

From Sickness to Badness: Michigan HIV Law as a Site of Social Control

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Women's Studies and Sociology)
in the University of Michigan
2014

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ACKNOWLEDGMENTS

I would first like to thank my dissertation committee for their generous support throughout my time here at Michigan. I am particularly grateful for the stewardship of David Halperin, my dissertation co-chair and longtime friend. I walked into his summer seminar on Foucault a decade ago as a wide-eyed undergraduate, and I have been lucky enough to have had his guidance and generous support ever since that day. It would be a gross understatement to say that I would not have made it here without that support. I would also like to thank Renee Anspach, my dissertation co-chair in Sociology who has been my enthusiastic cheerleader since I arrived at Michigan. I am so grateful to have benefited from her generous, thoughtful, and kind mentorship. It is an understatement to say that I am extremely lucky to have benefitted from Renee's hard work, logging countless hours in helping me to develop the historical and theoretical arguments found in these pages. I am also grateful to have learned from Sarah Burgard and Sandra Levitsky, who rounded out my incredible dissertation committee. Both Sarah and Sandra have been extremely generous with their time and feedback over the years, and I have had the great joy of learning from them both in the classroom. This group of four is truly the dissertation committee of my dreams; stories of the lengths they have gone to over the years to facilitate my education and intellectual growth instill envy in my graduate student colleagues. Their support has made me a better scholar and a better person.

I am grossly indebted to my friends and colleagues at Michigan. It really does take a village. I owe a particular debt to Aston Gonzalez, who kept me on task when I would have rather been doing just about anything else. I benefited tremendously from his dedication,

perseverance, and sense of whimsy. I am equally grateful for my fellow nerd-at-heart, Matt Burgess, whose fabulous culinary skills kept my tummy full during many hours of dissertation writing. I am so grateful for the support of fellow Michigan graduate students Matt Aslesen, Denise Bailey, Aaron Boalick, Emily Bosk, Andre Cavalcante, Scott De Orio (homo potluck!), Keon Dillion, Matthieu Dupas, Maxime Foerster, Kevin Goodman, Jessica Lowen, Matt Lowther, Annah MacKenzie, Rostom Mesli, Matt Leslie Santana, Lotus Seeley, Greg Storms, Jack Tocco, Bryan Victor, and Cookie Woolner. Each of them, at some point or another, has made being at Michigan a bit more fabulous. I am particularly grateful for my sister-in-another-life, Jay Borchert, who helped to distract me from the grey that is Michigan and make living in the tundra far more tolerable.

I am also grateful for the intellectual community here at Michigan. I have benefited tremendously from the stunning array of faculty here, including Elizabeth Armstrong, José Bauermeister, Carol Boyd, David Caron, Nadine Hubbs, Deborah Keller-Cohen, Lawrence La Fountain-Stokes, Karin Martin, Jeff Morenoff, Esther Newton, Mark Padilla, Gayle Rubin, Valerie Traub, Elizabeth Wingrove, Robert Wyrod, and so many more. I am also grateful for the many members of the vibrant workshops that have kept me energized and excited: The Doing Queer Studies Now Rackham Interdisciplinary Workshop (particularly Scott De Orio, Matthieu Dupas, and Rostom Mesli), the Medical Sociology Working Group (particularly Kathy Lin, Lucie Kalousova, Matt Sullivan, and Jen Torres), and the Sociology Department's Gender and Sexuality workshop (particularly Saida Grundy, David Hutson, Emily Kazyak, Zakiya Luna, Steph Osbakken, Carla Pfeffer, Jamie Small, and Jessi Streib).

I have benefited also from the guidance, mentorship, and friendship of scholars and mentors outside of Michigan. Kane Race has proven to be a model of fabulously critical and

brilliant scholarship – all while living an enviably glamorous life. Sam Lucas took a chance on my project and has been an incredibly supportive mentor. I am grateful to live in a scholarly community with Barry Adam, Juan Battle, Elizabeth Bernstein, Héctor Carrillo, Cati Connell, Steve Epstein, David John Frank, Amin Ghaziani, Adam Green, Michael Hurley, Janice Irvine, Roger Lancaster, Greggor Mattson, Tey Meadow, Eric Mykhalovskiy, CJ Pascoe, Kristen Schilt, Gregory Tomso, Salvador Vidal-Ortiz, Matthew Weait, and Fred Wherry. Outside of academia, I am grateful for the leadership of Chris Bartlett, Edwin Bernard, Mandy Carter, Deon Haywood, Todd Heywood, Catherine Hanssens, Amber Hollibaugh, Suzanne Pharr, Carol Queen, Sean Strub, Len Tooley, Urvashi Vaid, and Tony Valenzuela. I am especially thankful for the mentorship of the late, great Eric Rofes. His work continues to inspire me. I miss him every day. I also benefited from the wisdom of a large circle of smart graduate students at other universities, including Melissa Adler, Mark Gaspar, Nicole Greenspan, Eric Grollman, Jeff Kosbie, Alex McClelland, Tara McKay, Michelle Phelps, David Pedulla, and Evren Savci. I am especially grateful to have known the late Tim Ortyl, who tragically passed away in the weeks before he was to defend his brilliant dissertation.

I also could not have made it here without the support of my friends outside of Michigan. My platonic life partner, Jackson Bowman, has been the best, most supportive friend a graduate student could ask for – especially in the darkest days. My dear friend Justin Carter has always been there to cheer me up and keep me in good spirits, especially when I was tired of working on my dissertation. My amazing group of friends around the world has kept me going, including Win Chesson, Spencer Derrico, Alex Garner, Brad Gorman, Nolberto Gonzalez, Mitchel Hawkins, Erik Libey, Karen Paxton Erbe, Danny Resnick, Ethan Suniewick, and Troy Wood.

Financially, this dissertation is indebted to many institutions that have been generous enough to support my work over the years. The funding I received from the Rackham Graduate School (particularly the Herbert E. Boynton Scholarship), the Department of Sociology, and the Department of Women's Studies has been instrumental in keeping this project alive. I am also grateful for the support of the Social Science Research Council, the Institute for Research on Women and Gender, and the Center for the Education of Women.

Last and certainly not least, I have to thank my family. My parents, Robert and Susan, have been ridiculously supportive of me as I traversed nearly a decade of graduate school. They might not have always understood what I was up to or why, but they were always there to support me as I worked towards my dream. I am eternally grateful for their love and support. And last but not least, my siblings – Derek and Lindsay – who have managed to treat this middle child with a lot of love, tolerance, and patience.

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ABSTRACT

In the state of Michigan, people infected with HIV are required by law to disclose their HIV-status to their partners before engaging in sexual contact. Failure to do so is a felony, punishable by up to four years in prison. Like statutes in 32 states that specifically criminalize nondisclosure, Michigan's law does not require that the sexual contact pose a risk of HIV transmission – a fact illustrated vividly during the 2009 proceedings against a dancer convicted for not disclosing her status before her client's nose penetrated her vagina. Indeed, despite scientific advances in treating and managing HIV disease, prosecutions for nondisclosure have continued unabated and appear to be on the rise. My dissertation explains this paradoxical trend by arguing that Michigan's HIV disclosure law does not serve to control HIV as a virus but rather to identify it as a moral infection requiring interdiction and punishment.

To make this case, my dissertation tackles three interrelated issues. In Chapter 2, I analyze how local health officials enforce the larger "health threat to others" statute, which includes the felony nondisclosure law but also confers upon public health authorities additional powers for controlling individuals they declare to be deviant. Based on interviews with officials in 14 of Michigan's 17 jurisdictions for HIV, I argue that the techniques (such as STI testing and contact tracing) employed by some officials in order to identify potential "health threat" cases cannot actually reveal whether or not an individual disclosed his or her HIV-positive status. Yet, health officials' conflation of nondisclosure with other, perfectly legal deviant

practices (e.g. condomless sex) suggests that their intent is not simply to control the spread of disease but also to regulate a population they perceive to be deviant.

In Chapter 3, I draw on archival data associated with 95% of all convictions under the felony statute between 1992 and 2010 to analyze how legal actors transform HIV into a criminal matter in a court of law. Drawing on more than 4,000 pages of trial court transcripts, I demonstrate that legal actors frame nondisclosure as murderous and HIV-positive defendants as reckless killers – even in cases where the sexual contact alleged posed no risk of transmission. On that basis, I argue that the enforcement of Michigan’s HIV disclosure law is not driven by insights from medical science; rather, it serves to control and punish HIV-positive populations deemed deviant.

Finally, in Chapter 4, I examine disparities in conviction outcomes to identify whether certain groups are bearing the brunt of the disclosure law’s application. By comparing conviction outcomes with data documenting HIV-positive diagnoses during the same period, I argue that disparities under the disclosure law are better explained by variations in complainant characteristics (e.g. gender) than by characteristics of the defendant. For male defendants, having sex with women was associated with a higher rate of conviction as compared to men who have sex with men. Indeed, although critics have charged that HIV disclosure laws are homophobic, heterosexuals bear the brunt of the law’s application – particularly black men and white women. While many proponents of HIV legal reform have argued that HIV-specific criminal laws are bad for public health, the way state actors respond to these cases does not suggest that they are primarily interested in promoting public health. Of course, it is impossible to know what unspoken factors may have guided the decisions of prosecutors and attorneys in these cases. However, their patterned reliance on punitive and moral discourses – as well as their ignorance

and dismissal of scientific evidence – suggests that their understanding of these cases is tainted by stigma and morality. These ethical dimensions bear only a tenuous relationship to public health and medical evidence: their logic does not depend on science.

CHAPTER 1

Introduction

During a general panic about the potential for AIDS to spread from “high risk” minority groups to the “general population” in the late 1980s, Michigan legislators enacted a set of laws collectively referred to as “health threat to others” laws that require HIV-positive individuals to disclose their status to their partners before engaging in a wide range of sexual practices. Like many of the 32 states that have enacted such statutes, Michigan does not require proof of malicious intent, nor does it require evidence that the sexual practices alleged pose any risk of transmitting the virus (Wolf & Vezina 2004; Galletly & Pinkerton 2006; Center for HIV Law & Policy 2011). Violators are legally termed “health threats” and sanctions can include forced testing and counseling, quarantine, and/or incarceration under the felony criminal provision.

While conceptual approaches to theorizing social control have varied over time (Meier 1982), sociologists have a longstanding interest in understanding how categories of sickness are produced, regulated, and applied. Indeed, medical sociologists coined one of their signature concepts, “medicalization,” in order to describe the process through which social phenomena come to be regulated by medical authorities. Yet, while sociologists have acknowledged that medicalization could be “bidirectional and partial” (Conrad 2005:3), most research has centered on what was viewed as the usual direction of change: from badness to sickness (Conrad & Schneider [1980]1992). Much less is known about how phenomena historically controlled by medical authorities come to be governed by the criminal law.

Recent reports suggest that over a thousand HIV-positive Americans have been criminally prosecuted for not disclosing their seropositivity to their partners (Bernard & Nyambe 2012). Health scholars have criticized criminal disclosure laws, arguing that they may discourage HIV testing by inadvertently turning an HIV-positive test result into a potential legal liability – those who haven't been tested and thus diagnosed as HIV-positive cannot be prosecuted under these statutes, so there is a legal advantage to not knowing whether or not one has been infected with HIV (Galletly & Pinkerton 2006). Yet, beyond limited studies in public health and a handful of sociological case studies (Shevory 2004), we know little about how these laws are enforced or the sociological implications of their application.

The goal of this dissertation is to examine how Michigan's "health threat" laws are enforced. The first paper (Chapter 2) draws on interview data with local health officials tasked with monitoring HIV-positive clients. It seeks to understand how they go about identifying and controlling clients they suspect of posing a "health threat to others." Drawing on trial court data associated with 95% of all convictions under the felony statute between 1992 and 2010, the second paper (Chapter 3) shows how legal actors transform HIV into a criminal matter in a court of law. In other words, how do legal actors frame HIV as a legitimate site for legal intervention? The third paper (Chapter 4) analyzes conviction outcomes under the felony HIV disclosure law to ask whether certain groups are disproportionately punished under the law.

Background

The Social Context: A Brief Overview

The "health threat to others" laws that are the subject of this dissertation did not emerge in an historical vacuum. While a history of the AIDS pandemic in the U.S. is beyond the scope of this

dissertation (for examples, see Inrig, 2011; Brandt 1987), three developments that began in the 1980's deserve mention: the emergence and resurgence of infectious diseases, the birth and growth of AIDS activism, and the ascendance of the New Right during the Reagan years.

The emergence and resurgence of infectious diseases. Throughout most of the 20th century, public health and medicine took pride in what appeared to be a conquest of infectious disease. This triumphant victory was challenged in the last decades of the century, however, by several developments: the resurgence of tuberculosis; the emergence of HIV/AIDS in the 1980's; the discovery of new diseases such as Lyme disease, Legionnaire's disease, and hantavirus; and the emergence of antibiotic-resistance strains of old microbes such as *Staphylococcus aureus* (commonly known as "MRSA") and multi-drug-resistant tuberculosis. The rise of these infectious agents has been linked to a myriad of causes, from overcrowding in prisons and homeless shelters to globalization, increasing poverty, malnutrition, homelessness, and the over-prescription of antibiotic drugs by physicians and patient noncompliance (for a discussion of these issues, see Gostin et al 1999). In this new epidemiological context, public health officials in some cities returned to the coercive measures that had historically been used to control the spread of infectious disease, such as compulsory isolation or quarantine.

The Reagan years, the New Right, and the moral panic over AIDS. In the U.S., this change in the epidemiological environment coincided with a change in the political environment. The CDC (1981) reported the first cases of a strange new form of *Pneumocystis pneumonia* among gay men in June of 1981, coinciding with the election of Ronald Reagan. With the Reagan presidency came the ascendance of the New Right, a coalition of conservative politicians and the Christian conservatives who would become a formidable force in American politics. For the American right, AIDS became a symbol of America's moral decline. Members of the New

Right viewed the new “Gay Plague” as divine retribution for sexual sin, or in the words of Jerry Falwell, “the wrath of God against homosexuals.” A notable exception was Surgeon General C. Everett Koop, himself a pro-life advocate, who argued against the invasive social control of HIV-positive individuals advocated by the right wing, such as mandatory testing, arguing that such measures would cause HIV-positive people to “go underground” and make them unreachable by public health officials (Koop 1987:30; for a discussion, see Waller 2014).

Combining racism, homophobia, and xenophobia, commentators began to speak of the “4-H risk groups”—homosexuals, heroin addicts, hemophiliacs, and Haitians. However, the New Right continued to focus most of its ire on the perceived transgressions of gay men. This climate of fear and social hostility exhibited some of the features of a moral panic: widespread belief in the group’s negative impact on society; hostility toward the groups in question (gay men, injection drug users accused of spreading the disease); and actions taken that are disproportionate to the actual threat the group poses (Goode & Ben-Yehuda 1994). Political pundits fed the homophobia of a terrified public with doomsday proclamations about the plague imposed on “general public” by the hedonistic lifestyles of drug addicts and gay men. A 1987 Gallup Poll showed that, like conservative religious leaders, 43% of Americans said that AIDS was a punishment for moral decline (Kaiser Family Foundation 2011). In communities across the country, tensions were high. When a Florida couple successfully sued the De Soto County School District to allow their three hemophiliac, HIV-positive sons to attend school, they found their house had burned down, forcing them to leave town. (Thomas 1987).

By the mid-1980s conservative politicians and religious leaders, such as Jesse Helms and Pat Robertson, argued for draconian, coercive measures: mandatory testing of all those “at risk” of spreading the disease, branding people with AIDS with a visible tattoo, and quarantine and

criminal incarceration of “recalcitrant” AIDS carriers. (Waller 2014; Gostin 1989). In their call for coercion, conservatives were joined by members of a public increasingly frightened by the spread of an incurable disease. Public opinion polls conducted in 1985 and 1986 showed that between 28 and 51% of respondents agreed that “people with AIDS should be put into quarantine to keep them away from the general public” (Singer, Rogers, & Corcoran 1987:580).

Political activism among persons living with HIV. AIDS was the first epidemic to emerge during a period when the many “new” social movements that followed the civil rights movement had become a powerful force in American politics (Gostin 2004). Like the movements that had influenced it, the women’s health movement and the gay liberation movement, AIDS activism combined identity politics with concrete objectives and astute strategy. AIDS activists—many of them professionals, artists, and intellectuals—had a greater degree of social capital than is commonly found among oppressed groups. This was one factor in the unique accomplishment of the AIDS movement: their collective transformation from “disease victims” into “activist experts” (Epstein 1996).

Treatment activism began in the late 1980’s when the AIDS community, desperate for rapid approval of experimental drugs that offered a chance of survival, grew increasingly frustrated with regulatory bureaucracies, such as the FDA and National Institute of Allergies and Infectious Diseases (NIAID), that prolonged the approval process and restricted access to clinical trials. The most visible treatment activist group was ACT UP, a direct-action group known for staging well-attended, well-orchestrated protests at the NIH, FDA, CDC, and pharmaceutical companies. ACT UP members were instructed to do “homework before hell raising,” studying the intricacies of the drug approval process and mastering the vocabulary and culture of science while simultaneously establishing themselves as spokespersons for the AIDS

community. Their growing scientific sophistication established their credibility as “lay experts” and gave them access to officials in the highest reaches of the medical research establishment that had previously been closed to the public (Epstein 1996). AIDS activists influenced every aspect of clinical research, from funding priorities (e.g., treatment of opportunistic infections) to the design of clinical trials (inclusion in clinical trials of the full array of persons living with HIV and those who had been denied access because they had tried other treatments) to accelerated approval of treatments for HIV/AIDS and other life-threatening diseases to lowering the price of AZT (Killen, Harrington and Fauci, 2012; Epstein 2007).

AIDS activists also challenged the 100-year-old public health practices of surveillance: name-based reporting, contact tracing, and mandatory screening. At the beginning of the epidemic, states instituted mandatory reporting of the names of those diagnosed with AIDS to public health registries—a practice that was uncontroversial. However, activists strenuously resisted the move to implement named reporting of HIV-positive serostatus, arguing that it is an unwarranted invasion of privacy, one that carried a great risk of fomenting discrimination in housing and employments should the information become public. In the absence of effective treatment, early AIDS activists argued that compulsory programs using invasive surveillance strategies offered few benefits; voluntary programs, they argued, were more effective. Many public health officials agreed with them. Although all 50 states would eventually adopt name-based case reporting, states adopted programs based on voluntary counseling, anonymous testing, and pre-and-post-test counseling with strict confidentiality protections (Lazzarini 2001).

In the 1990’s, however, the tide began to turn against the activists. Several politicians and some commentators argued against what they called “AIDS exceptionalism” and called for the revival of “time-honored” surveillance practices (Bayer 2007; Lazzarini 2001). CDC officials

also began to argue for the epidemiological benefits of a national system of serostatus reporting – namely, that it would greatly enhance the ability of public health authorities to track individuals diagnosed as HIV-positive and would produce much more accurate statistical data about the national HIV/AIDS caseload. Despite objections, the CDC ultimately succeeded in persuading all 50 states to adopt name-based systems by 2008 (for a discussion, see Gostin 2004). Despite occasional breaches of privacy (see, for example, Landry 1996), in 2006 the CDC also recommended screening for HIV for all persons aged 13 to 64 who receive healthcare and who do not explicitly “opt out” or object, threatening to do away with informed consent (for a discussion, see Fisher, Hanssens and Schulman 2006). Of all the renewed surveillance measures, partner notification programs have drawn the most fire from activists as well as from many public health officials because they can lead to emotional or physical abuse; because those who have not disclosed can be reported to law enforcement; and because they have not been found to be effective (Gostin 2004). Despite these concerns, most states have instituted partner services programs. In short, while AIDS activists were extremely successful in reshaping treatment research, they have been far less effective in dissuading public health officials from re-instating “time honored” surveillance practices.

Controlling Disease, Controlling People: Public Health as a Site of Social Control

When confronted with the AIDS epidemic, legislators and public health officials drew upon a legacy of public health practices used to control the spread of disease. When I refer to “public health,” I am using the term broadly to refer to a set of practices used to promote the health of and prevent disease in populations, whether by governmental officials or professionals. Many of these practices emerged long before the professional schools of public health were established

early in the 20th century. For centuries, public health officials have waged a battle—sometimes against overwhelming odds—to prevent the spread of disease, and one of their weapons has been social control.

A brief survey of these disease control strategies illustrates how central social control is to the practice of public health. Most commentators classify public health measures as either voluntary or coercive. Rather than using this dichotomy, however, it is more useful to view social control strategies as arrayed along the following continuum ranging from the least to the most coercive:

1. *Persuasion.* In the second half of the 20th century, public health focused on STI's, HIV/AIDS, hepatitis, and the chronic illnesses that had become leading causes of death: heart disease, cerebrovascular disease, and diabetes. Increasingly, public health educators turned to ad campaigns designed to persuade individuals to adopt healthy lifestyles and modify the risky health behaviors now viewed as the new health threats: overeating, lack of exercise, careless driving, and unprotected sex (Colgrove and Bayer 2005; Bayer 2007). Despite its ostensibly voluntary nature, persuasion is a more subtle form of social control that shapes people's behavior by motivating them to manage their health risks (Petersen and Lupton 1997; Lupton 2013). Advertising campaigns have been criticized for exaggerating risks, for example instilling fear through grisly images of dying smokers (see Lupton 2013).

2. *Regulation.* When public health campaigns failed to persuade, organizations, cities and states have adopted rules and ordinances targeting risky health behaviors more directly. These include, for example, laws requiring drivers to wear seatbelts and motorcyclists to wear helmets; “sin taxes” that raise the price of cigarettes and alcohol; regulations prohibiting smoking in public establishments or restricting smoking to designated areas; and most recently, laws

forbidding restaurants to sell large, sugary drinks (Colgrove and Bayer 2005; Bayer 2007). Most of these measures work by creating disincentives or obstacles that make it more difficult to engage in risky behavior. The primary goal of these regulations, however, is not to improve the health of those who take risks. Rather, the courts have justified these regulations because of the threat risky behaviors pose to others or to the general public: the deleterious effect of passive smoke on others; the effect of seriously injured motorists on emergency personnel or other patients; the cost to taxpayers of caring for disabled accident victims (for a discussion, see Bayer 2007).

3. *Compulsion.* Public health surveillance practices, developed in the late nineteenth century, have included mandatory reporting of patients' names to public health registries, contact tracing, in which those diagnosed with an STI are asked to reveal the names of their sexual partners who can be examined and treated; and mandatory screening for some infectious diseases. All of these measures entail invasions of privacy and the risk of reputational damage should the information become public. As has been noted, most states have moved away from strictly voluntary counseling and testing and have returned to mandatory surveillance practices. Compulsory vaccination programs have provoked intense controversy since the 19th century and continue to do so today (Colgrove and Bayer 2005; Bayer 2007). With the resurgence of tuberculosis and the appearance of resistant strains, health departments have imposed mandatory treatment and directly observed therapy on patients seen as noncompliant (Bayer and Dupuis 1995; Bayer 2007). Compulsory screening, vaccination, and treatment programs involve coercion and violate the principle of informed consent and the right of patients to refuse treatment (for a discussion, see Fisher et al. 2006).

4. *Confinement.* Among the oldest measures of infectious disease control are quarantine (mandatory separation of well persons believed to be exposed to a disease from the rest of the population) and isolation (involuntary confinement of infected persons in their homes or institutions to prevent them from spreading the disease). Quarantine emerged as a formal system of social control in medieval Europe during the 14th century Black Death or bubonic plague, when officials in the Italian city states forced ships from plague-infested countries to remain anchored for 40 days, confined infected sailors to hospitals known as lazarettos, erected “sanitary cordons,” policed by soldiers, to prevent strangers from entering the city, and isolated infected persons in their homes. The practice of confining ships and infected persons became widespread in Europe, and colonists brought these practices to the New World (Parmet 2007; Tognotti 2013).

In the 19th century, quarantine and isolation were used to prevent the spread of smallpox, tuberculosis, and cholera; in the 20th century, they have been used during epidemics of scarlet fever, typhus, polio, and tuberculosis (Sullivan and Field 1988; Gostin, Burris, and Lazzarini 1999; Parmet 2007; Tognotti 2013). In the midst of the moral panic surrounding the AIDS epidemic, several states passed laws authorizing the isolation of “recalcitrant” seropositive persons who health officials believed were engaging in behaviors that posed a threat to public health (Gostin, Burris, and Lazzarini 1999), sometimes after receiving “cease and desist” orders from public health authorities. Isolation can be an effective method of disease control for airborne diseases that are highly contagious and spread by casual contact. However, it is ineffective in the case of HIV/AIDS, which is spread through actions such as needle sharing and sexual intercourse rather than through spatial proximity (Sullivan and Field 1988). People who are isolated for most infectious diseases are released once they recover or are no longer

contagious. By contrast, because no effective treatment for HIV/AIDS existed at the time, those isolated could face confinement for the duration of their lives.

Quarantine and isolation are highly coercive forms of social control—they represent the greatest extent to which people who have not committed a crime can be deprived of their freedom (Gostin 1989; Parmet 2007). In a 1905 decision, *Jacobson v. Massachusetts*, the Supreme Court nevertheless upheld these measures as a legitimate exercise of the state’s “police power” to limit individual freedom to protect the public’s health (Gostin, Burris, and Lazzarini 1999; Colgrove and Bayer 2005; Gostin 2005). The sweeping power of public health officials to quarantine and isolate falls under the civil law but rivals the power of the criminal justice system to deprive people of their freedom. Moreover, “until relatively recently, “the protections accorded to defendants in criminal prosecutions have not been extended to those viewed as a threat to the public health” (Bayer 2003:141). This was to change when, amid the “due process revolution” of the 1970’s, the courts ruled that mental patients facing civil commitment to mental institutions were entitled to the due process protections of the 14th Amendment and were given the right to be treated in the least restrictive setting that met their needs. These rights came to be extended to patients with physical illness (Bayer 2003; Bayer and Dupuis 1995).

5. *Criminalization*. During the 1980’s, state legislators responded to the demands of conservative politicians, the religious right, and frightened constituents to use the criminal law to incarcerate those blamed for spreading HIV/AIDS: drug users and particularly gay men. States have used two principal types of laws to criminalize exposing others to HIV. First, states have used general criminal laws against assault and battery, reckless endangerment, or attempted murder, to prosecute HIV-positive persons who have allegedly exposed others to the virus. A wide variety of cases have been tried using general criminal law, ranging from biting to the case

of a Virginia man who was accused of “infected sexual battery” when he infected his wife through sexual intercourse (Gostin 2004). Criminal law is based on intent—often notoriously difficult to prove in the courtroom—and, partly for this reason, states began to pass laws criminalizing actions that exposed others to HIV irrespective of their intent to harm. Many of these statutes were modeled on “venereal disease” laws enacted earlier in the century. Between 1986 and 2011, 33 states enacted HIV-specific criminal exposure statutes that made it a crime (usually a felony) for persons who are aware they have HIV to engage in a variety of behaviors and sexual practices without first disclosing their HIV-positive status (Lehman et al. 2014). Most of these statutes were enacted in the 1980’s, when little was known about the virus or how it was transmitted. However, seven states enacted statutes between 1999 and 2000, after the Ryan White Comprehensive AIDS Resources Emergency Act required states to certify that their criminal laws were adequate to prosecute those who knowingly exposed others to HIV in order to receive federal funding for HIV/AIDS programs (see, for example, Lehman et al. 2014).

State statutes vary widely in terms of the specific acts that are criminalized and the penalties that are imposed on those who are convicted. 24 states require disclosure of serostatus to sexual partners and/or needle-sharing partners (Lehman et al. 2014). 25 states criminalize one or more behaviors that pose a “low or negligible risk for HIV transmission,” such as oral sex, biting, spitting, or throwing blood. (Lehman et al. 2014). Some states prohibit other practices known to be safe, such as manual stimulation or using sex toys or other objects without prior disclosure (Galletly and Pinkerton 2006). Only four states designate condom use as a defense (Lehman et al. 2014). Several statutes do not specify the specific behaviors that are criminalized: it is a crime simply to expose another person to HIV—a wording which one observer calls “unconstitutionally vague” (Gostin 2004). In 16 states, failure to disclose seropositive status is

part of the crime, and the burden of proof is on the prosecution to prove failure to disclose. Other than relying on complainant testimony, it is virtually impossible to prove whether a defendant did or not disclose their status (Lehman et al. 2014).

Critics have argued that HIV disclosure statutes undermine the HIV prevention ethic of “safer sex,” which encourages using condoms as a way to circumvent the need for serostatus disclosure (Gostin 2004). Further, statutes in a few states are so vaguely worded as to criminalize exposure to HIV/AIDS regardless of whether one’s serostatus is disclosed, thereby criminalizing sex itself among HIV-positive persons (Gostin 1989). In the vast majority of states, HIV-specific criminal statutes do not require proof of the intent to expose another person to HIV or evidence that defendants actually transmitted HIV to their partners (Gostin 2004). In these states, simply engaging in behavior believed to expose another person to HIV without first disclosing one’s HIV-positive status is in itself a crime.

Penalties for failing to disclose HIV-positive status can be harsh. Most HIV disclosure and exposure laws impose felony penalties; in only two states is it a misdemeanor to expose another person to HIV without prior disclosure (Lehman et al. 2014). The average minimum sentence in states with felony penalties is 11 years (Wolf and Vezina 2004), and maximum sentences range from 10 years (18 states) to 20 or more years (12 states) (Lehman et al. 2014). Critics argue that such sentences are far more severe than penalties for violent crimes such as assault (1-5 years in the model penal code) and rape (1-10 years in the model penal code) (Galletly and Pinkerton 2006).

Many of these statutes reflect the climate of the period in which they were enacted: an exaggerated perception of the risk of transmission of HIV and punitive attitudes toward persons living with HIV. In 2010, however, the Obama White House released its National HIV/AIDS

strategy, stating that “in some cases, it may be appropriate for legislators to reconsider whether existing laws continue to further the public interest and public health” (cited in Lehman et al. 2014). A 2014 report bearing the authoritative imprimatur of the Department of Justice and the CDC noted that many state laws “criminalize behaviors that pose low or negligible risk for HIV transmission” and, in addition, most laws do not consider measures known to reduce the risk of transmission, such as condom use, HAART, or pre-exposure prophylaxis. The report encouraged states to “assess the laws’ alignment with current evidence regarding HIV transmission risk, and consider whether the laws...achieve their intended purposes.” For the many critics of these laws, these recommendations may come as welcome news. However, given that many of these points had been made as early as the late 1980s and, moreover, that antiretroviral drugs have been in use since 1996, others may also wonder why these recommendations came so late (see Center for HIV Law & Policy 2014). In any case, these recommendations do not yet have the force of law and many states legislatures will not be moved by suggestions from President Obama’s administration.

A persistent, pervasive pattern. Historians of public health have documented a persistent pattern: from their inception in the Middle Ages, campaigns to control the spread of infectious disease through coercion have consistently targeted those considered deviant, disfavored, or disenfranchised. In the United States, enforcement of these public health measures was often deeply discriminatory, reserving the harshest, coercive measures for the groups most unfavorably situated in the social structure. To give a few notable examples: In 1900, a San Francisco ordinance required that all Chinese residents of the city receive a dangerous experimental vaccine for plague. Following reports of nine deaths from plague, city officials roped off the Chinese quarter, quarantining 25,000 residents, closing Chinese businesses, while explicitly

exempting non-Asians from quarantine (Tyson 2004; Parmet 2007). Although smallpox is viewed as a “democratic epidemic” that targets rich and poor alike, the public health response has been notably undemocratic. In 1894, for example, Milwaukee officials forced immigrants and poor residents into a quarantine hospital. After cases were identified in Boston in 1902, public health officials, with police in tow, forcibly inoculated African Americans and immigrants (Annas, Mariner, and Parmet 2008). During the 1916 polio epidemic in New York City, health workers conducted door-to-door searches, forcibly removing sick children from their homes, but allowing the children of wealthy families to remain in a separate room in their homes (Risse 1988). In each case, coercive measures were aimed at marginalized groups, often viewed as a threat to the moral order. During epidemics, fear and the stigma of contagion served to heighten the social exclusion of already stigmatized groups. In this context, sanitary cordons, pesthouses, and jail cells express the need of elites to protect themselves from the “dangerous” classes. As this dissertation will demonstrate, the HIV/AIDS epidemic was no exception to this pattern.

Contributions

Toward a Critical Sociology of Public Health

As the previous section shows, public health is, at its core, an institution of social control. Indeed, medical historians and anthropologists have recognized that efforts by public health authorities to control and regulate disease can be considered a form of social control. Building on this insight, I show how public health serves as an institution of social control by examining the various strategies local health officials use to identify and regulate potential “health threats” cases. In so doing, I hope to contribute to a critical sociology of public health.

Social control has been one of sociology's enduring concepts. Parsons (1951) introduced this concept into medical sociology by noting that illness is a form of legitimate deviance and, conversely, that medicine is an institution of social control. In their role as "gatekeepers," physicians regulate access to the sick role and ensure that individuals return to their normal role obligations. Two decades later, "post-Parsonian" medical sociologists developed a more critical perspective on medicine's social control function by linking it to the use (and abuse) of professional power. In an influential essay, Zola (1972) argued that medicine had supplanted the law and religion as the predominant institution of social control by, for example, exercising authority over how people should live their lives to remain healthy and retaining access to "taboo" areas, such as sex and reproduction. In the course of treating disease, therefore, medicine defines and controls normative standards of conduct. Developing this perspective further, Conrad (1979; 1992) argued that medical social control should be understood as having four components: medical ideology (the imposition of a medical model as a result of the influence of physicians); collaboration (the role of doctors as "gatekeepers" of knowledge); technology (the use of medical technological innovations such as genetic screening); and, based on the work of Foucault (1973; 1977), surveillance (internalization of the "medical gaze").

An extensive body of empirical research has also documented the role of mental institutions (see, for example, Goffman 1961) and health professions in the control and surveillance of deviant behavior (for a review, see Conrad 1992). This research shows that control and surveillance often ironically exacerbate the very problems they purport to ameliorate. The findings of these studies parallel a body of sociological research that has analyzed how social work institutions, such as homeless shelters (Pitts 1996), battered women's shelters

(Murray 1988), and social welfare programs (Piven & Cloward 1971), despite their ostensibly benign purposes, operate as sites of social control.

Despite its importance, there is a significant imbalance in this literature: although an extensive body of theory and research has focused on medicine and related occupations as sites of social control, with few exceptions (Peterson and Lupton 1997; Lupton 2013), sociological studies have rarely examined social control in public health—a striking and surprising omission since social control is at heart of public health’s mandate. Like medicine, public health exercises authority over people’s lifestyles—including the intimate and “taboo” aspects of their lives. Public health officials, however, engage in strategies of social control that differ in two important ways from the more traditional forms of medical authority. First, the field of public health, in contrast to “clinical professionals” in medicine, focuses on *prevention* rather than *treatment*:

Public health professionals try to prevent problems from happening or re-occurring through **implementing educational programs, developing policies, administering services, regulating health systems and some health professions, and conducting research**, in contrast to clinical professionals, such as doctors and nurses, who focus primarily on treating individuals after they become sick or injured (Association of Schools of Public Health N.d.).

Second, while physicians focus on the *individual patient*, public health professionals focus on the health of *populations*:

Overall, public health is concerned with protecting the health of entire populations, as small as a local neighborhood, or as big as an entire country or region of the world (CDC Foundation 2014).

This mandate to focus on the health of populations rather than individuals poses ethical challenges that rarely arise in medicine. In contrast to medicine, Bayer and Fairchild (2004: 488) argue, “the core of public health practice is the charge to protect the common good,” which may “necessitate limits on the choices of individuals.” For this reason, public health ethics cannot be justified by the principles of biomedical ethics, which are grounded in the autonomy of the

individual patient (Bayer & Fairchild 2004). Moreover, in contemporary societies, populations are rarely homogeneous, consensual communities, but rather contain individuals and minority groups with divergent beliefs, norms, values, and interests (for a discussion, see Faden and Shebaya 2010). A public health policy can become contentious when the perspectives of majorities and minorities collide and public health officials impose their views on those with less power. Such cases are not unusual and some scholars in public health ethics argue that public health measures typically involve some degree of coercion (Bayer & Fairchild 2004; Faden & Shebaya 2010). Whether they focus on seatbelt or helmet laws, mandatory vaccinations, or controlling the spread of sexually-transmitted infections, public health campaigns involve efforts to compel groups to subordinate their beliefs or change their behavior to protect the health of larger collectivities.

In this dissertation, I analyze several strategies local health officials employ in order to identify and control potential “health threats” cases. Their primary objective is not to treat or diagnose individuals with HIV, but rather to prevent those individuals from putting the health of others at risk. I argue that these efforts to control HIV do not resemble those of medical authorities aimed at diagnosing, treating, and managing HIV disease. This difference is in part due to the fact that public health aims to prevent illness in populations. Thus, because it explicitly aims at the social control of populations, public health, no less than medicine, is uniquely deserving of critical sociological inquiry.

While the difference between social control in medicine and public health can become blurred in actual practice, each field requires a different set of strategies for social control and thus a different set of sociological tools for analysis. What analytical tools can we use to develop a critical sociology of public health? In the absence of an extensive body of sociological work,

we can look to the work of scholars in other fields. Social control in public health, whether in the form of mandatory screening, compulsory treatment, civil confinement, or criminal incarceration has been the subject of commentary and debate among scholars in history, public health law and policy, and the nascent field of public health ethics.

According to most commentators, at the heart of public health is an ineluctable tension between promoting the public's health and preventing disease on the one hand and civil liberties on the other (for a discussion, see Bayer 2007). Each level of social control reviewed above infringes on individual rights: Public health surveillance infringes on the right to privacy; mandatory treatment infringes on bodily integrity, autonomy, and the right to refuse treatment; and civil confinement and criminal incarceration infringe on personal liberty and freedom of movement (Gostin 1988; Bayer 2007). Writers agree that the challenge for policy makers is to strike a balance between public health and individual freedom but differ in the particular interventions they believe are justified. How they evaluate a particular measure depends on their assessments of the gravity of the health threat, the extent of infringement on liberty, and the relative weight attached to each consideration. Bayer (2007), for example, suggests that some compulsory measures, such as mandatory surveillance, may be necessary in the face of serious threats to public health. By contrast, Annas (2007: 1093) gives greater weight to civil liberties: "Sacrificing human rights...is almost always unnecessary and counterproductive in a free society."

Gostin has developed several criteria, based largely on constitutional and other legal principles, for assessing health interventions in the case of HIV/AIDS. The use of coercive public health powers that infringe on civil rights is justified only if it meets the following criteria:

- 1) There is a significant risk of transmission of the virus to others;
- 2) the intervention is effective

in preventing transmission of HIV—that is, it is reasonably likely to achieve the stated goal (i.e., the means chosen fits the ends); 3) the intervention is the least restrictive option that can achieve that goal; 4) the human rights burdens are reasonable compared to the projected benefits; and 5) the benefits and burdens are fairly distributed—that is, the burdens are imposed only where a public health risk exists (Gostin 1989; Gostin 2000; Gable, Gostin, & Hodge 2008).

By now, numerous reviews and commentaries focus on HIV exposure and disclosure laws. Using Gostin’s criteria as a framework helps explain why most observers conclude that these laws are unjustified: 1) Most laws can be applied to behavior that do not pose a significant risk of transmitting HIV to others, such as biting, spitting, manual stimulation, or using sex toys (Gostin 1988, 2004; Sullivan and Field 1988; Lazzarini, Bray and Burris 2002; Wolf and Vezina 2004; Gallety and Pinkerton 2006; Lehman et al. 2014). Only four states take into consideration measures known to lower the risk of transmitting the virus, such as condom use, anti-retroviral therapy, or pre-exposure prophylaxis (Lehman et al. 2014). 2) There is no empirical evidence that criminalization is effective in preventing or deterring the most common modes of transmission: unprotected, consensual sex and needle sharing (Burris and Cameron 2008). In fact, one study suggests that high-risk individuals in a state with criminal HIV exposure laws were no less likely to engage in high-risk sexual behaviors than those in a state without such laws (Burris et al. 2007). Moreover, the criminal law “discourages exactly those behaviors necessary for the collective good—testing, disclosure, and participation in clinical and public health programs” (Gostin 2004: 492). 3) With two exceptions, states have not implemented policies that offer persons believed to engage in high-risk behavior less restrictive options, such as counseling and education before they are prosecuted for criminal exposure. 4) Most laws impose excessive human rights burdens. In 28 states, exposing others to HIV without prior

disclosure of serostatus is a felony. Many HIV-specific criminal laws authorize excessively harsh prison sentences (Gostin 2004) that are more severe than penalties for comparable crimes, such as assault; penalties are comparable to or, in some cases, more severe than those applied to more serious crimes such as rape (Galletly and Pinkerton 2006). In addition, all of the statutes legitimize the state's intrusion into the most private aspects of its citizen's lives (Gostin 2004) and add the stigma of criminality to disfavored groups who already experience the stigma of a stigmatizing disease (Lazzarini et al. 2002; Wolf and Vezina 2004; Galletly and Pinkerton 2006).

5) The human rights burdens are unfairly distributed. HIV-specific statutes criminalize consensual sexual activities that are common and widespread, inviting selective, discriminatory enforcement against members of the most vulnerable or disfavored groups: sex workers, IV drug users, gay men, the poor, and members of racial minorities (for a discussion, see Sullivan & Field 1988; Wolf & Vezina 2004; Gostin 1988, 2004).

In short, these considerations lead almost all commentators to conclude that these criminal laws violate civil rights and are "unlikely to be an effective tool for public health" (Gostin 2004: 492). Some authors also conclude that criminal HIV exposure statutes do not fare well when assessed against the stated goals of the criminal law. While they do provide an outlet for collective outrage and retribution, prisons are unlikely to incapacitate or rehabilitate offenders, and the law is unlikely to deter behaviors that transmit HIV (see, for example, Burris and Cameron 2008).

Weighing the costs to human rights against public health benefits provides a clear set of standards for evaluating social control in public health. This framework, however, has its critics. First, to ask about the extent to which the state can abridge civil liberties in the name of public health arguably prejudices the issue at the outset by assuming that some restriction on freedom

will always be necessary. Moreover, as Jonathan Mann argued, the conflict between human rights and public health is a false dichotomy: voluntary measures, such as counseling, community outreach, needle exchange, and voluntary testing not only protect human rights but have also been shown to improve public health (see Fee and Parry 2008). Conversely, coercion and criminalization of HIV exposure is ineffective in encouraging people to alter their health behavior and drives them away from public health programs and therefore has a negative impact on both human rights *and* public health (see also Gostin 2004, Burris and Cameron (2008). For these reasons, the tension between human rights and public health is illusory.

An alternative view of public health—and one that human rights activists would endorse—places social justice and remediation of health disparities at the center of public health’s mandate (Faden and Shebaya 2010). Given that social inequality is a fundamental cause of health disparities (Link & Phelan 1995), it is not surprising that HIV/AIDS has increasingly affected the poor, immigrants, and Latinos and African Americans (Gostin 2004). Viewed from this vantage point, criminalizing HIV exposure not only leads to selective, discriminatory enforcement of the law, but, in addition, places the onus of responsibility on the individual (particularly the infected individual) to change his or her behavior rather than addressing the root causes of the epidemic. For example, rather than arresting sex workers for exposing others to HIV, a social justice-human rights paradigm would address the problems that led many to turn to prostitution in the first place and provide them with housing, food stamps, and welfare benefits (Sullivan and Field 1988). It would endorse needle exchange and methadone substitution programs rather than arresting more people who use drugs. Finally, a social justice-oriented program would also remove the barriers that prevent people from accessing anti-retroviral

therapy by providing housing, transportation, and economic support (see, for example, Open Society Institute 2008).

The body of literature I have reviewed suggests legal and ethical frameworks that can be used to create a critical sociology of public health. But such a sociology needs to be built on a solid foundation of empirical knowledge about how public health social control measures work in actual practice. On this point, as some writers acknowledge, the literature raises as many questions as it answers (see Lazzarini et al. 2002). While this literature analyzes the theoretical tensions between civil liberties and the public's health, there is much we still do not know about whether and how these tensions play out on the ground today. Many of the arguments against coercive social control are consequentialist and are based on the *presumed* and *predicted* consequences of criminalization: that it will drive people away from public health programs, be enforced selectively against disfavored groups, or exacerbate the stigma of HIV/AIDS. Yet we still know little about the actual consequences of these laws. While writers predict that the criminal law will further stigmatize people living with AIDS, much remains to be learned about how public health officials and court officers reproduce that stigma through their work.

Most commentators use as “data” the content of criminal statutes—the law on the books—from which they extrapolate its predicted consequences. The few multi-state surveys of criminal laws that discuss enforcement (e.g., Lazzarini et al. 2002) focus on the outcome of statutes—decisions—rather than the *processes* of decision-making in the court room. Thus, as Lazzarini and her colleagues observe, much remains to be learned about how the criminal law is applied and enforced:

There is a real difference between criminal law on the books and criminal law in practice. Some laws are heavily enforced, others rarely. The prohibitions can be broadly or narrowly interpreted. ...the people who really “make” criminal law are police and prosecutors. ...This “prosecutorial discretion” extends not just to the question of whether to arrest and charge a person, but also with which crimes to charge, and whether to accept a plea bargain....Police decide how intensively to

look for violations of the law or to investigate those brought to their attention. Exercise of prosecutorial and law enforcement discretion raises particular concerns where it is exercised arbitrarily or prejudicially (Lazzarini et al. 2002:240).

There are other questions as well: How do public health officials talk to and about their clients? Do they protect their clients from the criminal law or, as activists have predicted, collaborate with law enforcement? Do defendants understand that they are exposing others to HIV and recklessly ignore the consequences of their actions? Or do they believe they have taken precautions to protect their partners against infection? How do prosecutors and judges depict HIV and the actions of the criminal defendants?

In short, the literature underscores the need for empirical research. To build a critical sociology of public health we need to know how social control works at the “street level” in the transactions between health officials and clients, court officers and defendants. While sociologists have analyzed how mental hospitals, homeless shelters, battered women’s shelters operate as sites of social control, there is not a similarly rich empirical research that analyzes the negative repercussions that flow from public health efforts to control disease. The papers in this dissertation take a first step toward filling that gap in our knowledge.

From Sickness to Badness: Interrogating the Concept of Medicalization

Over the past four decades, medical sociologists have elaborated on the concept of medical social control. Freidson (1970) was the first to recognize that illness was a socially constructed phenomenon by analyzing how medical professionals came to define categories of deviance as illness in order to diagnose increasing numbers of individuals as sick. Conrad (1979, 1992) and Conrad and Schneider ([1980] 1992) later articulated these efforts through the concept of medical social control, which is conceptualized as the process whereby medicine and its practitioners come to govern types of non-conformity once viewed as crime or sin. Conrad’s

theory of medical social control became encapsulated within the well-known concept, “medicalization,” in his analysis of the development of the medical category “hyperkinesis” (see Conrad 1975).

With the rise of science and the increasing power of the medical profession, the process of medicalization followed an inexorable trajectory as an ever-widening variety of forms of deviant behavior or “badness” came to be defined as “sickness.” Conrad and Schneider first described the medicalization of child abuse, hyperkinesis, alcoholism, and mental illness, but in later decades, scholars applied the concept to such phenomena as female sexual dysfunction (Bancroft 2002) and fetal alcohol syndrome (Armstrong 2003)—and even processes that more readily seem “natural,” such as death and dying (Riley 1983). Those who wrote about medicalization also theorized the consequences of medicalization. Although the medicalization of deviant behavior purports to remove blame from the person who is labeled as sick, in fact there were other, more insidious consequences, such as the de-politicization of deviance and the disempowerment of patients. At the same time, medicalization resulted in the increasing authority of experts, such as physicians and members of related occupations (school psychologists), whose power increased as their jurisdiction expanded.

Conrad (2005) noted that with such developments as direct-to-consumer marketing, no longer were professionals the exclusive agents of medicalization; rather, the “engines” were often pharmaceutical companies, health insurers, and consumer groups. However, few questioned the belief that the process of medicalization was largely unidirectional, resulting in increasing numbers of conditions that had come to be defined and treated medically. With the exception of Fox’s (1977) observations on de-medicalization, only recently have observers come to question this picture of a one-way historical progression of events. While Conrad and Schneider ([1980]

1992) originally conceptualized medicalization as the process through which “categories of deviant behavior become defined as medical rather than moral problems” (p. 17), Conrad (2005) later argued that medicalization can be “bidirectional and partial” (p. 5). Anspach (2011:xxii) expands on this to suggest that “ideas about bad behavior... continue to exist in popular culture alongside the medical model.” Bosk (2013) argues that, while children with behavioral disorder diagnoses undergo partial medicalization, this does not protect them from criminalization.

Thus, one contribution of this dissertation is to interrogate the concept of medicalization by examining what happens when “sickness” (HIV in this case) comes to be defined as “badness.” In order to understand better this relationship between medical and legal governance, this dissertation examines what Timmermans and Gabe (2002) describe as the “medico-legal borderland” – that is, sites of overlapping jurisdiction between medicine and the law. By examining the criminal regulation of a disease, this dissertation puts the literature on medical social control in conversation with the criminological literature on the process of “criminalization”—or, how deviance becomes labeled as crime and controlled by criminal justice authorities (for a review, see Jenness 2004). Describing this transition as a “moral passage,” Gusfield (1967:187) argues that “What is attacked as criminal today may be seen as sick next year and fought over as possibly legitimate by the next generation.”

Discrimination in the Criminal Justice System

Explaining discrimination in the criminal justice system is a longstanding goal of socio-legal scholars. While the scholarship on the subject is too vast to review comprehensively here, there are important conceptual distinctions to note. In particular, legal approaches to conceptualizing discrimination have often formally distinguished between disparate treatment

and disparate impact (see Lucas, 2008). Disparate treatment studies on race, for example, examine racist practices that explicitly treat groups differently—such as racial bias in criminal sentencing (see, for example, Doerner and Demuth, 2010; Kautt, 2009; Crawford et al., 2006). Disparate impact studies, by contrast, examine practices that are not explicitly related to race, gender, or some other legally protected identity but nonetheless result in disparate outcomes, such as the well-documented disparate impact of the “war on drugs” on racial minorities (for a review, see Provine, 2011). Documenting the causal mechanisms underlying these outcomes has been more problematic; socio-legal scholars have noted that interpreting such trends as racist often conflicts with conventional notions of racial prejudice that implicitly understand it to be intentional (Murakawa and Beckett, 2010).

While racial discrimination is perhaps the most widely studied form of discrimination, a wide range of social factors have come under the scrutiny of socio-legal scholars interested in discrimination. These include various demographic characteristics of the defendant, such as their age (Steffernsmeier et al., 1995) and gender (Koons-Witt, 2002) and the interaction of these variables for black men in particular (Doerner and Demuth 2010; Steffernsmeier et al., 1998).

While far less numerous, studies have also examined whether the characteristics of crime victims—rather than just defendants—are also associated with criminal justice outcomes. In particular, numerous studies have examined how the gender and race of violent crime victims impact the imposition of the death penalty, finding that black defendants accused of killing white victims receive the death penalty at higher rates than others (see, for example, Holcomb et al., 2006; Radelet and Pierce, 1985). Similar studies of victim characteristics in non-capital crimes and their adjudication are less numerous. In this dissertation, I extend the insights of these scholarly efforts by evaluating whether defendant characteristics and partner gender (that is, the

gender of the sexual partner in cases of non-disclosure of HIV-positive status) are associated with disparate rates of conviction under Michigan's HIV disclosure law.

The Social Control of Sickness through Three Empirical Lenses

Despite scientific advances in treating and managing HIV disease, prosecutions for nondisclosure have continued unabated and appear to be on the rise. My dissertation explains this paradoxical trend by arguing that Michigan's HIV disclosure law functions to control HIV not as a virus but rather as a moral infection requiring interdiction and punishment. To make this case, my dissertation tackles three interrelated questions.

Chapter 2, "Controlling Sex in the Name of Public Health: Social Control and Michigan HIV Law," analyzes how local health officials enforce the larger "health threat to others" statute, which includes the felony nondisclosure law but also confers upon public health authorities additional powers for controlling individuals they declare to be deviant. Based on interviews with officials in 14 of Michigan's 17 jurisdictions for HIV, this chapter reveals the techniques (such as STI testing and contact tracing) employed by some officials in order to identify potential "health threat" cases and argues that these strategies cannot actually reveal whether or not an individual disclosed his or her HIV-positive status to his or her partner. Despite this, health officials' conflation of nondisclosure with other, perfectly legal deviant practices (e.g. condomless sex) suggests that their intent is not simply to control the spread of disease but also to regulate a population they perceive as deviant.

Chapter 3, "From Sickness to Badness: The Criminalization of HIV in Michigan," draws on archival data associated with 95% of all convictions under the felony statute between 1992 and 2010 to analyze how legal actors transform HIV into a criminal matter in a court of law.

Drawing on more than 4,000 pages of trial court transcripts, the analysis demonstrates that legal actors frame nondisclosure as murderous and HIV-positive defendants as reckless killers—even in cases where the sexual contact alleged posed no risk of transmission. These findings show that Michigan’s HIV disclosure law is not driven by insights from medical science; rather, it serves to control and punish HIV-positive populations deemed deviant.

Chapter 4, “Disparate Risks of Conviction under Michigan’s Felony HIV Disclosure Law: An Observational Analysis of Convictions and HIV Diagnoses, 1992-2010,” examines disparities in conviction outcomes to determine whether certain groups are bearing the brunt of the disclosure law’s application. By comparing conviction outcomes with data documenting HIV-positive diagnoses during the same period, this analysis shows that disparities under the disclosure law are better explained by variations in complainant characteristics (e.g. their gender) rather than those of the defendant. For male defendants, having sex with women was associated with a higher rate of conviction as compared to men who have sex with men. Indeed, although critics have charged that HIV disclosure laws are homophobic, heterosexuals bear the brunt of the law’s application—particularly black men and white women.

Chapter 5 serves as the conclusion to the dissertation. It reflects on the broader implications of these findings, taken together, and considers their import. While many proponents of HIV legal reform have argued that HIV-specific criminal laws are bad for public health, the way state actors respond to these cases does not suggest that they are primarily interested in promoting public health. Of course, it is impossible to know what unspoken factors may have guided the decisions of prosecutors and attorneys in these cases. However, their patterned reliance on punitive and moral discourses—as well as their ignorance and dismissal of scientific evidence—suggests that their understanding of these cases is tainted by stigma and

morality. These ethical dimensions bear only a tenuous relationship to public health and medical evidence: their logic does not depend on science.

CHAPTER 2

Controlling Sex in the Name of “Public Health”: Social Control and Michigan HIV Law

Introduction

During a general panic about the potential for AIDS to spread from “high risk” minority groups to the “general population” in the late 1980s, Michigan legislators enacted a set of laws collectively referred to as “health threat to others” law that requires HIV-positive individuals to disclose their status to their partners before engaging in any form of sexual contact. Like many of the 32 states that have enacted such statutes, Michigan law does not require proof of malicious intent, nor do they require evidence that the sexual practices alleged pose any risk of transmitting the virus (Wolf & Vezina 2004; Galletly & Pinkerton 2006; Center for HIV Law & Policy 2011). Violators are legally termed “health threats” and sanctions can include forced testing and counseling, quarantine, and/or incarceration under the felony criminal provision.

Recent reports suggest that over a thousand HIV-positive Americans have been criminally prosecuted for not disclosing to their partners (Bernard & Nyambe 2012). Health scholars have criticized criminal disclosure laws, arguing that they may disincentivize HIV testing by inadvertently turning an HIV-positive test result into a potential legal liability – those who haven’t been tested and thus diagnosed as HIV-positive cannot be prosecuted under these statutes (Galletly & Pinkerton 2006). Yet, beyond limited studies in public health and a handful

of sociological case studies (Shevory 2004), we know little about how these laws are enforced or the sociological implications of their application.

In this paper, I report findings from a study involving 25 local health officials who are responsible for managing “health threat” cases from 14 health jurisdictions in Michigan. Qualitative, in-depth interviews with these officials reveal two primary techniques of identifying “health threat” cases that I argue can be usefully conceptualized as informal and formal forms of social control. In what follows, I first provide an overview of the literature on the social control of public health. While sociological approaches to medical social control have typically examined the practices, forms of authority, and discourses of conventional medicine, I instead bring the insights of the literature on social control to bear on the field of public health. Although medicine and public health have similar aims, I argue that their contrasting orientations towards prevention (public health) and treatment (medicine) have important implications for their strategies of social control. In the second section, I survey the literature on the legal regulation of HIV disclosure. This paper builds on its insights by analyzing how public health enforces a broader set of “health threat” legal statutes by means that go beyond criminal sanctions. In the third section, I provide background on the history of sexual contact tracing and HIV testing in the United States.

In the fourth and fifth sections, I report findings from my research. I analyze the formal and informal strategies of social control that were described by participants. The first, “formal” strategy for social control is evidenced by reports from health officials in five jurisdictions who described harnessing epidemiological surveillance technologies, such as Partner Services and HIV testing, for legal surveillance. This strategy typically involved asking a client newly diagnosed with a reportable sexually transmitted infection (including HIV but also other

infections such as chlamydia) to report the names of their previous sexual partners as well as whether any of those named partners had disclosed that they were HIV-positive before sex. Officials would then check the list of named partners against the state's database that includes anyone ever diagnosed as HIV-positive in Michigan in order to identify potential "health threat" cases. As I show, the formal techniques for controlling "health threat" cases described by health officials often rely on misguided assumptions about sexual practices and HIV risk. Moreover, the application of those techniques reveals vast differences in how officials interpret the law, with some officials conflating not disclosing with engaging in unprotected sex.

The second, "informal" strategy for social control is evidenced by reports from health officials in five jurisdictions who describe receiving a large volume of "third party phone reports" in which local residents accuse others in the community of not disclosing their supposed HIV-positive status to their sexual partners. I argue that these patterned phone calls are suggestive of local gossip cultures fueled by gendered and raced forms of social stigma. Moreover, although the kind of disclosure practiced by community members through gossip is not encouraged by the state's HIV disclosure law, I argue that these practices reflect underlying assumptions about risk and informed consent similar to those encoded in the law.

Literature Review & Background

The Social Control of Public Health

This paper attempts to bridge two sometimes disparate traditions in the sociological literature on social control. First, it is framed by the work of medical sociologists who have analyzed how medical knowledge, authority, and technologies come to be an important site of social control. This literature can be traced back to Parsons' (1951) novel work on the "sick role" in which he

conceptualized illness as form of deviance and medicine as the appropriate resulting form of social control. With a more critical eye towards medicine, Conrad (1979; 1992) argued that medical social control should be understood as having four critical components: medical ideology (the imposition of a medical model as a result of increased influence by medical authorities); collaboration (the role of doctors as information providers or “gatekeepers” of knowledge); technology (the use of medical technological innovations such as genetic screening); and, based on the work of Foucault (1973; 1977), surveillance (including how the “medical gaze” becomes internalized).

Building on these important pioneering insights and the work of other medical sociologists who have revealed much about how medical institutions and practice operate as sites of social control, this paper attempts to bring these critical insights to bear on the field of public health. I argue that public health differs in important ways from more traditional forms of medicine and medical authority. For instance, the Association of Schools of Public Health distinguishes the field of public health from that of “clinical professionals” by its focus on *prevention* rather than *treatment*:

Public health professionals try to prevent problems from happening or re-occurring through **implementing educational programs, developing policies, administering services, regulating health systems and some health professions, and conducting research**, in contrast to clinical professionals, such as doctors and nurses, who focus primarily on treating individuals after they become sick or injured (Association of Schools of Public Health N.d.).

While this heuristic distinction between treatment and prevention can become blurry in practice¹, I argue that there are important differences in how public health produces social control as

¹ For instance, advocates arguing for the rapid scale-up of antiretrovirals to treat HIV infection in developing nations recently framed the need to provide HIV-positive people access to lifesaving treatments as an indirect but effective way to prevent future infections. Because these medications dramatically reduce or even eliminate the amount of virus in patients’ bodily fluids, patients treated with antiretrovirals are less likely to transmit the virus to others. Thus, “treatment as prevention” has become a slogan of many treatment activists – blurring the lines between these two conceptual approaches to health.

compared to traditional institutions of medicine. This difference is in part due to the fact that public health aims to prevent illness, which requires a different set of strategies for social control and thus a different set of sociological tools for analysis.

To say that public health is a site of social control is, admittedly, not altogether novel. Indeed, within the social sciences, historians of medicine and medical anthropologists have both developed rich, critical traditions analyzing the efforts of public health to control communities. For example, historians have shown how venereal disease control campaigns in the early 20th century (Davidson 2000; Holloway 1998), as well as psychiatry and mental hospitals (Foucault 1973; Sadowsky 1999; Jackson 2005) operate as institutions of social control. Anthropologists have a similarly rich tradition critical of public health; for example, scholars have criticized the way that stigmatizing, American epidemiological concepts such as the “bisexual bridge” have been problematically mapped on to HIV epidemics in Latin American and Caribbean countries where the word “bisexual” may not even exist (Carrillo 2003; Padilla 2007). However, while sociologists such as Peterson and Lupton (1997) have theorized how public health can become an important site of moral regulation, there is not yet a rich empirical knowledge base in sociology documenting the various forms that social control can take in public health practice.

Informal and Formal Social Control

In order to bring greater specificity to a concept that has been invoked to refer to very different kinds of social processes (for an overview, see Janowitz 1975; Meier 1982), I rely on a distinction in the criminology literature between “formal” and “informal” modes of social control. For the purposes of this paper, when I speak of formal social control, I refer to the regulation, surveillance, and control of individuals and their behaviors by institutions of authority

and officials who represent them. I am putting in conversation the concept of “formal” social control that comes out of the criminology literature with the previously described concept of medical social control outlined by Conrad (1992). In this paper, I draw on Conrad’s (1992) focus on technology and surveillance in particular to analyze the use of epidemiological surveillance technologies by health officials for formal social control.

When I speak of informal social control², I refer to the ways community members monitor, police, and control each other. Notably, I am drawing on the concept developed by sociologists and policy scholars to mean “what ordinary citizens do to keep where they live free from crime and disorder” (Carr 2003: 1249). This literature is often in conversation with “broken windows theory,” which postulates that decaying neighborhood conditions lead to social disorder and crime (Wilson and Kelling 1982). However, while informal social control is sometimes defined positively as a force promoting social order (Sampson, Raudenbush, and Earls 1997; Carr 2003), I argue that it does not necessarily yield laudable social outcomes.

In framing this paper around both formal and informal kinds of social control, I aim to highlight the need for a critical sociology of public health. While social work scholars have analyzed how institutions such as homeless shelters (Pitts 1996), battered women’s shelters (Murray 1988), and welfare programs in general (Piven & Cloward 1971) operate as sites of social control, public health scholarship is generally uncritical of the role public health institutions play in producing and organizing social control. For instance, while various studies have attempted to examine the role that social stigma plays in structuring the HIV epidemic (Herek 1999; Sayles, et al. 2009) the literature rarely acknowledges the role public health may

² Readers may note that my usage is somewhat different from how medical sociologists such as Bosk (1979) have used the term to designate the kind of regulation produced through ordinary, everyday social interaction, such as physicians scolding medical residents. The literature in public policy also highlights social interaction in its approach to informal social control, but highlights instead how lay individuals police each other when authority figures are not around.

play in producing stigma and the deleterious consequences that flow from it. While this paper is not primarily about stigma, I argue that the techniques of social control described and facilitated by public health officials are both informed by and reproduce social stigma.

HIV Disclosure and “Health Threat” Policies in the United States

Michigan’s “health threat” legislative package legally codifies the various steps health officials must follow in handling cases involving “an individual who is a carrier [and] has demonstrated an inability or unwillingness to conduct himself or herself in such a manner as not place others at risk of exposure to a serious communicable disease or infection” (Michigan Compiled Law Annotated § 333.5201). Once identified as a “health threat,” the offender must be served a “cease and desist warning notice.” If health officials later suspect that the individual is not complying with the warning notice, they may request that the case be reviewed by a probate court where a judge can order a variety of interventions, including mandatory education; counseling and/or treatment programs; forced HIV testing; quarantine; and “any other order considered just by the circuit court” (Michigan Compiled Law Annotated § 333.5205). Because the state does publicly release data on “health threat” cases, it is not known precisely how many cases are pursued beyond warning notices.

The “health threat” statute also includes a felony criminal provision that applies specifically and only to persons infected with HIV. It states:

A person who knows he or she has HIV, and who engages in sexual penetration with another person without informing that person of his or her HIV status, is guilty of a felony. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body; emission of semen is not required (Michigan Compiled Law Annotated § 14.15 [5210]).

While Michigan State Police records indicate that at least 68 criminal cases³ have been initiated under the felony HIV disclosure statute between the first prosecution in 1992 and October 2010 (Michigan State Police 2011), what role health officials have played (if any) in initiating or facilitating these charges has not been described until now.

Yet, while 68 known cases have been brought against (allegedly) HIV-positive defendants for failing to disclose their *own* status, no evidence exists that suggests anyone has ever been charged for unlawfully revealing *another person's* HIV-positive status. Under Michigan law, it is illegal for an individual to disclose another person's HIV status without that person's express, written permission. The law requires that "All reports, records, and data... that are associated with the serious communicable diseases or infections of HIV infection... are confidential" and states that anyone who violates this statute is "guilty of a misdemeanor, punishable by imprisonment for not more than 1 year or a fine of not more than \$5,000.00, or both, and is liable in a civil action" (Michigan Compiled Law Annotated § 333.5131). Even though this statute was enacted at the same time as the felony law requiring HIV-positive individuals to disclose to their sexual partners, I have not discovered any evidence to suggest that charges have ever been filed under its provisions.

Very little scholarship exists that examines the impact of non-criminal "health threat" statutes and laws like them in other states. However, in a survey of all fifty state health departments, Bayer and Fairchild-Carrino (1993) found that 24 states had either no policy in place for handling what they termed "recalcitrant" HIV-positive individuals (which the authors define as "those who knowingly persisted in exposing others to HIV" [p. 1471]) or took no

³ Michigan State Police data indicates there have been 49 convictions and 19 cases in which a defendant *with a prior criminal record* was either found not guilty or succeeded in having the charge dismissed. Records involving defendants who were not convicted *and who did not have a prior criminal record* are expunged, so the number of such cases is unknown. However, local news reports suggest they are few and far between.

action if they received reports about such individuals. Additionally, this study found that Michigan was one of 16 states where both quarantine and criminal prosecutions had been carried out, although the authors noted that quarantine was much less common than prosecution. They concluded that “despite [the law’s] procedural protections, [prosecution] has been deemed a more effective way of seeking to assert social control over individuals whose behavior was considered a threat” (p. 1475). More common than either approach, however, was the issuance of cease and desist orders to “recalcitrant” HIV-positive individuals as provided for under non-criminal “health threat” statutes.

Studies focused on criminal disclosure statutes are more abundant. Recent studies indicate that at least 24 states presently have a criminal law that makes it a misdemeanor or a felony for HIV-positive people to have sex without first disclosing their status. Including states with sentence enhancement policies that increase the severity of punishment for certain crimes such as prostitution, 32 states have HIV-specific criminal statutes (Wolf & Vezina 2004; Galletly & Pinkerton 2006; Center for HIV Law & Policy 2011). Michigan’s statute in particular has been criticized for being overly broad, in that it criminalizes sexual acts that carry no risk of HIV transmission (Heywood 2008). Like many state disclosure laws, Michigan law neither requires actual transmission or even risk of transmission in order to define the sexual behavior of the HIV-positive individual as actionable, nor does it require malicious intent. Beyond their criminalization of harmless sexual contact, these statutes have also come under attack for making knowledge of one’s HIV-positive status a criminal liability, potentially discouraging people at risk for HIV infection from seeking to be tested (see, for example, UNAIDS 2002). However, no study has yet systematically evaluated these claims.

Fourteen of the 24 states with felony or misdemeanor HIV-specific criminal disclosure laws were passed in the mid-1980s and early 1990s, before life-saving antiretroviral medications were introduced in 1995 (Galletly & Pinkerton 2006). The laws were passed, then, in a context of high mortality rates, at a time when most Americans were uninformed about AIDS and feared contracting it through highly improbable scenarios, such as kissing or malicious exposure (Bateson & Goldsby 1988; Brandt 1988; Burris, Dalton, Miller, & Yale AIDS Law Project 1993). Public debates over criminal disclosure statutes have tended to focus on extremely atypical cases that reflect those fears, such as the case of a black New Yorker, Nushawn Williams, who was prosecuted in 1999 for allegedly infecting over a dozen white women (Shevory 2004).

HIV-specific criminal statutes have only recently become a subject of sociological inquiry. For instance, Weait (2007) analyzed how notions of risk, harm, and culpability have been codified into English case law pertaining to HIV exposure. In a review of Canadian court cases regarding HIV transmission, Adam and co-authors (2008a) note that while the 1990s were characterized by a rhetoric of “mutual responsibility” – in which “HIV prevention through safer sex is the responsibility of both HIV-negative and HIV-positive people” – recent Canadian cases indicate that the “onus of responsibility may be shifting back toward HIV-positive people” (p. 8). In a qualitative study of HIV-positive people in Michigan, Galletly & Dickson-Gomez (2009) found that the majority of participants supported the law but expressed concern that it could be maliciously used against them. By contrast, a study of attitudes towards disclosure laws among HIV-positive people in the UK found participants were generally critical of criminal prosecutions (Dodds and Keogh 2006). However, a survey of both HIV-positive and HIV-negative gay men in the UK found that men in the study generally supported prosecution and expected partners to disclose before sex (Dodds 2008).

Building on these insights, this study is the first sociological analysis that examines the role that health officials play in enforcing “health threat” statutes. The evidence that it assembles is critical for understanding how these statutes are applied, and the problems that accompany their application. Further, this paper demonstrates how the strategies adopted by health officials for surveillance and enforcement can be understood as forms of social control.

Sexual Contact Tracing and HIV Testing in Michigan

The use of sexual contact tracing as a strategy for the prevention and treatment of sexually transmitted infections has a long history that stretches back to syphilis outbreaks in American urban centers in the early 20th century. Contact tracing was developed then as a novel way to help limit new infections (Smith & Brumfield 1933; Turner, Gelperin, & Enright 1939). A public health researcher in 1939 described contact tracing as a way to notify partners “in order that they may be brought under medical care and rendered non-infectious as promptly as possible” (Turner, Gelperin, & Enright 1939: 768). Since then, state health departments have relied on partner referrals as a way to identify, test, and, if necessary, treat partners of individuals newly diagnosed with a variety of sexually transmitted infections – typically gonorrhea, chlamydia, syphilis, and HIV (see, for example, Judson & Vernon 1988).

Contact tracing was initially developed to “trace” the origins of bacterial infections and to treat them before the infected individual unwittingly exposed others. Adapting this method to an incurable virus required a shift in priority: partners of infected persons could not be “rendered non-infectious” at the time they were identified; they could only be made *aware* that they might have been exposed. Indeed, early HIV prevention scientists noted that:

Emphasis should be on partners who are unlikely to know they were exposed to HIV e.g., female partners of bisexual men and of IV drug users... Lower priority should be given to notification of casual male partners of homosexual men and female prostitutes because they are difficult to reach and presumably are voluntarily taking a risk (Judson & Vernon

1988: 392).

In other words, the need to notify was normatively interpreted as directly related to the likelihood that the partner of an infected person was unaware of the exposure (or the “risk” of exposure). Partners of “homosexual men” and of “female prostitutes” were presumed to be “voluntarily taking a risk” and therefore aware of their possible exposure. They were also presumed to be asking for trouble and to be in less need of state intervention. Health scholars’ emphasis on awareness reveals how knowledge – a key component of disclosure – became a critically important factor when public health practitioners adapted contact tracing to the HIV epidemic.

In Michigan today, the state conducts contact tracing for all individuals newly diagnosed with gonorrhea, chlamydia, syphilis, and/or HIV. Michigan Department of Community Health (MDCH) staff identify the following goals for partner notification: “Counseling HIV/STD-infected clients on disease state and need to identify their sex and/or needle-sharing partners at-risk for HIV/STD; Locating partners, and notifying them of exposure and offer testing and treatment, prevention, education, and referral to medical and support services” (Peterson-Jones 2009). Thus, health officials in charge of partner referrals in Michigan conceptualize their function largely in terms of “health”: Find partners, inform them, counsel them, test them, and when necessary, treat them.

Just as contact tracing had to be adapted to the context of the HIV epidemic, so too did testing. Public health experts and HIV/AIDS advocacy organizations engaged in fierce debates over how HIV test results should be collected and stored by the state (see, for example, Gostin, Ward, & Baker 1997). Two competing strategies emerged for managing HIV testing data. The first, “code-based” method involved assigning each individual a unique, anonymous code that could not be traced back to the client. The alternative, “names-based” method, favored by the Centers for Disease Control and Prevention (CDC), involved collecting the names of individuals

who are tested and storing them confidentially, so as to correlate individual test results with the individual persons being tested. Michigan was an early adopter of names-based reporting in 1988 (CDC 2007; Nakashima, et al. 1998). Debates raged for years over the vulnerability of names-based systems to privacy violations, fueled by several widely reported leaks in Florida (Landry 1996). Despite these privacy concerns, most states adopted names-based systems and the CDC eventually pressured the states that did not already convert to names-based reporting to do so (CDC 2010b). Despite their widespread application, no studies have examined the role these technologies may play in facilitating the enforcement of HIV law.

Methods

Michigan is divided into 45 local health jurisdictions, 16 of which are classified by the MDCH as high-morbidity jurisdictions for HIV infection. Each of these 16 jurisdictions has its own program for handling HIV/AIDS, which includes staff responsible for managing and responding to “health threat to others” cases. The remaining 29 jurisdictions, classified as low-morbidity jurisdictions, share one overarching, centralized HIV/AIDS program. Thus, there are 17 proper cases (defined as local public health agencies charged with investigating HIV “health threat to others” cases) suitable for analysis in this project: 16 high-morbidity jurisdictions, and one, omnibus low-morbidity jurisdiction.

With assistance from MDCH staff, I identified two actors whose organizational roles and institutional responsibilities are most closely tied to responding to and managing “health threat to others” cases: the HIV/AIDS Services Coordinator and the Disease Intervention Specialist (DIS). The coordinator is responsible for overseeing the jurisdiction’s programs and services that are related to HIV/AIDS, while the DIS is charged with making site visits and organizing and

implementing interventions developed to deal with “health threat” cases. Notably, these roles are not distributed evenly: in smaller counties, they were sometimes united in the same person, while larger counties had multiple DIS positions. In cases where there were multiple DIS positions, I only interviewed staff who had direct experience with HIV “health threat” cases.

In coordination with MDCH, I visited 14 of the 17 local health jurisdictions where I interviewed 25 staff members. Two jurisdictions declined to participate because of recent staff turnover, and one never responded to requests to participate. Each in-depth, 45- to 90-minute, semi-structured interview was audio recorded. I asked each participant to choose a pseudonym, which are the names used in this paper. I conducted all of the interviews myself, and coded transcripts using NVIVO software. In particular, I coded interviews for general techniques of surveillance (e.g. using partner services or testing data); participants’ awareness and opinion of the HIV disclosure law; and direct experience with regulating HIV-positive clients. I obtained approval to do research with human subjects from both the University of Michigan’s Health Sciences and Behavioral Sciences Institutional Review Board and the Michigan Department of Community Health’s Institutional Review Board.

Results

Forms of Formal Social Control

Technologies of Surveillance: How Health Departments Employ Epidemiological Surveillance

Tools in the Service of Legal Surveillance

When clients visit one of the many publicly-funded health clinics in Michigan to be tested for HIV, they can expect more than just a finger-prick or blood draw. Counselors sit down with clients to review copious details pertaining to their sexual practices and partners: How many

times have you engaged in anal sex in the last six months? Did any of your partners ejaculate inside you? How many times in the past six months have you used narcotics when having sex? Clients' responses are often catalogued and collectively analyzed. Considered by health experts as an opportunity for clients to reflect on their sexual lives and perhaps commit to taking more care to prevent acquiring HIV in the future (if they test negative), pre- or post-test HIV counseling has long been one of the cornerstones of HIV prevention.

If a client tests positive for HIV or any other reportable sexually transmitted infection, the testing counselor will not only provide counseling and referrals for treatment but is also legally mandated to ask clients to report the names of everyone with whom they have had sex. Health officials later attempt to contact those individuals to recommend that they be tested for HIV and

Table 2.1: Techniques used in Public Health Jurisdictions in Michigan to Identify Cases of “Health Threats to Others”

Jurisdiction No.	Partner Services + Names	STI Testing	Contracts	Phone Calls
1	✓			
2			✓	✓
3	✓			✓
4			✓	
5				✓
6			✓ ¹	✓
7				
8			✓	
9	✓			
10				✓
11		✓	✓	
12				
13		✓		
14				

1. While their HIV/AIDS Coordinator stated that their health department did not employ such a contract, the local policy documents they gave to me included such a form. It is not known if this form is actually in use.

other infections. In this section, I argue that we can understand HIV testing and partner referral as forms of social control. HIV testing and the array of surveillance technologies built up around it are well suited to this concept. HIV counseling sessions are not just an occasion to educate people, raise their awareness of the risks they are taking, or collect data on how many people are taking what kinds of risks. The findings in this paper reveal that health officials use these encounters as opportunities to regulate their clients' sexual practices and, more specifically, to enforce Michigan's "health threat" law.

While health officials describe partner services as a tool for epidemiological surveillance and HIV and STI prevention (Peterson-Jones 2009), findings in this study suggest that partner services is also a tool for legal surveillance. As outlined in Table 2.1, local health officials in three jurisdictions report actively employing contact tracing in order to identify potential "health threat to others" cases. While these officials described a variety of scenarios in which these surveillance techniques were utilized, their descriptions typically featured an individual newly diagnosed with a reportable sexually transmitted infection, who named a sexual partner already known by the state to be infected with HIV. To be clear, there are several critical steps in this process:

1. Person A *tests positive* for HIV (and/or chlamydia, gonorrhea, syphilis);
2. The testing counselor *elicits the names of Person A's prior sexual partners*;
3. The testing counselor asks *if any of the partners disclosed* to Person A that they were HIV-positive;
4. The health official attempts to *ascertain the HIV-status of Person A's reported partners* – first against local records, and then against the state's mandatory, confidential names-based database – to see if any of the partners reported are known to be HIV-positive;
5. If anyone named is already known to be HIV-positive *and* Person A reported that no one said he or she was HIV-positive, *an investigation is launched* against the reported partner(s) known to be HIV-positive – who, in some cases, are automatically deemed a "health threat to others."

For example, Mitch (HIV/AIDS Coordinator, Jurisdiction #2) described how she would elicit the names of partners from a client newly diagnosed with HIV, following up with an additional question as to whether any of the reported partners had disclosed that they were HIV-positive:

We make sure that we say everything very confidentially. So the one question that we have that we always ask somebody when they're giving us names is – going to this other person, if that person gave me four names, I would say “Did any of these four people ever tell you that they were HIV-positive?” Because if they give me a name and I already know that one of them is HIV-positive, because I've dealt with that person so much, then that's gonna be a flag to me right there. But I can't say, “Well so-and-so is HIV-positive, did they tell you that?” So we just make it very generic, “Did any of these people ever tell you that they were HIV-positive?” I may not know any of those people on that list, but the next step that I do is I'm gonna go back to my files and see if I have a file on any of these people. I will then go to the state and see if any of these people have already been reported as positive. And when that report comes back or when we have a file that one of those four people is positive, that becomes a flag (Mitch, HIV/AIDS Coordinator, Jurisdiction #2).

Notably, Mitch mentions that they may “already know that one of them is HIV-positive,” meaning that they may simply recognize a partner's name by virtue of having worked with that person in the past. This was reported by several officials, such as Charlie – the HIV/AIDS coordinator and disease intervention specialist in jurisdiction #9:

I was actually testing another individual who had just come in for – for everything, I think they were testing for everything. I tested, they were positive, and after interviewing, I knew the name immediately. After they gave me one of their partner names, I knew the name immediately. After they gave me one of their partner names, I thought – I didn't say anything at that time. But I just, you know, I just said, [sighing] “Oh, I know that name.” Went back, sure enough, confirmed that this person was already positive (Charlie, HIV/AIDS Coordinator & Disease Intervention Specialist, Jurisdiction #9).

Several things are worth noting here. First, Charlie's account suggests that clients who have closer relationships with testing counselors (or whose names are for whatever reason more likely to be recognizable to counselors) may be more likely to be identified as a potential “health threat.” While health officials in these jurisdictions reported cross-referencing the names reported through the state's confidential names-based database, this is not an automated process. Thus, name recognition may increase the likelihood that health officials take the extra step of

checking a particular name against the state databank. Moreover, clients are often able to provide health officials only with nicknames (e.g. “Shorty”) or partial information (e.g. “Johnny who works at McDonald’s on Main Street”). In such instances, health officials may be more readily able to make positive identifications of clients with whom they have close working relationships.

This is sociologically important for several reasons. First, the clientele of public clinics is not a random sample of the surrounding population: Women, African-Americans, and men who have sex with men are overrepresented among those who seek services at state-run health clinics. Because racial and sexual minorities and women are overrepresented at health clinics, they may be more likely to be identified as a “health threat.” Second, health officials in jurisdictions with relatively large HIV-positive populations may be less likely to recognize a particular name than those who work in jurisdictions with smaller numbers of HIV-positive residents.

While this paper is not primarily about the legal outcomes of cases identified through these surveillance technologies, it is worth noting that legal action, while rare, may be a consequence of health officials’ cross-referencing the names of sexual partners reported by newly-diagnosed clients against the state database. For example, Mitch described how they had handled a recent case in which a newly diagnosed client reported a partner that the health department later identified as HIV-positive. Because regulations enacted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prevent the health department from reporting that discovery to their client, they described taking further action as requiring “tiptoeing”:

There’s a lot of tiptoeing. There’s a lot of, “Well, we’d like you to come back into the office and talk to you a little bit more about your situation.” And that’s when we’ll try and say, “Have you had any other partners? Have any of your other partners ever said anything about being HIV-positive?” And at that point, sometimes we might say, “Well, we’d like you to report this to the police. We’d like you to contact the police.” Recently we had somebody we had called back to come in and do that, and then the person never showed. We were going tell them to contact the police, because we have a person who is

being a “health threat to others.” But the person never showed up. (Mitch, HIV/AIDS Coordinator, Jurisdiction #2).

While reports suggest that individuals who allege that their partners did not disclose must be willing to testify in order for a prosecutor to intervene legally, health officials can facilitate their contact with law enforcement as Mitch describes here. Thus, the strategies and techniques health officials described employing to identify “health threat” cases can lead to serious legal consequences for the individuals under surveillance. For example, the only person ever known by the author to be quarantined under Michigan’s “health threat” law, in 1992, was a woman described in news reports as “mentally deficient”; she was later convicted under the felony disclosure statute in 1995 (Walsh 1992; *AIDS Policy and Law* 1998). As I show in the next section, health officials in several jurisdictions have recently begun implementing a record intended to prove that newly-diagnosed clients have been informed of their HIV-positive status and of their responsibilities under the “health threat” statutes. This suggests that health officials are invested in facilitating legal action against their clients.

Can HIV-Positive People Legally Have Sex Without Condoms – Even After Disclosing?

In addition to using the confidential names-based database to identify “health threat” cases, health officials in certain jurisdictions use STI-testing technologies more generally as a means of identifying “health threat” cases. In two jurisdictions (see Table 2.1), officials reported classifying as a “health threat” HIV-positive clients who later test positive for a secondary infection (such as syphilis or chlamydia) as well as HIV-positive women who become pregnant. When I asked Fern (Disease Intervention Specialist, Jurisdiction #11) how most “health threat” cases came to her attention, she replied:

Well, usually it’s all the sudden their name appears with another STD... All the STDs have to be reported on the [Michigan Disease Surveillance System]. So... if the [syphilis

coordinator] has any syphilis cases where they're also showing that they're HIV-positive, then her and I work together and we – you know, if I've got a case report – then it goes to a “health threat to others,” more or less. Because if they come up with syphilis, they're having unprotected sex (Fern, Disease Intervention Specialist, Jurisdiction #11).

The conclusion Fern reaches is notable: “they're having unprotected sex.” While Michigan's state health department maintains that contracting a secondary infection is not sufficient grounds for categorizing an individual a health threat (Michigan Department of Health 2011a), health officials in two jurisdictions reported using STI testing in order to identify “health threat” cases.

I followed up with Fern to try to clarify this logic:

Author: A positive STI test result... y'all see as evidence of non-disclosure – well, I guess, how... what's the... why is that interpreted as a potential “health threat”?

Fern: Well they're having unprotected sex. But, again too, sometimes what I come up against is when I do get there, they'll say, “Well I did tell them.” You know, “They're positive also.” I say, “Well that doesn't matter.” You know, “Just because they're positive also, you still need to be using protection” (Fern, Disease Intervention Specialist, Jurisdiction #11).

Fern's concern in this case is not that the client might not be disclosing their HIV-positive status, but rather that the client was not using condoms – despite the fact that the client was engaging in a harm reduction strategy known as “serosorting,” or intentionally seeking out sex with people of the same HIV-status to reduce or eliminate the risk of HIV transmission (Parsons, et al. 2005). Thus, it appears that at least some health officials believe that having unprotected sex was sufficient grounds to be classified as a “health threat.”

Moreover, in a 2008 e-mail obtained through a Freedom of Information Act request by Todd Heywood, a local reporter, the state health department's legal director interpreted Michigan's “health threat” statute to mean that HIV-positive people are legally forbidden from ever engaging in unprotected sex “even if the partner is HIV-positive”:

Would an HIV-infected individual who has unprotected sex be a health threat to his/her sex partner? Are there any circumstances where unprotected sex not be a health threat? ... It sounds like the individual would always be a health threat, even if the individual's partner is also HIV-positive. An HIV-infected individual is not relieved of all

responsibility to prevent transmission simply because he/she has warned their sex partner of the HIV-infection. We (in public health) and the infected person still have responsibilities to prevent the spread of serious communicable disease even if the infected individual's sexual partner consents to the risky behavior. In fact, under section 5203, the local health officer *shall* issue a warning notice against such an individual (Chrysler, 2008, emphases mine).

While the state health department maintains that Chrysler's statement was not an official legal opinion (MDCH 2011a), the fact that its own legal director believed that an HIV-positive person engaging in unprotected sex "would always be a health threat" suggests that what actually constitutes an actionable "health threat to others" is not a precise offense but turns out to be subject to a range of interpretations.

Local health department policies also indicate that many local officials do in fact interpret the "health threat" statute as requiring HIV-positive people always to use condoms. Five jurisdictions⁴ (see Table 2.1) have developed so-called "client acknowledgement forms" that newly diagnosed HIV-positive clients are asked to sign immediately after learning that they have tested HIV-positive. While there are various versions of the form, the most controversial language was found in forms that asked clients to place their initials beside the following statement (quoted from the form used in Macomb County⁵: see Figure 2.1): "You are required to inform individual/s of your HIV infected status **BEFORE** sexual contact. You and your sexual partner/s must use a barrier protection such as latex condoms, dental dams, and/or female condoms in a correct and consistent manner" (Macomb County Health Department, n.d., original emphases). While most forms were more ambiguous in that they simply referred to a requirement that clients engage in "safe behaviors" and/or "risk reduction," the language used in

⁴ Health officials either directly described using such a form (n=2), and/or they provided me with policy documents that included such a form (n=5).

⁵ This is a public document and its inclusion should not be read as an indication that Macomb County did or did not participate in this study.

some of these forms suggests that at least some health officials believe their HIV-positive clients must use condoms at all times.

More than just a way to inform clients about their legal responsibilities, these “client acknowledgement forms” are a means of holding clients legally responsible for not disclosing their HIV status at a later date. As Mitch reports, these forms were developed after clients suspected of not disclosing simply denied knowing they were HIV-positive in the first place:

Sometimes, they’ll try and say, “Well, nobody ever told me I was positive. I tested but I didn’t get my results. They didn’t tell me I was positive.” And that’s why – we do a lot of paperwork now about, a lot of the education that we do, we actually have to have the people sign, anytime we have a positive, we go through felony law and do all of this education – what you need to do and what you don’t need to do. Get them hooked up with support services and then we make them sign a paper that basically says, “I’ve been educated. I know that I can’t do this without disclosing my status. I’ve been warned of that and I could potentially have charges brought against me if I don’t do that.” So we make everybody sign that, so that when we have that piece of paper and the name, say this person were to come up again all of the sudden, we’ve got that on file and we would say, “You can’t tell me that you didn’t know that you were positive, because we’ve got this on file” (Mitch, HIV/AIDS Coordinator, Jurisdiction #2).

These forms have already played a role in prosecuting HIV-positive people in Michigan. Indeed, a news report on the 2007 sentencing of a man to 5-15 years in prison for failing to disclose his HIV-positive status to two sexual partners noted that “Police say [the defendant] knew what he did was illegal because he had signed a disclosure form with [a neighboring county’s] Department of Public Health” (*WWMT News* 2007). Other reports suggest these forms have been used to help prosecute HIV-positive defendants in three additional counties (Heywood 2011a).

Thus, at least in some places in Michigan, HIV-positive individuals are asked to sign a document that the Center for HIV Law and Policy criticizes for “effectively [asking] the client to acknowledge in writing his/her potential liability for failure to disclose under Michigan’s HIV-specific criminal law” (Center for HIV Law & Policy 2007). Curiously, while Mac (HIV/AIDS Coordinator, Jurisdiction #6) indicated that their jurisdiction did not employ such a form, the policy documents that they provided me actually included one (perhaps the form had been

developed but was not being used). Nonetheless, they criticized the use of such forms because “it takes that right away from them”:

Mac: There are some agencies that actually have them sign that they are aware of that law. We don't have anything at the health department stating that. And I don't know... I kind of feel... I guess I have mixed feelings on that.

Author: In what way?

Mac: In the way that it was stated in the form that was sent to us, it was basically... I just feel like it doesn't... it takes that right away from them almost. I don't know how to explain it. Some of the wording just didn't sound – I don't wanna say “good” to me. I don't know. It was just something about the wording of it. I don't know. I don't know how to explain it... But basically saying, “You” – and I'm not saying that they don't have to follow it, they do. But it's more strong and stern and to the point where it's like, “Oh my gosh. You *have* to do this.” And I know they have to, but it just didn't sound right to me (Mac, HIV/AIDS Coordinator, Jurisdiction #6).

Based on Mac's comments, it appears that controversy over the use of these “client acknowledgement forms” extended to within health departments themselves. As data were being collected for this project, however, the controversy exploded publicly when Todd Heywood obtained these “contracts” and published a series of articles highlighting their problematic nature (Heywood 2011a; Heywood 2011b; Heywood 2011c; Heywood 2011d). Heywood quotes Catherine Hanssens, the director of the HIV Center for Law and Policy, as saying:

The form... treats all types of sex as equally risky, and all persons with HIV as equally infectious... This is a level of medical inaccuracy that is unacceptable from a state Department of Health. Lawyers who think that banning only unprotected sex is legal might want to acquaint themselves with the U.S. Constitution and legal opinions which have long since established the decision to conceive children as a Constitutionally-protected, fundamental right (Heywood, 2011a, n.p.)

After these articles were published, the Michigan Civil Rights Commission expressed interest in investigating the use of these forms (Heywood 2011c), prompting state health officials within a few hours to “reverse” their position by deciding to advise “local health departments that if they are going to use client acknowledgment forms... – and there is nothing saying they must use

such forms – they need to quote the law” (Heywood 2011d). However, state health officials did not require that local health departments discontinue their use.

Moreover, even if local health departments decided to discontinue using these forms, the practice of relying on STI and HIV testing technologies to facilitate the identification of “health threat” cases may continue. While previously I described jurisdictions in which HIV-positive people who present with secondary infections are classified as a “health threat,” it is important to point out that partner referrals for other sexually transmitted infections (such as chlamydia or syphilis) are also used to identify “health threat cases.” Donna – a disease intervention specialist in jurisdiction #13 – describes this process:

Let’s say, they come in and they have a secondary infection. Let’s say they have chlamydia and gonorrhea. Okay, by law – or by our duty, basically – gonorrhea cases are reportable to us... So we ask, part of our investigation process is to ask, “Who’s your partner?” In this instance, this person mentioned, “So-and-so is my partner.” So when we pulled up the file looking for the other person, we realized at that time that the person was HIV-infected also... so that tells us, “You’re having unprotected sex” (Donna, Disease Intervention Specialist, Jurisdiction #13).

The logic inherent in this process is that sexually transmitted bacterial infections such as gonorrhea are necessarily the result of unprotected sex – but this is not necessarily true. While latex condoms can *reduce* the risk of transmission of STIs such as gonorrhea, they do not eliminate it (Centers for Disease Control and Prevention 2006). Recent legal cases suggest that this logic is not restricted to Michigan: an HIV-positive man in North Carolina was recently found guilty of violating his probationary agreement not to have sex without condoms when he tested positive for an undisclosed sexually transmitted infection at a local health clinic (Thorpe 2008).

The evidence presented in this section suggests that health officials are using information about sexual partners gathered from clients in ways they do not announce publicly. These practices may conflict with some health law scholars’ demand that:

Where government authorizes or mandates the collection of identifiable health data, both the data to be collected and the reason for collection should be a matter of public record. The public ought also be entitled to know the proposed use, how long the data will be stored, the circumstances under which the data will be expunged, and the extent to which third parties (e.g., regulators, researchers, and government officials) may obtain access thereto (Gostin, Burris & Lazzarini 1999: 125).

Many studies have demonstrated that patients often fear disclosing sensitive information to medical providers because they do not know for what purposes that information will be used: this research includes studies of battered women (Rodriguez, Quiroga, and Bauer 1996), men who have sex with men (Miamaga, et al. 2007), and sex workers (Cohan, et al. 2006). Data from this section suggests that that sense of mistrust may be warranted in some circumstances.

This section has documented the formal techniques of social control reported by health officials. In the next section, I describe the ways in which community members police one another, reaching out to health officials to report others in their communities. As I argue in this section, while the practice of disclosure that underlies the gossip cultures described by officials is not consistent with official health policy, it relies on a similar practice of documentation and exclusion, whereby knowing who is HIV-positive allows one to avoid sexual contact with them.

Forms of Informal Social Control

Gossip, Rumor, and Stigma: How Communities Practice Disclosure as a Form of Informal and Formal Social Control

You know, the big thing we have here is people talk. And that's how most things are done around here, how most complaints are filed. In fact, it all usually starts with the same phone call. And they're like, [impersonating stereotypical black female voice] "Well... I'm calling because I know..." – and they'll go on this whole rampage, like – my cousin's baby's daddy's uncle who watches TV and they produce for the show – you know, it's like, all these weird things! You know, like they find every string to connect this person to them. "And I just wanna verify if that's true." [And I ask,] "Well, why do you wanna do that?" "Well, because I know... I can't find it today, but I know that there's a book" – oh my God, this whole county swears to God that there's a book that's down by some railroad tracks in [name of town] by the river. There's a book that has all the HIV-positive people's names in it (Therese, Disease Intervention Specialist,

Jurisdiction #5).

Therese described numerous inquiries to health department staff invoking the notorious “book down by the river,” a near-mythical object that allegedly contains the names of everyone in the area who is HIV-positive. Pointing to a map on the wall in the conference room we were in, Therese pointed out the general area where residents claim the book can be found – emphasizing that it was “*not* a good area.” When her job requires her to visit this particular area, she makes a point to bring along a male co-worker whose physicality resembles his nickname, “Muscles.” The neighborhood in question is almost entirely African-American, plagued by widespread poverty and devastatingly high rates of unemployment. Like countless towns across the state, the manufacturing jobs that once provided the lifeline to this neighborhood are long gone.

Even if the book does not in fact exist as a real object to be found and consulted, it is still useful to consider what social purposes or ends this legendary volume may serve in the community Therese supervises. I argue that we can think of the book as something of a social vector – a kind of social pipeline – through which gossip and rumor flow:

Even people that just moved to this county... they will say the same exact thing. “Yeah, I just moved here and I heard that there’s a book here. And I wanna see the book of all the positive people” (Therese, Disease Intervention Specialist, Jurisdiction #5).

Through years of gossip and rumor, “the book” has become a vehicle that enables individuals to trade, seek, and reveal information about others without anyone being held responsible for doing the original telling. As described in the beginning of this article, it is illegal in Michigan for anyone to disclose another person’s HIV-positive status without their express, written permission. The book, then, may well provide the perfect alibi for community members looking to trade information without being held legally liable.

The rumor of a list of everyone in the county who is HIV-positive was not idiosyncratic to this jurisdiction. I heard a similar tale from health officials in another jurisdiction, who also

spoke of people asking to see “the list.” As Doctor Q (Disease Intervention Specialist, Jurisdiction #14) laments:

Well, and you’d be surprised too... the people that come in and want to see the list of HIV-positive people [laughs]... They think it’s just like the Post Office, where you’ve got your “Ten Most Wanted” – well, we got the HIV-positive list here! I had some woman here, God, it was probably six months ago, she came in with her two teenage daughters. She wanted to see the list. And I said, “We don’t keep a list of HIV-positive people.” “Oh c’mon now, I know you got a list of HIV” – and I says, “And if we did, why would you want to see that list?” “Cause I want my daughters to look at it, so they know who not to have sex with.” I wanted to reach across there and slap her. “You stupid bitch, is that how you teach [your daughters], “Oh here’s the list, don’t fuck any of these guys” (Doctor Q, Disease Intervention Specialist, Jurisdiction #14).

After years of working in the same job at the health department, Doctor Q was secretly planning to call it quits. His frustration with his job and his clients was, to say the least, palpable.

However, Doctor Q’s frustrations may have unintentionally revealed much about the contradictions of disclosure as public health imperative. As he points out, his client was seeking the identities of everyone in the area known to be HIV-positive so that her daughters could avoid having sex with them. The state actually *does* possess that information, even if the county does not keep a list available for the public to consult. So the client was not in fact as “stupid” as Doctor Q inferred. While her desire to gain access to such information is obviously in direct conflict with medical confidentiality, it is perfectly aligned with the strategy embedded in the logic of disclosure as a public health strategy. Disclosure as a strategy presumes that knowledge is prevention: if an HIV-negative person knows who is HIV-positive and who is HIV-negative, then he or she can make informed decisions that will mitigate the risk of contracting HIV. Within this logic, disclosure is conceived as the basis of informed consent.

As a prevention strategy, however, disclosure is flawed for several reasons. First, many people who are HIV-positive do not know that they are infected and believe themselves to be HIV-negative. Nationally, the CDC recently estimated that approximately one in five people in

the United States living with HIV is not aware of being infected (CDC 2008a). Moreover, given that the most commonly used HIV antibody tests cannot detect infection until three to six months after transmission, the disclosure of the results of a nonreactive HIV-antibody test from *yesterday* may not be a reliable indicator of someone's actual HIV-status. Compounding this problem, those who are undiagnosed also tend to be the most infectious, because their viral loads remain unchecked by available antiretroviral treatment and because HIV viral load typically peaks soon after infection. A recent study estimated that between 54% and 70% of new sexually transmitted HIV infections were attributable to sexual contact with someone unaware of their HIV-positive status (Marks, Crepaz & Janssen 2006). Some scholars have argued that antiretroviral treatment may be rendering some HIV-positive individuals noninfectious in specific contexts (Vernazza, Hirschel, Bernasconi, & Flepp 2008). Under certain conditions, then, having unprotected sex with an HIV-positive person may actually be *safer* than having unprotected sex with someone who does not know their status or who thinks they are HIV-negative.

This evidence suggests that disclosure is a crude and dubious tool for mitigating HIV risk. As I show in the following section, the way that community members like Doctor Q's client go about practicing and promoting "disclosure" may not quite resemble what health officials intend, though it follows from it. While the notion of disclosure in public health discourse resembles medical informed consent, health officials report a rather different form of "disclosure" in operation within the communities they serve, one that more readily resembles social control.

Third Party Phone Reports: How Stigma and Gossip Produce Formal Social Control

In five jurisdictions (see Table 2.1), health officials reported receiving a large volume of what they term “third party phone reports.” These calls typically involve a resident phoning the health department to report that someone they believe to be HIV-positive is having sex without disclosing their HIV status. This is what criminologists would describe as “indirect” informal social control, because it involves community members not taking action themselves, but demanding intervention from authorities (Warner 2007). Notably, these callers do not report actually having sex with the accused; instead, they offer a variety of explanations for how they know an individual is not disclosing their status (usually word-of-mouth rumor). According to guidelines distributed to local health departments by MDCH in 2006, officials should “determine if the information has merit” by:

1. Securing the full name, address, and if available, the telephone number of the third party.
2. Requesting that the third party submit a written statement that describes the behavior/s of the suspected carrier, and supports the allegations.
3. Requesting that the third party provide the local health department with the suspected carrier’s name and other information such as an address or telephone number to locate the suspected individual (MDCH 2006: 3-4).

These instructions turn out to be flexible. The standards for determining the merit of third-party denunciations may be relaxed where: 1) the reported individual has previously been identified as an at-risk partner during contact tracing; or, 2) there have been repeated allegations concerning the same individual by different parties.

Health officials were often ambivalent about relying on this kind of “rumor mill” to identify “health threat” cases. For example, Therese, the official quoted at the beginning of this section, acknowledged that most phone calls she received were “bogus claims” that were sometimes maliciously motivated. To illustrate this, she recounted a case in which the health department received a series of coordinated phone calls all reporting the same individual:

[People around here are] very judgmental and just angry. And they don't like to talk about controversial subjects. And it's an older population that was calling in. It wasn't like I had somebody young calling in. I had somebody in their sixties calling in, and [they were all older]. And it turns out they all actually belong to the same church. And as you may know, it's very big around here too in our black churches – in our African-American churches here. They do express... um... not good things about people who are gay and homosexual and people who have HIV and AIDS and so on and so forth... [The person they were calling in about] was a female who had male partners, however... that doesn't... you know, it... they were black and so... in the churches around here, somebody told their business and everybody just kind of ganged up. A lot of people around here... you think you're... living in the Salem Witch Trials, basically, and it's terrible (Therese, Disease Intervention Specialist, Jurisdiction #5).

After investigating these claims, she discovered that the callers were all members of the same church. Linking the local church's negative views about homosexuality to its prejudices against HIV, Therese speculates that it was the churchgoers' judgmental attitudes that resulted in callers "ganging up" on one sexually non-conforming individual – a coordinated attempt that exemplifies how communities police individuals they suspect of being HIV-positive people.

Notably, race and gender played a significant role in the way that "health threat" cases were narrated by health officials in several jurisdictions in which "third party" phone reports were common. In the citation above, Therese notes the influence of black church leaders in stigmatizing HIV and non-normative sexuality more generally. Moreover, it is significant that the HIV-positive person targeted for harassment by church members was not just African-American, but more specifically a black woman who lived in the community. Indeed, Therese's reference to the "Salem Witch Trials" is a tellingly gendered reference point, suggesting that black women who are HIV-positive in this community may face a particularly raced and gendered form of stigma – a stigma that results in not just gossip and rumor, but reports to the health department that could result in serious consequences.

While black men were also discussed as objects of concern, in jurisdictions where race was explicitly invoked by health officials, black women featured prominently in discussions of

“health threat” cases. For instance, in another jurisdiction across the state, I interviewed an HIV/AIDS Coordinator who chose the pseudonym, “Sentient.” They reported that third party phone reports were a common way cases were identified, but they also noted a peculiar annual trend: During the “holiday season,” they received numerous prank calls reporting famous African-American women as potential health threats:

Author: Can you walk me through – point A to point B – in terms of how those cases come onto your radar screen?

Sentient: Usually, they come in the form of a phone call. If they call the health department’s general number, they usually go to the administrative floor for HIV... and then they take down the person’s information and they call me and give it to me and I call the person back. And usually the person will say, “I know someone who’s HIV infected and they’re having unprotected sex.” Or, “I was infected by this particular person, and I wanna know how to report them or what I should do.” During the holiday season, we usually have unusual claims. Like, they’re a star and – like, Aretha Franklin seems to be a very common one. Diana Ross. And they have been infected and they’re infecting all these people in the area” (Sentient, HIV/AIDS Coordinator, Jurisdiction #3).

Though it could well be a coincidence that both celebrities Sentient named were African-American women, it is also plausible that this pattern is the result of community members perceiving black women’s sexualities as threatening.

Although black male sexuality has been the source of considerable HIV panic, both within and outside of black communities in the US (Cohen 1999; Boykin 2005), limited research does suggest that black women’s sexualities are the subject of particular scrutiny and anxiety in black communities. For example, Lichtenstein (2003) found that black health workers in the Deep South expected their black female clients to be “lady like” and held stigmatizing views of “bad girls” whose sexualities did not conform to those expectations. While the findings reported here are not conclusive in demonstrating a gender bias in black communities’ informal social control of sexuality, they do suggest there may be a trend worth exploring in future research.

In the remaining jurisdictions in which third party phone reports were common, health officials gave few clues about the race or gender of the individuals involved. Because of the

delicate confidentiality issues involved in these interviews, officials sometimes chose to talk neutrally about individuals – avoiding male or female pronouns or other demographic markers. While there were scant indications about the individual doing the calling or about whom they were calling to report, it was clear in one instance that a concerted effort had been made against an individual. Following up about a recent case that Lucy (one of the two Disease Intervention Specialists in Jurisdiction #10) had described, I asked how that case came to her attention:

It was just a community person – somebody from the community concerned about somebody in their neighborhood who they were thinking had HIV. And I guess they just felt that they needed to report it to the health department as a concern. Preliminary record search, nothing was found on this individual. The caller was unwilling to give their information – and it was a situation where there were other people in the background, kind of egging the person on the phone on. So in that case, after I briefed my supervisor about it, no further follow-up was done (Lucy, Disease Intervention Specialist Jurisdiction #10).

The presence of “other people in the background” whom Lucy heard and suspected of “egging on” the caller implies a collective effort at social control. In this case, Lucy went ahead and attempted to verify whether the accused person was known to the state to be HIV-positive. The person was not, and thus the case was closed. However, the fact that Lucy took the call, recorded the information about the person being accused, and conducted a record search suggests that she nonetheless determined the anonymous group report deserved further inquiry. She did not speculate about what she might have done had the accused person been found to be HIV-positive.

However, Mitch – the HIV/AIDS Coordinator from Jurisdiction #2 – reported having serious doubts about the validity of information obtained from informants over the phone. But just as Lucy decided to run a record search in the case described above, Mitch similarly indicated that if the accused person was in fact determined to be HIV-positive, someone from the health department would “make an appearance”:

We get a lot of phone calls, “I know that so-and-so’s positive and I know that they’re sleeping around with a whole bunch of people and not telling their status.” You know, if that person is not willing to come in and write out a statement, then we may look for that name and see if there is actually a report on that name and then we may try and make contact and go, “Hey, how’s things going? You remember that felony law thing that we talked about? You doing okay with that?” [Laughs]. Kind of just make an appearance with them. But we don’t put a whole lotta... a whole lotta... what do I wanna say? We have a lot of people that call us and complain about other people and a lot of the time it ends up being a, you know, a he said-she-said type of thing, because so-and-so- is mad at so-and-so because they slept with so-and-so.” (Mitch, HIV/AIDS Coordinator, Jurisdiction #2).

Mitch stressed that this “appearance” would be more akin to a check-in than a serious investigation. However, while these meetings may on paper be nothing more than a “check-in,” having a health official show up on your doorstep asking questions about your knowledge of the HIV disclosure law is likely to have a chilling effect: We’ve got eyes in the community, don’t do anything stupid. And that effect is presumably intended.

Conclusion

The ethical issues raised by state health surveillance are complicated. Many people may think that disclosing one’s HIV-positive status to one’s sexual partners before having sex with them is the ethical thing to do – perhaps, even a moral mandate. Many people may believe that HIV-negative people have a “right” to know their partner’s HIV-positive status. Others may consider that HIV-positive people have a “right” to decide when to reveal that status. It seems indisputable that every effort should be taken to reduce new HIV infections – but what are the best ways to do that, and what limits should be imposed?

While this paper cannot resolve such ethical questions, it does open up new possibilities for inquiry by reframing public health as critical site of social control. I have argued that the forms of social control produced through institutions of public health differ from those forms produced through traditional institutions of medicine. By extending the insights of medical

sociologists and criminologists to the field of public health, this paper suggests new possibilities for theorizing and empirically analyzing social control. More specifically, while previous studies have demonstrated that criminal HIV disclosure laws may be counterproductive for public health, this study indicates for the first time how public health institutions themselves contribute to and facilitate the enforcement of Michigan HIV law. I do not seek to advance a complete theory of the social control of public health; there are other important kinds of social control exercised by public health that are not examined in this article, such as longstanding traditions of managing population health that typically include testing, treatment, and vaccination campaigns. Thus, more research is necessary to begin to adequately theorize collectively all the many facets of the social control of public health.

Rather than an all-inclusive treatise, then, this article is intended to be a starting point for thinking critically about a set of institutions that have yet to be thoroughly examined by sociologists. While historians and anthropologists have their own rich traditions in critical public health, sociologists' methodological and theoretical tools can offer unique contributions to this field. In particular, conceptualizing HIV testing as a form of social control allows for a critical analysis of what are generally regarded as taken-for-granted public health necessities. Tens of thousands of people never question having to reveal to the state extremely intimate details about their sexual histories in order to be tested for HIV. Should we provide the state with this kind of information, if we discover it could potentially be used to put others in legal jeopardy? This information is a form of power, and some may well consider resisting its exercise.

Of course, these critical insights extend well beyond HIV testing and counseling. Framing public health surveillance as social control opens up possibilities for examining not just strategies of surveillance, but also their potentially stigmatizing outcomes within communities;

their impact on sexual behavior more generally; and even the potential for the emergence of forms of resistance that may respond to these interventions. Such a critical approach would help inform policy initiatives, such as the now-widespread use of so-called confidential names-based reporting surveillance systems. These systems were not intended for legal surveillance, yet this paper shows that data collected by them are susceptible to being used for criminal proceedings. Now that it has become clear that these data can be used for legal purposes, it is necessary for policymakers, advocates, and stakeholders, including HIV-positive and -negative community members, to consider whether or not they *should* be used in this manner.

Furthermore, as I have shown in the second section of this paper, stigma and fear often drive community members to police HIV-positive neighbors' disclosure practices. While these findings are limited to Michigan and may not be generalizable, they do suggest that the practice of euphemistically synonymizing informal social control with the positive concept of "collective efficacy" (see, for example, Sampson et al. 1997) may not always be warranted. More research is necessary to evaluate the generalizability of this study's findings regarding HIV disclosure and local gossip cultures, as well as to determine whether health officials' reports of gossip cultures accurately reflect the communities in which they work. Future research might also explore the potential gender bias in the informal social control of female sexuality – particularly within black communities.

In terms of practice, this paper suggests that how officials interpret the law – and therefore their techniques for enforcing it – may vary greatly from jurisdiction to jurisdiction. As I have shown, some health officials interpreted the law to mean that HIV-positive clients must always use condoms even when they have disclosed their status. This interpretation was codified into policy in counties that employed a kind of "contract" that newly-diagnosed individuals were

asked to sign – agreements that could later be used in court against them (as they have already been). Multiple, conflicting interpretations confound the ability of state or local actors to communicate the law clearly to their clients and community members, potentially adding confusion to a situation with relatively high stakes—including incarceration.

Finally, while critics have charged that these laws are poor behavioral deterrents and that they may in fact be discouraging some people from *testing* and not just from failing to disclose, there is not yet sufficient scientific evidence to evaluate such claims. We know even less about the impact of treatment and/or education programs legally mandated by “health threat” statutes. Further, while the data presented in this paper suggests that race and gender may in part be shaping the application of Michigan’s “health threat” law, no systematic data on prosecutions yet exist that would demonstrate whether or not the application of these statutes is patterned by discrimination.

In its broadest dimensions, this paper raises questions about the complicated logics that undergird punitive approaches to problems traditionally conceptualized as medical. For instance, should patients who test positive for illicit substances through their doctor be investigated for drug use? Should the mothers of obese children diagnosed with diabetes be investigated for child abuse? As medical issues come to be discursively framed in terms of morality and responsibility that are more readily legible to the law, both officials and community members may find the law a more appealing recourse for intervention and punishment. This is not just a theoretical possibility; examples across the globe suggest a widespread interest in using punitive measures to combat disease, from Canadians being prosecuted for herpes exposure (Syms 2010); to Australian lawmakers punishing parents who do not vaccinate their children (Betts 2010); to Ugandan efforts to make HIV infection a capital crime for gay men (*BBC News* 2009). These are

just a few of the many examples that we might better understand collectively if we framed them through the critical lens of sociology.

CHAPTER 3

From Sickness to Badness: The Criminalization of HIV in Michigan

Introduction

Calling it a crime “akin to murder,” Kalamazoo County Circuit Court Judge Philip D. Schaefer ordered a Kalamazoo man to spend nine months in jail for failing to tell his sexual partners he was HIV-positive. “Quite frankly there isn’t a sentence long enough that I could give you that would be justice,” Schaefer told [the defendant]. “You have signed a death warrant for another human being. God forbid that you ever do it again” (Ricks 2004).

While conceptual approaches to theorizing social control have varied over time (for a review, see Meier 1982), sociologists have a longstanding interest in understanding how categories of sickness are produced, regulated, and controlled. Indeed, medical sociologists coined one of their signature concepts, “medicalization,” in order to describe the process through which social phenomena come to be regulated by medical authorities. Yet, while sociologists have acknowledged that medicalization could be “bidirectional and partial” (Conrad 2005:3), most research has centered on what was viewed as the usual direction of change: from badness to sickness (Conrad & Schneider [1980]1992). Much less is known about how phenomena historically controlled by medical authorities come to be governed by the criminal law, or what I term in this paper “the criminalization of sickness.”

In order to conceptualize this process, I draw on a variety of sociological literatures. In the first section, I review the literature on the social control of sickness. The bulk of this work has followed in the tradition of Conrad (1975; 1979; 1992), whose groundbreaking research highlights the processes by which medical authorities come to regulate and control ever-greater

domains of social life. While these insights into social control have helped to describe and analyze a wide range of social problems, I argue that they have tended to bracket analyses of how problems historically defined as medical come to be regulated by other institutions and forms of authority – including criminal law. I then review the literature on criminal laws prohibiting HIV-positive people from having sex without first disclosing their HIV-positive status. While reports suggest the reach of such laws is increasing (Bernard & Nyambe 2012), few empirical studies have examined their application.

In the second section, I report findings from an original analysis of 58 Michigan trial court cases in which defendants are convicted under the felony nondisclosure statute. Drawing on trial court transcripts, newspaper reports concerning those proceedings, and court records associated with cases convicted between 1992 (the year in which the first defendant was convicted) and 2010, I argue that legal actors employ moralizing narratives of HIV infection that serve to construct HIV as a form of badness deserving of legal intervention and, thus, social control. Because HIV-specific criminal laws deal with a problem that is conventionally understood as medical (a virus), many have presumed that such laws reflect a societal interest in promoting the public's health. However, I argue that Michigan's HIV disclosure law does not serve to promote public health; rather, it reflects the perception of the virus as a moral infection requiring regulation and punishment.

As I show, while the HIV epidemic has changed dramatically since the late 1980s when many HIV disclosure statutes were enacted, the way these cases are argued in Michigan courts has not reflected the transformations in medicine and HIV prevention. My analysis suggests that HIV disclosure laws continue to be used not to enhance public health but to control and punish populations deemed deviant.

The Social Control of Sickness: From “Medicalization” to “Criminalization”

Conrad (1979, 1992) and Conrad and Schneider ([1980]1992) have explained how medicine and its practitioners come to govern types of non-conformity once viewed as crime or sin. Conrad’s theory of medical social control became encapsulated within the well-known concept, “medicalization,” which was informed by both Zola’s (1972) argument that medicine has come to supplant religion as the major institution of social control, as well as Freidson’s (1970) pioneering work analyzing how medical professionals came to define categories of deviance as illness in order to diagnose increasing numbers of individuals as sick. In his analysis of the development of the medical category “hyperkinesis,” Conrad (1975) coined the term medicalization in order to explain this very process.

Conrad and Schneider’s ([1980] 1992) original conceptualization describes medicalization in either/or terms, framing it as the process through which “categories of deviant behavior become defined as medical rather than moral problems” (p. 17). More recently, Conrad & Schneider (2005) updated their approach by arguing that medicalization can be “bidirectional and partial” (p. 5). Anspach (2011:xxii) expands on this to suggest that “ideas about bad behavior... continue to exist in popular culture alongside the medical model.” Bosk (2013) argues that, while children with behavioral disorder diagnoses undergo partial medicalization, this does not protect them from criminalization. Thus, by titling this paper “from sickness to badness,” I am not suggesting that these states are mutually exclusive; rather, I am pointing to a case in which criminal justice authorities are claiming jurisdiction over a phenomenon conventionally understood in medical terms (e.g. a virus).

In this paper, I build on these contributions by examining what Timmermans and Gabe (2002) describe as the “medico-legal borderland” – or, sites of overlapping jurisdiction between

medicine and the law where, at times, authorities “vie for hegemony in an attempt to redraw the borders to their advantage” (p. 507). Citing Abbott’s (1988) influential work on competition for professional jurisdiction, Timmermans and Gabe call for greater attention to the intersection of medicine and crime in order to better explicate the complexities of social control. In the next section, I turn to the literature on the use of the criminal law to control sickness in order to further conceptualize this particular borderland.

The Criminalization of Sickness

Sociolegal scholars have a longstanding interest in analyzing how deviance becomes labeled as crime and controlled by criminal justice authorities (for a review, see Jenness 2004). Describing this transition as a “moral passage,” Gusfield (1967:187) argues that “What is attacked as criminal today may be seen as sick next year and fought over as possibly legitimate by the next generation.” Recent studies have examined how social movements (Jenness and Grattet 2005) and moral panics (Jenkins 1998) can contribute to the construction of categories of crime and criminalization more generally.

This paper builds on these insights by examining how criminal justice comes to control phenomena historically defined as medical. This is not entirely novel. For example, Schneider (1978) describes historical tensions in punitive and medical approaches to defining and controlling alcohol intoxication. A wide array of sociologists has similarly analyzed punitive approaches to the crimino-legal control of mental illness, which have become particularly problematic in an era of deinstitutionalization and mass incarceration (see, for example, Erickson and Erickson 2008; Pescosolido et al. 1999; Link, Andrews, and Cullen 1992). Although sociologists have attended to the criminalization of sickness, these efforts resemble medical

sociology's focus on phenomena sometimes referred to as "existential problems" whose etiologies are more readily understood as socially constructed. How "organic diseases" such as HIV come to be regulated by the criminal law is not yet well understood.

In organizing this paper in terms of "criminalization," I aim to avoid confusion with the use of civil law procedures (such as quarantine and forced treatment) to control disease. There is a vast public health law literature examining the use of civil procedures for controlling disease (see, for example, Bayer and Dupuis 1995). For a discussion of the differences between civil and criminal law for controlling sickness, see Gostin (2001:224-5). While criminal laws regulating infectious diseases do not make infection itself a crime, they do impose restrictions on the freedoms of those infected that are not imposed on others. Moreover, they codify forms of punishment for those infected who breach normative behavioral guidelines. To the extent that the criminal law is applied to only those who are infected, it is appropriate to refer to this process as the "criminalization of sickness."

The Criminalization of HIV in the United States

Laws in 33 states presently have HIV-specific criminal statutes on the books (Center for Disease Control and Prevention 2013a). Nondisclosure prosecutions have also been reported in additional states under statutes not specific to HIV, such as attempted murder. None of the HIV-specific criminal laws requires that the complainant in the case contract HIV and most prohibit even no or low risk sexual contact (such as oral sex or the sharing of sex toys) without disclosure (Center for HIV Law & Policy 2010). The majority of such laws in the US were enacted during the mid-1980s and early 1990s in the context of high AIDS-related mortality, a general panic about its transmission, and before life-saving medications known as antiretrovirals (ARVs) were

introduced in 1996 (Burris et al. 1993; Galletly and Pinkerton 2006). While comprehensive national data on the enforcement of such laws do not exist, advocacy groups report that over 1000 HIV-positive defendants have been prosecuted under HIV-specific criminal statutes; Michigan is reported to have the fourth highest number of prosecutions of any country or territory in the world (Bernard and Nyambe 2012).

Public debates over criminal HIV disclosure laws have focused on atypical defendants accused of infecting multiple partners who are understood to be particularly vulnerable, such as the case against Nushawn Williams, a black man accused in New York of infecting nine, mostly white women and girls. Shevory (2004) argues that the media spectacle surrounding Williams' case reflected social anxieties not just about HIV, but also about race and crime more generally. Paralleling Metzl's (2010) argument that the diagnosis of schizophrenia became a tool for medical control of black men, Shevory argues that Williams' criminal case proved to be an occasion to shore up social values by linking anxieties about a deadly disease to deep-seated fears of black male sexuality and masculinity.

While Williams was not prosecuted under an HIV-specific statute, the portrayal of his case in the media reveals discursive elements central to prosecutions under HIV-specific laws: defenseless and/or undeserving victims; reckless and/or malicious HIV-positive offenders; and a debilitating and fatal disease (see Wait 2007). In an analysis of Canadian HIV exposure court cases, Adam et al. (2008a) argue that the "onus of responsibility may be shifting back toward HIV-positive people" (8). In all of these contexts, the discursive construction of a polarity between malice and vulnerability, guilt and innocence, culpability and victimhood enables reframing sexual behaviors as criminal negligence on the part of the HIV-positive partner – facilitating legal intervention and, thus, a punitive form of social control.

Study Design, Sample, and Methods

Michigan is useful as a case for two reasons. First, it was the site of the first known conviction in the United States under an HIV-specific law in 1992. Second, its statute is characteristic of those nationwide in that features a broadly construed concept of “sexual penetration” that has enabled prosecutors to file charges in cases involving a wide range of sexual practice. To analyze the enforcement of Michigan’s HIV disclosure law over time, I obtained public records of convictions from The Michigan State Police Information Center, which include the county, sentencing date, and court disposition of all convictions reported to the state. While the state did report 28 non-convictions, these data were limited to those cases in which the defendant had a prior criminal record. Because of this inherent bias, these data were excluded from the analysis. I attempted to identify the defendant in each case by reviewing local newspaper archives, searching for any mention of a case within two weeks of the sentencing date indicated in the police data. I successfully identified the defendant in 29 cases this way and in another 29 cases using county clerks’ records and internet searches. As such, I identified the defendant in 95% of the known 61 convictions between 1992 and 2010.

In the 58 cases in which the defendant was identified, I ordered courtroom transcripts from the county circuit court. I obtained 145 court transcripts totaling 4,529 pages from 46 of the 58 cases. In the 12 cases for which no transcripts were available, I requested copies of other documents in the court file that detailed the basic facts of the case and relevant legal matters. For the purposes of this analysis, I also draw on 125 local newspaper reports located through archival research, internet search engines, and electronic newspaper database queries. This research design was reviewed by a University of Michigan ethics board and determined to be exempt from review.

Upon receipt, I digitized records using a scanner and a computer outfitted with ABBY FineReader text recognition software. Once digitized, the court transcripts were read and coded by the author using ATLAS.ti qualitative analysis software. For the purposes of this analysis, I coded for framing devices employed by legal actors to justify punishing defendants. This includes public health framings (e.g. “they’re a risk to public health” or “exposed another to a risk of contracting HIV”) and moral framings that depart from medical science (e.g. “they’re a reckless killer” and “they sentenced another to death”). I also coded for references to medical science, such as undetectable viral loads, transmission probabilities, and HIV virology.

In addition to defendant pseudonyms, I also use pseudonyms to refer to counties in this paper. County pseudonyms were generated randomly using the names of counties in Wisconsin (counties in that state follow a naming scheme similar to Michigan’s).

Findings

“Restrain Reckless AIDS Carriers”: The Making of A Moral Social Problem

During the 1988 legislative debates over the felony HIV disclosure provision, the House Legislative Analysis division (which produces analyses of all bills originating in the house) prepared a telling report, “Restrain Reckless AIDS Carriers,” which detailed the arguments both for and against its passage. Anticipating present-day critics (Mykhalovskiy 2011; Heywood 2008; Galletly and Pinkerton 2006), the arguments against passage are based on the view that criminalizing nondisclosure is bad for public health:

Criminalization could actually foster the spread of HIV infection by driving it underground, impeding cooperation from infected individuals both in counseling and testing and in partner notification... Imposing punitive criminal penalties on recalcitrants may reflect the frustration and fear some people feel about the AIDS epidemic, but what is needed to control the spread of HIV is effective public health initiatives, not ineffective emotional reactions (House Legislative Analysis Section 1989:4).

Rather than responding to these public health arguments in the terms presented, the report's authors respond instead by recasting the problem from one of public health to one of moral regulation and social control. Indeed, the authors even suggest that such behavior might be deserving of capital punishment if Michigan had not abolished it in 1846:

Such reprehensible and morally repugnant behavior ought to be punished... A clear message should be sent to those people, however few in number, who recklessly and callously expose other people to a possible death sentence by engaging in sex without even informing them of the risk to which they are being exposed. Some people believe that capital punishment, were it available, would not be too strong a penalty... Imposition of felony penalties is in fact a mild punishment for such reprehensible behavior (4).

These legislative debates are important because indicate the intent of the law's framers. While public health and medical narratives might have proved to be useful in framing the perceived problem, legislators opted instead to shift the terms of the debate to moral and punitive terms.

Indeed, the bill's statutory language further evidences legislators' reliance on discourses of badness. Michigan's criminal nondisclosure statute reads:

A person who ... knows that he or she is HIV infected, and who engages in sexual penetration with another person without having first informed the other person... is guilty of a felony... "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required (Michigan Compiled Law [MCL] § 333.5210).

The definition of "sexual penetration" employed by legislators did not emerge out of the ether; it has a history. Rather than devising a narrow, medically appropriate definition covering only those forms of sexual activity by which HIV can be transmitted, legislators simply copied and pasted from the 1974 criminal sexual conduct act that restructured Michigan's rape law (MCL § 750.520a). This discursive recycling suggests that legislators understood non-disclosure as analogous to rape – a social problem that, while not without public health concerns to be sure, is clearly first and foremost understood in terms of badness. As I show, cases brought under the

unanimously enacted disclosure law reflect legislative intent: badness is punished, often without regard to its implications for sickness.

“A Carrier of Death”: Setting Narrative Precedent in Michigan Case Law

A prosecutor in a small, remote county in Northern Michigan made national headlines when he petitioned to have the first defendant charged under Michigan’s felony HIV disclosure statute extradited from New York in 1991 to face charges. The prosecutor explained that he aggressively pursued the case against “Eric,” a white gay man, because he wanted “to see that [Eric] does not give any more death notices out” (Bruning 1991:2C). The case against Eric centered on the allegation that he had engaged in receptive and insertive oral sex without disclosing his HIV-status during a one-time casual sexual encounter with a 21-year-old man, “Sam.” Sam went to authorities months later when Eric’s ex-lover, “Tom,” revealed to him that Eric was, in fact, HIV-positive (Preliminary Examination:81).

Although oral sex was generally regarded as a possible route of transmission at the time, some suspected that it was less risky than other sexual practices. Indeed, Eric’s defense counsel argued that Eric had been counseled at an HIV support group “that protection was not needed for oral sex” (Motion Hearing:103). In a written brief, the judge argues that engaging in lower risk sex “does not negate culpability”:

[Eric] may have been of the opinion that oral sex is not as dangerous as receptive anal sex at the time of the alleged encounter between the complaining witness and [Eric], but that does not mean the statute was not violated. Such an argument, if the Defendant is found guilty, may bear upon the extent of culpability, but it does not negate culpability (21).

In the Court’s view, engaging in low-risk sex might result in milder treatment at sentencing – but it does not foreclose a conviction under the law.

In the wake of a lengthy, widely publicized extradition process, as well as a judicial ruling that Eric's medical records were unlawfully obtained and thus inadmissible, criticism of the case against Eric began to mount (Kellogg 1991). The AIDS Coalition to Unleash Power (ACT UP) raised \$25,000 to free Eric on bail, and the American Civil Liberties Union provided Eric with counsel with the intention of challenging the statute's constitutionality. But Eric's resolve to see the case to trial and through a potentially lengthy appeal process had waned. When the prosecutor offered Eric a deal to minimize jail time by pleading no contest, Eric acquiesced and was sentenced to one year in jail and five years' probation.

Eric's conviction is important for several reasons. First, while there was not yet a consensus in 1992 as to whether oral sex was considered safe, HIV prevention campaigns by 1995 had begun promoting it as "safer sex" (National Library of Medicine n.d.). While the CDC assigns precise statistical odds for vaginal and anal sex from 5 in 10,000 for insertive, condomless vaginal intercourse to 50 in 10,000 for receptive, condomless anal intercourse, they simply note that "HIV transmission through oral sex has been documented, but rare. Accurate estimates of risk are not available" (n.p.). Yet, five additional defendants were convicted for engaging in oral sex without first disclosing in 1993, 1996, 2001, 2002, and 2004. More generally, Eric's conviction paved the way for future nondisclosure prosecutions. While he was the sole defendant convicted in the four year period after the law's 1989 enactment, 14 defendants were convicted under the disclosure law during the four year period following Eric's conviction. A prescient media report published the day Eric was convicted cited a number of investigations across the state that "have proceeded quietly in the wings as authorities carefully followed the progress [of Eric's case]" (Hogan and Murphy 1992:A1).

The case against “Sandra,” a 32-year old white woman, was among the cases cited in the report. She was described as having an IQ “above the level considered developmentally disabled” (Walsh 1992:2A). In court, it was revealed that her IQ was 72, which was in fact barely above the clinical threshold for a diagnosis of disability of 70 identified in the *Diagnostic and Statistical Manual of Mental Disorders* (First, Frances, and Pincus 2004:373). After reports surfaced that she was having sex without disclosing her HIV-positive status, local health officials sought to have Sandra quarantined under the provisions of the state’s “health threat to others” statute that allows officials to confine an individual deemed to be a threat to public health (MCL § 333.5207). The prosecutor reported to media outlets that “he also will review potential criminal sanctions” (Walsh 1992:2A).

Not long after her civil confinement ended, Sandra again found herself in legal jeopardy. After frequent complaints to her legal guardian about the foster care home in which she resided, Sandra was allowed to move into what was characterized in court as a rundown motel notorious for sex work and drug use (Jury Trial Vol. II:203). Only two days later, Sandra called and begged him for permission to return to the foster care home. She reported that she had been having sex with another tenant, a fact that her guardian then reported to the police.

Sandra’s case was tried by jury in 1995. The prosecutor opened his case against Sandra by framing her as a “carrier of death” who needed to be locked up:

She had been told and discussed with her repeatedly that she should not have sex with another person unless she first told them of her HIV status. It was a condition that was made clear to her that... could in fact kill another individual, another human being. The facts will show... that she knew that she was literally a carrier of death in this situation... It is the facts of this case, that the disease was a fatal one, that in fact she passed it onto another person (Jury Trial Vol. I:74).

While these statements prompted a sustained defense objection preventing the prosecutor from making similarly inflammatory comments again, the image of a “carrier of death” had already

been planted in jurors' minds, as had the prosecutor's false assertion that she had "passed" the disease onto the complainant (who did not contract HIV).

Although the prosecutor only needed to prove that Sandra had engaged in "sexual penetration" without first disclosing her HIV-status, he laid out his case by framing Sandra as "a person acting out of self—self- fulfillment, someone that wanted to satisfy her own sexual desires" (Jury Trial Vol. III:392). Switching to the first person and deploying a rough grammatical style, the prosecutor decried that Sandra did not tell her partners she was positive "because that means that he won't keep comin' back to give me more sex and to satisfy my sexual desires" (392). She needed to be punished not just because she had not disclosed her status, but because she was a selfish "carrier of death" – a menace to the community.

The jury found Sandra guilty. At sentencing, the judge declared that her irresponsibility while "carrying a deadly weapon" warranted taking her "out of circulation":

She is carrying a deadly weapon with her and... she could go around killing people by her lack of concern.... I think she has a feeble understanding of how dangerous she can be in a public setting such as that in which she was placed by her so-called guardian... I feel that, for the protection of our community, that I have to take [Sandra] out of circulation. (Sentencing: 6-9).

The judge sentenced her to 32 months in prison.

Just as Eric's case paved the way for future prosecutions of oral sex, Sandra's case resonates with seven future convictions involving defendants described in various ways as having "limited intelligence" in 1993, 1995, 1998, 2000, 2001, 2002, and 2003. More generally, the discursive dimensions of both Sandra and Eric's cases echo throughout future cases. For an overview of the cases analyzed, see Table 3.1 (note that three cases sentenced simultaneously are combined for a total of 43 cases for which there were transcripts available). As the data make clear, the specter of the homicidal HIV-positive menace spreading death looms over the adjudication of HIV nondisclosure cases long after effective treatments became available. In what follows, I describe

a series of typical cases in greater detail.

Table 3.1: Persistence of Death Narratives in 43 HIV Nondisclosure Cases with Transcripts Available, Sorted by Year

Name	County	Race	Gender	Age	Partner	Year	Sentence Type and Minimum	Transmission Alleged?	Examples of Death Narratives
Eric	Forest	W	M	29	M	1992	Jail – 12 mo.		Prosecutor: "I'd like to see that [Eric] does not give any more death notices out."
Adam	Marinette	W	M	25	F	1993	Prison – 24 mo.		
Terrance	Sauk	B	M	45	F	1993	Prison – 32 mo.		
Aaron	Ozaukee	W	M	30	F	1995	Prison – 24 mo.		Prosecutor: "But now we have the other case, which he knows that he has got a very dangerous disease. Yet he has chosen to have sex with another woman and not told her. He may have sentenced her to death, also."
Jason	Jefferson	W	M	34	M	1995	Prison – 24 mo.	✓	
Maria	Door	L	F	29	M	1995	Jail – 12 mo.		Prosecutor: "Quite frankly, I don't know what's wrong with the state legislature in only making this a four-year offense. This conduct is life threatening to other people."
Sandra	Portage	W	F	33	M	1995	Prison – 32 mo.		Prosecutor: "The facts will show in this case however that despite the fact that she knew that she was literally a carrier of death in this situation..."
Andrew	Washburn	B	M	24	F	1996	Prison – 32 mo.		Judge: "I would suggest that, given the impact of the potential death, that most people are kind of anxious to find out what the story is in connection with it...."
Susan	Grant	W	F	37	M	1996	Prison – 32 mo.		
John	Rock	B	M	35	F	1999	Prison – 48 mo.		Judge: "It seems appropriate that this offense variable should be scored... where there is a high probability of transmitting a fatal disease to an unknown victim."
Darnell	Jefferson	B	M	42	F	2000	Prison – 12 mo.		
Lynette	Iron	W	F	27	M	2000	Jail – 3 mo.		
Tim	Washburn	W	M	34	M	2000	Prison – 58 mo.		Prosecutor: "If you -- if you know you have AIDS... and you don't disclose, well, what does that achieve? 'Only further dissemination of a lethal, incurable disease, in order to gratify the sexual or other physical pleasure of the already-infected individual.'"
Charlie	Ozaukee	B	M	41	F	2001	Prison – 28 mo.		
Lynette	Iron	W	F	29	M	2001	Prison – 32 mo.		
Mark	Iowa	L	M	44	F	2001	Jail – 9 mo.		
Sam	Barron	W	M	39	F	2001	Prison – 24 mo.		Judge: "You're a person who has continued to endanger life of others without apparently too much concern about your activities..."
Thomas	Pierce	B	M	40	F	2001	Prison – 12 mo.	✓	Prosecutor: "You're saying even though [she] knew you were HIV positive, she wanted to have sex with you and was willing to expose herself to the risk of catching HIV and possibly death?"
Xavier	Rusk	W	M	29	M	2001	Jail – 1.5 mo.		
Xavier	Rusk	W	M	29	M	2001	Jail – 1.5 mo.		
Reginald	Dunn	B	M	33	F	2002	Prison – 16 mo.		
William	Price	W	M	45	M	2002	Prison – 32 mo.		

Lynn	Portage	W	F	33	M	2003	Jail – 6 mo.	
Edgar	Grant	W	M	43	M	2004	Prison – 12 mo.	
Greg	Iowa	W	M	33	M	2004	Jail – 3 mo.	
Maurice	Rock	B	M	42	F	2004	Jail – 9 mo.	Judge: " Having unprotected sex with another person while you've got AIDS and you're not informing them. That's akin to murder. You have signed a death warrant..."
Peter	Barron	W	M	52	M	2004	Probation	Judge: "It never occurred to you that you might kill the man?"
Roselyn	Vernon	B	F	30	M	2004	Probation	
Kevin	Jefferson	W	M	27	F	2005	Jail – 6 mo.	
Letsego	Oconto	B	M	37	F	2005	Jail – 9 mo.	Judge: "By having unconsented sexual intercourse, you may indeed be doing your best to infect or lead someone to death ultimately."
Tyler	Grant	B	M	38	M	2006	Prison – 12 mo.	
Derrick	Grant	B	M	57	F	2007	Probation	
Jay	Vernon	B	M	38	F	2007	Prison – 60 mo.	✓ Judge: "Even if someone can live 20 years now with that disease, if you're 20 years old to die at an age 40 is an unseemly quick death..." "
Jermaine	Ashland	B	M	43	M	2007	Prison – 14 mo.	
Christina	Rock	W	F	36	M	2008	Jail – 68 days	
Alex	Rock	W	M	25	F	2009	Jail – 2 mo.	Judge: " It's a disease that can be passed from one person to another. That means it can be potentially fatal to them. "
Benjamin	Burnett	L	M	21	F	2009	Jail – 9 mo.	Prosecutor: "When you talk about rape, you talk about murder, this ranks right up there. I can't believe that this is a four year offense and we've got zero to nine guidelines."
Jackson	Gr. Lake	W	M	32	F	2009	Prison – 30 mo.	Prosecutor: "Because as I think they'll tell you, they're not out of the woods yet. They still may come down with this fatal disease."
Jennifer	Richland	W	F	23	M	2009	Jail – 5 mo.	Prosecutor: "The disease she carried is terminal, and the way it's sent and that is through sexual activity, and that's exactly what she engaged in with unknowing patrons."
Newt	Florence	W	M	41	F	2009	Prison – 36 mo.	Judge: "This is a tragedy; and, again, people's lives are at risk."
Newt	Lincoln	W	M	42	F	2009	Prison – 96 mo.	
Lilly	Wood	W	F	54	M	2010	Prison – 17 mo.	
Lilly	Ashland	W	F	54	M	2010	Jail – 11 mo.	Prosecutor: "[A] harmful biological device... means a bacteria, virus or other micro-organism or toxic substance derived from or produced from an organism that can be used to cause death, injury or disease in humans, animals or plants. So I do think that that fits."

“Death to Innocent Third Parties”: The Persistence of Death Narratives, Post-ARVs

When combination therapy was introduced in 1996, mortality rates from HIV began to plummet. CDC (1999) surveillance data indicates that AIDS-related deaths peaked at 50,489 in 1995, dropping by over 25% in 1996; over 50% by 1997; and by nearly 65% by 1998. This rapid decline received considerable attention in the media. The cover of the December 2, 1996 issue of *Newsweek* asked, “The end of AIDS? Not yet – but new drugs offer hope” (Leland & Gordon

1996). Stories of the so-called “Lazarus effect” – a reference to the Biblical figure who was raised from the dead by Jesus – were widespread, even filtering down to small-town Michigan newspapers. A *Muskegon Chronicle* story in 1997, “A sign of hope,” tells the story of one local man who was recovering quickly after beginning treatment. “The combination of drugs doesn’t work for everyone. But around the country, reports of amazing things have been happening, leading some AIDS workers to describe the medicine as having a ‘Lazarus effect.’ Bringing people back to life.” (Harrison 1997). Less than a year later, a *The Holland Sentinel* (1998) story matter-of-factly stated, “Over the past few years, the three-drug AIDS ‘cocktail’ has turned AIDS from a death sentence to a manageable illness.” In gay communities ravaged by the epidemic, activists began to imagine a life “post-AIDS” (Sullivan 1996; Rofes 1998).

News of the dramatic turn-around in the prognosis for HIV-positive people was not limited to print media. CNN coverage in February 1997 highlighted a report from the CDC detailing a “dramatic decrease” in AIDS deaths during the first half of 1996 (Woodruff 1997). Similar reports aired on ABC (Mora 1997) and CBS (Rather 1997). While sitting Presidents were not often very vocal when it came to HIV/AIDS in the early years, former President Bill Clinton (2002) penned an editorial for *The New York Times* on World AIDS Day declaring that “AIDS is not a death sentence.” Then-President George W. Bush echoed this claim in 2004 in a televised policy speech announcing his renewed commitment to the President’s Emergency Fund for AIDS Relief, declaring that “HIV is no longer a hopeless death sentence... New drugs and new treatments are dramatically extending and improving lives.” (Department of State 2004).

In contrast to this marked shift in public discourse towards a consensus that HIV was not a death sentence and that treatment was extremely effective, discourse in Michigan courtrooms remained stuck in 1992. Tim was accused in 1999 of not telling a new roommate that he was

HIV-positive before they engaged in oral and anal sex. According to testimony, the complainant in the case did not ask Tim, a 34-year old white gay man, about his HIV-status until the following day. When the defendant revealed his HIV-status, the complainant “basically freak[ed]”, returned home, found the defendant’s HIV medication, and went to a hospital where he was prescribed post-exposure prophylaxis to reduce his risk of infection. Hospital attendants also performed a rape kit and encouraged the complainant to contact the police, suggesting that either the staff or the complainant interpreted his experience as a form of sexual assault (Jury Trial Vol. I:143). Tim was subsequently charged; he pled not guilty and exercised his right to trial by jury.

With a signed confession on the record, there was little room for the defense to argue the facts. Instead, the defense countered the prosecution’s claim that Tim had exposed the complainant to “that deadly virus” (141) by arguing that Tim’s viral load (or, the amount of virus in his blood) was “undetectable” and thus the risk of transmission was low. While recently published data suggest that HIV treatments can reduce the risk of heterosexual transmission by 96% by reducing viral load (Cohen 2011), nearly a decade would pass after Tim’s trial before any major scientific statement on the subject (Vernazza et al. 2008) – although many had long suspected this to be the case (see, for example, Smith & Van de Ven 2001:18).

The prosecution argued that, undetectable or not, the defendant was still obliged to disclose: “It doesn’t matter how positive — how much positive they are... It’s like saying, ‘Well, I’m only a little bit pregnant.’ I mean, you’re either pregnant or you’re not pregnant.” (Jury Trial Vol. II:138). Quoting from a Michigan Court of Appeals decision, *People v. Jensen (On Remand)* (1998), which affirmed the HIV disclosure law’s constitutionality, the prosecutor argued that not disclosing one’s HIV status leads to “death to innocent third parties.”

If you know you have AIDS or you know you have HIV and you don’t disclose, well,

what does that achieve? "Only further dissemination of a lethal, incurable disease, in order to gratify the sexual or other physical pleasure of the already-infected individual." And I am reading off of something here because I don't want to get the words wrong... "Indeed, the probable results accompanying the nondisclosure are fairly predictable: Death to innocent third parties" (139-140).

In only four of the 58 cases did the complainant(s) allege to have contracted HIV from the defendant. Yet, in order to frame nondisclosure as a moral, criminal problem, prosecutors and judges continue to deploy analogies to murder and death sentences throughout the study period.

Indeed, legal actors did not appear to feel constrained by medical evidence. For example, while Tim's complainant testified that he did not contract HIV from Tim, Tim was treated as if he had at sentencing. When a felony defendant in Michigan is sentenced, the judge completes a spreadsheet containing an assortment of variables that assigns levels of "badness" to the crime. Higher scores result in higher penalties. In Tim's case, the prosecutor argued that the offense variable (OV) for "physical injury to a victim" (MCL § 777.33) should be scored at 25 points, defined as "life threatening or permanent incapacitating injury occurred to a victim." Despite defense objections, the judge agreed. "I cannot think of anything more life-threatening" (Sentencing: 6). The judge sentenced Tim to 58 months to 15 years in prison, scolding him for his "callous disregard for life" (10).

Of course, many HIV tests do have a "window period" of up to six months between an exposure and the ability for the test to detect an infection – although the CDC (2010a) reports that 97% of people will develop detectable antibodies within three months after exposure. Yet, prosecutors and judges sometimes invoked the possibility of infection in order to justify harsher punishment in cases where the window period had clearly lapsed. For example, none of the four women who accused Jackson, a 32-year old white man in Green Lake County, of not disclosing had tested positive when he was sentenced eight months after the last alleged encounter. Yet, the prosecutor argued that "they're not out of the woods yet. They still may come down with this

fatal disease” (Sentencing:22). The judge agreed, sentencing Jackson to 30 to 48 months in prison. “You have impacted, as [the prosecutor] has indicated, you know, potentially given four others a life sentence and that’s something this Court cannot overlook” (Sentencing:24).

In other cases, the virus itself was viewed as a weapon. Lilly, a 54-year old heterosexual white woman, was convicted in both Wood and Lincoln counties in 2010 for not disclosing her status to the same male partner. In one of those counties, the judge and prosecutor debated whether they should score the offense variable marked for “aggravated use of a weapon” (MCL § 777.31) at 20 points, defined as “the victim was subjected or exposed to a harmful biological substance, harmful biological device” (ibid.):

Judge: Any comment, [prosecutor], on OV two? That’s like the use of a weapon.... Do you think it fits?

Prosecutor: I looked at that and I think it does. I looked up the definition of the harmful biological device... Yeah, it says it means a bacteria, virus or other micro-organism or toxic substance derived from or produced from an organism that can be used to cause death, injury or disease in humans, animals or plants. So I do think that that fits (Sentencing:13).

Echoing a controversial case that same year in which an HIV-positive Michigan man was charged under a law intended to combat bioterrorism for biting a neighbor (Stanglin 2010), judges in Lincoln County and Wood County agreed that the scoring was appropriate. The Wood county prosecutor argued, “If we want to talk about aggravated use, the fact that she continued to have sexual relations... each time, placing him in risk of loss of his life, I think it’s an appropriate scoring” (Sentencing: 7-8). Lilly was sentenced to 11 months in jail in Lincoln County and 17 to 48 months in prison in Wood County.

analogies to homicide continued well into the study period. Peter, a 52-year-old white gay man, was convicted in Barron County in 2004 after being accused of not disclosing his HIV status to a casual male sex partner before engaging in receptive anal intercourse. At sentencing,

Peter told the court that he was unaware that the law existed and that he thought using a condom was sufficient. Unsympathetic, the judge pointed to the risk of killing his partner:

Peter: I had no idea that the law even existed, and I know that ignorance is not a justification of it but I did what I thought I was supposed to do. We did it safely and I thought that was the way it was supposed to be done

Judge: It never occurred to you that you might kill the man?

Peter: I was recently diagnosed. I mean we practiced safe sex which is basically the only thing you can do.

Judge: Well, I guess if you knew what you had when you did this there's always a huge risk that you could infect somebody with a horrible disease. (Sentencing: 4-5).

Notably, like the vast majority of these cases, Peter's partner did not contract HIV. The case was unusual, however, in that Peter was extremely ill during both of his appearances in court. While he was sentenced to probation, he was arrested for violating its terms a year later after allegedly failing to attend his doctor's appointments to receive HIV treatment – a violation that may have resulted in his incarceration. Peter, however, was not incarcerated; he died just days before he was to be sentenced for not seeing his doctor (*The Gazette* 2005:n.p.).

“That’s Not in the Statute”: The Irrelevance of Sickness in the Face of Badness

Charlie, a 41 year-old black man, was convicted in 2001 of not disclosing his HIV status to a woman with whom he had sex after they had smoked crack together one evening. The complainant initially told the police that she was “the victim of a carjacking, and a kidnaping by two unknown black men” (Sentencing:17), but she later admitted that she had gone willingly to the defendant's house seeking drugs and sex. Charlie admitted to having sex without disclosing his status, but claimed that he believed he had abided by the law by wearing a condom.

Given Charlie's admission, his defense attorney attempted to mitigate his client's culpability on medical grounds. Noting that Charlie had used a condom and that his viral load

was undetectable, the attorney pleaded with the judge to consider that his client was not “in full-blown AIDS status and going about knowingly infecting people” (21). The prosecutor disagreed, arguing that the statute does not require proof of risk:

The fact that the argument is being made that [the defendant] thought that he was adequately protecting the Complainant, because he was wearing a condom. Well, that’s not in the statute. It doesn’t say if you wear a condom it’s only a misdemeanor or—or anything like that (Sentencing: 16).

The judge came close to acknowledging the relevance of medical risk, but only in order to dismiss defense claims that Charlie’s use of a condom mitigated his culpability: even when using a condom, the judge ruled that the risk of transmission was “overwhelming” (25). “You don’t need a statute to tell you that this is behavior which is just absolutely reprehensible” (25). Arguing that Charlie “did manipulate and take advantage of the victim” (26), the judge sentenced him to 28 to 72 months in prison.

The scientific literature, however, suggests that the risk might have been less than “overwhelming.” In their review, Davis and Weller (1999) estimate condoms to be 87% effective at preventing heterosexual HIV transmission (Davis & Weller 1999), while Leynaert, Downs, and Vincenzi (1998) estimate the per-incidence risk of male-to-female vaginal transmission *without a condom* to be roughly 1 in 1000 (1998). Thus, the theoretical risk of transmission during condom-protected vaginal intercourse could be crudely estimated to be 1 in 7,500. While not available at the time, accounting for recently published figures showing that treatment reduces the risk of heterosexual transmission by 96% would further shrink the estimate to roughly 1 in 190,000 – a risk so low as to be negligible. Under such circumstances, it would seem difficult if not impossible to justify punishment based solely on medical grounds.

While there were many cases in which the level of risk was arguably small to negligible, some readers might contend that any level of risk would be sufficient grounds for criminal

intervention. Thus, to argue that the application of Michigan's HIV disclosure law has no basis in medical science, the most persuasive example would be a case in which the complainant was exposed to no risk at all. Such is the case against Jennifer, a 23-year old white woman arrested in Richland County in 2009 after police raided the strip club where she was employed. The prosecutor justified the raid by describing the club as a "dangerous common nuisance due to ongoing drug activity, prostitution and repeated acts of lewd behavior" (Mumford 2009). Initially charging Jennifer with prostitution and drug-related offenses, the prosecutor tacked on felony HIV disclosure charges after it was discovered that she was HIV-positive. In order to minimize time spent in jail, Jennifer accepted a plea deal. During an otherwise routine plea hearing, the detective testified as to exactly what transpired between Jennifer and her client, a confidential informant, which yielded the HIV charges:

Prosecutor: Let me focus you particularly on a situation involving a penetration with his nose or nasal area of his face.

Detective: He would pay her twenty dollars a song for a lap dance, and on this occasion she was topless, she began dancing, started grinding on him, trying to arouse his penis. At one point she exposed her vagina area to him and placed it on the tip of his nose and began grinding on his nose with her vagina.

Prosecutor: Did the confidential informant indicate that his nose actually went inside or penetrated her vaginal area?

Detective: Yes, it did (Plea:12-13).

There are many conceivable pathways for HIV to be transmitted during intimate contact; nasal-vaginal penetration is not among them. Yet, at sentencing, the prosecutor alleged that Jennifer's actions "clearly threatened the health and safety of specific individuals as well as the general public. The disease she carried is terminal" (Sentencing:3). Jennifer was sentenced to five months in jail and will be labeled a felon for the rest of her life.

Cases like Charlie's and Jennifer's that involve no risk or extremely low risk of HIV

transmission confirm my argument that the disclosure law is a tool wielded to control and punish badness. While legislators would surely claim to be concerned with sickness and the public's health more generally, the HIV disclosure law they devised is not primarily concerned with controlling sickness, promoting public health, or protecting the public from medical harm. In the words of Charlie's prosecutor, "that's not in the statute."

As the data in Table 3.1 show, the trends described in this paper are persistent over time. In nearly half of all cases analyzed, legal actors explicitly analogized HIV or HIV nondisclosure to death: HIV was described as a death sentence in 5 cases; nondisclosure was compared to murder in 4 cases; and nondisclosure was described as exposing the victim to a risk of death in 11 cases. In the bulk of the remaining cases, judges and prosecutors simply proceeded through the hearings mechanically, without saying much more than asking the defendant if he or she is guilty and imposing a sentence. In fact, in only one case did a prosecutor or judge actually describe HIV as a manageable or chronic disease. In the case against Reginald in 2002, the judge told the defendant that "I want you to take the kind of medication that they are developing now that will take care of AIDS. They have new medications coming out that apparently are having a positive effect. And I hope that helps you" (Sentencing:9). Thus, it was a rare occurrence in these cases for judges or prosecutors to describe HIV as anything but a terminal disease.

Conclusion

Controlling the spread of HIV is a laudable goal. However, Michigan's HIV disclosure law does not primarily serve this goal. Rather than controlling HIV as a virus, I have argued that Michigan's HIV disclosure law serves to control HIV as a moral infection deserving of interdiction and punishment. Legal actors indicate that HIV infection is a death sentence, that it

is a deadly weapon, and that HIV-positive people are homicidal threats. In some cases, they do so to justify the defendant's conviction. In other cases, they do so to justify more severe punishment at sentencing. As I have shown, these powerful narratives are persistent, despite effective therapies that have transformed HIV from a terminal illness to a chronic disease and despite the fact that the vast majority of defendants are not accused of transmitting the virus. Indeed, defendants are convicted for not disclosing even when their alleged sexual conduct did not pose a significant epidemiological risk of transmission.

Some readers may wonder whether it is reasonable to expect judges and prosecutors to have been aware of effective HIV treatments. As I have shown, the dramatic drop in AIDS-related deaths was covered extensively by major media outlets. Stories appeared in national outlets such as *Newsweek* and *The New York Times Magazine*, as well as local outlets such as *The Holland Sentinel* and *The Muskegon Chronicle*. Major television news outlets ran primetime stories, and former President Bill Clinton penned an editorial in 2002 in *The New York Times* declaring that "AIDS is not a death sentence." It therefore seems reasonable to conclude that judges and attorneys involved in cases concerning HIV arguably should have known about the HIV's improved prognosis by the late 1990's. By the early 2000's, a description of HIV-AIDS as a "death sentence" was patently inaccurate.

Despite having no basis in medical science, the moralized discourses invoked by prosecutors and judges indicate that Michigan's disclosure law largely serves to impose retribution against defendants accused of committing a moral harm. However, it is important to note that retribution is not the only possible justification for these statutes. Astute readers will have noticed judges at times justifying the incarceration of defendants for the good of public safety, or what criminologists would call an "incapacitation" argument. An example of this

would be when the judge told Sandra that she needed to be “taken out of circulation” for the good of the community. Although not described in this analysis, these arguments were observed in 10 cases (half the time overlapping with analogies of death; half the time existing on their own). Although it is beyond the scope of this article, future studies might explore such alternative justifications for enforcing HIV-specific criminal laws.

Even in cases when judges relied primarily on public safety arguments, however, medical arguments did not generally prove persuasive to judges or juries tasked with adjudicating these cases. Social control theories help to explain why this is so. While medicalization explains how particular phenomena come to be diagnosed, treated, and controlled by medical authorities, criminalization explains how particular phenomena come to be legally codified, punished, and controlled under the law. In the case of HIV disclosure laws, social control helps explain how legal systems render legible social phenomena that might seem to exceed their purview; disease is not an immediately obvious site for criminalization. Thus, in order for the legal system to expand its mandate and to intervene, what was typically constructed as a medical phenomenon must be recast in legal terms: blame must be assigned and victimhood must be established. As I have shown, this is often achieved in Michigan trial courts by framing HIV as a deadly disease and HIV-positive defendants who fail to disclose as murderers and/or as exposing others to a risk of death.

While more research is necessary to understand how this process works in other cases, these findings reflect the problems that emerge when particular phenomena become defined and governed by multiple forms of authority. In the case presented in this analysis, medical evidence on HIV risk did not prove influential to criminal justice authorities tasked with adjudicating felony HIV disclosure cases. The illegibility of medical evidence in the courtroom reflects the

divergent epistemic assumptions that undergird law and medicine: whereas the law is presumed to assign culpability, promote justice, and impose due punishment, medicine is presumed to remain neutral, promote health, and offer treatment. What serves as compelling evidence on one side of the medico-legal borderland is not necessarily legible on the other.

To be clear: I am not suggesting that there is some ontological “truth” underlying HIV that sociologists should be able to uncover, nor am I suggesting that badness and sickness are preordained polarities within which legislators and public health officials must situate their work. Rather, I argue that the institutions and their actors (re)produce these competing discursive frameworks through their efforts to exert control over social life. Yet, despite the fact that many working in the field of HIV prevention will know well that HIV has always been chased by badness, most arguments against the use of HIV-specific criminal laws have largely been framed in terms of sickness: they’re bad for public health; they decrease testing; they deter people from disclosing. These arguments are not persuasive in a court of law because the discursive grounds on which the law operates are fundamentally different. Releasing HIV from the clutches of the criminal law will require engaging with the law in terms that are institutionally legible.

Of course, not all forms of sickness are equally likely to come under the control of the criminal law. Perhaps not surprisingly, sexually transmitted diseases have borne the brunt of such efforts historically (Brandt 1987). Arizona representatives, for example, recently attempted to criminalize exposure to a variety of STIs including gonorrhea without first disclosing infection (Peick 2013). That sexually transmitted diseases are particularly vulnerable to legal intervention – despite a myriad of other communicable diseases with undesirable clinical outcomes – suggests that the criminalization of sickness and sex are linked. As these findings suggest, stigma serves to lubricate the moral passage from sickness to badness.

CHAPTER 4

Disparate risks of conviction under Michigan's felony HIV disclosure law: An observational analysis of convictions and HIV diagnoses, 1992-2010

Introduction

Sociolegal scholars have a longstanding interest in explaining discrimination in the criminal justice system. While conceptual approaches to studying discrimination under the law vary, criminologists have a longstanding interest in analyzing associations between a variety of criminal justice outcomes and the demographic characteristics of both defendants (see, for example, Steffernsmeir et al., 1995; Koons-Witt, 2002) and victims (see, for example, Baldus et al., 1983; Holcomb et al., 2004). This paper builds on these insights by examining whether defendant and complainant characteristics are associated with disparate observed, population-level risks of conviction⁶ under Michigan's felony HIV disclosure law, which makes it a crime for HIV-positive individuals to have sex without first disclosing their HIV-status.

Over thirty US states currently have similar HIV-specific criminal statutes (referred to hereafter as "HSCS") on the books (for a review, see Lehman et al., 2014). The majority of these laws were enacted in the late 1980s and early 1990s when little was known about the disease, and they almost invariably criminalize a wide range of behaviors irrespective of the risk those behaviors pose for transmitting the disease (Galletly & Pinkerton 2006). In Michigan, for example, a recent study documented a 2009 case in which an erotic dancer was convicted of not

⁶ Notably, this concept should be distinguished from "conviction rates," which generally refers to the proportion of cases convicted versus the total number prosecuted. As I employ it here, conviction risk refers to the proportion of cases convicted versus the total number of individuals governed by the law.

disclosing her HIV-positive status to a client before his nose penetrated her vagina – a behavior that could not plausibly have transmitted the virus (Hoppe 2014).

Notably, although the CDC (2013b) estimates that 15.8% of HIV-positive people do not yet know they are infected, an individual must have first been diagnosed as HIV-positive by a medical provider before he or she could be prosecuted under HSCS. The CDC has required that state public health departments maintain precise, names-based surveillance data regarding the remaining 84.2% of diagnosed HIV-positive people since at least 2008 (CDC 2013c). In many cases (including Michigan), state health officials began collecting names-based HIV surveillance data before the state's HSCS was enacted.

These factors create a unique legal context, in which a great deal is known about the narrowly delimited population of HIV-positive people who are governed by HSCS. This study takes advantage of this unique context in order to estimate and compare the observed, population-level risks of conviction for particular HIV-positive subpopulations by comparing two sources of data. First, I draw on an original dataset describing 95% of convictions (n=51) under Michigan's HSCS between 1992 and 2010 – including the defendant's race, gender, and the gender of the complainant(s) in the case. I compare these data against Michigan Department of Community Health data documenting new HIV-positive diagnoses⁷ in the state's Lower Peninsula during the study period – including the individual's race, gender, and the gender(s) of their reported partners.

While scholarly interest in HIV disclosure laws and their application has increased in recent years, there is not yet a rich empirical literature analyzing their enforcement. For example, although critics have charged that these laws are homophobic and racist (Strub 2010), we do not

⁷ Because all new HIV-positive diagnoses must be reported to the state by law, this data describes the population of potential offenders and is thus useful for comparison.

actually know whether sexual and/or racial minorities are disproportionately convicted under the law. While this study's observational methodology cannot identify the causal mechanisms driving the disparate impact observed, this study nonetheless contributes to our understanding of the impact of HIV disclosure laws and the implications such laws may have for inequality.

Documenting and Explaining Disparate Outcomes in the Criminal Justice System

There is a long tradition in criminology of documenting disparate criminal justice outcomes between various groups – often distinguished as either “disparate treatment” or “disparate impact” studies (Lucas, 2008). Disparate treatment studies on race examine racist practices that explicitly treat groups differently – such as racial bias in criminal sentencing (see, for example, Doerner and Demuth 2010; Kautt 2009; Crawford et al. 2006). Disparate impact studies, on the other hand, examine practices that are not explicitly related to race, gender, or some other legally protected identity but nonetheless result in disparate outcomes, such as the well-documented disparate impact of the “war on drugs” on racial minorities (for a review, see Provine 2011).

While racial discrimination is perhaps the most widely studied form of discrimination, a wide range of social factors have come under the scrutiny of socio-legal scholars interested in discrimination. This has typically involved examining demographic characteristics of the defendant, such as their age (Steffernsmeier et al. 1995) and gender (Koons-Witt 2002) and the interaction of these variables for black men in particular (Doerner and Demuth 2010; Steffernsmeier et al. 1998).

While far less numerous, studies have also examined whether the characteristics of crime victims – rather than just defendants – are also associated with criminal justice outcomes. In particular, numerous studies have examined how the gender and race of violent crime victims

impacts the imposition of the death penalty, finding that black defendants accused of killing white victims receive the death penalty at higher rates than others (see, for example, Baldus et al. 1983; Holcomb et al. 2004). Similar studies of victim characteristics in non-capital crimes and their adjudication are less numerous. Examining a broader set of crimes, Curry (2010) finds that the trend of harsher punishment for homicide cases involving white victims did not extend to sexual assault and robbery cases.

Evidencing the casual mechanisms underlying these varied, disparate outcomes has been more problematic; sociolegal scholars have noted that interpreting such trends as racist often conflict with conventional notions of racial prejudice that are implicitly understood to be intentional (Murakawa and Beckett 2010). Myriad studies have documented various mechanisms that could be driving disparate outcomes. These include discriminatory attitudes and practices among police (Beckett, Nyrop and Pflingst 2006; Petrocelli, Piquero and Smith 2004; Bernstein and Kostelac 2002); prosecutors (Radelet and Pierce 1985), judges (Curran 1983), and juries (Mazella and Feingold 2006; Schuller and Hastings 2002). Other studies have examined “supply-side” factors that result in fewer criminal complaints. For example, studies have shown that gays and lesbians are less likely to report crimes to the police than heterosexuals (Miles-Johnson 2013) and that crime is less likely to be reported to the police when the offender is white or when the victim is male or white (Hart and Rennison 2003).

The examples cited in this brief review represent but a fraction of the vast literature on the subject and are intended to familiarize the reader with current conceptual approaches to explaining discrimination in the criminal justice system. In this paper, I extend the insights of these scholarly efforts by evaluation whether defendant characteristics and partner gender (that

is, the gender of the sexual partner in cases of non-disclosure of HIV-positive status) are associated with disparate risk of conviction under Michigan's HIV disclosure law.

HIV Disclosure Laws in the United States, Michigan

Criminal laws in 24 U.S. states currently impose misdemeanor or felony penalties on HIV-positive people who have sex without first disclosing their HIV-positive status to their sexual partners. Including states that have sentence enhancement policies for other crimes when HIV risk is involved (for instance, rape or prostitution), 32 states currently have an HSCS on the books. While these laws vary in their specifics, none requires that the virus be transmitted and most do not differentiate sexual contact that poses no or low risk of transmission from contact that poses a significant risk (Bernard and Nyambe 2012; Center for HIV Law & Policy 2010).

Of the 24 states that classify non-disclosure as a felony or misdemeanor, the majority (14) enacted their HSCS during the mid-1980s and early 1990s in the context of high HIV/AIDS mortality rates, relatively low levels of public knowledge about the disease and a general anxiety about how it was transmitted, and before life-saving medications known as antiretrovirals were introduced in 1995 (Burris, et al. 1993; Galletly and Pinkerton 2006). Based on their historical coincidence, legal scholars have suggested that the President's Commission on the HIV Epidemic's final report issued in 1988 and the Ryan White Care Act of 1990 prompted state legislatures to enact these statutes (Lahey 1995; McArthur 2009). Enacted before either of these policy efforts, Michigan's felony HIV disclosure law was voted into law by legislators in 1988 and specifically states:

- 1) A person who ... knows that he or she is HIV infected, and who engages in sexual penetration with another person without having first informed the other person... is guilty of a felony.
- 2) As used in this section, "sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's

body, but emission of semen is not required (Michigan Compiled Law [MCL] § 333.5210).

Thus, the statute does not require evidence of transmission and criminalizes a wide range of sexual practices that, according to records from a conviction as recently as 2009, involved an HIV-positive woman convicted in 2009 for allowing a man to “penetrate” her vagina with his nose without first disclosing (Hoppe 2014). Additional evidence suggests that local health officials in Michigan employ epidemiological surveillance technologies to assist in identifying HIV-positive clients who are not disclosing, and have enacted policies that can facilitate their prosecution under the criminal law (Hoppe 2013).

American policy debates over criminal prosecutions for nondisclosure of HIV infection have tended to focus on atypical cases involving multiple partners who are understood to be particularly vulnerable. Perhaps the most widely cited case involved Nushawn Williams, a black male defendant accused in New York of infecting at least nine women (some of whom were underage and white). Without a criminal HIV disclosure law on the books, New York prosecutors instead prosecuted Williams for having sex with minors (Shevory 2004). As Shevory argues, the frenzied media spectacle surrounding the case reflected social anxieties not just about HIV, but also about race and crime more generally.

A handful of studies have analyzed attitudes towards HIV disclosure laws and, specifically, whether not disclosing one’s HIV-positive status should be a crime (Galletly et al. 2013; Galletly et al. 2012; Horvath et al. 2010). These studies have tended to draw convenience samples of HIV-positive residents and/or men who have sex with men, and their specific questions have varied, thus making it difficult to collectively interpret their findings. While these studies have consistently found high levels of support for criminalizing non-disclosure in at least some scenarios, no representative study has yet attempted to analyze whether demographic

characteristics are associated with attitudes towards HSCS and, more specifically, one's willingness to pursue criminal charges against potential offenders. As I suggest later in the paper, such variations (if they exist) might help to explain the disparate impact of Michigan's disclosure law.

While large-scale, representative studies analyzing the enforcement of HSCS do not yet exist, Galletly and Lazzarini (2013) examine arrests under Tennessee's HSCS in Nashville courts between 2000 and 2010. Notably, Tennessee's HSCS is broadly defined to criminalize any "HIV exposure," including non-sexual exposures such as biting and spitting. Most individuals arrested for HIV exposure were men (74%) and white (56%). Of the 15 cases involving adult sexual relationships (as opposed to spitting and biting cases), 12 (80%) involved men or women with opposite-gendered partners. Notably, despite the disparate law enforcement contexts, many of these findings echo those presented in this paper and are thus highlighted.

Expectations

This study examines a series of hypotheses to understand the impact of various social factors on the risk of conviction observed under Michigan's HIV disclosure law. Based on the myriad of findings demonstrating the vulnerability of racial minorities to incarceration in America, the first hypothesis tests the independent effects of race on the observed risk of conviction:

Hypothesis 1: The risk of conviction under Michigan's HIV disclosure law between 1992 and 2010 was greater for HIV-positive black people as compared to whites.

A second hypothesis aims to test whether the independent effects of gender similarly follow from expectations that men are more likely to face criminal prosecution than women:

Hypothesis 2: The risk of conviction under Michigan's HIV disclosure law between 1992 and 2010 was greater for HIV-positive men as compared to women.

Based on findings that black men and women in particular face a disparate impact under the law as compared to their white counterparts, the third hypothesis tests the joint effects of race and gender:

Hypothesis 3: The risk of conviction under Michigan's HIV disclosure law between 1992 and 2010 was greater for HIV-positive black men as compared to other race-gender groupings.

Hypothesis 3a: The risk of conviction under Michigan's HIV disclosure law between 1992 and 2010 was greater for HIV-positive black women as compared to other race-gender groupings.

Informed by critics of these laws who suggest they are motivated by anti-gay bias, the fourth hypothesis tests the effect of the partner's gender for HIV-positive men⁸.

Hypothesis 4: The risk of conviction under Michigan's HIV disclosure law between 1992 and 2010 was greater for HIV-positive men with male partners as compared to HIV-positive men with female partners.

Building on these expectations, the fifth hypothesis tests whether the partner's gender modifies the effect of race on men's risk of conviction:

Hypothesis 5: The risk of conviction under Michigan's HIV disclosure law between 1992 and 2010 was greater for HIV-positive black men with male partners as compared to HIV-positive black men with female partners and other groupings.

Study Design, Data, and Analysis

I obtained public records of convictions from The Michigan State Police Information Center, which include the county, sentencing date, and court disposition of the 48 convictions reported to the state between 1992 and 2010⁹. In order to analyze each case, including the social identity of those convicted of violating Michigan's HIV disclosure statute, I attempted to identify the

⁸ This cannot be tested for women, since there were no women accused of not disclosing their HIV-status to other women, which reflects the fact that HIV prevalence among women who have sex with women is exceedingly low. Indeed, the data provided by the Michigan Department of Community Health does not distinguish women infected with HIV by their partners' gender.

⁹ While the state data did include some information on non-convictions, it was limited to only those cases in which the defendant had a prior criminal record. As such, they are excluded from this analysis.

defendant in each case by visiting county libraries in which local newspaper archives were housed. I searched for any mention of a case in newspaper records within a two-week period of the sentencing date indicated in the state police data. I successfully identified the defendant in 29 cases this way. I identified the defendant in an additional 29 cases using county clerks' records and internet sites documenting criminal records – including 13 cases not documented in the state police records¹⁰. In total, I identified the defendant in 58 (95%) of the 61 known convictions between 1992 and 2010. These 58 cases included 51 discrete defendants, as several defendants were convicted multiple times. I obtained court records that revealed the basic facts for each case, including the defendant's demographic characteristics and the complainant's gender. This research design was reviewed by the University of Michigan Health Science and Behavioral Sciences Institutional Review Board and determined to be exempt from review.

In order to examine differences between the demographic characteristics of convicted defendants and HIV-positive residents generally, I requested data from the Michigan Department of Community Health detailing individuals diagnosed as HIV-positive any time between 1992 and 2010 in all Lower Peninsula¹¹ counties. Notably, in cases in which the health department data indicated “<5” HIV diagnoses instead of specifying a definite number of individuals for a particular risk-group, I substituted either an indirectly determined precise figure or an average estimator. For example, if the data indicated that 7 HIV-positive women were diagnosed between 1992 and 2010 in a particular county and that five of those HIV-positive women were white and zero were “other”, then necessarily 2 were black because these categories were mutually exclusive. In other instances where it was not possible to deduce the precise figure, an average of

¹⁰ Of these 13 cases, ten were sentenced in 2008 or later. Of the 48 cases reported by the state, zero were sentenced after 2008. This suggests a delay in reporting to the state or in the state's aggregation of that data.

¹¹ There are hardly any cases of HIV to report in the Upper Peninsula of Michigan. Indeed, the state health department does not even regularly report such figures. There were also no reported convictions in U.P. counties.

the possible values was substituted. For example, if the data indicated that 8 HIV-positive women were diagnosed in a particular county, and that 4 of them were white, <5 were black, and <5 were “other”, I used the average of the minimum and maximum possible values as an estimator. In this example, since the sum of the possible values could not exceed four, the estimate substituted would be the average of 1 and 3 or 2.0. Of the 352 data points for the 22 jurisdictions analyzed, it was necessary to substitute 25 such estimates. Because the estimators were necessary only in cases with very small numbers, this strategy has a negligible effect on the validity of the overall estimates for HIV-positive diagnoses in these jurisdictions.

For the purposes of this analysis, population-specific risks of conviction are presented both with and without data from Wayne County (which includes Detroit). Wayne County is an exceptional case for many reasons, and presenting the data without distinguishing its effects muddles efforts to interpret the findings. While Wayne County represents 62.19% of all HIV-positive diagnoses during the study period, it represents only 15.52% of convictions under the disclosure law. Thus, diagnosis in Wayne County is clearly negatively associated with the dependent variable in this analysis (the risk of conviction). Further, 82% of the individuals diagnosed as HIV-positive in Wayne County between 1992 and 2010 are black, compared to 36.4% of those diagnosed as HIV-positive in the remainder of the state. In this sense, diagnosis in Wayne County is also associated with the independent variable of race used in this analysis.

Because it is associated with both an independent (e.g. race) and the dependent (e.g. risk of conviction) variables in this analysis, diagnosis in Wayne County can be understood as a spurious, “lurking” variable that confounds the associations observed in some of the analyses in this paper. While it is not possible to “control” for these effects using the methods employed in this paper, analyzing data excluding Wayne County allows for its effects to be disentangled from

other factors in the rest of the state. As the number of convictions in Wayne County on its own is so small (n=9), an analysis of its figures alone would be extremely crude and unlikely to yield meaningful results. As such, each analysis includes figures both including and excluding Wayne County. The populations for the analyses including Wayne County include 51 convicted defendants (representing 58 criminal cases) and 15659 HIV-positive diagnoses. The populations for the comparisons excluding Wayne County include 42 defendants (representing 49 convicted cases) and 5921 HIV-positive diagnoses.

While the number of convicted defendants is small, both defendant data and health department data can be treated analytically as populations because they represent nearly 100% of all possible cases during the study period. The conviction data includes 58 out of 61 cases (95.08%) known to have been convicted in the state between 1992 and 2010. Notably, the number of convictions was fairly consistent over the study period: there were 13 convictions between 1991-1995; 10 between 1996-2000; 18 between 2001-2005; and 17 between 2006-2010. The demographic characteristics of these cases also did not vary substantially over time. The cases were geographically diverse, representing 28 of the 68 counties in Michigan's Lower Peninsula. For a more detailed description of these cases, see Table 3.1.

Regarding the health department data, the law requires that information on anyone who is diagnosed as HIV-positive be reported to the state. This has been the case for the entire study period. This includes individuals who were diagnosed first out of state and later moved to Michigan, as any HIV lab-work done after their arrival would fall under the same legal reporting requirements as a new diagnosis. While there are individuals who were HIV-positive but not diagnosed as such during this time, they are not relevant to this analysis because one must be diagnosed as HIV-positive in order to be prosecuted for failing to disclose.

Because both sets of data include nearly the entire population, statistical significance tests are unnecessary because the probability that the differences observed between the two data sets were the result of random error (or “chance”) due to sampling is negligible. Statistical significance figures for the analyses conducted in this paper would estimate the probability that the differences observed between groups were the result of random error due to sampling rather than actual differences in the population. Because these two sets of data represent entire populations (or, in the case of the conviction data, 95% of the entire population), statistical significance tests are inappropriate.

Findings

The Independent Effect of Race

The first hypothesis predicted that a higher risk of conviction would be observed for blacks as compared to their white counterparts. As demonstrated by the data presented in Table 4.1, this hypothesis is easily rejected for the analysis excluding Wayne County. Overall, this analysis estimates a risk of conviction of approximately 70.95 convictions under the HIV-disclosure law per 10,000 HIV-positive diagnoses during the study period. The differences between racial groups in this analysis are negligible: 69.58 and 71.67 for black and white HIV-positive diagnoses, respectively.

As described earlier, diagnosis in Wayne County confounds this relationship. Because of the spurious effect of Wayne County, including its data would seem to suggest that whites – not blacks – faced a greater risk of conviction than other groups. Indeed, the conviction risk observed for whites is three times greater than that observed for blacks (60.20 convictions versus 18.73 convictions per 10,000 HIV-positive diagnoses). However, this apparent association

between race and risk of conviction is spurious and explained by diagnosis in Wayne County where the risk of conviction among its large, mostly black population is comparatively very low.

Table 4.1. Independent Effects of Race, 1992-2010

Excluding Wayne County					
Race	<i>Convicted Defendants</i>		<i>HIV-Positive Diagnoses</i>		<i>Convictions Per 10,000 HIV+ Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
White	23	54.76%	3209	54.20%	71.67
Black	15	35.71%	2155.5	36.40%	69.58
Other	4	9.52%	555.5	9.38%	72.01
<i>N</i>	42		5920		70.95
Including Wayne County					
Race	<i>Convicted Defendants</i>		<i>HIV-Positive Diagnoses</i>		<i>Convictions Per 10,000 HIV+ Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
White	27	52.94%	4485	28.64%	60.20
Black	19	37.35%	10142.5	64.77%	18.73
Other	5	9.80%	1030.5	6.58%	48.52
<i>N</i>	51		15658		32.57

The Independent Effect of Gender

The second hypothesis predicted that a higher risk of conviction would be observed for HIV-positive men as compared to their female counterparts. As demonstrated by the data presented in Table 4.2, this hypothesis is rejected for both comparisons. Excluding Wayne County, this study estimates a risk of conviction during the study period of 70.00 convictions per 10,000 HIV-positive male residents, and finds a similar risk for female residents of 74.66 convictions per 10,000 HIV-positive female residents. The estimated risk of conviction including Wayne County is lower overall (32.56 convictions per 10,000 HIV-positive diagnoses), but do not differ greatly by gender. Thus, gender does not seem to have an independent effect on the estimated risk of conviction for HIV-positive Michiganders.

Table 4.2. Independent Effects of Gender, 1992-2010

Excluding Wayne County					
Gender	<i>Convicted Defendants</i>		<i>HIV-Positive Diagnoses</i>		<i>Convictions Per 10,000 HIV+ Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
Male	33	78.57%	4714.5	79.62%	70.00
Female	9	21.43%	1205.5	20.36%	74.66
<i>N</i>	42		5920		70.95
Including Wayne County					
Gender	<i>Convicted Defendants</i>		<i>HIV-Positive Defendants</i>		<i>Convictions Per 10,000 HIV+ Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
Male	40	78.43%	11903.5	76.02%	33.60
Female	11	21.57%	3754.5	23.98%	29.30
<i>N</i>	51		15658		32.57

The Joint Effects of Race and Gender

While no clear evidence exists that race and gender on their own are associated with a disparate impact under Michigan’s HIV disclosure law, the third hypothesis predicted that these factors would be jointly associated with disparities. In particular, I expected to observe a heightened risk of conviction for black men as compared to other groupings. Based on the analysis excluding Wayne County, there is evidence to support this hypothesis. While this analysis estimates a risk of conviction for white men of 57.10 convictions per 10,000 diagnoses outside of Wayne County, the risk for black men is more than 60% greater at 93.80. Just as in the previous analysis of the independent effects of race, diagnosis in Wayne County confounds this relationship, resulting in estimates that would suggest a higher risk of conviction for white men at 46.31 convictions per 10,000 diagnoses versus 24.87 for black men.

However, the parallel hypothesis that predicted black women would also face a higher risk of conviction is not just rejected but inverted whether or not Wayne County data is included. While this study observed a risk of conviction for black women of 15.08 convictions per 10,000

Table 4.3. Joint Effects of Race and Gender, 1992-2010

Excluding Wayne County					
Race-Gender	<i>Convicted Defendants</i>		<i>HIV-Positive Diagnoses</i>		<i>Convictions Per 10,000 HIV+ Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
White Men	16	38.10%	2802	47.32%	57.10
White Women	7	16.67%	407	6.87%	171.99
Black Men	14	33.33%	1492.5	25.21%	93.80
Black Women	1	2.38%	663	11.20%	15.08
Other Men	3	7.14%	420	7.09%	71.43
Other Women	1	2.38%	135.5	2.29%	73.80
<i>N</i>	42		5920		70.95
Including Wayne County					
Race-Gender	<i>Convicted Defendants</i>		<i>HIV-Positive Diagnoses</i>		<i>Convictions Per 10,000 HIV+ Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
White Men	18	35.29%	3887	24.82%	46.31
White Women	9	17.65%	598	3.82%	150.50
Black Men	18	35.39%	7237.5	24.87%	24.87
Black Women	1	1.96%	2905	3.44%	3.44
Other Men	4	7.84%	779	5.00%	51.35
Other Women	1	1.96%	251.5	1.61%	39.76
<i>N</i>	51		15658		32.57

HIV-positive diagnoses (3.44 when including Wayne County), white women faced a risk more than 10 times greater at 171.99 convictions per 10,000 diagnoses (150.50 when including Wayne County). Despite representing 23.02% of all Wayne County HIV-diagnoses, not a single black woman is known to have been convicted under the HIV disclosure law in Wayne County during the study period. While this is consistent with the general trend towards a lower risk of conviction within Wayne County, it is nonetheless noteworthy (especially given that two white women are known to have been convicted in Wayne County and yet they represent less than 2% of all Wayne County HIV-positive diagnoses). In both analyses, white women were observed to

have faced the greatest risk of conviction of any group analyzed, suggesting that they may face a particular burden under the HIV disclosure law that deserves further attention.

The Modifying Effect of the Partner's Gender

I hypothesize in this paper that the gender of the complainant in HIV disclosure cases may be associated with disparities conviction outcomes. Based on activist critiques charging that these laws are driven by anti-gay prejudice, I expected to find a heightened risk of conviction among men with male partners as opposed to men with female partners. As shown in Table 4.4, this hypothesis can be uniformly rejected. HIV-positive men with female partners face a higher risk

Table 4.4: Modifying Effect of Partner's Gender on Male Convictions, 1992-2010

Excluding Wayne County					
Partner's Gender	<i>Convicted Male Defendants</i>		<i>HIV-Positive Male Diagnoses</i>		<i>Convictions Per 10,000 HIV-Positive Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
Female	23	69.70%	2084	38.37%	110.36
Male	10	30.30%	3348	61.63%	29.87
<i>N</i>	33		5432*		60.75
Including Wayne County					
Partner's Gender	<i>Convicted Male Defendants</i>		<i>HIV-Positive Male Diagnoses</i>		<i>Convictions Per 10,000 HIV-Positive Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
Female	26	65.00%	5900	43.18%	44.07
Male	14	35.00%	7765	56.82%	18.03
<i>N</i>	40		13665*		29.27

* These analyses are based on risk group data from the health department. The number of total cases included in this data is larger than in previous analyses (e.g. a total of 5432 cases are defined as male in the data excluding Wayne County, whereas previous analyses indicated a total of 4714.5 male cases) because the categories defining the gender of the partner are not mutually exclusive: some men have both female and male partners. With this in mind, the figures presented here underestimate the risk of conviction for both groups. However, because the overlapping cases are necessarily equally distributed among both groups analyzed here, the estimated difference observed between the groups is not biased by the lack of interdependence.

Table 4.5: Modifying Effect of Male Defendant’s Partner’s Gender on Race, 1992-2010

Excluding Wayne County					
Race-Partner Gender	<i>Convicted Male Defendants</i>		<i>HIV-Positive Male Diagnoses</i>		<i>Convictions Per 10,000 HIV+ Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
White MSW	8	24.24%	1031	18.98%	77.59
White MSM	8	24.24%	2214	40.76%	36.13
Black MSW	13	39.39%	840.5	15.47%	154.67
Black MSM	1	3.03%	880.5	16.21%	11.36
Other MSW	2	6.06%	212.5	3.91%	94.12
Other MSM	1	3.03%	253.5	4.67%	73.80
<i>N</i>	33		5432*		60.75

Including Wayne County					
Race-Partner Gender	<i>Convicted Male Defendants</i>		<i>HIV-Positive Male Diagnoses</i>		<i>Convictions Per 10,000 HIV+ Diagnoses</i>
	Frequency	Percent	Frequency	Percent	
White MSW	8	20.00%	1434	10.49%	55.79
White MSM	10	25.00%	3040	22.25%	32.89
Black MSW	15	37.50%	4059.5	29.71%	36.95
Black MSM	3	7.50%	4270.5	31.25%	7.02
Other MSW	3	7.50%	406.5	2.97%	73.80
Other MSM	1	2.50%	454.5	3.33%	22.00
<i>N</i>	40		13665*		29.27

* While these analyses are based on the same denominator for HIV-positive diagnoses as the previous set, the overlapping cases (e.g. men who reported female and male partners at diagnosis) in these analyses are not necessarily equally distributed across racial groups. In the first analysis excluding Wayne County, for example, while 24.12% of men diagnosed overall reported male and female partners, 23.38% of white men, 27.10% of black men, and 18.45% of other men diagnosed as HIV-positive between 1992 and 2010 reported both male and female partners. The proportional distribution is similar for the analysis including Wayne County (25.42% overall; 22.69%, 27.32%, and 21.37% for white, black, and other, respectively). Because of this, the estimated differences observed between the racial categories in both analyses may be biased. Specifically, the estimated number of convictions for black men is slightly overestimated as compared to the white and other estimates, while the estimate for other men is slightly underestimated as compared to the white and black estimates. However, the differences observed between MSM and MSW within racial groupings are unbiased by this distribution.

of conviction in both analyses – nearly four times as high when excluding Wayne County (110.36 versus 29.87) and more than double when including it (44.07 versus 18.03). In both

analyses, the estimated risk of conviction for MSW is higher than the mean while the estimated risk for MSM is consistently lower.

As shown in Table 4.5, this association extends to the impact of race on the risk of conviction. The previous analysis revealed that the partner's gender was associated with a disparate impact under the HIV disclosure law. In this analysis, this difference is found to be consistent across all three racial categories and is consistent whether or not Wayne County is included in the comparison. The risk of conviction is higher for black, white, and other MSW than for their MSM counterparts both when including and excluding Wayne County – although the estimated difference is most dramatic for black men. For example, whereas 154.67 convictions are estimated for every 10,000 HIV-positive black MSW when excluding Wayne County, only 11.36 convictions are estimated for every 10,000 HIV-positive black MSM. Due to the association between Wayne County and the risk of conviction, these differences are smaller when including Wayne County (36.95 versus 7.02 convictions per 10,000 HIV-positive diagnoses), but they are nonetheless consistent. Among men outside of Wayne County, black MSM faced the least risk of conviction while black MSW face the *greatest* risk of conviction.

Discussion

As I have shown, there were far fewer HIV nondisclosure cases involving MSM defendants in Michigan between 1992 and 2010 than would be expected given their vast overrepresentation among those diagnosed as HIV-positive during that same time. Similarly, the inverted racial dynamic for men and women observed suggests that black men and white women are at a comparatively higher risk of conviction under the law than white men and black women, respectively. While these observed population-level are suggestive of disparities under the law,

this paper does not explain how individual cases come before the court or why they are adjudicated in a particular fashion. Rather, the observational approach to studying risk is useful for determining whether there are population-level patterns that might point to underlying factors shaping the application of the law. Before it is possible to conclude that the findings observed in this analysis are actually evidence of discrimination under the law, more research is necessary.

With these limitations in mind, this study provides little evidence to suggest that race and gender are independently associated with disparate risks of conviction under the state's HIV disclosure law. There is some evidence to support the view that these factors are jointly associated with disparate risks of conviction, but these findings also do not readily conform to expectations. In particular, while the heightened risk of conviction observed for HIV-positive black men (outside of Wayne county) is in line with the vast literature documenting discriminatory patterns against black men in the American criminal justice system, the dramatically low risk of conviction observed for black women (both when including and excluding Wayne County), and the comparatively high risk for white women, defy expectations.

As I argue in this paper, accounting for complainant characteristics may help to explain disparate outcomes by bringing the identity of those who file charges into the analysis. While advocates have expressed concerns that criminal HIV disclosure laws could be used in a discriminatory way against gay men, this study observed a substantially lower risk of conviction for MSM during the study period as compared to MSW. While more research is necessary to understand this finding that held consistent across racial groups, partner gender appears to be associated with legal outcomes for HIV-positive men in the state.

Why might this be? Future research should examine the varied set of mechanisms that could be shaping this disparate impact. Perhaps MSM are simply more likely to disclose and are,

thus, less likely to be prosecuted. However, the literature on HIV disclosure suggests that it is relatively commonplace for HIV-positive MSM to engage in sexual contact without first disclosing their HIV-status (see, for example, Holt et al. 2009; Prestage et al. 2001; Kalichman & Nachimson 1999). Although no comparative study on HIV non-disclosure rates between MSM and MSW is known to the researcher, these findings suggest that variations in non-disclosure are unlikely to entirely explain these differences.

However, while variation in behavior defined by the state as criminal may not explain disparate rates of conviction, normative differences in how communities define non-disclosure may have an effect. For example, while it may be common for MSM to engage in sexual contact without disclosing one's HIV-status, MSM may be less likely to interpret that behavior as a criminal act deserving of punishment. As they are often targeted for HIV prevention messages that encourage them to take responsibility for protecting themselves against HIV infection, they may be less likely to adopt the model of the victim requisite under the criminal justice system. Further, given the history of police persecution of same-sex sexualities, MSM may be less likely to report incidents of non-disclosure to law enforcement authorities. Indeed, Amnesty International (2005:3) concludes in a report on police brutality against LGBT Americans that "in the U.S., LGBT people continue to be targeted for human rights abuses by the police based on their real or perceived sexual orientation or gender identity." Empirical studies back up these claims, suggesting, for example, that many police officers hold antigay attitudes (Bernstein and Kostelac 2002); that many LGBT victims of hate crimes do not report their crimes to police because they fear police mistreatment (Herek, Cogan, and Gillis 2002); and that reports of police misconduct and inaction in cases involving LGBT crime victims are persistent over time (Wolff and Cokely 2007). As such, MSM potential complainants in HSCS cases may not trust the police

to take their case seriously. Alternatively, they may be more likely to have anonymous partners that they could not report to the police, even if they wished to do so.

The mechanisms underlying these trends may extend beyond “supply-side” factors. There are a variety of discretionary factors that could be influencing the observed trends. In particular, some readers may wonder whether the biases of prosecutors, judges, and/or juries might result in fewer convictions in cases involving gay male complainants because they view these cases as less deserving of legal intervention. This would echo findings that black men convicted of murdering white victims are more likely to receive the death penalty than those who are convicted of murdering black victims. Although studies have documented discriminatory attitudes among law enforcement towards gays and lesbians, more research is necessary to understand how that would impact the handling of HIV nondisclosure cases. While many plausible explanations exist, the evidence is clear that Michigan’s HIV disclosure law is not disproportionately enforced against MSM defendants.

The findings regarding white women are perhaps more vexing. Many of the nine white women convicted in these cases are especially disadvantaged (for a detailed account of one such case, see “Sandra” in Author, 2014). Five were described in court as having substance abuse problems; three suffered from mental illness; three were engaged in sex work; and one was homeless. Only two of the nine women are not known to fit into any of these categories (by comparison, the lone black woman convicted under the disclose statute in the study period was not described as suffering from any of these issues). The vulnerabilities facing white female defendants in this study may have contributed to their increased risk of conviction under the disclosure law. Many of the white women in this study had prior criminal records that would have made plea bargains to lesser crimes less likely; their highly stigmatized practices (e.g. large

number of sexual partners, engagement in sex work, etc.) may have made them particularly attractive for prosecution and/or conviction to prosecutors, judges, and/or juries; and their engagement in other illegal activities may have simply made interactions with the law more likely. This is especially true for those engaging in sex work, since all three were originally picked up for engaging in sex work; HIV-related charges were added after their arrest.

Yet, while these vulnerabilities seem to in part explain the increased risk of conviction for the white women in the study, we would expect the same vulnerabilities to afflict HIV-positive black women. How can the apparent protective effect for black women against conviction be explained? This might in part be due to the fact that their partners are most likely to be black men. Black men may be less likely to report their partner's non-disclosure to authorities, either because they are less likely to consider the failure to disclose a crime or because they are distrustful of law enforcement authorities. The evidence of mistreatment of African-Americans in the criminal justice system demonstrates a pervasive pattern of abuse and discrimination that has created a hostile and adversarial relationship between law enforcement and black communities (see, for example, Rios 2011; Alexander 2010; Wacquant 2010). Legal scholars argue that these trends extend beyond police and frontline law enforcement personnel to prosecutors who wield considerable discretionary power in deciding who to charge and for what offense (for a review, see Davis 1998). This combative legal context understandably discourages many black men from inviting the state into their lives.

All of these possible explanations deserve further inquiry. While this study was only able to evaluate the association between complainant gender and risk of conviction, future studies might examine whether other demographic characteristics – such as their race or socioeconomic status – are associated with disparate outcomes under the law.

Conclusion

In the wake of the fatal shooting of Trayvon Martin in Florida and his assailant's controversial acquittal under Florida's "Stand Your Ground" statute, there has been a renewed public interest in the relationship between victim characteristics and criminal justice outcomes (see, for example, Hundley, Martin & Humburg 2012). While studies on violent crime have demonstrated an association between victim-defendant characteristics and criminal justice outcomes, the enforcement of laws regulating other non-violent forms of crime may also prove to be fruitful sites of inquiry. While the relatively smaller number of studies examining victim or complainant characteristics (versus simply defendant characteristics) is likely due to the fact that state agencies generally do not collect or report such information, it is possible to collect such data independently and such efforts may prove fruitful for explaining trends that otherwise elude explanation. While HIV disclosure cases are a unique case in many ways, the methods employed in this analysis may be useful for understanding other statutes that are enforced largely through complainant reports.

While the complexity of the causal relationships inherent to criminal justice will make conclusively demonstrating the mechanisms underlying these trends difficult, future studies might attempt to examine – at least indirectly – the plausibility of such mechanisms. For example, large-sample attitudinal studies could evaluate whether there are differences between various demographic groups in attitudes towards HIV disclosure laws and more generally the criminality of failing to disclose. If such differences were found and reflected expectations from studies such as this one on conviction outcomes (namely, that MSM are less likely to perceive non-disclosure as a crime and/or report such an event to authorities), this would indirectly

support the argument that variations in potential complainant attitudes helps to shape the disparate impact of HIV disclosure laws.

In regards to HIV disclosure laws, this study contributes to our understanding of how these laws are implemented on the ground. While previous cases studies have suggested that race and gender play a role in shaping these cases and their trajectories, until now it was not clear whether demographic characteristics were associated with disparate legal outcomes. As this study's findings are limited to Michigan and may not be generalizable to other states with similar statutes, future research might examine the extent to which these patterns are consistent across jurisdictions and what implications such disparities might have for law and social inquiry.

CHAPTER 5

Conclusion

Taken together, the three empirical chapters of this dissertation reveal the problems connected with enforcing Michigan's "health threat to others" laws. Chapter 2 reveals that health officials in some jurisdictions were actively employing public health surveillance technologies in order to identify and hold legally responsible clients they believed to be a "health threat to others." Chapter 3 reveals that the enforcement of Michigan's HIV disclosure law is not driven by insights from medical science; rather, it serves to control and punish HIV-positive populations deemed deviant. Finally, while most HIV-positive diagnoses continue to be among men who have sex with men, Chapter 4 reveals that it is heterosexual black men and white women who bear the brunt of the felony disclosure statute. In this concluding chapter, I begin by noting the studies' limitations. I then summarize the key findings and their sociological implications. I conclude by identifying the policy implications of this research for both public health and the legal regulation of sickness.

Limitations and Future Research

More research is necessary to evaluate the impact of HIV disclosure laws nationwide. Although it is representative of similar statutes nationwide, Michigan's law, which has provided the exclusive focus of this study, should not be viewed in isolation. While the case law in other states has not yet been systematically analyzed, media reports and small studies in other jurisdictions strongly suggest that the pattern of punishing HIV-positive people who do not

actually pose a risk to others is consistent nationwide in at least in some respects. In Nashville, Tennessee, for example, a recent study found that nearly half of all criminal charges filed under the HIV exposure statute were against defendants accused of nonsexual behaviors that do not pose a risk of transmitting the virus, such as spitting and biting. Future research is necessary to understand the case law in the 33 states in which HIV exposure and/or nondisclosure is explicitly made criminal.

This study is also limited by the fact that it could not evaluate cases in which a conviction was not secured against a defendant and court records were therefore expunged. The lack of conviction could be due to a variety of reasons, such as the dropping of charges or a jury's verdict of not guilty. This problem is pervasive in the criminology literature, since information on non-convictions is often purged to protect the privacy of defendants who are not found guilty. I did locate a small number of news reports about cases in which the charges against a defendant were dropped, invariably because the complainant failed to appear at a hearing to testify against the defendant. Since HIV disclosure cases generally garner media attention, the fact that no other cause of non-conviction was ever identified is noteworthy. Nonetheless, these reports cannot be said to be representative of the larger number of non-convictions. While it was not feasible to evaluate non-convictions under Michigan's HIV disclosure law systematically, it is possible that other state agencies may keep records that would permit an analysis of all prosecutions under the law, not just all convictions.

Key Findings and Their Sociological Implications

From Sickness to Badness

While the findings of this dissertation are not without limitations, they clearly suggest that the sociological study of social control should extend beyond the study of medicalization. The reformulation of deviance “from badness to sickness” has proven an extremely fruitful line of inquiry for understanding how medical authorities have expanded and deepened their authority over numerous domains of social life. Medicalization has been a potent historical force, as categories such as ADHD, mental illness, and alcoholism have come under medical authority. As consumer groups and pharmaceutical corporations become the new “engines” of medicalization (Conrad 2005), new forms of “sickness,” such as PMDD and fetal alcohol syndrome have been manufactured. However, as this dissertation suggests, it is misleading to read the trajectory of history as moving in a single direction: institutions beyond medicine can jockey for control over phenomena conventionally understood as medical problems, and legal institutions can control a jurisdiction that once came under medical authority. This dissertation has examined the intersection of medical and legal forms of social control by considering the social control of disease under the law—what I term the criminalization of sickness.

In partner services programs, public health workers occupy a liminal space between public health and legal forms of authority. Public health workers were engaged not simply in testing and or referring to treatment, but also in identifying lawbreakers and facilitating their prosecution. They did so by employing HIV surveillance technologies not intended for legal surveillance and by the use of “client acknowledgment forms” created solely for the purpose of demonstrating criminal liability at a later date. Workers do not merely engage in counseling on how to avoid exposing others to HIV—rather, their “advice” is backed up by the threat of

involuntary detention. The isolation of the “recalcitrant” sick, while technically falling under the civil law, melds the logic of preventing future dangerous behavior with retribution for past behavior found in the criminal law (Sullivan & Field 1988; Gostin 1989). For the person newly diagnosed with HIV, the encounter with public health workers may be the first station in the moral passage from sickness to badness: the sick person is “potentially bad.”

The criminalization of sickness helps illuminate how legal institutions exert control and authority over a phenomenon that would be conventionally thought of as a medical problem. By reframing HIV as a moral problem deserving of interdiction and punishment, legal actors carve out a space in which their intervention becomes legible and legitimate. For those accused of violating Michigan’s criminal exposure law, courtroom proceedings are a rite of passage in which sickness is transformed into badness—a passage completed by a guilty verdict and a sentence. Absent from the court is the rhetoric of the medical model in which patients are treated rather than punished. Even when faced with a defendant showing the clinical signs of AIDS, judges and prosecutors did not invoke illness to explain or excuse the defendant’s behavior. Instead, when he violated parole, this defendant received a jail sentence he would not live long enough to begin. Medical arguments carry little weight in a setting in which the language of criminal culpability prevails.

The criminalization of sickness is not confined to HIV criminal exposure laws. As I noted in Chapter 3, in the U.S. and internationally, governments and communities are using the criminal law to combat disease. For this reason, it is imperative that we, as actors and as sociologists, recognize the importance of this trend and consider the complicated moral trade-offs that come with making such a move.

Public Health as a Site of Social Control: Toward a Critical Sociology of Public Health

This dissertation has examined how public health serves as an institution of social control by revealing how Michigan's health threat statutes are enforced in two settings: Michigan's Partner Services and courtrooms where persons living with HIV are tried for allegedly having violated Michigan's criminal exposure laws. Both settings have been the subject of critical commentary from HIV advocates and scholars. Advocates have criticized surveillance programs such as those in Michigan for recording the names of those diagnosed with HIV in a central registry, thereby exposing them to serious discrimination should the names become public (see Bayer 2003, 2007). Contact tracing has been particularly controversial because of its deep intrusion into the private lives of persons with HIV/AIDS, and because it exposes persons with HIV to violence from partners who learn they may have been exposed to HIV (Gostin 2004).

Critics have noted that HIV exposure statutes sometimes impose stiff sentences and criminalize behaviors that pose little risk or are widespread: having consensual sex without disclosing one's HIV-positive status, whether or not one uses protection, is so widespread that it would be impossible to identify and prosecute all the "offenders." This opens the door to selective, discriminatory enforcement against disfavored, unpopular and vulnerable groups (for a discussion, see Gostin 2004).

To evaluate the claims of critics, we must examine how public health professionals and court officers "make" the law and policy by enforcing Michigan's health threats statutes (Lipsky 2010 [1980]; Wolf and Vezina 2002). We must also go beyond the "law on the books" to examine the "law in action." A critical sociology of public health must rest on a solid empirical foundation. When the enforcement of Michigan's health threat statutes is examined empirically,

this study confirms some of critics' most dire predictions. It also finds, however, that the law is enforced in ways critics did not anticipate.

Public health professionals' exercise of social control goes well beyond CDC directives or even Michigan's criminal HIV nondisclosure statute. A key finding is that workers in Michigan's Partner Services program occasionally use contract tracing to identify and investigate people believed to represent health threats, thereby transforming an epidemiological surveillance tool into a technique of forensic surveillance. Once contact tracing is yoked to the enforcement of health threats statutes, "confidential" registries containing the names of people with positive diagnoses of HIV or STIs can be put to service as tools in the investigation of potential health threats.

Michigan's health threat statutes and criminal exposure laws introduce an adversarial element into workers' relationships with their clientele. Once workers are charged with enforcing health threats statutes, HIV-positive persons are transformed from "clients" in need of "services" into potential lawbreakers to be controlled and investigated. This can be seen in the practice of requiring HIV-positive persons to sign contracts in which they agree to disclose their seropositive status and refrain from unprotected sex—documents designed to provide incriminating evidence in the courtroom. Public health workers do not merely engage in counseling on how to avoid exposing others—rather, their "advice" is backed up by warnings and the threat of involuntary isolation.

Public health workers in different jurisdictions differ dramatically in their definitions of "health threats." Workers in some jurisdictions, following Michigan's criminal HIV nondisclosure laws, view a "health threat" as failure to disclose one's HIV-positive status to sexual partners. In other jurisdictions, having sex without using a condom is sufficient to qualify

as a health threat—a definition that goes beyond Michigan’s criminal exposure law, which criminalizes only sex without disclosure. Although “cultural competency” has become a mantra in today’s healthcare settings, public health officials are unaware of or fail to consider “safer sex” practices in HIV-positive communities, such as serosorting, to be an acceptable means of preventing the spread of HIV.

Partner services workers exercise wide discretion as to whom they investigate. Judgments about whether to take third-party complaints seriously suggest gendered and racialized views about whose complaints are considered credible. Whether a person with HIV/AIDS comes to be investigated as a potential health threat depends on a variety of contingencies: how much contact the person has with public health workers; the prevalence of HIV/AIDS in an area; the definition of “health threat” that prevails in a particular jurisdiction; and the identity of the complainant. It is these contingencies, more than their risk behaviors, which distinguish the HIV-positive persons who are targeted as health threats from others in the community.

Stigma follows defendants with HIV into the courtroom. Several cases confirm critics’ predictions that the law will be enforced selectively against members of the most powerless groups. Many who come before the court represent vulnerable groups in society: women described as having low intelligence, some living in group homes, whose understanding of the law was arguably limited. In the discourse of badness that prevails in the courtroom, neither their sickness nor their poverty nor their limited understanding is invoked to explain defendants’ behaviors. Instead judges and prosecutors characterize them as recalcitrant repeat offenders who continue to expose others to HIV and deserve long sentences to protect the public.

When cases are examined as aggregate data, the analysis reveals that the enforcement of

Michigan's HIV disclosure law is not even across demographic categories. In line with their increased risk of legal entanglements more generally, heterosexual black men were found to be disproportionately convicted under the statute. Surprisingly, white women were found to face a similarly disproportionate risk of conviction under the disclosure law. No evidence was found during the course of this study that would suggest officials are more likely to select cases involving heterosexual black men or white women—or heterosexuals more generally. Future studies might evaluate such a claim, or they might examine whether some potential complainants are simply more likely to seek legal intervention than others. Yet, while the underlying mechanisms driving these disparities are not known, such a disparate impact highlights the political dimensions of enforcing the HIV disclosure statute.

In numerous other cases, defendants were charged with criminal exposure even though their behaviors had a low or negligible risk of transmission. Defendants were charged with failing to disclose their HIV status to their partners before engaging in oral sex. Others were prosecuted despite having a viral load that had been suppressed by antiretroviral drugs, or despite wearing a condom. It is exceedingly unlikely that an HIV-negative person would contract HIV from an HIV-positive person when the latter has a treatment-suppressed viral load and/or when a condom is used. Defense attorneys' medical arguments that their clients posed little risk carried little weight in the courtroom. Although they had made conscientious efforts to protect their partners from exposure to HIV, these defendants nevertheless received prison sentences and now bore the stigmatizing mark of a criminal record and an already discrediting disease. Prosecutors and judges compared them to "murderers" who "sentenced partners to death" by exposing them to a "deadly virus." These defendants were the casualties of a statute that criminalized low-risk behaviors and failed to consider condom use as a defense; the logic of criminal law that is

focused on blame and culpability; and court officers who seemed uninformed about the risks of transmitting HIV.

Indeed, it was not always clear how well informed judges and prosecutors were about the dynamics of HIV transmission. While it would be unreasonable to expect judges and prosecutors to be familiar with the latest scientific findings regarding HIV, to continue to refer to HIV as a death sentence in the 21st century, when HIV is widely viewed as a chronic, rather than a fatal, illness, is irresponsible at best. One could attribute the statements of prosecutors to strategies designed to win cases through hyperbole that play to jurors' fears. It is, however, impossible to explain away the apparent ignorance of judges.

The harmful repercussions of such antiquated thinking extend beyond the courtroom, where defendants are treated as homicidal threats to the public. As these cases garner considerable media attention—often featuring prominent quotations from the judge or lead prosecutor on the case—outdated notions about HIV transmission and risk are then disseminated to a public that is not often knowledgeable enough about the disease to view them critically. For example, in sending HIV-positive people to prison for engaging in safer sex practices, judges may be unintentionally communicating to the public the mistaken notion that HIV is highly contagious and can be transmitted even when sexual partners are using protection. Readers of much of the news coverage of these cases could not be blamed for concluding, erroneously, that defendants had intentionally tried and succeeded in infecting (and thus killing) as many innocent partners as they could.

The more complicated social context in which HIV disclosure takes place is rarely acknowledged, either in the courtroom or the media. For example, did the defendant fear that disclosing their status would put them at risk of violence? These fears are understandable since

the dangers of such disclosure are very real. (Decker et al. 2011; Maman et al. 2000; Gielen et al. 1997). Did the complainant ever think to ask the defendant if they were HIV-positive? A Canadian study recently found that 36% of both HIV-positive and HIV-negative men who have sex with men did not ask their partners about their HIV-status (Moore et al. 2012). Many people instead make assumptions about their partner's serostatus based on a variety of unreliable factors, such as the person's appearance or their desire to engage in sex with or without condoms (Wilton & Rogers 2014; Eaton et al. 2009; Adam et al. 2008b). While health campaigns encourage HIV-negative people to take responsibility for their own health by engaging in safer sex practices, it is HIV-positive individuals who shoulder the responsibility under the law.

In documenting the role of public health officials, prosecutors, and judges in blaming, punishing, and stigmatizing persons with HIV/AIDS, this study lends support to the work of historians who have shown how public health stigmatizes the very communities it intends to serve. For example, Gussow (1989) analyzes historical efforts to control leprosy by public health officials in the early 20th century, arguing that their policies were largely informed by racist attitudes towards Chinese immigrants rather than by medical evidence. Along similar lines, Markel (1999) argues that public health efforts to quarantine Jewish immigrants in the late 1800s were largely the product of racist and class-based prejudice—not epidemiological science. In short, there is a long tradition in public health of using paternalistic, stigmatizing, and coercive measures against minority communities. HIV is not unusual in that respect. What may be new about the control of HIV, however, is the emergence of a criminal justice response to punish and incarcerate those the state seeks to control. Although the criminal law is its own institution separate from public health, my dissertation reveals that these two institutions are deeply imbricated.

These findings underscore the need for an empirically-grounded critical sociology of public health. Critical analysis of the “law on the books” is a necessary, but ultimately insufficient, first step toward understanding Michigan’s health threat statutes. When we examine how public health officials and court officers interpret and enforce the law, we find they do so in ways that the law on the books does not predict: epidemiological surveillance is used as a tool of forensic surveillance; definitions of “health threat” vary among jurisdictions; public health officials exercise considerable discretion in investigating health threats; and attorneys and judges continue to voice an antiquated view of HIV/AIDS as a “death sentence.” Whether health threat statutes actually undermine public health objectives and deter people from testing or treatment should also be considered an open question that merits empirical investigation.

Policy Implications

Implications for Public Health

In the last two decades, social control (though the term is not used) has been at the center of debates in public health as the CDC has gradually moved away from its focus on strict confidentiality and voluntarism toward surveillance measures that are less protective of civil rights. Despite dramatic advancements in the treatment of HIV/AIDS, one in five HIV-positive people is unaware they are infected with the virus. In the view of CDC officials, this situation demands more extensive systems of surveillance. To this end, the CDC recommended nationwide reporting of HIV and, despite the objections of AIDS activists, recommended name-based reporting (CDC 1999). This was followed by a recommendation that states develop partner services (CDC 2008a). Recently, in what is perhaps its boldest move, the CDC (2006) called for universal screening for HIV in most healthcare settings unless patients “opt out” or explicitly

object to being tested. This recommendation replaces the system of pre- and post-test counseling and voluntary informed consent. Given what is viewed as the success of some programs in controlling the spread of tuberculosis and the popularity of “treatment as prevention,” it is only a matter of time before the CDC takes the next step and calls for compulsory treatment with HAART to stop the spread of the epidemic (for harbingers, see Maryland Department of Health and Mental Hygiene 2011). Moreover, HAART is a complicated regimen with significant side effects and consequently a high rate of non-compliance. Given that, as has been the case with tuberculosis, nonadherence contributes to the proliferation of resistant strains of HIV, the predictable next step would be a CDC recommendation that state public health departments institute DOT (directly observed treatment) programs to ensure that persons with HIV/AIDS comply with mandatory treatment regimens. In fact, the CDC (2013d) recently announced its new “serostatus approach” to combatting HIV, which specifically includes DOT as a measure for increasing adherence to treatment regimens. These developments suggest that public health, as a practice, administrative regime, and profession is at a crossroads. Increasingly, public health officials will face hard choices about whether and to what extent they can embrace compulsory measures of social control. It is therefore important to ask about the policy implications of this research for partner services and the enforcement of “health threat” statutes and its more general policy implications for social control in public health.

The study of Partner Services reveals wide variation in how “health threats” are defined—that is, whether it is failure to disclose seropositivity or failure to use a condom that is needed to be considered a health threat. Public health workers who used the latter definition seemed unaware that it contradicted the definitions used in Michigan’s criminal exposure law,

which criminalizes HIV exposure. This suggests, at minimum, a need for improved coordination between public health officials and law enforcement.

Second, public health department officials (and legislators) should reconsider whether contact tracing programs—particularly when coupled with health threats investigation—are a wise investment of their resources. Partner services programs are quite costly, but there is little empirical evidence of their effectiveness in reducing the spread of HIV (Gostin 2004). In addition, this research suggests myriad other problems: wide variation in the definition of health threats and targeting as health threats some people who employ measures of risk reduction. While invasion of the privacy of newly diagnosed persons is said to be ethically justifiable because of their partners' right to know they have been exposed to HIV, contact tracing programs fail to respect partners' right *not* to be informed of their risk of exposure.

Although officials promise not to reveal the identity of the “index case” to partners, in fact, particularly in ostensibly monogamous relationships, partners can easily identify the person who spoke with officials. By insisting on disclosure, partner services programs may expose some newly diagnosed persons to unacceptable risks of intimate partner violence. While some readers may view such a claim skeptically, an HIV-positive woman was in fact murdered last year in Texas after she disclosed her status to her boyfriend (Emily 2013). Despite the fact that he did not contract the disease, the defendant reportedly said that his actions were justified because “she killed me, so I killed her.” While disturbing, the defendant's view that his victim had “killed” him by having sex with him without disclosing her HIV-positive status closely resembles the language used by judges and prosecutors in Michigan HIV nondisclosure cases. While this case is clearly exceptional, studies have shown that HIV-positive people—particularly women—experience a variety of negative outcomes when they disclose, including rejection, abandonment,

verbal abuse, and physical assault (Decker et al. 2011; Maman et al. 2000; Gielen et al. 1997).

While partner services are ostensibly voluntary and based on informed consent, participants are not informed of one of the most serious risks of these programs, particularly when used to investigate “health threats”: the “risk of exposure” to surveillance and regulation of their intimate lives. Neither “index cases” nor their partners are informed that “confidential” information about their serostatus or infection with STI’s (should they test positive) may come to be used to investigate their sexual behavior, possibly leading to involuntary confinement or arrest. Nor are they informed that the contracts they sign may be used against them in criminal proceedings. This research demonstrates that the fears of AIDS activists that names-based reporting may one day be used to discriminate against people living with HIV/AIDS are not, in the last analysis, unfounded.

Moreover, while one would expect compassionate attitudes from public health workers toward those who have been diagnosed with a life-altering disease, in fact public health officials display moralistic and even punitive attitudes toward those deemed “health threats.” As my research shows, many of the strategies reported by local health officials for enforcing Michigan’s “health threat” law reproduce the very same stigmatizing perspectives that plague the criminal law. Asking individuals newly diagnosed as HIV-positive to sign a contract stating that they will not break the law sets up provider-patient relationship that resembles that of a parent and a badly-behaving child. In his posthumously published book, the late gay men’s health activist and scholar Eric Rofes (2007) argued that this is precisely the kind of approach public health agencies adopted in their efforts to control the sexual behaviors of gay men, post-AIDS:

In the minds of many, AIDS proved that gay liberationists had been wrong. Gay men were, in fact, not capable of caring for themselves and others. Not only did homosexuals bring this epidemic onto themselves, but they were responsible for HIV becoming endemic by repeatedly and knowingly infecting one another. All of a sudden gay men

became damaged goods—damaged by homophobia, damaged by AIDS, damaged by out-of-control sexuality, damaged by addiction. Damaged goods demanded a paradigm of health promotion focused on surveillance, control, discipline, and punishment—a paradigm that treats adults like children, a model focused on the colonizer and the colonized (47).

For these reasons, I would suggest that the resources spent on partner services programs coupled with health threats investigation could be better spent on programs less likely to violate privacy, dignity, and potentially the liberty of both partners—programs that have been demonstrated to be effective in preventing the spread of disease, including: education, peer counseling, needle-sharing programs and programs that make treatment more widely available.

Third, public health officials should resist the lure of the more coercive measures of mandatory antiretroviral treatment and DOT. Such programs may extend lives, but this benefit comes with the heavy price of intrusion on individuals' "bodily integrity." DOT, which involves taking pills in the presence of a supervisor, is a highly demeaning, paternalistic practice, and people are understandably unwilling to participate in such programs unless threatened with involuntary confinement. There are also problems adapting a program used to control tuberculosis, a highly contagious but curable disease, to a less contagious but incurable disease such as HIV. Treatment of curable diseases typically ends when the person is cured or no longer contagious, but compulsory treatment for HIV/AIDS, a disease that is not yet curable, could potentially last for the duration of the treated person's life. Supervising thousands of people for lengthy periods poses possibly insurmountable logistic and financial problems. On the one hand, having a tiered system allows officials to offer less restrictive alternatives before moving to more coercive ones. On the other hand, the move toward coercion is part of a larger pattern: the enchainment of social control measures, in which each disease control technology demands a more coercive measure in the background to compel people to comply (e.g., mandatory treatment

leads to noncompliance and DOT, which is backed up by the threat of involuntary confinement). Compulsory interventions diffuse rapidly, and measures shown to be effective in controlling the spread of one disease may be less effective in controlling another. The specter of using these measures to police noncompliance in medical settings suggests that this chain should be broken.

Fourth, in addition to considering the human rights burdens of coercive control measures, public health policy makers should also consider the costs of coercive social control to public health professionals themselves and to the moral foundations of their profession. Social control can take a toll on workers' job satisfaction. Research on psychiatric emergency teams (Emerson and Pollner 1976) has shown that idealistic young professionals who enter the helping professions with service ideals may become disillusioned when they find that their work consists largely of social control. Indeed, this research suggests that several partner services workers exhibited signs of burnout.

Social control also entails risks for workers' personal safety. Public health professionals may encounter violence when they venture into the field to deliver unwelcome news. The murders of child protective services workers are a sobering reminder of the dangers that accompany the exercise of the state's police power (Kresnak 1998). In its 2008 guide for partner services professionals, the CDC (2008b:33) recognized these risks when it advised workers to become "skilled at problem solving and dealing with situations that might be encountered in the field (e.g., personal safety, intimate partner violence, violence to others)." Having warned professionals of the dangers, the CDC continues to recommend that professionals deliver the news to partners in person and stops short of what would seem to be the inescapable conclusion: that there are occasions when the exercise of the state's police powers had best be left to the police.

These considerations suggest that coercive social control should be relegated to the periphery, rather than the core, of public health's mandate. The state has given public health officials enormous powers, not the least of which is the power to deprive individuals of their freedom in the name of public health. But with that power comes the potential for its abuse. This research demonstrates the corrosive consequences that can ensue when partner services workers are charged with enforcing Michigan's health threat statutes: adversarial relationships with clients, punitive attitudes toward them, and burnout. The casualties of this development are informed consent and the privacy and dignity of persons living with HIV/AIDS. The marriage of public health and law enforcement is not an equal partnership, and the discourse and practice of the latter soon comes to prevail. As Colgrove and Bayer (2005: 573) note of substance abuse programs, by policing and controlling sex, public health runs the risk of becoming "little more than the handmaiden of criminal law."

Socio-legal Implications: HIV/AIDS and the Criminal Law

A disturbing finding of this study is that prosecutors and judges seemed poorly informed about the transmission of HIV and the risks associated with various modes of transmission. As a first, small step toward reform, I propose that all attorneys, prosecutors, and judges involved in cases concerning HIV be required to complete a survey course or an online certification program on the epidemiological and social aspects of HIV to fulfill their continuing education requirement. The course would include such topics as the transmission of HIV and progress in its treatment; the experience of living with HIV; and the stigma of HIV.

This simple intervention may influence how prosecutors handle cases in which defendants make good-faith efforts to avoid transmitting HIV to their partners or are accused of

behavior that poses minimal risk. At best, the proposed intervention could sensitize court officers to their own role in perpetuating the stigma of HIV and to the role of the court as an active shaper, rather than simply a mirror, of society's values. At the very least, it can do little harm. I am not suggesting that education and information in themselves have the potential to cure society's ills—a belief common among public health professionals. Rather, I am suggesting that, in the absence of alternatives, education should be given a try.

The findings of Chapter 3 point to a need for broader changes in the law. Many of the cases involved sexual behavior that carried a very low risk of transmission. HIV-positive defendants often used condoms or believed that their undetectable viral load protected their partner against infection. Indeed, fewer than ten percent of complainants alleged that they contracted HIV from the defendant. While prosecutors and judges may be justly criticized for making inflammatory, stigmatizing statements about HIV and for meting out excessively harsh sentences in some cases, the decisions fell within the boundaries of Michigan's criminal HIV exposure statute. To avoid the outcomes I have just mentioned, it is therefore necessary to revise or repeal Michigan's statute. Moreover, these flaws are not unique to Michigan's law, but rather, as critics note, are commonly found in many other HIV-specific statutes and have led critics to call for reform (for a review, see Lehman et al. 2014).

Recently, federal officials and policy makers have begun to pay attention to critics. In March, 2014, CDC and Department of Justice researchers issued a joint report. After surveying U.S. HIV-specific criminal laws, they concluded that:

Many of these laws criminalize behaviors that pose low or negligible risk for HIV transmission. The majority of laws were passed before studies showed that antiretroviral therapy (ART) reduces HIV transmission risk and most laws do not account for HIV prevention measures that reduce transmission risk, such as condom use, ART, or pre-exposure prophylaxis. States with HIV-specific criminal laws are encouraged to use the findings of this paper to re-examine those laws, assess the laws' alignment with current evidence regarding HIV transmission risk, and

**TABLE 5.1 PROPOSED, ACCEPTED, AND REJECTED VERSIONS OF IOWA'S
CONTAGIOUS OR INFECTIOUS DISEASE TRANSMISSION ACT**

A. Original Proposed Bill, Proposed and Rejected by House in 2013

Class*	Intent	Transmission	Crime	Penalty
1.	Yes	Yes	Class C Felony	≤10 yrs. + \$1,000—\$10,000
2.	Yes	No	Class D Felony	≤5 yrs. + \$750--\$7,500
3.	Reckless Disregard	Yes	Aggravated Misdemeanor	≤2 yrs. + \$625--\$6250
4.**	No	No	No	None

*Classes 1, 2, and 3 do not apply if the infected person takes practical means to prevent transmission or informs uninfected person of that s/he has a contagious disease and the offer to take practical means to prevent infection is rejected. Proving the uninfected person knew about the infected person's condition is an affirmative defense.

Persons found guilty are no longer placed on list of sex offenders, and previous offenders' names are removed.

**Class 4 is decriminalized in original proposed bill.

**B. Senate File 2297. Contagious or Infectious Disease Transmission Act, Approved by Senate
February, 2014, Approved by House May, 2014**

Class*	Intent	Transmission	Crime	Penalty
1.	Yes	Yes	Class B Felony	≤25 yrs.
2.	Yes	No	Class D Felony	≤5 yrs. + \$750--\$7,500
3.	Reckless Disregard	Yes	Class D Felony	≤5 yrs. + \$750--\$7,500
4.	Reckless Disregard	No	Serious Misdemeanor	≤2 yrs. + \$625--\$6250

*Classes 1, 2, 3 and 4 do not apply if the infected person takes practical means to prevent transmission or informs uninfected person of that s/he has a contagious disease and the offer to take practical means to prevent infection is rejected. Proving the uninfected person knew about the infected person's condition is an affirmative defense.

Persons found guilty are no longer placed on list of sex offenders, and previous offenders' names are removed.

**C. House Amendment to Senate File 2297. Contagious or Infectious Disease Transmission Act,
Proposed by House Judiciary Chair Chip Baltimore and Rejected by House**

Class*	Intent	Transmission	Crime	Penalty
1.	Yes	Yes	Class B Felony	≤25 yrs.
2.	Reckless Disregard	Yes	Class C Felony	≤10 yrs. + \$1,000--\$10,000
3.	Yes	No	Class D Felony	≤5 yrs. + \$750--\$7,500

*Classes 1 and 2 do not apply if the infected person has been informed by a healthcare provider that he or she poses no measurable risk of transmitting the disease. Proving the uninfected person knew about the infected person's condition is an affirmative defense. The names of persons found guilty of classes 1, 2, and 3 are placed on the list of registered sex offenders.

consider whether the laws are the best vehicle to achieve their intended purposes (Lehman et al. 2014).

Should state legislators take the CDC-DOJ report's recommendation seriously—as activists will surely urge them to do—the report may one day be seen as a defining moment in the history of the HIV epidemic. Commentators have proposed two approaches to reform: 1) revising and redrafting existing HIV-specific laws and 2) repealing HIV-specific laws and using general criminal laws to prosecute those who intentionally transmit HIV. Some states are also redrafting HIV-specific statutes so they can be applied to other infectious diseases.

Wolf and Vezina (2004) recommend redrafting existing HIV-specific statutes in order to target those with the highest level of culpability. The authors recommend: using enhancement statutes to impose additional penalties on serious sex crimes only; requiring an intent to harm and a serious risk of transmission as conditions for prosecution; excluding those who use risk reduction methods (e.g., condoms); focusing on those who expose multiple partners after failing less restrictive public health measures; and decreasing the penalties, particularly for first-time offenders (Wolf and Vezina 2004). An example of an HIV-specific law that fulfills many of these conditions is California's law, which criminalizes sexual exposure to HIV only if the defendant clearly intended to harm another person by transmitting HIV *and* did so through high-risk sexual practices (Galletly & Pinkerton 2004).

Iowa is the first, and so far the only, state to attempt a significant reform of its HIV-specific statute. Iowa's law, one of the toughest in the nation, carried a severe 25-year maximum sentence for failing to disclose one's HIV status before exposing another person to HIV and required those convicted to register as sex offenders (Hernandez 2013). One catalyst for the introducing the new bill was the public outcry over the case of Nick Rhoades, who was given the maximum sentence of 25 years for having sex without disclosing that he was HIV-positive even

though he used a condom, had an undetectable viral load, and did not transmit the virus (Hernandez 2013) The law, which was years in the making, underwent revision and survived challenges (for a review of the bill’s progression, see Table 5.1), before it was finally adopted by both the Senate and the House in 2014. For lawmakers in other states contemplating changing state HIV laws, Iowa’s experience demonstrates that the road to statutory reform can be long, winding, and fraught with political negotiation and compromise (for reports on Iowa’s bill, see Pena 2013; Hernandez 2013; One Iowa 2014; Red Wing 2014).

Iowa’s new law (Table 5.1B) creates a tiered approach to punishing offenders that would reserve the most severe sentence (up to 25 years) for those intentionally transmitting the disease. People who intend to transmit but only expose another person to a disease without transmitting it and those who transmit the disease through “reckless disregard” (e.g., through condomless sex) are subject to a sentence of up to five years in prison and a fine. Finally, merely exposing another person to a disease through “reckless disregard”—decriminalized in the first iteration of the law—is a serious misdemeanor, punishable by up to two years in jail and a fine. Under the new law, defendants cannot be found guilty when they take measures to prevent transmission, or if the defense is able to prove the complainant consented to risky behavior. The law no longer requires people found guilty to register as sex offenders, and the names of those who were previously found guilty are removed from the list.

By including only behavior that carries a serious risk of transmission, excluding cases where the person took reasonable measures to prevent transmission, and making penalties proportionate to the seriousness of the offense, Iowa’s law follows many of the recommendations for statutory reform that call for more carefully and narrowly tailored laws. (e.g., Lehman et al. 2014). There is, however, an additional feature of the new law that may be drafted too broadly:

Presumably as a response to the criticism that HIV-specific laws unfairly single out persons with HIV for prosecution, Iowa's law, now called the "Contagious or Infectious Disease Transmission Act," applies not only to HIV but also to all forms of hepatitis, tuberculosis, and meningococcal disease. These diseases differ in how serious they are; whether a vaccine exists; the degree to which they are contagious; and how they are transmitted. Such differences raise the question of whether a single law can be applied to a heterogeneous collection of infectious diseases.

Meningococcal disease, for example, is spread through direct contact with the nasal or throat secretions of an infected person, who sneezes or coughs on another person, or through kissing, and is encountered in environments where people stay in close proximity. Suppose a teenager attending summer camp develops meningitis but neglects to tell her boyfriend to see his doctor for preventive antibiotic treatment and he becomes sick. Should the young woman be tried under the new statute? Should she be tried as an adult? Or should her parents be tried for failing to have her vaccinated, leaving a sick patient without a parent to care for them? My point is that criminalizing the transmission of very different diseases can have unanticipated and untoward consequences when applied to actual cases—consequences that may not become apparent for years.

Iowa is not unique in extending its law to other diseases: since 2007 legislators in Tennessee and two other states have expanded HIV exposure laws to include hepatitis B and C (Hernandez 2013). Despite some differences in mode of transmission these diseases are most common among the same marginalized groups at greatest risk of HIV: injection drug users, MSM (especially African Americans and Latinos), and African American women (Hernandez 2013). These laws, then, are subject to the same criticisms applied to HIV-specific laws: that they selectively target disadvantaged and disfavored groups. Moreover, while it is less harmful to

extend a carefully drafted law, such as Iowa's statute, to other diseases, most HIV-specific laws are, as has been argued, quite flawed. In fact, some states have simply extended existing HIV-specific laws to other diseases without redrafting existing statutes. If it is unfair to apply a "bad" law to those with HIV, is fairness served when the same "bad" law is extended to other diseases? A more equitable solution would be to decriminalize the transmission of HIV rather than criminalizing the transmission of other diseases. Extending HIV-specific laws, regardless of how well drafted they may be, to other diseases has a clearly foreseeable consequence: it broadens the legal precedent for punishing sickness and reinforces the idea that the criminal law is a legitimate model for controlling disease.

Revising existing HIV-specific laws has potential pitfalls as well as promises. On the one hand, having carefully tailored disease-specific laws has the potential to restrict the kinds of cases in which individuals could be found criminally liable and to reserve the most severe punishments for those who are most blameworthy. On the other hand, enacting or even reforming disease-specific statutes would further entrench the idea that punishing someone for exposing someone else to a disease agent is a valid use of the criminal law. As many have argued, this approach tends towards reproducing stigmatizing attitudes and does little to actually curtail the spread of the disease in question. As a policy solution, many would argue it does more to harm public health than to protect it. While enacting more precise and narrowly tailored laws that reserve punishment for individuals who actually put others at risk of contracting a disease may be a sensible step, the question remains of whether the criminal law is an appropriate recourse for controlling sickness. It is difficult to argue that someone intentionally infecting another person with a disease should not be viewed with contempt. But do we need laws specific to disease to allow for their punishment under the law? Existing case law indicates that

individuals who expose others to disease agents have been prosecuted under a variety of general criminal statutes that have nothing to do with sickness (see Center for HIV Law & Policy 2010).

Several human rights organizations have recommended the second approach: using existing criminal laws to punish the most serious offenders. For example, the United Nations' (2006) *International Guidelines on HIV/AIDS and Human Rights* recommended that legislators not enact specific laws against the deliberate transmission of HIV but should instead apply the general criminal law to these cases. This would “ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties (Guideline 4, para 29(a)).” Moreover, UNAIDS urged governments to repeal existing HIV-specific laws and “apply general criminal laws only to the intentional transmission of HIV,” such as “where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it” (UNAIDS 2008: 1, 6). Lowering the threshold of criminal liability beyond intentional transmission to reckless conduct—an ambiguous concept—would have the same effect as excessively broad HIV specific statutes: subjecting large numbers of people to criminal prosecution and selective enforcement against marginalized groups (UNAIDS 2008). Cases of intentional transmission are quite rare. Two clear examples are the cases of a man who injected his son with HIV to avoid making child support payments (Strait 1998) and a physician who sought revenge on his ex-lover by injecting her with HIV and hepatitis B viruses (Schultz 1998; for a description of these cases, see Gostin 2004). Most would agree that these defendants should have been punished.

General criminal laws, however, have not been applied narrowly to the intentional transmission of HIV. Quite the contrary, criminal laws have been used to prosecute individuals whose behavior poses no risk of transmitting HIV. For example, a Kentucky inmate was

recently charged with attempted murder after he threw urine at one of the corrections officers (WAVE 3 News 2013). Although assaulting a corrections officer is clearly not a behavior that should be legally condoned, it is difficult to justify attempted murder charges on medical grounds. Not only can urine thrown on someone not transmit HIV, but even if it could, to describe such an act as murderous would seem to belittle the crime of homicide. Nor is this case unique. In courts throughout the country, people living with HIV have been charged with aggravated assault or even attempted murder for biting, spitting, or throwing bodily fluids, usually on police or corrections officers, and their teeth, saliva, or blood have been described as “deadly weapons.” In such cases, the risk of actually transmitting the virus is negligible (see Gostin 2004; Center for HIV Law & Policy 2011).

These cases occur because existing criminal laws are open to multiple interpretations. Rarely are the laws on the books written so narrowly as to apply exclusively to those who intentionally attempt to infect others. Instead, “the laws create an ambiguous zone of condemnation that can potentially encompass everyone from deliberate exposers to ‘average’ negligent non-disclosers” (Burriss et al. 2007: 490). It is prosecutorial discretion and judicial interpretations that determine how traditional criminal offenses are applied to particular cases (UNAIDS 2002). If we are to follow UNAIDS’ guidelines and limit prosecutions to the intentional transmission of HIV, the question then becomes how to limit prosecutorial discretion without enacting yet another HIV-specific statute. UNAIDS (2002, 2006) proposes that states issue guidelines that limit prosecutorial discretion in applying criminal laws by providing narrow and clear definitions of “intentional transmission” and specifying conditions that militate against prosecution. For example, persons who disclose their HIV status to partners or who use reasonable measures to prevent the transmission of HIV should not be prosecuted because they

did not intend to transmit the virus (UNAIDS 2006). As is also relevant to this dissertation, the guidelines should advise prosecutors to “avoid publicity that may prejudice a trial...and [contribute] to widespread misconceptions about how HIV may be transmitted” (UNAIDS 2002: 40). There is no guarantee that guidelines will always be followed, and like laws, they are subject to interpretation. In the end, it is neither possible nor desirable to eliminate the interpretive processes through which laws are linked to actual cases. These interpretive processes become problematic when they include cultural schemas that stigmatize persons with HIV. The enforcement of the law—whether criminal laws or HIV statutes—depends on the cultural context, and it is this context that must change.

The purpose of this dissertation is not to devise the correct approach to controlling sickness. If there is a “perfect” policy solution, it is not known to this author. That said, there are clearly costs associated with the continued enforcement of Michigan’s HIV disclosure law. If the HIV-disclosure statute makes it possible in 2009 to convict an HIV-positive dancer of a felony for (allegedly) allowing her client’s *nose* to penetrate her vagina, then there is clearly a need for policy reform. It amounts to punishing an HIV-positive person for no other reason than that she was HIV-positive. This violates basic human rights guarantees and a constitutional right to equal protection under the law. While this case is exceptional in some ways, many of the cases involved sexual behavior that was not actually blameworthy. Moreover, no evidence was presented in any of the cases reviewed that would have suggested that the defendant maliciously intended to infect their partners. While defenders of HIV-specific criminal statutes often invoke stories of malicious offenders who wreak havoc by attempting to infect as many innocent, unwitting partners as possible, this narrative does not accurately reflect any of the cases analyzed

in this dissertation. The HIV-positive monster in many people's minds is a product of stigma and has no basis in reality.

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