INTRODUCTION

Punishment

AIDS in the Shadow of an American Institution

The states should pass laws and/or step up enforcement of their laws against homosexual activity. As much of a moral issue as it is, homosexual activity is also now a health threat of epidemic proportions, and it simply cannot be allowed.

—Rev. Jimmy Swaggart, July 20, 1986[1]

It is time for the homosexual community to publicly chastise itself for its promiscuous sexual practices that is causing the spread of AIDS more to its own people and now the heterosexual community.

—Louis Sheldon, October 5, 1985[2]

AIDS carriers are a threat to society, and the state has a compelling interest in protecting the uninfected. I am weary of politicians who pander to perverts with an eye to the next election.

—Former Indiana Representative Don Boys, June 24, 1988[3]

We sue for everything that our forefathers would never have done, and we blame everybody for everything. Now that we have done all of this, we have AIDS, child abuse, wife abuse, satanic cults, gang killings, rampant dope dealers and users, children killing children, people wanting everything free, having children to get more, AFDC, murder rising, rape more than ever in history, and the police cannot get the paper work done before some judge lets those arrested back out on the street.

—Joan Parrish, February 28, 1989[4]

From the very beginning of the epidemic, AIDS was linked to punishment. For evangelical Americans, AIDS represented divine punishment for the moral depravity sweeping America—namely, what conservatives derisively termed the "homosexual lifestyle." According to a 1987 Gallup poll, 61 percent of American evangelicals and 50 percent of non-evangelicals agreed with the statement "I sometimes think AIDS is a punishment for the decline in moral standards."[5] Televangelists like Jimmy Swaggart and Pat Robertson took to the airways to publicly condemn homosexuality as the cause of AIDS. Their like-minded political counterparts, activists such as William F. Buckley and Lyndon LaRouche, spearheaded campaigns aimed at getting states to pass punitive laws: to criminalize homosexuality, to tattoo newly diagnosed patients, to raid gay establishments.[6]

AIDS activists fiercely resisted these policies as draconian efforts to trample on civil liberties—policies that they argued were stigmatizing and thus likely to be counterproductive in the fight against AIDS.[7] Activists argued that freedom and privacy, not coercion and intrusive surveillance, were the keys to a successful disease control strategy. Despite their efforts, in the late 1980s state lawmakers around the country began to introduce criminal legislation targeting people living with HIV, whom they viewed as recklessly exposing their sexual partners to the disease. Echoing the sentiments of many Americans, a California newspaper editorial argued in 1987 that these laws were needed "to prevent unstable AIDS victims from passing on a death sentence to others."[8] Although they are sometimes mislabeled as "HIV transmission laws," most criminal laws enacted in the United States governing HIV exposure and/or disclosure make no mention of transmission or even the risk of that outcome. Instead, these new offenses resemble what prosecutors call a "crime of omission": by failing to reveal their HIV status to their partners, HIV-positive people in dozens of states can now face stiff prison penalties if charged under these felony statutes.

Although AIDS crystallized a specific set of social anxieties about sex, drugs, and death, the brand of punitive rhetoric and policies it spirited was not unique to AIDS in the 1980s. While President Reagan's administration is notorious for its callous indifference to the epidemic, First Lady Nancy Reagan is equally notorious for her Just Say No campaign against drugs. President Nixon first announced a war on drugs in 1971, but it was ratcheted up to new heights in the 1980s as federal and state authorities instituted a swath of new policies aimed at keeping drug users behind bars for as long as possible.[9] In the midst of these

heated policy debates, some authorities even made extremely sensational calls for drug dealers to be put to death. In 1986, for example, Vice President George Bush told reporters that he would probably support the death penalty for large-scale drug dealers.[10] Four years later, Los Angeles Police Chief Daryl Gates (founder of the D.A.R.E. school program) testified before Congress that he believed casual drug users were treasonous and "ought to be taken out and shot."[11]

There are striking similarities between the conservative backlash to AIDS and the crackdown on drugs. While conservatives promoted policies that targeted homosexuality in the face of AIDS, so too did they promote policies that targeted stigmatized minorities in their war on drugs. The racism underlying the Reagan-era drug war was belied by its special focus on a drug that was disproportionately used by poor Black Americans: crack cocaine.[12] Indeed, Congress enacted the Anti-Drug Abuse Act of 1986 that mandated extremely different sentences for crack cocaine (five years for five grams) and its powdered cousin more commonly used by Whites (five years for *five hundred* grams); while this one hundred-to-one disparity was on its face "color-blind," critics nonetheless viewed it as racist because of its devastatingly disparate impact on Black men.[13] By the end of the decade, America's jail and prison population had doubled to over one million inmates; while African Americans constituted just 12.1 percent of the American population in 1990, they made up a lopsided 48.4 percent of its booming prison population.[14] Like the homophobia that haunted the conservative backlash to AIDS in America, racism drove America's obsession with punishing crack cocaine.

The war on drugs and the punitive response to HIV are but two examples of a more seismic shift in American corrections policy; lawmakers increasingly turned away from the rehabilitative spirit of the 1960s and 1970s in favor of far more punitive approaches that were rooted in retribution—or punishment for punishment's sake. This trend away from rehabilitation was driven by three key social factors. First, crime rates had risen sharply from the 1960s, reaching historically high levels just as AIDS began to emerge in the early 1980s.[15] Second, inconsistent social science findings had eroded the confidence of American criminal justice authorities in the effectiveness of such programs, although they had seen rehabilitation as a key part of their mission during the 1960s and 1970s.[16] Third, conservatives organized a racist backlash to civil rights activism that linked criminality with race and frequently portrayed young Black men as lawless "superpredators" that needed to be controlled and punished.[17] These three factors struck fear

into the hearts and minds of middle-class and White Americans, leading to escalating calls for "tough-on-crime" policies that disproportionately impacted the poor and racial minorities.[18]

This network of punitive policies led to dramatically higher rates of incarceration in the United States. Since 2002, America has had the highest incarceration rate in the world—surpassing even repressive regimes such as Russia.[19] Although the total correctional population peaked in 2007, 716 of 100,000 Americans were behind bars in 2013 (the latest year this figure was available at the time of publication).[20] Far from being a reflection of increasing crime rates, incarceration rates have skyrocketed while crime rates have plummeted. This spike in incarceration cannot be entirely explained by increasing crime or even a rise in the number of arrests; sociologists instead explain that much of the increase in incarceration can be explained by determinations made after arrest: rather than issuing warnings or minor citations, criminal justice authorities are incarcerating a greater share of arrested defendants than ever before.[21] This panoply of punishment has reinforced and deepened racial inequality in American society, leading to some to charge that it represents a new era of Jim Crow.[22] For example, researchers estimate that in 2004, 33.4 percent of African American adult males had a felony conviction as compared to 7.5 percent of adults overall.[23] Higher rates of incarceration are associated with numerous negative outcomes, from unemployment to worsened health and family dissolution.[24] This "mass incarceration" has led sociologists to argue that punishment has become a new American institution that is fundamentally disrupting the way our society is organized.[25]

The story of mass incarceration is now well known among social scientists and even among many Americans as popular books such as Michelle Alexander's *The New Jim Crow* have helped to disseminate its central thesis: that a highly racialized war on drugs in the 1980s and 1990s helped to propel a massive spike in incarceration rates, with particularly devastating consequences for African Americans. However, scholars have recently pointed out that the war on drugs is but one of many theaters in the American war on crime. For example, experts argue that an undeclared war on sex simmered and eventually erupted just as Americans had begun to lose confidence in the war on drugs.[26] Even as the number of Americans under correctional supervision (including those in jail, in prison, on probation, and on parole) flattened and declined slightly between 2006 and 2013, the rolls of state sex offender registries ballooned 35 percent to include nearly 750,000 Americans.[27] A

recent study found that Black Americans are registered at rates twice that of White Americans—reflecting the broader racialized dynamic of American criminal justice.[28]

Because HIV is sexually transmitted and was immediately linked to homosexuality, it may be tempting to view efforts to criminalize HIV as merely another example of efforts to criminalize nonnormative sexuality. However, *Punishing Disease* reveals that punitive policies toward people living with HIV are not driven solely by an interest in policing sexual morality. The first three chapters of *Punishing Disease* reveal that, instead, the criminalization of HIV is but one of the more recent examples in public health history of an effort to control disease by coercion and punishment—what this book terms *punitive disease control*. Although calls for punitive HIV control measures quickly became intertwined with (and at times nearly indistinguishable from) calls to police sexual norms, these two social projects are not the same. As this book reveals, the impetus to control, segregate, and punish the sick has a long history that stretches back to plagues such as smallpox and the Spanish flu, epidemics whose spread had little to do with sex.

The popularity of the punitive strain of public health practice has waxed and waned over time in concert with a changing medical landscape. Public health began to make headway against infectious disease mortality in the early twentieth century through an emphasis on promoting nutrition and sanitation. There has been considerable debate over whether these improvements in quality of life were responsible for reducing mortality as compared to the advent of vaccines, antibiotics, and other new medical technologies in the mid-twentieth-century.[29] Whatever the true causes may have been, however, many medical authorities attributed much of the twentieth-century declines in mortality to medical technologies and, as such, came to view pills and needles as the public health tools of tomorrow. In light of this changing medical landscape, many medical authorities were hopeful that involuntary and coercive measures would be unnecessary in a new era of low mortality associated with infectious disease. As *Punishing Disease* reveals, however, AIDS gravely undermined this new optimism as a chorus of critics trumpeted a return to the coercive strategies of the past.

Although the history of punitive disease control stretches back centuries, no disease in modern American history has been met with a similarly systematic campaign to criminalize people living with an infectious disease. The second half of this book examines a second story: how a social problem typically perceived as medical—in this case, infectious disease—

became a target for criminalization. This story flips on its head the classic approach in medical sociology to studying the process of "medicalization," or how social problems previously understood as nonmedical come under the jurisdiction of medical authorities and institutions. Although this concept may seem foreign to readers new to medical sociology, many may recognize the sociological critique of its most famous example: attention deficit hyperactivity disorder (ADHD). As sociologists have pointed out, that diagnosis did not exist before the 1960s in America.[30] Crucially, pharmaceutical companies quickly began profiting off the sale of new stimulant therapies as doctors diagnosed ever-greater numbers of American children (and, increasingly, adults) with the disorder.[31] Sometimes described in short as the transformation "from badness to sickness," the concept of medicalization is now widely used in the social sciences as studies demonstrating its many forms have multiplied.[32]

The second half of *Punishing Disease* looks, instead, at how HIV was transformed from sickness to badness under the criminal law, or what this book terms the *criminalization of sickness*. Under what circumstances do police and prosecutors claim jurisdiction over social problems typically thought of as medical problems? How is HIV litigated in a criminal court? And what are the effects of criminalizing sickness? The final three chapters of this book grapple with these questions.

It is no mistake that authorities responded to the HIV epidemic with a new punitiveness. Three historical factors helped to shape the punitive response to AIDS. First, the coincidence of HIV's emergence with the birth of mass incarceration as a social institution meant that lawmakers were already in the habit of proposing handcuffs and prisons as solutions to social problems. *Punishing Disease* reveals the consequences of the emergence of AIDS in the shadow of this American institution's ascent.

Second, HIV was immediately linked to stigmatized social groups that were, at that historical moment, particularly hated and, in many cases, already viewed as suspected criminals. In 1981, when the first cases of AIDS were reported, consensual sex between same-sex partners was a criminal offense in twenty-two states and the District of Columbia. Initial news reports described the disease as a "gay cancer" that was linked to marginalized social groups collectively known as the 4-H club: homosexuals, Haitians, heroin users, and hemophiliacs.[33] That the epidemic was symbolically synonymous with so many highly stigmatized and potentially criminal classes of people—rather than housewives, babies, or some other sympathy-engendering group—made criminalization a more obvious response.

Third, during the early 1980s, there was widespread uncertainty and fear over the cause and effects of AIDS. This uncertainty created an opportunity for alternative theories to emerge, particularly the theory that AIDS was caused not by a virus but by a deviant lifestyle (namely, drug use and promiscuous homosexual sex).[34] Early missteps by medical authorities allowed these alternative theories to thrive. For example, by originally naming the disease gay-related immune deficiency (G.R.I.D.), authorities communicated an implicitly causal relationship between homosexuality and infection to the general public.[35] Such lifestyle theories of AIDS were made particularly appealing by the disease's bizarre and terrifying progression; instead of presenting with a unique set of symptoms, AIDS patients were instead disfigured and/or killed by a litany of normally rare and horrifying diseases described euphemistically as "opportunistic infections." These diseases included Kaposi's sarcoma (a cancer that causes purplish splotches on the skin), cytomegalovirus (a virus that causes blindness), and toxoplasmosis (a fungal infection that can cause seizures and swelling of the brain).

Taken together, these three historical factors created a perfect storm for punitive rhetoric and criminalization on a level not seen before in the modern history of American disease control.

Although many readers are likely to associate punishment most readily with the criminal justice system, the analysis contained in these pages is not limited to that institution. The first section of the book examines how institutions of public health helped to shape punitive policies toward infectious disease historically and, more recently, toward AIDS. Although some readers may view public health as a comparatively benevolent institution, this book does not view either public health or criminal justice as inherently good or bad. Instead, this book adopts the classic sociological approach to examining how public health and the law label and control *deviance*—defined by sociologists as behavior perceived as violating social expectations.[36] *Punishing Disease* tracks the historical origins of these norms as well as the punitive responses to their violation. From this labeling perspective, understanding how punishment became a legitimate disease control strategy requires an examination of both institutions of criminalization and institutions of disease control. In this way, this book not only contributes to an understanding of how public health labels, surveils, controls, and *punishes* people living with infectious diseases ("punitive disease control"); it also illuminates how the criminal justice system has come to control a conventionally medical category and with what effects ("the criminalization of sickness").

Punitive disease control and the criminalization of sickness represent two sides of the same coin; they share an interest in enforcing social norms and sanctioning behavior labeled deviant but differ in their institutional contexts (for example, public health versus criminal justice). In some cases, the norms in question are literally spelled out, as is the case in the twenty-eight states with criminal statutes that require people living with HIV to disclose their HIV-status to sexual partners before having sex. In other cases, these norms may be less formalized and subject to greater degrees of interpretation, such as public health laws that grant health officials authority to sanction people living with infectious diseases whose behavior they determine constitutes a "health threat to others."

While criminal justice and public health policies may determine how authorities *ought* to respond to such norm violations, their enforcement is not automated; legal and health authorities (prosecutors, judges, health officials, nurses, and others) must investigate rule breakers and decide how to proceed in each case. Taken together, their actions bring the criminal, civil, and administrative law to life. In this way, *Punishing Disease* continues the long tradition in sociolegal studies of examining the gap between the law on the books and the law in action.[37]

As this book shows, however, punishment is more than just the sum of state laws and policies and the actions of state authorities who enforce them. At the cultural level, stigma and ignorance often serve as invisible hands guiding the wheel as lawmakers draft statutes and authorities determine how they are applied.[38] Stigma—against HIV, against gay men, against prostitution—can lubricate the transition from "sickness to badness," while ignorance about how HIV is transmitted can facilitate punitive responses to scenarios that involve little or no risk of transmitting the disease.

This book also examines how individual events and actors can provoke the spread of criminalization under the right conditions. For example, sensationally reported crimes can quickly prompt a legislator to introduce a bill aiming to punish related future offenses. This is especially true when moral entrepreneurs (or individuals who champion a particular cause) lobby for lawmakers to draft legislation or for prosecutors to press charges.

Each chapter of *Punishing Disease* examines a different facet of a social problem that is collectively referred to as "the criminalization of HIV." While that moniker implies a unidirectional and monolithic social process, the reality is far less tidy; it involves a wide array of players operating in different institutional contexts and is dependent on numer-

ous cultural and political variables. Moreover, the pathways to criminalization and end products vary tremendously by state and sometimes even by county. Laws might be passed but never enforced. Or lawmakers may have shunned HIV-specific criminal laws, but creative prosecutors nonetheless find ways to punish under general statutes (typically felony assault). Nor is criminalization a dichotomous state, with HIV being "criminalized" in some states and "not criminalized" in others; punitive approaches to HIV instead fall along a spectrum of possibilities. No single book could reasonably claim to have told all the stories about the relationship between punishment and HIV. Instead, each chapter of *Punishing Disease* tells a different slice of a complicated story.

As such, this book should not be read as an exhaustive review of every attempt by health and legal authorities to control infectious disease or even just HIV throughout recent history. For example, public health practitioners reading this book from progressive coastal cities such as San Francisco or New York City may find the punitive strain of public health practice described by some of their Midwestern counterparts in chapter 3 to be entirely foreign or even objectionable. In highlighting these punitive strategies, the goal is not to erase or negate less punitive approaches to controlling disease that certainly do exist. Instead, the goals of *Punishing Disease* are (1) to examine under what conditions an impulse to punish becomes fused to the social project of controlling disease, and (2) to analyze the effects of this marriage.

OVERVIEW OF THE BOOK

The chapters in the first section, "Punitive Disease Control," collectively analyze policies and enforcement practices. This analysis focuses on a strain of public health and policy that promotes coercive and punitive strategies for controlling disease. This is sometimes evidenced through the direct action of health officials who surveil and coerce people living with diseases. Or punitive disease control may be achieved indirectly, by promoting the idea that people living with infectious diseases are (at least in part) individually responsible and thus culpable for their infection and the infection of others.

Chapter 1, "Controlling Typhoid Mary," mines the history of infectious disease control to analyze how AIDS prompted calls for a return to the coercive techniques of the past. For centuries, quarantine was a staple of public health efforts to combat such scourges as the plague and Spanish flu. However, that begin to change as improved nutrition and

sanitation and then the advent of vaccines, antibiotics, and new treatments effectively put an end to diseases that had once killed or maimed millions, such as polio and smallpox. In this optimistic context, public health practitioners in the mid-twentieth century began to view quarantine and coercive public health tactics as retrograde approaches of yesteryear. As chronic illness replaced infectious disease as the leading cause of death in the twentieth century, public health began to view individual health behaviors—such as smoking and diet—as the primary causes of disease. But the rise of an unknown and terrifying infectious disease eventually called AIDS threatened to turn back the clock on public health practice, as conservative advocates demanded that public health tattoo everyone diagnosed with HIV and quarantine or imprison those individuals deemed a threat to public health.

Chapter 2, "'HIV Stops with Me,'" examines how shifts in HIV prevention policy and practice have deepened the notion that HIV-positive people are individually responsible for the epidemic. While many Americans still imagine HIV prevention campaigns as billboards telling HIV-negative people to use a condom, that approach is increasingly a relic of the past. In practice, health authorities reorganized the entire prevention enterprise beginning in the 2000s: people already infected with HIV were urged not to infect their partners and, more recently, to take their medication. The most visible break in the nation's prevention strategy came in 2003, when the Centers for Disease Control and Prevention (CDC) announced its new priorities for HIV prevention. Critics expressed alarm that condoms were virtually absent from the document. This announcement came on the heels of a growing sentiment among public health experts that declining rates of condom use required new strategies for keeping the epidemic in check. This chapter tells the story of how a series of CDC policy shifts over the next decade worked to "repolarize" the very notion of doing HIV prevention away from targeting HIV-negative people and toward targeting people living with HIV. As it turns out, there is a very fine line between assigning individual responsibility and assigning blame. By advocating for HIV-positive people to take individual responsibility for preventing new infections, public health has inadvertently contributed to the notion that people with communicable disease are responsible for their illness and, as such, blameworthy for its continued spread.

Chapter 3, "The Public Health Police," examines how local health officials police the behavior of people living with HIV in their efforts to end new infections. As the HIV epidemic wore on in the 2000s, public

health authorities became enamored with the idea of ending AIDS. Health departments began to track HIV-positive clients more closely, aiming to control their behavior and ensure their adherence to treatment regimens. This chapter explores how local health authorities in Michigan ensure that HIV-positive clients behave in a manner officials deem responsible—and how they catch and punish those who do not. While the state maintains that the work of local health officials is done solely in the interest of promoting public health, their efforts to control HIV-positive clients reveal that they are also engaged in policing and law enforcement.

The second section of the book, "The Criminalization of Sickness," examines the history and application of HIV exposure and disclosure laws in the United States. Taken together, these chapters reveal how stigma, fear, and ignorance have driven efforts to criminalize people living with HIV—sometimes with unexpected effects.

Chapter 4, "Making HIV a Crime," analyzes the state legislative debates that led lawmakers to pass new, HIV-specific criminal laws across the United States. Initially, prosecutors pressed charges against HIV-positive people under general assault and attempted murder statutes. However, prosecutors repeatedly fumbled efforts to legally secure defendants' medical records or, in other cases, failed to prove that they had acted with criminal intent—a key element in common law known as *mens rea*. In the wake of a series of high-profile dismissals and acquittals under general statutes, calls for HIV-specific criminal legislation grew louder. Police organized early campaigns to criminalize HIV by publicly shaming HIV-positive women arrested for prostitution. Misdemeanor prostitution statutes, they argued, failed to protect society from their recklessness; new felony laws were needed. In other cases, the impulse to criminalize HIV grew out of simultaneous debates over the decriminalization of sodomy. Lawmakers invoked the specter of legal gay sex in their calls for new, HIV-specific criminal legislation. Finally, one state lawmaker helped to institutionalize HIV criminalization when a bill she introduced in Illinois formed the basis of a widely disseminated American Legislative Exchange Council (ALEC) model statute. Together, these social anxieties and interest-group campaigns sparked an epidemic of legislation that ultimately spread to forty-five states.

Chapter 5, "HIV on Trial," goes inside American courtrooms to analyze how HIV exposure and disclosure laws were enforced between 1992 and 2010. After a widely reported and sensationalized conviction in Michigan in 1992, the number of criminal cases against HIV-positive people quickly grew throughout the 1990s. While medical advances

dramatically changed HIV outside the courtroom, those changes were scarcely evident in Michigan and Tennessee courtrooms over the next two decades: prosecutors and judges continually justified their harsh sentences by calling HIV-positive defendants murderers and by casting HIV as a deadly weapon—even in cases where HIV could not have plausibly been transmitted. By tracing the impact that stigmatizing language has on courtroom decisions, this chapter demonstrates that courtroom talk is more than "just words."[39]

Finally, Chapter 6, "Victim Impact," analyzes which communities are most affected under HIV exposure and disclosure laws. In the wake of a sensational 2014 case involving a Black gay male defendant, some critics charged that HIV-specific criminal laws could be used to target Black gay men. This chapter draws on an original dataset of convictions under HIV-specific criminal laws in six states to evaluate whether the enforcement of HIV exposure and disclosure laws has discriminatory effects. Findings show that victim characteristics—rather than defendant demographics—shape uneven patterns in the application of the law. This "victim impact" flips expected patterns of discrimination, resulting in disproportionately high rates of convictions among heterosexual male defendants; yet, at sentencing, Black defendants are punished more severely, women are treated more leniently, and men accused of not disclosing to women are punished more harshly than those accused by men. This chapter digests these trends using the tools of sociology, epidemiology, and criminology to offer a specific diagnosis for reform.

The conclusion threads the needle of these six chapters, building a cohesive model of the engines driving the criminalization of sickness. In addition, the conclusion makes explicit the pitfalls of using the criminal justice system to tackle disease. Put simply, punishment is not the appropriate response to infectious disease; the criminal justice system is poorly suited for managing epidemics. The conclusion explains why this is so and what an alternative approach might look like.

At the heart of *Punishing Disease* is a central question: Why punishment? Although public health and medical institutions are designed to manage epidemics and viruses, punishment as an institution is built to manage crime. The tools designed for one job—pills versus handcuffs, hospitals versus prisons—are not effective for the other. The tool for creating social order is a hammer ill-suited for managing disease. In criminalizing sickness, HIV exposure and disclosure laws threaten to erode the boundary between sickness and crime, paving the way for a new era of criminalization that targets disease.

Punishing Disease reveals that criminalization has predictable effects. It reproduces stigma. It does not prevent disease. And it codifies outdated and deeply flawed ideas about HIV into law. Now that the door to criminalizing sickness is open, what other ailments will follow? When our colleague shows up to work with the flu in the future, will we wonder whether we should call the police? While we cannot predict what will happen tomorrow, moves in several state legislatures to extend their HIV-specific criminal laws to include new diseases such as hepatitis and meningitis demonstrate that this possibility is more than academic.