Erin Welsh	Hi, I'm Erin Welsh and this is This Podcast Will Kill You. Thanks for joining me today for this latest installment in the TPWKY Book Club, this season's miniseries of bonus episodes where I chat with authors about their excellent popular science books. If this is your first time tuning into one of these book club episodes, be sure to check out the other ones in the series to learn about why sweating is actually a superpower, how the Vatican deals with rogue flower-eating birds, where some period myths come from, and so much more. If I'm counting correctly, this is the sixth episode in our miniseries and there will be three more coming out this season for a total of nine. So hopefully your library card or e-reader or bookshelf is getting a workout. And as always, we love hearing from you about how you're liking these episodes, any favorites you have so far, and what other books you'd love to have featured in this miniseries or any future miniseries.
	One of the most important questions that comes up in this podcast in public health, in life really is why we get sick. Not how we get sick, like airborne transmission vs mosquito borne, or what happens when you get sick like the path of physiology or symptoms of a disease, but why. Why does one person get sick while someone else does not? Disease does not happen in a vacuum, as we're fond of saying, there are countless factors that determine whether or not an individual is exposed to or develops a disease, from individual level variables like age or immune system function to ones operating on a societal level, like unequal access to healthcare, racism, and poverty. Measuring the many determinants of health and disease and how they interact is foundational to the field of epidemiology.
	In theory, if we understand the risk factors for developing a disease or the variables that lead to the spread of a disease, we can use that information to prevent disease and improve health. But in practice what ends up happening all too often, especially here in the US, is that public health policies are too narrow, failing to take into account many of the social determinants of health and reinforcing the racism, classism, and ableism that drive health disparities. In 'The Viral Underclass: The Human Toll When Inequality and Disease Collide' author Dr. Steven Thrasher explores 12 social vectors that create unequal opportunities for infectious disease transmission as well as compound the negative impact of infection on someone's life.
	Viruses are not the quote unquote "great equalizers" that some people claim them to be. Rather they expose and exacerbate existing structural inequalities. A bout of influenza for one person could mean using paid sick days to recuperate at home for a week before heading back to work. But for someone else, those missed days could be unpaid, forcing them to choose between food or heat or rent or the missed days could lead to them getting fired. Dr. Thrasher, who is the Daniel H. Renberg Chair of Social Justice and Reporting and Assistant Professor of Journalism at Northwestern University examines these dynamics and impacts of viruses far beyond their biology, creating an essential new framework through which we can study the relationships between viruses and marginalization.
	But 'The Viral Underclass' is so much more than a skillful and important academic investigation into these complex systemic issues. The inclusion of personal stories throughout the book brings a sense of humanity and compassion to the analysis of each social vector and serves as a necessary reminder that like the factors driving health inequalities, we too are all interconnected, that if one person is vulnerable to disease or the impacts from it, then we all are. I am so excited for the opportunity to chat with Dr. Thrasher about 'The Viral Underclass' for today's episode and just wanted to make a quick note that this interview was recorded all the way back on January 31st of this year, so keep that in mind if you hear references to current events. I already know that there is so much we aren't going to be able to cover in this interview, so make sure you all check out your local library or bookstore for a copy of this exceptional book. Okay, but now I should get to the interview right after this break.
TPWKY	(transition theme)

Erin Welsh

Dr. Thrasher, thank you so much for being here today. I really enjoyed your book 'The Viral Underclass' and how it explores the role of viruses as exposing or amplifying these existing structural inequalities in the US that leave some people much more vulnerable to viral infections like COVID or HIV. Before we get into some of the vectors that you discuss that produce a viral underclass, can you give me a bit of background on how this book came to be?

Steven Thrasher

Sure. And thanks so much for having me on. I've been writing about HIV for more than a decade, first as a staff writer with The Village Voice and sort of seeing some of the patterns between HIV and poverty. But for about 10 years or almost 10 years now I've been writing about when HIV is prosecuted, when people are charged with HIV transmission which happened through a story that I wrote for Buzzfeed. And so I've been seeing these patterns come together between viruses and crime, viruses and race, poverty, and incarceration particularly for a long time. I spent quite a bit of time reporting on this story about a young man named Michael Johnson who was arrested for HIV transmission near Saint Louis, in the county next to Saint Louis, in the beginning of 2014.

And then I ended up going to back to Saint Louis to write about Michael Brown. And I asked the HIV activists that I had been working with what I should be looking for in that area because I didn't know what this Ferguson was exactly, that town. And they told me that they had recently been in the exact apartment complex where Michael Brown was killed because there had been some new cases of HIV infections in the apartment complex and Ferguson had this high rate of AIDS. And so I started thinking about the ways that when you would see concentrations of black poverty, you would also see police violence and police killings. But you would also see viruses and particularly HIV, that the social factors that led to criminalized black poverty were also leading to new infections. And so I started thinking about that relationship then.

And when COVID-19 broke out in the beginning of 2020 in the United States, I started seeing that the same maps that I worked with and seeing overlap between police violence and HIV were the same emerging maps for COVID-19. The first 12 deaths that happened in Saint Louis were all of black people in the north county, which is the part of the county where Ferguson is. And similar patterns were emerging in New York City as well. And of course COVID came to be a virus that affected people all over the world and all over the country. But the concentrations of severe sickness and death uh particularly at the beginning of the pandemic and again now as we're shifting into what President Biden is calling the endemic stage, we're seeing the same kinds of concentrations of who's getting affected by these viruses.

And so the book kind of came out of this reporting. I was trying to figure out, like the story I wrote about HIV criminalization became the basis for my dissertation. I was trying to in 2019, early 2020 figure out how I was going to turn that into a book after I'd finished graduate school. And that's when COVID happened. And it was my agent Tanya McKinnon who's really great, who said let's go back and look at your dissertation again and she saw the last chapter is called The Viral Underclass and she was the one that encouraged me to think about that as an analytic to understand why this very, very different virus, and as you know, SARS-CoV-2 is a very different virus by many metrics than HIV. And why was it this very, very different virus was affecting similar populations? And so that's how I started thinking about the theory of a viral underclass and making it into a book.

And I was very grateful that my editors at Celadon Books and Macmillan saw the vision for this at a time, I mean we sold the book in late March, early April of 2020 when nothing was happening business wise. And I didn't know if I was gonna lose my job, I didn't know if there would still be book publishing. Fortunately people in book publishing thought that people are gonna get tired of watching Netflix and they're gonna keep buying books. Which is exactly what happened. But that's kind of how the book came to be. Really for me the sort of aha moment was trying to understand why these viruses with very different properties were affecting similar populations.

Erin Welsh

What is the viral underclass and where did this term come from?

Steven Thrasher

The term comes from an activist named Sean Strub, who I interviewed extensively in the book and he used it first in 2011 and coined it and he used it as a way to talk about when HIV was criminalized. And so for your listeners who don't know, in about 70 countries around the world, and it's fallen since I've started researching, it was about 30 or so when I began, it's probably about 24-25 now, states in the US, you can be prosecuted for transmitting HIV. And there are a variety of ways that these prosecutions happen. The most nefarious is somebody can even be charged for spitting if they have HIV. And this has come up with police cases where they've tried to say that somebody who is arrested, who either spits during the arrest or even bleeds during the arrest, who's had their head bashed into a police car or against the sidewalk, if they haven't told the officer they're HIV positive, the officers can charge them with attempted murder. That's kind of the most nefarious end of it.

The most common way is that if people who are living with HIV don't disclose their status to people who they have sex with or who they're sharing injection needles with, they can be prosecuted for transmitting HIV to them, whether or not the person becomes positive. And it doesn't matter if the person is using a condom, it doesn't matter if they are what's called undetectable, that they're on medication and their viral load is so low that they literally cannot transmit HIV, they still can be prosecuted for this and it becomes an incentive to not know your status. And so Sean wrote about how this was creating a viral underclass of laws that apply differently to people with what we call immutable characteristics. So in the US there have been periods of time where the law is explicitly about immutable characteristics like race, there have been laws in the history that explicitly are written to apply about black people.

But for the most part, and this is what critical race theory helps us understand, the law itself is written in a way that's colorblind, it's not literally saying that things apply only to black people even when it's more often applied to black people. With these HIV laws, that's not the case. It's explicitly saying if you're living with HIV, you live under a different set of laws than other people for very normative life activities. And the example that Sean uses to illustrate it best is to say that infants that become HIV positive while still fetuses and then they're born as babies with HIV, they're going to be living under a different set of laws their whole life as second class citizens. So that's how the term started. I heard activists use it in a different way when I first heard the term when they were debating about whether or not to revise or abolish HIV laws.

And there's been a fair amount of successful movement in not abolishing these laws. The laws have only been abolished in a couple of US states, in Illinois where I live and actually in Texas. So it can happen in very blue or very red states. But most states have revised their laws and said well if you're undetectable, if you're on medication, then you shouldn't be able to be prosecuted for these laws. But who is undetectable and who is not? The people who are undetectable are homeless, they are poor, they're disproportionately black, they are people who don't have health insurance and can't stay consistently on medication for a variety of reasons. And so I heard activists talking about a viral underclass that was produced in that way, that some people could be prosecuted and others would not. And I use it in in kind of a third way, I use it as an analytic to think about and understand why is this viral underclass being produced? Why is it happening? What are the social factors that are making it happen? And then also how do viruses themselves produce an underclass?

And while in the book and conceptually I think that a viral underclass can be used to think about viruses in different countries, I think that last part is very much a US version of what happens and it is very particular to the US. Because we don't have universal healthcare, because the majority of bankruptcies come from medical debt, here in the US we are particularly punishing of people who have viruses. And so being infected with something can throw you off an economic cliff and that can make you fall down the class ladder. So that's kind of the origin of the term and how I think about it. And I've really enjoyed hearing from readers who find it interesting to think about how it can apply in different ways or to think about its limits.

Erin Welsh

In each of 12 chapters of your book, you examine one social vector that plays a role in creating or perpetuating the viral underclass. And I'll briefly list them here: racism, individualized shame, capitalism, the law, austerity, borders, the liberal carceral state, unequal prophylaxis, ableism, speciesism, the myth of white immunity, and collective punishment. And throughout these discussions, you interweave these powerful personal stories that exemplify the structural issue at hand. And before we dive into some of these vectors in a bit more depth, I wanted to ask about how you landed on this format which I think was really impactful, balancing academic big picture discussions with grounded stories of individuals who have been deeply affected by being a member of the viral underclass.

Steven Thrasher

Thank you. So my background is both as a journalist and now I have a PhD in American Studies which can be many different things and I do like studying the history of the United States. But in my program, in my studies, I did really study kind of medical anthropology and epidemiology, sort of social epidemiology and cultural epidemiology because I ended up studying so much HIV and how it intersects with law and culture. But the journalist in me always likes to tell stories and I worked as a staff writer for The Village Voice for three years before I went to graduate school and then I was a writer for The Guardian all through graduate school, largely writing about the Black Lives Matter movement as it was happening. The plan as I read about in the book was I was gonna write for The Guardian and just kind of riff on politics and not do a lot of original reporting. But I ended up getting sent to Ferguson and traveling around the country and documenting a lot of what was happening with the Black Lives Matter movement.

And so I've always found that it's really effective to tell stories because that's the best way to connect with people. But I wanted to write a book that was theoretically rigorous. This is maybe a bit in the weeds but when one becomes a professor as I became right before I started writing this, you often have to write what's called an academic book for an academic press that's written in a very particular way to get tenure, to have a steady job. I was very relieved when I found out when I started at Northwestern because my home line was in the journalism program that I could actually write a trade book. So I knew that that was a possibility but I still wanted to do something that was theoretically rigorous. And some of my inspirations are people like Naomi Klein who wrote 'The Shock Doctrine', 'Fast Food Nation' which is a fantastic book about fast food that's also I think one of the best books about economics and how economics and labor play out in the United States. So those are some of my guides.

So I wanted to write something that had this combination of stories and theory. And I began with the idea of this viral underclass and some of the themes in that were very familiar to me. I had written about for years the connections between racism and disease, how that intersected with sexuality. For me what felt like the growing edge in this book in a way was to go beyond race, and race is never away from these things, race is the first vector that I write about. The story of Michael Johnson is actually the only one I really keep coming back to throughout the book. It starts and ends with his story and I write about it a couple times in the middle. But like in chapter five, I'm writing about a situation I found in Athens, Greece.

And I went while I was working on my dissertation, I had a writing fellowship in Athens through my university and I thought I'm just gonna get to have a break from all this police violence in the United States and get to clear my mind and eat feta cheese and eat olives and not have to think about some of these things while I'm doing my writing.But within about the first week that I was there, there was a police killing in Athens within a mile of where I was working and it just happened to be the most prominent HIV activist in the country. And so for me, I started to see the situation that was not connected to so much of my work had been not only with the contemporary race relations in the United States but the history of the transatlantic slave trade and sort of the ways that race had been made across different national borders. I was very much getting to see a situation within Europe that was not connected to the United States that did still have a lot to do with viruses and with queerness.

And this young man, I was thinking about him a lot the past couple of weeks as we've seen these horrific videos out of Memphis. This young man was kicked to death by a mob, by several people and four police officers as well who just kicked him until he was dead. And he was HIV positive. And so I started looking into the story of how did he become HIV positive. And I saw this story of how in Greece they had actually been doing very, very effective HIV work at keeping that virus down through taking sterile syringes to the street and getting them to people who used injection drugs. It wasn't actually even particularly expensive to do so. But they were keeping HIV pretty in check in that way. And when they had their economic crisis and the EU imposed austerity, they cut all those kinds of programs, they said you can't pay for those things. And HIV went up 3000% in just a couple of years.

And so it was like a very, very similar story that happened outside of the United States. And so that's how I started thinking about okay, I can write about austerity as one of these vectors in a way that can hopefully create a sense of solidarity between white people in other countries and people in Asia and people in Africa and in the Americas who are having similar things happening that's not only about this dynamic we have with race relations in the United States. So I started seeing what are these different social vectors that try to explain why certain bodies are put in front of viruses routinely, why they come into contact with them the most, and then why they have very different results and how they'll survive, who's going to become infected, who's going to get seriously sick and who's going to die?

And I think I started with 8 when I proposed the book and then it became 10 and then I begged my editors for 12 and they were fine with that. And I think that it explains 12 different ways. And I've heard readers say there are other ones they've thought of or some resonate more with them than others. But I hope that they help people think about these vectors are socially constructed. And I don't know if you struggled with this in your work, and I write about this a little bit in the book, there was a challenge at the beginning of the pandemic that people were using language that typically had only been used by public health people. And there were good things about this. I'm glad that people were wanting to read and wanting to understand this global phenomenon that was happening. At the same time, it could be very damaging when lay people were using terms like host or describing individuals as vectors.

And so one of the things I want to say is the individual is not a vector. Somebody like Zach who became infected with HIV and eventually was killed by police, he became HIV positive in part because the EU stripped the money away from what had been happening in Greece. And then suddenly there was a lot more virus circulating. That's the vector, it's not any one individual person. So that was one of the reasons why I wanted to think about emphasize that these vectors are beyond our control, which is not to say that we don't play a part in them, but no individual is a vector. Viruses don't just develop in a person, dropped into them by a stork or anything like that. They're socially connected. And that should be our focus in understanding how are these vectors operating, what can we do to work with them to minimize the harm that they're doing?

Erin Welsh

Absolutely. And you mentioned one of these vectors, austerity, but let's get into a few others starting with individualized shame. And I know many listeners of this podcast are likely familiar with the true story of patient zero. But could you take us through it and also talk a bit about the ways that we saw scapegoating used during the COVID pandemic?

Steven Thrasher

So the term patient zero is originally just a mistake. Originally this Canadian French Canadian flight attendant, Gaëtan Dugas, was identified as the quote unquote "patient zero" who brought HIV to the United States, to North America actually, both Canada and the United States. And there's a fantastic book called 'Patient Zero and the Making of the AIDS Epidemic' by Richard McKay that writes out a lot of this history about how Dugas was trying to actually be very helpful with contact tracers when people were trying to understand what was happening with this epidemic. And in talking to one person who was talking to like 40 different people, everyone he'd been talking to was in California, Dugas was the one person who was outside of California. And so he noted that he was the patient O, as in the letter, for outside California. And Randy Shilts, who was a very celebrated and very complicated gay journalist, misidentified this as the number zero and called him patient 0. And the marketing by Saint Martin's Press really, really focused on that in his book tour and made much more of it than should have been.

And so I kind of have some linguistic fun in the book trying to understand the history of that term. And I think it actually also dovetails with thinking about ground zero and the ways that we broadly, not hopefully you and me and and your listeners, but journalists often write about people living with disease as if they're akin to an atom bomb, like they're a biological bomb waiting to go off in a community. And so there is something I think about that number zero. But also when people are called by numbers and when any time an individual is made to feel like a disease is their fault, really bad things happen. And so that's one of the reasons why as I write about in the book, including with somebody that I knew and loved, why you have high rates of suicide with people who are living with HIV. That the shame and the isolation that people feel when they need support the most can be a real tragedy.

And what we want with any kind of communicable disease, whether it's HIV, COVID-19, as I will write about for the paperback edition because it happened right after the book was published, with monkeypox as well, we want people to be able to have open honest communication with one another and know that they're going to be supported and helped. This happened with monkeypox quite differently than with early COVID. If somebody gets a diagnosis of monkeypox and they're told you must isolate now for 4-6 weeks but you get no money, there's every impetus to lie about it and/or to feel shame and isolated and to suffer. And most people, no matter how wealthy in the United States or how middle class they might think they are, most people can't go 4-6 weeks without their income. And so this can be a really devastating thing.

And the idea of a patient zero I think helps corporations and governments enact that kind of shame and austerity to say you are a bad person, you brought this on yourself, it's your responsibility to keep the rest of the community from getting it. Whereas in reality if everyone got paid sick leave, they could more effectively be able to stay home and not feel so scared and frightened about coming out to each other and being able to reach out to other people and say I've been exposed to this, you might want to get tested for it. And I think that the idea of the patient zero just does a lot of work in letting the society broadly off the hook and putting the responsibility on the individual. But the consequences from that can be tragic for the individual and they can also be quite bad for the population level of public health.

Erin Welsh

One of the stories that you feature in your book and you mentioned earlier is that of Michael Johnson, a young black man who was convicted for allegedly not disclosing his HIV status to his sexual partners. Can you share a little bit more about Michael's story and what effect the criminalization of HIV can have or has had on shame and stigma and seeking care?

Steven Thrasher

Sure. So Michael, when I met him, was a young man. It's been almost nine years now so we're both older than when we first met. He was a college student at Lindenwood University in Missouri and he was almost done, he only had one more year to go, even though he couldn't really read or write very well. This is unfortunately not an uncommon story for some black male students who are very good athletes, he was a fantastic wrestler. And he was accused of having sex with six different young men and not disclosing his HIV status. Two of the charges were that he had transmitted HIV to them and the rest were that he had just exposed them to HIV. And the trial was one of the most disastrous things I've ever seen. I sat through every minute of the trial, it was kind of every disaster of Black America and of how we deal with disease and sexuality in this country. And he was actually sentenced to 30 years in prison, of which he served about six before we got him out, largely because the prosecutor had engaged in prosecutorial misconduct. But he spent most of his 20s in prison. And it was a disastrous case for him.

And it's a good jumping off point to think about how criminalization doesn't work. At the time that Michael was arrested, there were headlines about him all over the world, Australia, Europe, all over the place. 40 million people were living with HIV at that time. One American college student who was largely illiterate cannot be held responsible for 40 million people living with HIV. We can't lock up all 40 million people, we can't lock up everyone who infected someone else, nor should we. And as I was saying earlier, what we really want is people to be able to have open communication when they are dealing with sickness. The more stigmatized the sickness, the more we want to support them in being able to have open communication. So this is a real problem with HIV and in many ways much more so than COVID, because HIV's history is largely associated with queer sexuality and injection drug use. Obviously people are affected for other reasons as well but that's a lot of the history and why a lot of shame comes up around it.

And so when I started reporting on the story, I immediately heard from the HIV people that I worked with how much harder their work was getting, that we knew I would say within a year of reporting on the story, the CDC came out with a statistic that one out of every two black gay men is projected to become HIV positive in our lifetime. And that has to do with all kinds of different social factors, it actually doesn't have to do with having more sexual partners or using injection drugs more, black gay men use them a bit less. But it has to do with all these social factors. And so the population that you want to try to support and protect and prevent from becoming HIV positive, largely you need to do a lot of work with young black gay men.

And the people that I worked with in Saint Louis said it is getting harder and harder and harder for us to get people tested because of this case. Because if you see somebody go to prison for HIV and the law says if you know you're HIV positive, you could go to prison, and if you don't know, you can't ever be prosecuted, then it becomes even harder to get people tested. And it's just a complete misuse of funds that the government could be spending differently. In the county where Michael was arrested, and I think this was, I'm trying to remember what year it was, I think it was shortly before or after he got acquitted, before his sentence was overturned, that county also stopped having an STI clinic. And so the state was on one hand saying we want to spend all this money prosecuting someone because he's making people HIV positive but we're also gonna get rid of the clinic. So you want to have the clinics.

And there's this relationship, I've been thinking about this a lot since Roe was overturned, there's this relationship you can see between abortion and sexually transmitted infections and who's doing this work. In Indiana when Mike Pence was governor, the fastest HIV outbreak in the country happened. And a big reason for that was because they are effectively chased out all the abortion providers who were also the people who were doing STI testing. So everyone doing HIV testing in the lower half of that state was no longer doing it when HIV happened and then no one knew it was circulating until the infection had gotten quite wide.

	And so I was horrified to see that in the county where Michael was prosecuted the same setup is happening, you get rid of the surveillance network to test for STIs and then you're leaving people vulnerable to becoming infected with them. And something similar now it's happening with COVID as COVID money dries up, as the federal government moves it into the private market, there's going to be less surveillance and more circulation of the virus. I've moved a lot and I've seen a lot of other people move a lot in how they think about criminalization with HIV, I think it should not be criminalized at all for a variety of reasons but even just at the population level, public health reasoning, nobody should want anything to be criminalized in this way because it's going to affect the kind of people you might think are doing the quote unquote "wrong thing" but it's really going to affect everybody and have a big effect on everybody. And the more stigma that happens, it does create worse public health levels for the people who receive that stigma the most but it also just affects the whole population quite badly.
Erin Welsh	Absolutely. All right. We will take a quick break here and when we get back, some more questions about the vectors of the viral underclass.
TPWKY	(transition theme)
Erin Welsh	Welcome back everyone. Let's dive back in another chapter in your book deals with borders, both political and social. How do these different types of borders reinforce the viral underclass?
Steven Thrasher	So borders, this is one of these terms that I did think about a lot in my PhD program and what constitute borders. And on the national level, we try to imagine that there are hard borders to the US, water or a wall. The Trump administration has been trying to build this wall. But borders are very porous over what is in the US and what isn't in various different ways. And I do this often, I just spoke to a group of about 1000 people last week and the answer came as it almost always does when I asked people when did Guantanamo Bay start getting used as a site of infinite detention? And people always think it's 9/11 but it was actually a decade before that when it was activated to put Haitian refugees who were trying to flee Haiti and the Coast Guard didn't want them to get to Florida. And so they diverted them, they said where can we send them where the US can control them but that they can't make a claim to US law? And they said well we have the space in Guantanamo Bay, let's do that there.
	So the whole history of having the site of infinite detention is predicated on this inbetween zone where where exactly the border is is not clear and viruses are used as the justification for it. And we've seen this in all kinds of bad national policy. Right now again, we're only testing people from China have to have a test before they come to the United States, from no other country, for COVID. The virus is used for justification for how we misunderstand how viruses actually move is if they respect national borders. And the last China policy with the US requiring testing just from that country is happening as the virus is allowed to move completely freely within the borders of the US. And as we've had the among the highest rates of the virus for anyone, so of any country in the world.
	Something really similar and bad happened with South Africa, with a number of countries about a yeah, year and a half ago, when they first discovered the Omicron variant. Now Omicron didn't necessarily come from South Africa, South Africa is a relatively poor country. But because of their experience with AIDS, they have very smartly and as a great gift to the entire world, put resources into genomic surveillance ever since they've dealt with HIV. And so even though they have modest resources, they still put a lot of effort into understanding what's happening with viruses. So often they're the ones finding variants first and they're punished for it, they're told okay, you can't come to the EU or UK or the United States because there's something diseased about you. And then the US has an idea in their mind that the border of Africa is defined by a virus in this way.

And so I think a lot about those kind of borders but also about the borders that are imagined to be between genders. So one of the things I read about in the book, and unfortunately I feel like the situation's gotten even worse since I've published the book, are how much trans people are in the crosshairs in the United States. And the state and a lot of media and certain elements of science, not other elements of science, are very invested in the idea of creating the idea that there are two distinct genders and there has to be a hard border between them. And that creates all kinds of bad health effects.

One of which in very, very direct ways create viral risk for people who are trans. So if the state will allow you to have trans medical care, as most states were allowing until the past couple of years, then someone who's transitioning and taking hormones is going to get sterile syringes, the medication, the medication they need under the care of a doctor. If they're not getting that and it's been taken away in Florida, I think Wyoming just passed a really bad bill, Texas as well, if they can't get it from their doctor, they're going to get it from the contraband market. And the more people are using syringes from the contraband market, the more likely they're going to get hepatitis, HIV, any number of other things. And so that's a very direct way I think the state is opening up the veins of people and making them more susceptible to viruses.

In a very related way, the same happens with education. We've long known that children who get abstinence only sex education or no sex education are more likely to become pregnant and more likely to get STIs. And so as we see these Don't Say Gay bills, these very draconian bills happening around the country, these classrooms that are having all books taken out of them, you might be in a district where they're not allowing any kind of queer knowledge of any kind but the teacher could on their own get a book like 'Heather Has Two Mommies' or something like that, all those books have been taken out of classrooms. So in denying young people the ability to know about how to protect their bodies, they're going to become more susceptible to viruses. And so they are very, very direct ways that this is the literal virus entering people's bodies because of decisions by the state.

But as I write about in the book, there's kind of a secondary way this happens as well with the ways that not getting proper medical care, feeling shame and stigma creates depression, creates barriers to getting care that you need. I write about this wonderful trans Latin activist named Lorena Borjas in the book who died of COVID. She was the first person in my social circle to die of COVID, my outer social circle, I'd only met her once but she was very close to a number of my friends. And in her final days she did not want to go to the hospital when she had COVID. And part of the reason why was because she was terrified about how badly she had always been treated, both for her language as someone whose first language was not English, but also for being a trans person.

And I write very briefly about an experience I had of being made feel unwelcome once in a medical setting. And the more times people have that, which happens particularly with people who are undocumented, who are immigrants, who are trans, who are queer, the more likely they're made to feel like they're not welcome in the medical system, the more likely something that maybe could have been dealt with easily could become a life threatening situation or take their life. And the hierarchy of borders is why a lot of this happens. When the US has really harsh enforcement of our national borders, that makes people who are undocumented unlikely to seek medical attention. When we have really harsh borders around who is allegedly a male or a female and act like there's nobody who's intersex or trans or nonbinary inbetween, the hierarchy and the enforcement of those borders drives people out of care that they could be receiving and the consequences of that are really deadly. And we can see it in very irrefutable ways in looking at viral transmission and who is affected.

Erin Welsh

Yeah. So I want to shift a bit to talking about capitalism which is another of the vectors that you discuss in your book. How can we use capitalism as a lens through which to view some of the large scale geographic differences in COVID incidents or mortality, especially in the context of, this is a part of your book I really enjoyed, of how the US spends money on certain aspects of healthcare compared to other countries.

Steven Thrasher

Capitalism is the driver of so much viral transmission. And it's a very opposite message that most of us get in school and certainly in mass media. Historically, one of the things that I come to in lectures and I write a bit about in the book is understanding the origins of modern capitalism cannot be decoupled from the history of the transatlantic slave trade. Modern capitalism in North America and in Europe is based on the middle passage where money came from Europe, it was used to buy human beings in Africa and to convert them into enslaved people, and the enslaved people were used to extract raw goods in the Americas, cotton, gold, silver, things of that nature, and then those were sent to Europe for manufacturing and turned into money. And this triangle goes around and around and around. And that's the birth of modern capitalism.

It's also the biggest transfer of pathogens in human history, I think that the slave ship itself is the vector. Again not the enslaved people, the ship itself where 20%-25% of people could die from the conditions in the crossing. And then there was this mass movement of bringing together more people than had ever been together from different parts of the globe and then moving those viruses and those pathogens and bacteria to the Americas in that process. So that's the birth of modern capitalism. It was one of great viral transmission and one of enormous racial pain and suffering and trauma. And coming to modern day times, the point of capitalism is just to extract value. It must extract as much value from as many sources as possible and people's bodies get moved into the crosshairs when that happens.

And so people who were at the higher end of the ladder of capitalism were relatively well protected at the beginning of COVID-19. If you could stay home, that was the biggest thing that would change things for you. And then among people who could not work from home, doctors, certain people who were working in settings where they still had medical gear that would protect them. The huge report that was done out of UC Berkeley Public Health School that looked at California found that the deadliest job in the pandemic was line cook. And line cooks were people who worked in very, very tight spaces with poor ventilation, many of them are undocumented, many of them live in intergenerational homes or in dense homes. And so if somebody gets sick in that setting, they're not going to be able to really isolate in the rest of their household. So capitalism is always playing a role in why public health things are playing out as they do.

And as the president just said that we will move out of the emergency period of the pandemic on May 11th, when that happens, this is all going to create a much more entrenched viral underclass and ruling class, that the people who don't have insurance are going to lose access to testing, treatment, and prevention efforts. And they've already been cut off of many of them already but they'll be completely cut out of all of them. And then people with insurance will get a COVID booster, Pfizer, Moderna look like they're going to charge a lot more for it, they've been charging $25-$30 a shot to the federal government, they're gonna charge probably $100-$130 to individuals. Those with insurance, their insurance will go up. But the viral rate will probably be much lower amongst the insured if they can still get shots and people who don't have insurance are not going to get shots and the viral load is gonna be much higher.

And this is a pattern that we've seen and I've seen this in my research for years with AIDS, that in 1995, tens of thousands of people were still dying every year in the US. And there was no medication. Then the medication comes in '96 and it's like a miracle and people hope that this is going to be the end of AIDS. But the drugs don't go to other countries for another seven years. And in the US, they're very, very unequally accessed. And for the most part, 80%-90% of white gay men get access to the drugs and the level goes way, way down. But black people don't really get access to the drugs that much. And then all these other social factors I've been talking about keep people from getting consistent access to the drugs. So if you don't have insurance, if you're homeless, if you're incarcerated, it makes it really hard to get medication.

And so capitalism is kind of the driving force for this. A phrase I really like that activists told me while I was reporting the book is that in '96 they knew that science had won the battle but then capitalism won the war. We know how to keep people from getting HIV, we know how to keep people from dying from AIDS. HIV is such a slow acting virus that there's no reason why people should die of AIDS, even though the better part of a million people globally do every year. You have 5, 10, maybe 15 years before somebody is going to die from HIV. But bolstering capitalism and keeping profit for the drugs for it keeps people from getting the care they could have. And I really fear that we're heading into something similar with COVID. We could have as happened with AIDS, more people could die of COVID after there's medication than before if people aren't actually getting it and if they're not getting the things that they need to survive this virus.

Erin Welsh

So one of the things you mentioned just now was this discussion around COVID vaccines. And I want to talk a little bit about anti vaccine sentiment in the US. And this modern anti vaccine sentiment or vaccine hesitancy can be traced back to discredited former physician Andrew Wakefield, who claimed to find a causal link between the MMR vaccine and autism. How does this story illustrate a couple of the vectors in your book, namely ableism and the myth of white immunity?

Steven Thrasher

There's vaccine hesitancy in different countries around the world for different reasons. In the US and in England, it very much does trace back to Andrew Wakefield and the idea that the MMR vaccine that had three different vaccines together was somehow causing autism. And so the way I grew to think about that in conversation with disability activists requires for a moment, I'll keep giving disclaimers, but requires trying to think about the logic that's happening there. And the idea of it is that if a vaccine causes autism, which it does not, but I'm just saying for a moment, the idea that if the vaccine causes autism, that is somehow worse than death. And that's a very ableist idea to think if my child could become autistic from this thing, I would rather risk their life, I would rather risk the lives of the other children around them than the idea that that my child could be autistic. Again, vaccines don't cause autism. But this logic is what is at play.

And so I think that both illustrates the really grotesque nature of disability and ableism, which was one of my growing edges in understanding this book as we're talking earlier about kind of how I moved from thinking about race and then also about austerity, thinking about disability and ableism was a real growing area for me in this book and to see how embedded it is and how it's used as an excuse for not giving care. Zeke Emanuel, who wrote this horrible Atlantic essay, 'Why I Wanna Die at 75' was just tweeting it out in the last week again, saying that you shouldn't want to be infirm and have people remember you not being a contribution to society. And so that also dovetails with capitalism. We often think about people who are disabled, either with something like autism or some kind of physical disability, that oh you're not being maximally productive in society and therefore you have no value which is not true. But that's a lot of the logic under it. And in the book, and this chapter took a fair amount of work and my editor made it much better I think, in understanding the myth of white immunity and when white people think they're immune.

So four of Michael Johnson's accusers were white. One of the things I saw in that trial was that none of the young men were having open communication about sex and they seemed to think they could just say are you clean or not and that was going to protect them. And I think that for a lot of the white accusers, the idea that something bad could happen to them in sex just didn't come into their mind. And sex is not risk free. Nothing in life is risk free. But certainly whenever we're involved in intimate connections with another, viruses show us that there can be transference that happens, people can get pregnant, and of course pathogens can move between our bodies. And I think that the myth of white immunity speaks to when white people will think well this bad thing that happens to black people or happens to queer people, it's not going to happen to me. But of course it can happen to them.

And Jonathan Metzl who wrote the introduction to my book, his book 'Dying of Whiteness' goes deep into how some of these states that have large poor white populations will not want Medicaid expansion because they think oh, black people could get it too, so I don't want it. Besides I'm I'm going to be okay. And I think something similar happens with vaccines is that... And this was not actually, the class dimensions here I think are very interesting in that vaccine hesitancy came into upper middle class America first and upper class America, the idea that my child is so genetically superior and so hearty and hale, they don't need a vaccine. And that ties not only into ableism but to a kind of white superiority and the notion that my natural body doesn't need these things. When you step back and look, you can see that one of the greatest advances in human mortality has been vaccination. That's one of the reasons why. And I didn't get into this in the book, it's come up a couple of times in conversation but I wish I thought to use this in the book because it's a really good illustration.

So many people I think believe that humans used to live much shorter lives before the 20th century. And in fact, no, I mean humans have lived 50, 60, 70, 80 years or so in that range for some time. The huge difference is child mortality, is that children didn't make it out of childhood. And that's why you see an average life span of 30 years or 40 years in certain societies, it's because so many children were dying. The biggest thing, one of the biggest things that has changed that for children has been vaccination. And so it's been really alarming and quite concerning to see how not only has there been low COVID vaccine uptake for children, even though there was a JAMA paper that just came out this last week showing that COVID was the number one killer of people 0-19 in the United States, that that was the the most common thing to kill young people the past couple of years. And so there's been very low uptake of the COVID-19 vaccine. But even vaccines for other things are falling now because of so much blowback against this vaccine. And so that's really, really concerning.

Erin Welsh

Do you think that this hesitancy around the SARS-CoV-2 vaccine has similar drivers to this Andrew Wakefield type thing or do you think that the drivers for anti vaccine sentiment have changed?

Steven Thrasher

I think they're related. I think that the basis of where Wakefield came from, that my child is so hardy they don't need it, I think that's a much more popular idea. I do think that there was understandable skepticism about how quickly this was moving, not to the extent that people shouldn't take it but I think that the federal government should have put more effort into explaining what was happening. I think that there is a real problem in understanding collectively how we sort of share one body.And this is a big difference to me and why not just as a gay man, as a practicing gay man myself, but also sort of as a queer theorist and understanding that queer people and particularly queer men understand quite well this is like a shared responsibility.

When something like monkeypox happens, nobody wanted to get the pox themselves. But they also understood and gay men were just like lining up waiting for this vaccine, wanted to get it as quickly as they could. Because for the past 40 years with HIV, we've understood that this is like we all share the responsibility for the virus moving amongst our community. It's not just every individual person on themselves, we have to manage the viral load amongst us. And I'm disappointed that the US has not taken that on more. So I think a lot of adults, like a lot of adults did eventually get vaccinated but very few are vaccinating their children because they think that well it's only gonna hurt old people.

One, as I just said, it was the biggest killer of children over the past couple of years. But also the children's bodies are part of this collective that we all need protected because the children don't live in a vacuum. The children interacting with their teachers, with their parents, their grandparents, their bus drivers, their lunchroom attendants, everybody. And so I had hoped that that kind of understanding would be much broader coming out of this pandemic or as this pandemic goes on, that we share a collective responsibility and there's been a lot of rejection for that and I think a lot of people are rejecting it through their children. The other thing that I do find difficult but I do give some credence to, and this isn't just about children and it's come up with relatives in my own family, I think that in the US we are so bad about telling people you're on your own with medical conditions. And if something like cancer happens to you, like you're on your own, like you better take care of that.

So then when the government comes along and says well you really should take this thing and it's good for you and it'll be good for the rest of the community, there is a lot of skepticism. And that's not an easy thing to fix. I think if we had a universal healthcare system, if people didn't think they were gonna go off an economic cliff every time they were sick, there could be a different response. And I certainly saw that, I worked on successfully, I will toot my own horn here, with a couple of people and trying to understand and explain, okay, what is it you are afraid of? Oh, you are a shift worker and you're afraid you take the vaccine and you might lose a day's work. Okay. I will help you find a place where you can do it Friday afternoon and then you'll have the weekend to recover. And doing that, I found that very effective with two of my friends, that kind of one-on-one care was effective in lots of ways.

But also if we had a general healthcare framework where you get sick, you take time off and you don't go to work and you get paid, that would make people less anxious in the first place. So I'm probably mixing a little bit of what you were asking about children. But I think that of course affects how people think about it with their children too. And I think that there was a lot of worry that okay, if the child's gonna react, I can't take time off from work, who's gonna take care of the child? There are all these things that contribute to it as well. But I found the Andrew Wakefield line, which was something my editor actually asked me to add, was mostly taking things out of the book, but she asked me to kind of look into that and think about that and I'm glad she did. I think that that gives us a very generative place to understand the general dynamics of ableism and how we imagine immunity. And there are new challenges that happen, particularly with COVID too.

Erin Welsh

I love the point that you made and I'm probably paraphrasing here, hopefully not butchering it too much, about how viruses themselves are not necessarily predictable yet they do move in predictable ways. How can this framework of the viral underclass help us to prevent disease spread or at the very least distribute resources more equitably?

Steven Thrasher

Something that I've, and I think I came to this phrasing after I'd finished the book, is that viruses demand a sense of humility. So like we can predict them, we try to, and we have long histories with some of them and we can predict them very well. But they can mutate, they can change. And I think we need to have a sense of humility about that. This did happen after I finished the book. Monkeypox, we'd understood monkeypox for about 70 years and then 5-6 years ago it evolved and started behaving very differently and presenting differently and ending up in a particular population because it seemed to be behaving in a way seemingly, from my best understanding now, transferring mostly through unprotected anal intercourse which had not been the case with how it behaved before. And that's not a rejection necessarily of the 70 years of research that was done in it, there were things about that research that help understand how to treat it.

But they are living evolving things, they evolve much faster than we do as human beings. And so I think that we should always just have a sense of humility about that. And I do think the particulars of viruses are important to understand and to know that the way that this came up for me a lot in doing public health speaking about monkeypox and reassuring people this is not like COVID. We're starting to see very clearly how it's moving, it's moving 97%, 98%, 99% amongst men who have sex with men, which means it's probably not moving through air because otherwise it would be moving to other people too. So these particulars are important to understand but at the same time, these social vectors I think do help us understand like where a lot of the risk is going to be and even within those populations.

So within monkeypox, we'll know, okay, it's primarily moving amongst the MSM population but we could pretty quickly see oh, it's much more moving so through Black and Latin men. And who's getting the vaccines? White men. Okay, that's something that we need to address. And I think that with any kind of virus or any kind of pathogen or sickness, we know who is most likely to be affected the most and where resources need to be deployed. And often the policy goes counter to that. So research has been pretty clear around the world, not just in the United States, that people who have access to health insurance fared much better in COVID. People who didn't have health insurance fared much worse. And some of that's because they're not getting care.

It's also reflective in our country, those are the people who don't have any kind of preventative care in the first place. So if you're the kind of person who doesn't have health insurance, you probably can't work remotely and you're probably going to lose pay if you miss a day of work. And so we know that the uninsured are the most likely to get COVID, get seriously sick from COVID, and die from COVID. And yet we're taking away the cure from them and that's going to kill them, to be very blunt about it. But it's also going to let the virus circulate much more throughout the country. And this is, yes, this is true in a very particular way for COVID.

One of the reasons why LGBTQ people are more affected by COVID has nothing to do with sex or gender identity but has everything to do with LGBTQ people being poor, and in a very explicit way, being overrepresented in retail work. So as people are working in retail and face to face work, they're going to be more exposed. But even though this is very, very true with COVID, the same social dynamic is true with HIV, influenza, with any number of other pathogens. And so we know what we need to do, we know who we need to protect, we know who in the society is not being protected. And if you're not being protected in terms of having access to medicine, food, safe shelter, education, the things that make for equality and healthy life, if you don't have access to those things, when pathogens come into the picture, you're going to be the most likely to be in their path. And so that's something that I think that we just need to not let go of and keep focusing on.

	The particularities can change, the situation, the why and how transmission happens can change. But that was kind of the genesis of my book of saying these are very different pathogens that are affecting the same kinds of people. And yes, anyone could in theory be affected by COVID but the reasons why and who's going to survive are going to create very different odds. And I think that as COVID came into the US and as we understood it in the United States and we saw who was affected, who was affected most at the beginning. And then there was this period of socialized medicine, of people being able to show up and get what they needed for this. And then as that dissipates, that same viral underclass is going to really emerge again. We're gonna see, yeah, it's the poor areas of towns that are getting it the most. And it's the states where people don't even have Medicaid, where people are going to get the sickest. And that's the thing that we need to keep combating.
TPWKY	(transition theme)
Erin Welsh	That was absolutely wonderful. Thank you so, so much Dr. Thrasher for taking the time to chat. It was really great talking with you. And if you listeners enjoyed this conversation as much as I did and want to learn more, check out our website thispodcastwillkillyou.com, where I'll post a link to where you can find 'The Viral Underclass: The Human Toll When Inequality and Disease Collide'. And don't forget, you can check out our website for all sorts of other cool things including but not limited to transcripts, quarantini and placeborita recipes, show notes and references for all of our episodes, links to merch, our bookshop.org affiliate account, our Goodreads list, a firsthand account form, and music by Bloodmobile. Speaking of which, thank you to Bloodmobile for providing the music for this episode and all of our episodes. Thank you to Lianna Squillace for our audio mixing. And thanks to you, listeners, for listening. I hope you liked this bonus episode and are loving being part of the TPWKY Book Club. A special thank you as always to our fantastic patrons, we appreciate your support so very much. Well until next time, keep washing those hands.