negative person takes medication to protect against HIV.) The first indications of PrEP’s impact on responsibility politics were visible in the wake of a highly publicized prosecution in San Diego, California, involving a gay male defendant accused of infecting a male partner with HIV. The complainant in the case gave a media interview in which he expressed regret for not being more educated about HIV, telling a reporter that “I didn’t know about PrEP. . . . I was not as educated as I needed to be and I think a lot of people aren’t.”¹⁵ His comments are suggestive that the burden of responsibility may be ever so slightly shifting in the shadow of PrEP. Yet, the uptake of the drug has so far been slow among the communities hardest hit by HIV—with 12 percent of prescriptions being issued to Latino patients and 10 percent to Black patients (by contrast, the CDC estimates that 45 percent and 24 percent of new HIV diagnoses in 2015 were among Black and Latino people respectively).¹⁶ Moreover, as most efforts to promote PrEP (and most of its subsequent uptake) remain limited to gay men, PrEP as it presently is being rolled out has done little to reshape the responsibility politics in the population identified in this book as hardest hit by criminalization: heterosexuals.¹⁷

c. Ignorance and irrational fear. As described throughout the book, many Americans (including the prosecutors, judges, and health officials tasked with enforcing the law) have a simplistic understanding of HIV. Lacking a nuanced or even a medically sound understanding of HIV and its transmission facilitates the generic conclusion that sex = risk =

harm. This pervasive ignorance acts as a moderator, clearing the path for criminalization to push ahead in the face of mountains of contrary scientific evidence. If HIV was a more normalized part of social life, criminalization would likely be less pervasive. Indeed, as shown in chapter 6, there appears to be a nearly perfect inverse relationship between communities most impacted by HIV and communities most impacted by criminalization—suggesting that criminalization flourishes in those communities that are least familiar with the disease.

2. *The Criminal Justice and Policy Level*

a. Crime policy. As described in chapter 4, laws enacted in twenty-eight states provide the infrastructure or foundation upon which criminalization is built. Although there were attempts to use laws already on the books (such as assault with a deadly weapon or attempted murder), a series of prosecutorial failures led many lawmakers and prosecutors to believe that the general law—with its problematic requirement to prove malicious intent—was not well suited for criminalizing unintentional HIV exposures; in twenty-eight states, lawmakers constructed a new system of legal infrastructure built to specification. This strategy differs from that of criminal justice authorities in Canada, who rely on existing sexual assault law to punish people living with HIV who do not disclose their status to partners.¹⁸ But the criminal code in Canada is federalized, while the United States has a decentralized criminal justice system in which criminal codes vary by state. This makes it possible for different states to enact widely different policy approaches. The particularities of each state law shape the cases that flow from it. For example, chapter 5 analyzed the cases brought under Michigan law (which criminalizes a failure to disclose before engaging in “sexual penetration”) and Tennessee law (which criminalizes “exposing” another to HIV). Because sex is built into Michigan law, spitting and biting cases that are relatively common in Tennessee are largely unknown to Michigan courts.

b. Complainants, law enforcement, and public health. Complainants, health officials, prosecutors, and judges are steering the ship. Their collective decisions, which were analyzed in chapters 3, 5, and 6—to call the police, to report a client, to press charges, to sentence harshly—ultimately determine how the laws in twenty-eight states described above are enforced. Their individual decisions are important, but they also are

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in many cases interdependent. For example, if a complainant decides not to report a client to police, the prosecutor cannot push forward; alternatively, if a prosecutor drops charges or a judge tosses a case out, the complainant cannot prosecute on his or her own. Although their hands are all on the ship's wheel, as it were, their influence is somewhat constrained by the laws in their respective states.

c. State governments. Lawmakers and the legislative branch of government ultimately hold the authority to decide the scope of criminalization efforts. As analyzed in chapter 4, this is a story that plays out mostly at the state level; federal agencies, such as President Reagan's Presidential Commission on the HIV Epidemic, play an institutionalizing role. Ultimately, state lawmakers determine the wording of the law and what criminal penalties get attached to it. While judges and prosecutors do not determine what the law says, as chapter 4 revealed, along with the general public they nonetheless attempt to exert their influence on state lawmakers. Police unions have often successfully lobbied state lawmakers to enact HIV-specific criminal laws, but, in the end, it is the lawmakers whose votes decide the fate of a particular bill.

3. The Event Level

Chapter 4 revealed how individual events and actors can trigger enormous change. Given enough sensational media coverage, a single arrest of an HIV-positive prostitute triggered entire campaigns to enact new HIV-specific criminal laws in many states. Chapter 4 also showed how individual actors (so-called moral entrepreneurs), such as Illinois representative Pullen, have been able to mobilize an array of resources at the federal and state levels to help catapult a model law to legislatures across the United States. In the right institutional and cultural contexts, these seemingly minor events and people can play an outsize role in shaping criminalization efforts.

Taken together, these levels offer a conceptual map for HIV criminalization. It is not intended to be a perfect or exhaustive list of every single factor that can play a role; rather, it provides an overview of the most critical puzzle pieces. Although it will not provide a perfect template for other diseases, efforts to criminalize sickness in the future will almost certainly share many of the same elements. Stigma, pervasive ignorance, and a belief that people with a particular disease are to blame for their

infection are likely hallmarks of efforts to criminalize sickness. But they alone are not enough.

WHY NOT PUNISH DISEASE?

Some readers may wonder what is so bad about criminalization? Criminalization magnifies many of the problems that plague coercive strategies for managing public health problems analyzed in chapter 1. Because the risk of criminalization spreading to other areas of American life appears high, it is especially important to address this question head-on. This section will discuss five of the most distressing problems posed by criminalizing sickness.

1. *It often gets it wrong.* As chapter 1 revealed, coercion is nothing new in public health history. Although there are successful examples of coercive practices historically, there is also evidence that the state often implements coercive practices in ways that do little to control the spread of disease. For example, cordons sanitaires were a common tool to control the plague in medieval times, yet these blockades did little to stop the disease vector, rats, from traveling and spreading infected fleas to people in other neighborhoods. In the case of HIV criminalization, the tool promoted by the state for controlling disease is HIV-status disclosure rather than blockades. But there are good reasons to believe that disclosure is just as shoddy a tool for managing the spread of HIV.

First, many people who are HIV positive do not know that they are infected and believe themselves to be HIV negative. The CDC recently estimated that approximately 15 percent of people living with HIV in the United States are not aware of being infected.¹⁹ People who do not know they are infected with HIV obviously cannot disclose their status to partners. This is a much bigger problem than it may seem: evidence shows that individuals who are HIV positive but do not know it also tend to be the most infectious. This is because people with HIV who are undiagnosed and thus not yet on a treatment regimen can have up to a *million* copies of the virus in every milliliter of their bodily fluids, making it far more likely that a sexual partner will contract the disease; after diagnosis, however, doctors prescribe antiretroviral treatment that clamps down on the virus's ability to replicate—often to the point that the virus becomes undetectable. To this point, one study estimated that 54–70 percent of all new sexually transmitted HIV infections were attributable to sexual contact with someone unaware of their HIV-positive status.²⁰

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In addition, as chapter 2 described, there is a growing consensus among public health experts that people living with HIV who are on treatment and whose viral load is undetectable cannot infect their partners. By contrast, because the most commonly used HIV antibody tests do not always detect infection until up to six months after transmission, the results of a nonreactive HIV-antibody test from *yesterday* may not reliably indicate someone's actual HIV status. Taken together, these findings suggest that the best way to contract HIV is to have condom-
less sex with someone who thinks he or she is HIV negative. Mandating disclosure implicitly promotes this risk by making it appear as though sex with HIV-negative partners is safe; in many cases, however, choos-
ing to have sex only with HIV-negative people may result in a greater risk of infection. In short, if preventing HIV is the goal, then promoting disclosure is the wrong strategy.

2. *It is subject to abuse.* Chapter 1 revealed how coercive strategies have often been mired by the ignorance and/or prejudice of the officials in charge of implementing them. Seattle's tuberculosis sanatorium became a de facto prison for homeless alcoholics, while turn-of-the-century efforts to control an outbreak of the plague in San Francisco led to racist policies that selectively quarantined Chinatown. As chapters 4 and 5 revealed, HIV exposure and disclosure laws were borne out of stigmatizing views of HIV that continue to guide the hands of law enforcement as they punish people living with HIV today. Blatantly ignorant views of HIV are codified into case law by judges who have no expertise in infectious disease but nonetheless accept a prosecutor's claims that a victim may wind up testing positive decades after a sexual encounter.

3. *The stakes are high.* While quarantine programs generally end relatively quickly, incarceration can last for years—and under new state sexual predator laws, perhaps even for life. After inmates are released from prison, they go back to a life marred by the label of a felon, facing not just the loss of rights like voting and social benefits like food stamps, but also patterned unemployment and a high risk of poverty.²¹ Defendants convicted in Louisiana and Tennessee also face having to publicly register as a sex offender. In Louisiana, that means having the phrase *SEX OFFENDER* printed in red capital letters underneath one's driver's license photo. In short, criminalization can have devastating effects on convicted defendants that can be both immediate and long-lasting.

4. *It is hard to change.* Even in cases where lawmakers agree that the criminal justice system is broken and in need of change, actually

enacting that change is an uphill battle. Once a criminal law is on the books, it is exceedingly difficult to get it removed. This problem did not recently arrive alongside the gridlock in American governance in recent years; it has a long history driven by American lawmakers and political parties locked in a race to be seen as ever tougher on crime.²² In a context in which repealing a criminal law can make a lawmaker vulnerable to losing the next election, criminal laws tend to accumulate ad infinitum. This tendency has led some legal philosophers to argue that criminalization ought to be a last resort.²³

In contrast to the criminal justice system, epidemiology and medical science can change overnight, as new treatments, vaccines, and prevention measures are developed. These advancements radically change the context for people living with a particular disease. When most state legislatures decided to criminalize HIV, the virus was largely untreatable and, for many, terminal. Today, one recent study estimates that a twenty-year-old gay man diagnosed with HIV who starts treatment immediately will live to be 89.3 years old (as mentioned in chapter 2, this is several years longer than life expectancy estimates for twenty-year-old men in the general population).²⁴ HIV is not the same disease it was in 1985 (or 2015, for that matter), yet the laws regulating it have scarcely been touched since they were enacted.

Even if a cure for HIV is developed, these laws will not automatically disappear. Recent developments for hepatitis C raise ominous signs for how an HIV cure might play out in a legal context. While the hepatitis C drugs cure the disease in most patients, the pharmaceutical companies making them charge upward of \$100,000 for a course of treatment—making these life-saving medications out of reach for many people living with the disease.²⁵ If a \$100,000 cure for HIV comes to market, will the poor continue to face legal sanction for not disclosing their status? Because the move to criminalize hepatitis C in Iowa came one year *after* the FDA approval of one of these revolutionary hepatitis C therapies, all signs point to an emphatic yes.

5. *It does not accomplish what we want it to do.* Why do we punish? Experts on criminal justice have long held that there are several schools of thinking when it comes to answering this question. Four are worth describing here as they each represent one yardstick by which we might measure the “success” of criminalization efforts. In each case, the evidence suggests that these laws are either not effective or are vastly disproportionate to the offense in question.

le. Once a criminal law is on the books, it is removed. This problem did not exist in American governance in recent years. American lawmakers and political leaders have been ever tougher on crime.²² In a context where a lawmaker vulnerable to public opinion tends to accumulate ad infinitum philosophers to argue that criminal

system, epidemiology and medical treatments, vaccines, and prevention advancements radically change the trajectory of the disease. When most state laws were enacted, the virus was largely untreatable. The recent study estimates that a person with HIV who starts treatment within 100 days (as mentioned in chapter 2, on life expectancy estimates for twenty-year-olds).²⁴ HIV is not the same disease it was in 1980, yet the laws regulating it have remained largely unchanged.

And, these laws will not automatically address hepatitis C raise ominous signs for a legal context. While the hepatitis C patients, the pharmaceutical companies of \$100,000 for a course of treatments out of reach for many people. The \$100,000 cure for HIV comes to a legal sanction for not disclosing criminalize hepatitis C in Iowa came from one of these revolutionary hepatitis C treatments.

We want it to do. Why do we punish? It is held that there are several schools of thought on this question. Four are worth mentioning as one yardstick by which we might evaluate criminalization efforts. In each case, the evidence is either not effective or are vastly distorted.

Retributive theories of punishment argue that we punish because people who break the law deserve social sanction. Of the four schools of thought presented in this section, retribution is by far the predominant narrative in HIV disclosure and exposure cases. In particular, in many of the victims' narratives described in chapter 5, they explicitly plead with the court to impose harsh punishment because of the harm the defendant inflicted. But as chapter 5 illustrated, the harm may often be illusory and in many cases largely based on ignorant views of HIV. Indeed, the laws are worded in such a way that the crime is failure to speak, a crime of omission; the state is not required to prove that defendants actually inflicted physical harm (or even the risk of harm) on their partners. Psychological duress—rooted in many cases in an irrational fear of HIV—seems in many cases to be the only measurable harmful outcome. If psychological duress is the primary harm punished under HIV exposure and disclosure laws, then an average prison sentence of nearly nine years seems out of step with most just deserts theories of punishment.

Rehabilitative theories of punishment argue that we punish to improve criminals so that they can be reintegrated back into society. Rehabilitation narratives were few in HIV disclosure and exposure cases. Although most cases received prison sentences, the minority of cases sentenced to probation often included terms that required the defendant to seek treatment or counseling, requirements that seem to exhibit a rehabilitative spirit. Although this study did not systematically evaluate whether these terms were effective, the case of William K. (discussed in chapter 5) reveals that, at least in his case, the system utterly failed. When William missed several appointments with a counselor, the court violated his probation and threatened to put him behind bars, ignoring his complaints that he felt unwell. William died of cryptococcal meningitis days before he was to be sentenced for violating his probation for missing appointments with a counselor. While his case is but one, it reveals the hollow, empty vision of rehabilitation practiced in some criminal justice contexts; beneath the thin veil of rehabilitation lies a system built for retribution. Rehabilitation might be an effective approach in these cases, but its spirit is largely unknown in the application of HIV-specific criminal laws today.

Incapacitation theories argue that we punish in order to separate dangerous individuals from society in the interest of public safety. For example, when Brenda J. was sentenced to prison in 1995 in the Michigan case described in chapter 5, the judge explicitly argued that he was

sentencing her to prison in order to protect the public. Although some defendants may pose a threat to society, the law does not require that the state prove that anyone was put in danger by the defendant; instead, it presumes that the failure to disclose is itself dangerous. This presumption may have been arguably more sustainable when HIV was untreatable and largely terminal, but in a contemporary context the argument loses steam. Today, both defendants and complainants have at their fingertips tools that can stop sexual transmission dead in its tracks: condoms, pre-exposure prophylaxis (PrEP), and effective treatment. These technologies make it harder to categorically describe all cases of nondisclosure as inherently dangerous. Consequently, incapacitation seems an increasingly untenable justification for most state HIV exposure and disclosure laws.

Finally, *deterrence* theories argue that we punish so that other people will think twice before engaging in the same criminal behavior. Some people might argue that having HIV exposure and disclosure laws on the books is important because they deter nondisclosure. Studies have actually attempted to evaluate whether HIV-specific criminal laws have an effect on people's sexual practices. For example, a study published in 2007 found that individuals living in a state with an HIV-specific criminal law (Illinois) did not differ in their self-reported HIV risk behaviors from individuals living in a state without such a law (New York).²⁶ Similarly, a study published in 2010 found that the reported rates of condomless sex among MSM living with HIV did not vary between states with and without an HIV-specific criminal law.²⁷ A separate study of 384 people living with HIV in Michigan published in 2012 found that awareness of their state's HIV disclosure law was not associated with increased likelihood of disclosing their HIV-status to all potential sexual partners.²⁸ Finally, a 2017 study found no association between state-level HIV diagnoses rates and criminal HIV-exposure laws.²⁹ Taken together, these findings suggest that HIV-specific criminal laws are not an effective strategy for changing the behaviors of people living with HIV.

CONCLUSION: BEYOND BLAME

As this book makes clear, no one lawmaker, defendant, or interest group could reasonably be said to be solely responsible for criminalizing HIV. In chapter 4, Representative Pullen is described as Lawmaker Zero with tongue planted firmly in cheek. Rather than an attempt to blame a par-

to protect the public. Although some society, the law does not require that put in danger by the defendant; instead, the defendant is itself dangerous. This presumption is sustainable when HIV was untreatable in a contemporary context the argument that defendants and complainants have at their disposal is dead in its tracks: condom use (PrEP), and effective treatment. These arguments egorically describe all cases of nondisclosure. Consequently, incapacitation seems an option for most state HIV exposure and

the idea that we punish so that other people will not engage in the same criminal behavior. Some HIV exposure and disclosure laws on the other hand deter nondisclosure. Studies have actually shown that HIV-specific criminal laws have an effect. For example, a study published in 2011 in a state with an HIV-specific criminal law found that their self-reported HIV risk behaviors without such a law (New York).²⁶ Similarly, a study found that the reported rates of condom use with HIV did not vary between states with and without criminal law.²⁷ A separate study of 384 people published in 2012 found that awareness of the law was not associated with increased condom use to all potential sexual partners. There was no association between state-level HIV-exposure laws.²⁹ Taken together, these findings suggest that HIV-specific criminal laws are not an effective means of protecting people living with HIV.

ME

Lawmaker, defendant, or interest group is equally responsible for criminalizing HIV. The book is described as Lawmaker Zero with the focus rather than an attempt to blame a par-

ticular person for bringing HIV criminalization to pass, the notion of a Lawmaker Zero and this book more generally are attempts to turn the classic public health model of studying the HIV epidemic on its head. Scholarship on HIV tends to focus on the practices of people living with the disease or those at risk of contracting it. We know far less about the practices of lawmakers, prosecutors, and health officials who manage the epidemic. However, as this book shows, their practices, beliefs, and institutional contexts play a significant role in shaping our response to the epidemic—and thus the epidemic itself.

Some readers may have found the Lawmaker Zero concept a bit silly precisely because popular discourse on communicable disease control is not filled with images of prosecutors or elected officials. The notorious figures in infectious disease history such as Patient Zero and Typhoid Mary are fictions created to stigmatize individuals living with infectious diseases. And yet, the stigmatizing efforts of conservative leaders have contributed far more to inflaming HIV stigma and thus the epidemic than any one French Canadian flight attendant could have ever done. In the popular imagination, the responsibility for HIV has not been equally shared by people living with the disease and the authorities who manage our response to it. In that sense, *Punishing Disease* is a plea to turn our critical gaze to the political leaders, institutional forces, prosecutors, and judges that also play a critical role in the social life of HIV.

There are signs that states are responding to critics such as UNAIDS that charge that these laws are overly broad.³⁰ Notably, in 2012, Illinois amended its felony HIV-specific criminal law to require proof of intent; to prevent prosecution for oral sex, kissing, spitting, or biting; and to provide an affirmative defense for condom use.³¹ As already mentioned, Iowa lawmakers amended their state law to reduce the penalties for the least egregious types of cases. A Tennessee appeals court ruled in 2012 that courts must have a medical professional testify that a defendant's actions actually posed a "significant risk" to their partner or victim as seemingly required under the law (although the impact of this ruling remains unclear, as prosecutors continue to file HIV exposure charges related to spitting and/or biting incidents).³² Whether other states will follow their leads remains to be seen.

Even as state lawmakers and appeals courts winnow their laws in ways that would seem to limit their scope, the basic notion that punishment is an appropriate tool for controlling disease remains unchallenged. Ultimately, if we are to resist the impulse to punish disease, we

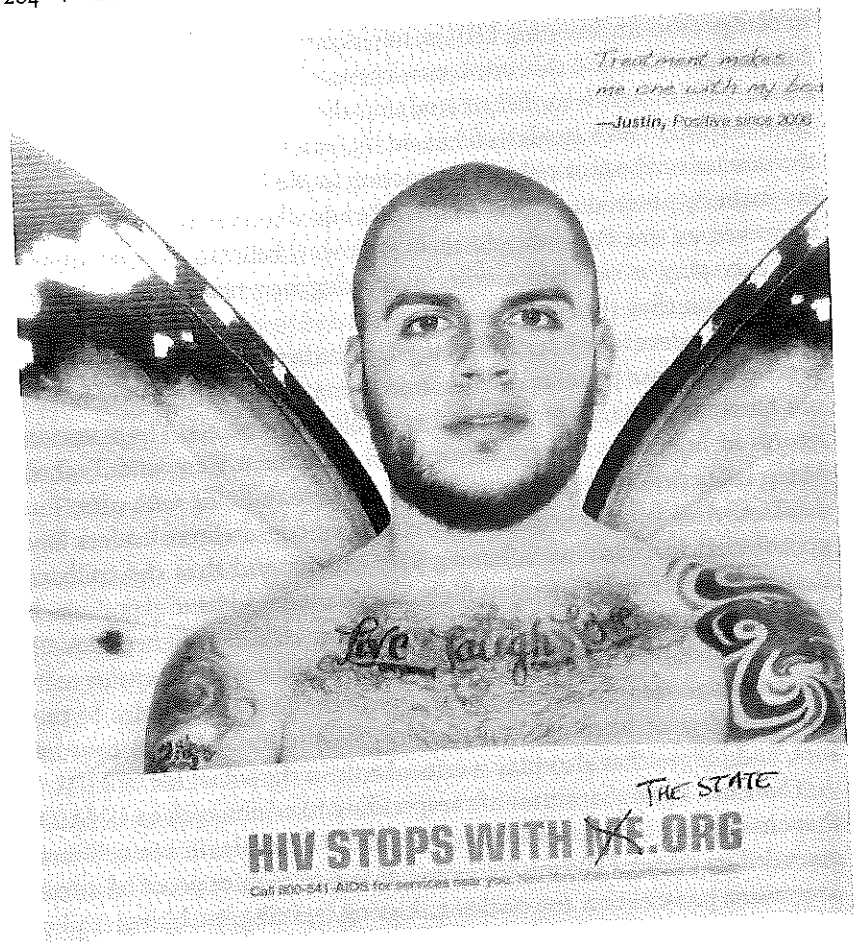


FIGURE 2.2. HIV Stops with the State. Source: Theodore Kerr.

must find a way to move beyond blame.³³ The following three strategies might help communities do that.

1. *Promote collective responsibility.* Although it makes for a great slogan, HIV does not truly ever stop with “me.” The responsibility for managing, containing, and preventing the spread of HIV rests on the shoulders of not just individuals but also communities, organizations, institutions, state governments, and international agreements. In 2016, an unknown AIDS activist defaced an HIV Stops with Me campaign poster in Brooklyn, New York, to make a similar point, crossing out “Me” and writing in black marker “THE STATE” (see figure 2.2).



Source: Theodore Kerr.

lame.³³ The following three strategies

ability. Although it makes for a great op with “me.” The responsibility for uting the spread of HIV rests on the out also communities, organizations, d international agreements. In 2016, d an HIV Stops with Me campaign o make a similar point, crossing out c “THE STATE” (see figure 22).

As this book has shown, promoting a model of individual responsibility facilitates the transformation of HIV as a medical problem to HIV as a criminal problem. Recontextualizing people living with HIV within their broader communities and institutional environments would make it more challenging to frame HIV as a criminal problem.

What might that look like in practice? Many of the testing campaigns targeting HIV-negative individuals reviewed in chapter 2 provide some clues. Those campaigns placed the decision to get tested for HIV-negative individuals in the context of their intimate relationships, families, and friends. But more than just making an appeal based on interpersonal relationships, public health might seek to highlight the ways that institutions such as health care, public health, housing, and the economy shape the ways in which people navigate HIV. This could entail putting doctors, health officials, hiring managers, and landlords at the center of a public health campaign. Instead of focusing on promoting an ethic of individual responsibility among people living with HIV, this hypothetical HIV Stops with Us campaign might instead promote the ways that authority figures in our lives can help to normalize HIV and make disclosure a nonevent.

2. *Promote alternatives to responsibility.* Responsibility—shared or individual—is not the only social good worth promoting in the name of public health. As previously mentioned, recent debates over pre-exposure prophylaxis (PrEP) are often framed in terms of whether its users might interpret the drug as giving license to individuals to behave “irresponsibly.” But there are other frameworks other than individual responsibility for understanding PrEP’s public health significance. In January 2017, the Los Angeles LGBT Center launched a public health campaign that promoted PrEP without emphasizing responsibility. Its campaign slogan, “F*ck without fear,” instead highlighted the liberatory aspects of PrEP to free its users from the fear of contracting HIV.³⁴

Although the LGBT Center did not say so explicitly, the F*ck without Fear campaign was likely a tacit response to efforts by the nation’s largest AIDS-service organization, the AIDS Healthcare Foundation (AHF, also based in Los Angeles). The organization’s executive director, Michael Weinstein, has been an outspoken critic of PrEP; he has previously derided the HIV prevention tool as a “party drug” and even taken out full-page advertisements in LGBT news outlets criticizing PrEP.³⁵ AHF has instead aggressively promoted condom use, sometimes by using nationalist and punitive tactics. In 2012, the foundation launched a Condom Nation campaign (complete with an Americana motif and a

slogan that intentionally rhymes with “condemnation”) and later fought to put an initiative on the California ballot in 2016 that would have required adult film actors to wear condoms or face punitive fines (the initiative was defeated at the ballot box).³⁶

Whatever position on PrEP’s utility that one takes, the LGBT Center’s campaign reveals that promoting responsibility (and/or blame) need not be the sole strategy for HIV prevention practitioners. Given the resonance that responsibility rhetoric can have with efforts to punish people living with HIV, public health organizations wishing to resist efforts to criminalize sickness may strive to imagine alternative approaches when designing interventions.

3. *Combat stigma and ignorance.* Let’s face it: People living with HIV are often afraid to disclose their HIV status because many Americans hold extremely prejudiced and ignorant views of the disease. Although some readers may presume that most Americans are well informed about HIV, surveys suggest otherwise. As previously noted, upward of one-third of Americans report believing that HIV can be transmitted through casual contact such as kissing—a figure that hasn’t changed much since the 1990s. Data such as these suggest that many Americans grossly overestimate the risk of transmitting HIV through sexual contact—not to mention ignoring how HIV treatment and undetectable viral loads can mitigate risk. Consequently, fighting for comprehensive sex education that includes scientifically accurate information about HIV could be one key strategy in a movement to combat HIV stigma. This is especially needed for low-HIV-prevalence communities that are disproportionately affected by criminalization (as chapter 6 revealed).

Finding ways to normalize HIV and people living with HIV is key to reducing stigma. Beyond primary schools, this could include featuring HIV-positive characters in popular media. For example, in 2015, the popular ABC drama *How to Get Away with Murder* included a story line featuring a gay couple in which one person tests HIV positive and the other begins taking pre-exposure prophylaxis (PrEP).³⁷ To write the story line, writers worked with CDC staff to accurately portray PrEP and HIV.³⁸ That coverage undoubtedly provided countless American households with their first exposure to the idea that HIV transmission could be prevented by taking a daily pill. According to Nielsen data, episodes of *Murder* during that season reached an average of 13 million households—far more than any billboard or bus poster campaign could ever hope to reach.³⁹

The success of *Murder* and its PrEP story line reveals how cooperation between Hollywood and public health can produce effective results.

with “condemnation”) and later a California ballot in 2016 that would require condoms or face punitive fines (allot box).³⁶

It is the reality that one takes, the LGBT Center’s responsibility (and/or blame) need to be addressed by prevention practitioners. Given the challenges that can have with efforts to punish, health organizations wishing to resist may strive to imagine alternative solutions.

Let’s face it: People living with HIV are stigmatized because many Americans have ignorant views of the disease. Although most Americans are well informed about the disease. As previously noted, upward of 80% of people living with HIV are unaware that HIV can be transmitted through sharing needles—a figure that hasn’t changed in decades; these suggest that many Americans are not understanding HIV transmission. Preventing HIV through sexual contact, using HIV treatment and undetectable viral load, frequently, fighting for comprehensive and scientifically accurate information about HIV, and a movement to combat HIV stigma. In HIV-prevalence communities that are undergoing criminalization (as chapter 6 revealed), and people living with HIV is key to reducing stigma. In schools, this could include featuring HIV in media. For example, in 2015, the popularity of *Murder* included a story line in which the person tests HIV positive and the person receives PrEP (PrEP).³⁷ To write the story to accurately portray PrEP and HIV.³⁸ And countless American households with HIV transmission could be prevented. Nielsen data, episodes of *Murder* during the last 13 million households—far more than any campaign could ever hope to reach.³⁹ The PrEP story line reveals how cooperative health can produce effective results.

However, because the story line depicts a gay couple negotiating HIV risk, it is conceivable that heterosexual audiences will not view it as especially relevant to their own lives. Yet, as chapter 6 revealed, it is these heterosexual audience members who are disproportionately affected by the criminal law. In the minds of many TV viewers, HIV infection remains a thing that happens to other people. Precisely because of its infrequency, destigmatizing HIV in low-prevalence communities will be an especially challenging task.

4. *Promote alternatives to prosecution.* In cases where legal reform is unlikely or not possible in the short term, it may be possible at the local level to institute alternative programs aimed at reducing the number of felony cases filed. As incarceration rates have exploded over the past three decades, advocates have increasingly called for authorities to devise and implement restorative justice and alternatives to criminal prosecution. Instead of spending years in prison, a defendant might instead be called on to volunteer or engage in community service, to make financial amends to the crime victim, or to meet with the crime victim directly for mediation or arbitration.⁴⁰ Given that the harm in the vast majority of HIV exposure and disclosure cases is limited to psychological duress, this seems to be a proportionate and particularly suitable strategy for keeping HIV-related cases from proceeding to prosecution.

5. *Speak the same language (or at least try to translate).* This book has argued that lawmakers and prosecutors translate HIV from the language of medicine to the language of criminality. For legal authorities, the impetus to criminalize HIV does not depend on medical evidence; it is instead a matter of morality and ethics. Those are the grounds of debate. Many critics of criminalization begin their critique on the basis of public health evidence; as this book shows, these arguments were uniformly unsuccessful in courts of law. They are also unlikely to sway lawmakers who view the problem in moral terms.

Trying to persuade lawmakers and prosecutors to move beyond blame will require either speaking the language of the law or translating between law and medicine. To the first point, critics might seek ethical and moral grounds upon which to defend individuals accused of not disclosing their HIV-positive status to sexual partners. To do so, they might frame their arguments in the language of privacy rights or other constitutionally guaranteed protections. This is, admittedly, likely to be an uncomfortable proposition for many HIV advocates, who are far more fluent in the language of science and public health. For those unable or unwilling to mount a moral or ethical defense of nondisclosure,

it may be possible to instead translate between the language of the law and the language of public health. That translation necessarily begins with an acknowledgment of both perspectives in an effort to find a common understanding. This will require grappling with complicated and difficult questions such as what is the difference between “risk” (a public health concept) and “harm” (a legal concept).

These strategies are not exhaustive, by any means. Instead, they are presented to begin a conversation about how we can control infectious disease while also avoiding shaming, blaming, and punishing. Those tactics are counterproductive and do not end epidemics. If this book has demonstrated anything, it is that the causes and effects of criminalizing sickness are themselves social ills. Stigma begets stigma. Ignorance begets ignorance. To break the link between disease and punishment, we need new tools.