# Reappraising AIDS

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*Mothering* editors conclude:

## AIDS NON-INFECTIOUS, HIV HARMLESS, TESTING INVALID

*Mothering* magazine took a shockingly courageous stand against mandatory HIV screening for pregnant women in its Summer 1997 edition ("Health News," p40). The editors used the opportunity to issue a general commentary rejecting the infectious AIDS model. A portion of it reads as follows:

> The scientific community disagrees about whether HIV is the cause of AIDS or is simply a virus that sometimes accompanies it. There is not one documented case of 'full blown AIDS' where HIV has been shown to be the sole risk factor. On the contrary, AIDS occurs where there are multiple risk factors, multiple toxicities and is itself a syndrome of 28 different disease conditions.
>
> HIV seropositivity, on the other hand, is not in itself a disease but indicates alleged exposure to the presence of an alleged pathogenic antigen.
>
> ...HIV testing of pregnant women and newborns implies that they will be routinely treated ...without the presence of symptoms. Standard treatment includes very toxic and immune-suppressive antibiotics. The drug treatments for HIV, especially AZT, can themselves contribute to immune deterioration.

The editorial included references to books by Peter Duesberg (*Inventing the AIDS Virus*) and Robert Root-Bernstein (*Rethinking AIDS*), and the famously provocative academic paper "Lack of Evidence for Transmission of HIV Through Vaginal Intercourse" (*Arch. Sex. Behav.* 24, no.4, Aug. 1995). *Mothering* provided no references to sources favoring the HIV/AIDS model, and directed readers to two groups for more information: HEAL and *Reappraising AIDS*, both of which reject infectious AIDS.

The language could hardly have been any more plain: "Serious practical and ethical questions exist about universal, mandatory medical testing for a virus that may not cause anything." The commentary even questioned the very existence of HIV, referring to claims in the June, 1993 issue of *Biotechnology* that HIV has never truly been isolated, meaning that "all 'HIV positive' test results should be treated as false positives."

Whew.

For readers who might still cling to the HIV/AIDS model, *Mothering* pointed out that so few American babies (1/500th of one percent) ever test positive, that universal screening would involve testing four million babies annually at great cost in order to identify a maximum of just 400 born HIV-positive each year. The article reasoned that since 95% of all AIDS patients are gay men and drug injectors (and making sure later to note that "the real risk group is substance abusers, both heterosexual and homosexual, and their sexual partners"), then testing for the supposed AIDS virus should focus on those populations.

We couldn't have said it better ourselves.

*Mothering's* editors will no doubt take heat from readers who think the public should be protected at all cost not only from HIV, but from criticism of the HIV/AIDS model. We suggest you address support and encouragement to:

*Mothering*, PO Box 1690, Santa Fe, NM 87504
(505)984-8116 voice, 986-8335 fax <mother@ni.net>

*— Paul Philpott*

## NEW HIV TEST COST-BENIFIT DISPARITY SPARKS CONTROVERSY

### Real disparity ignored: Facts contradict HIV/AIDS model

The FDA wants the nation's blood banks to spend an additional $42 million annually to add a new test that would detect an extra four to six "HIV infected" donors each year, the *New York Times* reported (March 8, 1996, pA25).

You read those figures correctly. Forty-two million dollars to catch four to six "HIV-positive" donors who would be "HIV-negative" according to the current screening process.

The recommendation is controversial because the FDA's own advisory committee recommended against the plan. "Such a rejection is highly unusual," the *Times* observed. The article cited "critics" concluding that the plan's large cost outweighed its "very limited public health benefits," and that the FDA was "responding to pressure from members of Congress."

An FDA spokesman responded by saying that "the benefit from the [new] screening test, though small, is real."

The current screening process uses antibody tests, which are made with viral proteins (called *antigens*) that react if the blood contains viral antibodies. The new test works the opposite way: it is an antigen test, made with antibodies that react if the blood contains viral proteins.

The standard "HIV test" — the one used for blood screening — is actually a

battery of two types of antibody assays, ELISA and Western blot, each made with five different HIV proteins. The new antigen test is made with an antibody that reacts with one of those proteins, p24, which is believed to be the constituent building block of HIV's hollow core.

The FDA worries about donors who might have HIV infections that are so new that their immune systems haven't had a chance to produce a detectable level of antibodies. Such people would have HIV — including p24 — in their blood, but would be negative according to the antibody testing battery. The p24 test would supposedly read positive "about six days before the standard test does."

This raises one fundamental and obvious question: Why not just replace antibody testing with the p24 test? After all, since HIV requires p24, p24 should be abundant in every case of active HIV infection. With HIV now considered a super virus characterized by hyperactivity — high *viral load* — that begins on day one of infection and lasts forever, the p24 test ought to make antibody testing obsolete.

So why isn't the p24 test being proposed as a replacement for antibody testing? Because p24 is usually *absent* in people with detectable amounts of HIV antibodies.

And that's a problem for the HIV/AIDS model. Detectable levels of viral proteins indicate an active viral infection, and detectable levels of antibodies indicate an active immune response. Presence of both indicates a struggle for dominance, and presence of one in the absence of the other indicates dominance of one over the other. The classic model of viral infection calls for initial exposure to be followed by a few weeks of viral dominance, then a few weeks of viral/immune struggle, and then years of immune dominance.

This exactly describes HIV's behavior. If p24 alone was tested for, most people who have HIV antibodies would test HIV-negative. That leaves us with the first fatal flaw of the HIV/AIDS model: the absence of AIDS within weeks of infection, when HIV levels are high, and antibodies are undetectable. Logic does not permit a virus to cause a symptom after the immune response that it can not cause before the immune response. Nor does logic permit a virus to be considered active when its constituent antigens are undetectable.

— *Paul Philpott*

# MAGIC TIMES

## Strohman Speaks

*Richard Strohman, emeritus biology professor at UC-Berkeley, submitted to the editors of the* New York Times *the following letter that was not published*:

Your report of Magic Johnson's "undetectable" HIV levels (April 5, 1997) is irresponsible and misleading; it fails to report the current medical concern over use of molecular and chemical tests as substitutes for "real" clinical end points and it implies that Mr. Johnson has been cured of a disease he never had. In this case the basic flaw is the substitution of a chemical test (DNA polymerization reaction) for an actual pathogen (HIV) in the diagnostic process.

In February 1994, in an editorial accompanying my analysis of this general question in the international journal *Biotechnology* we have the problem stated in a nutshell: "...We must carefully consider what we actually hope to achieve by using genetic and molecular testing. Such testing is not yet a replacement for analyzing and treating disease processes, although there does at times seem to be a big push to make it appear to be the case." Your report disregards this now generally recognized warning and says that "...powerful drugs have reduced the AIDS virus in Magic Johnson's body to undetectable levels..."

But we know no such thing from what was actually measured and we have no idea about the level of actual virus in his body. The use of chemical and other surrogate markers rather than the more expensive and difficult-to-measure actual virus or other pathogens is a short cut to false positives, false negatives, and just plain bad medicine. The use of sophisticated analysis to amplify what is believed to be an "HIV sequence" and thereby to provide proof of the presence of active viral particles is a case in point. The fact is we are not yet able to match these amplification numbers to actual viral counts in any reliable way.

The second flaw in your article makes the case against your misleading reporting. We all know that Mr. Johnson was never ill... he never displayed any symptoms of AIDS. If he had, he would never have been allowed to return to playing professional basketball. But now because of what you call powerful drugs related to the lowering of a bogus chemical test your report leads the reader to believe that these same drugs have removed his AIDS symptoms; symptoms that he never had. You never mention the obvious possibility that Magic Johnson is one of thousands or hundreds of thousands of HIV+ people who, for reasons we do not understand, never show any symptoms of disease. To "cure" him of a disease he never had with a drug protocol costing thousands of dollars a year per person creates a clinical disaster involving billions of potentially wasted dollars and untold lives devoted to an untested and potentially hopeless cure.

How are your readers to come to any understanding of what is going on in "AIDS science" with this kind of news analysis?

— *Richard Strohman*

### PROTEASE INHIBITOR COCKTAIL POPULARITY RESCUES AZT SALES

Before the popularity of "antiviral cocktails," which combine AZT with the new protease inhibitors, AZT sales were nose diving, according to the *San Francisco Chronicle* (Aug. 1, 1996 pE1). The article displayed data showing that annual sales of AZT — the standard pharmaceutical treatment for people who test "HIV-positive" — followed the same path as annual new US AIDS diagnoses (*HIV/AIDS Surveillance Year-End Reports*, CDC, 800-458-5231 to order): up every year through 1992, then dropping each subsequent year.

But when the press announced in early 1996 that combinations of protease inhibitors with AZT caused reductions of "viral load," AZT sales rose to levels that exceeded the 1992 peak. Meanwhile, AIDS diagnoses continued to drop.

# CULT OF DOOM

*Men, it has been well said, think in herds; it will be seen they go mad in herds, while they only recover their senses slowly, and one-by-one.*

Charles Mackay
*Extraordinary Popular Delusions and the Madness of Crowds*

"There are not one but two main classes of contagious illness in man," Casper G. Schmidt, MD, proposes. Infectious epidemics are spread by germs, while psychosomatic epidemics are "psychological disturbances... spread by suggestion."

Schmidt's thoughts are lifted from his 1984 commentary, "The Group-Fantasy Origins of AIDS," which has been included in a collection of essays published recently as a book entitled *The AIDS Cult* (Pagan Press).

Authors John Lauritsen (*The AIDS War; AZT: Poison by Prescription*; *The Early Homosexual Rights Movement*) and Ian Young (*The AIDS Dissidents, The Stonewall Experiment*) collected the essays — including some of their own — and co-edited the book.

The eight contributors, including Schmidt, don't attribute AIDS entirely to psychological factors, though those are the foci of their essays. Although subtitled *Essays on the Gay Health Crisis*, most of the discussion in *The AIDS Cult* applies to all AIDS patients. This book distinguishes itself as the first to recognize that know-ledge of exactly how the "AIDS virus" should affect a person — general deterioration of health, including immune suppression and wasting — has always preceded an "HIV-positive" designation, and extreme dread, hopelessness, and even stigmatization have always followed.

Surely these psychological pressures can have physical manifestations. Could some of them be official "AIDS" conditions?

**The AIDS Cult**
**Essays on the Gay Health Crisis**
Edited by John Lauritsen and Ian Young
Pagan Press, 224 pages (1997)
To order, send $15 check
(in US dollars, drawn on US bank) to:
Pagan Press, Box 1902
Provincetown, MA 02657-0245
Overseas orders add $8 per book.

## EPIDEMICS OF HYSTERIA

Schmidt doesn't discuss HIV anxiety because he wrote his essay in 1984, a year before HIV testing was available to sort out the positive from the negative.

Schmidt, now deceased, was a white South African who worked two years as a general practitioner in the Soweto ghettos during the 1970s. Then he moved to New York City to study psychiatry and practice psychoanalysis, and came to view AIDS as a gay disease.

"One of the major distinguishing features between epidemics of infection and epidemics of hysteria," he wrote, is that infectious epidemics "do not display an ability to follow cultural fault lines."

Schmidt did not realize at the time that the gay men developing AIDS prior to HIV testing — including many who turned out to be HIV-*negative* — were all habitual consumers of street drugs, injected or otherwise, though he did recognize they had all sorts of other medical problems, such as repetitively acquired venereal diseases. He thought the prime causes of AIDS conditions among these men were the special social pressures of gay life in the early '80s. Looking back thirteen years later with all the data that have been subsequently amassed, it's easy to overlook the factors presented by Schmidt, which probably were secondary compared to the physical assaults we now know about.

Although his psychosomatic model seems over-stated in regard to the original gay AIDS patients, it appears amazingly on-target when applied to the thousands of people — including many with no other reason to become sick — who would soon be labeled as "HIV positive."

## PSYCHOSOMATIC-AIDS AND DRUG-AIDS

Had Schmidt lived long enough to see recreational drug consumption recognized as a common denominator among the original AIDS patients he might have defined a third class of contagious illness: habitual. A habitual illness is caused by an unhealthy habit, and spreads to new individuals as unhealthy habits gain in popularity. Lung cancer from cigarette smoking, or cirrhosis from alcohol drinking, are examples. So are the effects of consuming toxic recreational and pharmaceutical drugs.

John Lauritsen has said elsewhere that different AIDS patients are sick in different ways and for different reasons. In his essay, "Psychological and Toxicological Causes of AIDS," he gives equal billing to toxicological and psychological factors

"The following profile fits most, if not necessarily all, gay men who have developed 'AIDS,'" he writes. "In the decade preceding their diagnoses they contracted venereal diseases many times, treated with ever stronger doses of antibiotics; they took antibiotics prophylactically, to avoid getting VD again; they drank too much; they used 'recreational' drugs; they smoked heavily."

The damaging components of this novel "fast lane" lifestyle, though, are not limited to unhealthy chemicals and microbes, Lauritsen argues. It also inherently includes a very negative psychological component. "Sexuality itself was reduced to fleeting encounters in baths or pitch-black rooms... [and] was expressed in ways that were morbid."

Lauritsen, like some of the other authors, promoted the gay pride movement of the 1970s. He expected its success would lead to "happiness" and healthful romantic relationships. This was not the case for those who went on to develop AIDS.

## HIV HYPNOSIS

Master hypnotherapist Michael Ellner, co-founder of HEAL, contributed an essay, "Programmed to Die: Cultural Hypnosis and AIDS," co-written with Andrew Cort.

"In our culture, doctors and the media have considerable authority, and people usually accept their suggestions," they write.

In one of his essays, Lauritsen describes the "classic elements of hypnosis" according to Ellner: perceived authority, fixation, suggestion, repetition, confusion, relaxation, imagination, and post-hypnotic suggestion. He finds that all these elements "are present in the 'Living with AIDS' campaign, in innumerable pro-

nouncements from AIDS groups and public health agencies."

It's easy to follow this rationale. People who become HIV-positive are "programmed... to become sick," writes Lauritsen. The pervasive HIV campaign provides people who test positive "with a schedule" and instructions for "exactly how and when to become sick." Ubiquitous ribbons repeatedly remind them of their instructions, mass sympathy relaxes them, and the ever-changing and increasingly complex HIV model both confuses them and appeals to their imagination.

Even believers in the HIV/AIDS hypothesis ought to appreciate the tenability of this model.

### ANOTHER DISSENTING PHYSICIAN

In addition to Schmit, there is a second physician, George Hazlehurst, who contributes to *The AIDS Cult*. Hazlehurst is an internist who worked two years with the Atomic Bomb Casualty Commission in Hiroshima in the 1950s. While there, he concluded that the excess mortality among survivors could not entirely be explained by the physical effects of radiation exposure. Today he recognizes a similar phenomenon attending "AIDS."

"Belief in early death is a cause of early death," he writes. Those branded as having been exposed to the atomic bomb blasts were convinced they were doomed, as are people today who get branded HIV-positive. "The certain doom associated with HIV positivity does itself cause eventual AIDS... [a] crash [of the] immune system."

Hazlehurst dismisses a pathological role of any sort for HIV and, like the other authors, does not regard psychological factors as the only AIDS causes. He points to "treatment with powerful drugs" to combat "an entirely fictional AIDS virus" as a physical cause of AIDS conditions brought on by an HIV diagnosis.

As for AIDS cases diagnosed before HIV testing, "something did cause the outbreak of AIDS, but it wasn't HIV," he says without offering an alternative explanation. (Is he unaware that those patients were connected to street drugs and other factors?)

The psychological consequence of the HIV-positive brand Hazlehurst calls a "hex" is part of "a glorification of HIV/AIDS... [promoted by] a huge cult of true believers in their own doom, and they will permit no interference in this mind set. They sympathize with and support one another with religious fervor, feeling they have finally discovered the meaning and purpose of their lives... purpose for lives that may have lacked such qualities before... taking on heroic proportions as kinds of martyrs."

Schmidt shares this view of mass ritual killing. "Anything that threatens to resolve the situation is fought bitterly as if it were the enemy," he says. "If you go to a primitive tribe where they are about to sacrifice fourteen babies [and try to stop them]... they'd kill you on the spot! Because you are interfering with their sacrificial ritual."

### NO ROLE FOR HIV

Schmidt also shares Hazlehurst's view of HIV as a non-pathogen. Given that he wrote his essay in 1984, just months after the famous press conference in which Robert Gallo announced the HIV model, Schmidt's take is eerily prophetic. "The virus which has been discovered is probably just another opportunistic infection," he said, "and plays, if at all, only a late role in the causal chain of AIDS."

Hazlehurst initially accepted the HIV model. His first essay in the collection proposed that AIDS resulted from two sources, the biological activity of HIV and the "hex" that went along with a positive HIV test. By the time of his second essay, a sequel to the first, he'd considered enough data to discard a role for HIV.

"What happens when a mistake is made at the top of the medical hierarchy?" he asks. "Disaster, widespread disaster, affecting the very lives of a great multitude of people. This is exactly what has happened in the HIV/AIDS fiasco: A gross mistake in the cause of AIDS attributed to a relatively innocuous virus."

### GAY-AIDS

Collectively the book proposes two psychological sources of AIDS. One affects people who test positive for HIV — the HIV hex — and the other operates prior to the identification of HIV.

The pre-HIV psychosomatic factor offered here is specific to gay men. Lauritsen is one of the first to note on record — and he repeats his observation here — that "it is only a very small, particular subset of gay men who are getting sick."

The drug-based fast lane already described was "extremely unhealthy psychologically," he says. Schmidt concurs, citing profound "guilt over sexual and addictive excesses" that were unseen prior to the gay liberation movement of the early 1970s.

Lauritsen relates how he'd spoken over the years to hundreds of gay AIDS patients and how they responded to his profile of them. "Always I have asked if there were any to whom my risk-profile did not apply," he writes. "The overwhelming audience response has been that the profile was right on target. I have encountered only a handful of exceptions. One man said he had not used drugs; it turned out he didn't have 'AIDS,' but was merely HIV-positive. The others were not speaking of themselves — to whom the profile did apply — but about friends or acquaintances they imagined were 'not like that.'"

Michael Callen, the famous New York gay activist who died a few years ago, supports Lauritsen's claim in his own essay: "I have gone to a great deal of trouble to find these people who claim to [not fit Lauritsen's profile], I found ten of them in all, and each one ended up telling me they had been lying."

That's quite an endorsement from someone who, according to Lauritsen, personally knew as many gay AIDS patients as anyone ever has. Lauritsen says he once asked his friend Callen if he'd ever encountered a gay man with AIDS who did not fit the profile. "His answer was: 'No. Not in eleven years.'"

### "TREATMENT REJECTIONISTS"

The March 21 issue of *AIDS Treatment Activism* made the following encouraging claim:

"Growing numbers of people with HIV are now dropping out of almost all medical care — i.e., rejecting the drug cocktails about which there has been so much hype — because they believe the ideology that HIV is not the cause of AIDS, and that almost all mainstream AIDS organizations, activist organizations, and physicians are part of a huge conspiracy 'worse than Lysenko' to defraud the public of billions of dollars."

The article branded such people as "treatment rejectionists," a term that is growing in currency among those with conventional views of AIDS.

*The AIDS Cult* presents a long list of reasons why fast-laners (both positive and negative for HIV) should, as Lauritsen says, "get sick in ways that are called AIDS": recreational and prescription drugs, assorted infections, a degrading, self-loathing attitude. Omitted from discussion is rectal insemination, which some scientists think can cause AIDS conditions when practiced to the excess that Lauritsen describes in his profile as "morbid."

"There is nothing wrong with all-male sex," Lauritsen asserts, "though like anything else it should be conducted in accordance with common sense and rational ethical standards."

This statement does not contradict the hypothesis that rectal insemination from a wide variety of donors can significantly suppress immune function. The original gay AIDS patients had hundreds of anal sex partners. It makes sense to Lauritsen that this excess could cause psychosomatic pathologies qualifying as "AIDS." Why not direct physical problems?

He does acknowledge one: pain. "Poppers facilitate anal intercourse by relaxing the muscles in the rectum and deadening the sense of pain."

Why would a book subtitled *Essays on the Gay Health Crisis* not directly address the rectal insemination issue? Perhaps because of the nature of this debate among AIDS reappraisers. Those who express opinions in favor of rectal insemination as an AIDS cause receive from those who disagree the sort of angry fist-shaking and name-calling all reappraisers get from the HIV cultists. Even *gays* who advance this view are called "homophobes" by some of their fellow gay reappraisers.

## SENSIBLE MEN

Lauritsen notes that the psychosomatic-AIDS and drug-AIDS hypotheses presented here have not been tested rigorously by scientists. "The existing medical literature is hopelessly inadequate to evaluate the consequences of such prodigious chemical intake. No one ~~(except for a few underground chemists) even knows~~ what many of the drugs were, to say nothing of the bewildering and varying combinations in which they were consumed, and their interactions with a confounding array of antibiotics."

He continues: "Is it likely that any researcher will conduct a study to evaluate the long-term toxicities of [all these drugs] in combination? The only thing of which we can be sure is that this kind of drug abuse is very bad for the health."

Lauritsen just as sensibly addresses the equally untested "immunological overload hypothesis." This idea holds that the repeated bouts of hepatitis, herpes, gonorrhea, etc. that typify the health histories of gay AIDS patients can batter down the immune system until it collapses.

"There is no doubt an element of truth in the hypothesis," he concludes. "Diseases take their toll on the body, and no rational person would allow himself to contract VD all the time."

Schmidt also assumed that this aspect of the gay fast lane had something to do with AIDS. In his essay he presents graphs ~~showing~~ that since 1960, low, steady rates of syphilis, gonorrhea, suicide, and amebiasis among gays rose steadily to levels five or more times higher by 1980.

As for the antibiotics prescribed repeatedly for recurrent bouts of VD and sexually spread enteric infections, Lauritsen says "There is a blind spot, especially among physicians, regarding the role of medical treatments in making people sick."

Michael Callen similarly regards the pharmaceuticals prescribed to people who test HIV-positive. "I do not understand the current drugs-into-bodies frenzy," he writes. "The activists only seem to talk about two possible outcomes to taking an experimental drug: one is that it works and the other is that it doesn't work. But there is a third, much more common possibility, which is that you will be worse off than if you did nothing at all."

Such views used to be considered common sense. In the age of AIDS, they are not considered at all — or branded as dangerous and crazy. And that is madness, of the sort that Charles Mackay warned about in the opening quotation. *—Paul Philpott*

## PHILADELPHIA REAPPRAISER

British-born Philadelphia therapist Pam Ladds has had a largely gay and lesbian clientele since the 1970s, and today many of her patients are HIV-positive.

She never bought the party line, even in 1981, when it was first proposed that a contagious new syndrome of immune deficiency was spreading among gays. After studying the medical literature, she concluded that "HIV is frequently the least of peoples' problems." (She doesn't consider herself knowlegable enough about microbiology to dismiss HIV entirely.)

The proposal that recreational drug use was the real cause of AIDS among gays matched her personal and professional knowledge about the health histories of individual gay men. "The ones I knew who were developing AIDS in the early years were doing lots of drugs," she recalls. "Those who didn't stayed healthy."

Ladds thinks that too much receptive anal sex with too many men can also play a causal role, "although it is socially unacceptable to express such an opinion."

Not until HIV testing was introduced in 1985 did Ladds notice AIDS spreading to gays who were chemically and sexually moderate. "The only mistake bigger than blaming HIV," she says, "is prescribing immune-destroying chemotherapies like AZT to everyone who tests positive."

"When I was a student nurse, a woman came into the hospital where I was interning on her 60th birthday," Ladds recalls. "She insisted that she was going to die, but presented no symptoms, had no specific complaint, and the doctors found nothing wrong with her. But she got so sick anyway, we had to admit her, and her health deteriorated over several weeks, and she died right there at the hospital. Later I found out from her family that when she was 23, a clairvoyant told her that she would die when she was 60."

Ladds calls this voodoo death, and thinks this explains a lot of AIDS cases. Her word for it is "FRAIDS."

Ladds believes that AIDS in other groups can also be explained by non-HIV factors. For example, she thinks AIDS in India, which she has visited, might be "just a new name for an old problem of malnutrition and abysmal sanitation. This might also explain some cases of AIDS in American inner cities as well." — *Paul Philpott*

# THE 60 MINUTES PROF

## *Notes from med school*

*A medical student submitted this article under the condition that his name, and the name of his school, be withheld to protect agaisnt censure.*

In January our director of the Internal Medicine Department presented an "Integrative Clinical Correlations" lecture designed to integrate all the microbiology lectures from the previous semester and to add some clinical applicability.

Inevitably the professor got around to talking about AIDS. He issued the usual contrived statistics and outright falsehoods in order to claim that the number of AIDS cases was skyrocketing and that it was now a disease affecting all segments of society. He warned that as health care providers, we were especially at risk.

He relayed a story that had aired on *60 Minutes* the previous Sunday. The story centered on a physician who had supposedly contracted AIDS while performing surgery on an HIV-positive patient.

According to the professor, the doctor's T-cell count plummeted to alarmingly low levels after becoming HIV-positive. Then the doctor started taking the AZT/protease inhibitor cocktails and his T-cells rose to levels *above* normal!

The lesson was that HIV is very dangerous and that the cocktail therapies are effective.

This version of events directly contradicted everything I understood about AZT, AIDS, and HIV. I wanted to challenge the lesson, but I had not seen the *60 Minutes* episode, so I felt uneasy about questioning my professor about it. But I had to ask anyway.

"Excuse me, Professor?"

"Yes."

"Was it documented that this physician's T-cell count did indeed drop *before* he was put on AZT, or is it possible that it fell *after* he started taking AZT?"

"Oh, well, uhhhh. No, it must have fallen *before* the AZT. That's what this shows: that the new drug combination is great in treating AIDS and boosting T-cell counts."

"Well, how can a nucleoside analog stimulate T-cell production? Doesn't AZT terminate polymerization?" [Polymerization is the technical term for constructing DNA from DNA building blocks. Nucleoside analogs, including AZT, prevent both T-cell polymerase and HIV reverse transcriptase from polymerizing, and consequently kill both T-cells and HIV.]

"No, AZT is a reverse-transcriptase inhibitor."

"But AZT was originally designed as a chemotherapy against leukemia, long before we even knew that HIV existed!" [Leukemia is unrestrained proliferation of immune cells, including T-cells, and AIDS is considered mass death of T-cells.]

"Well, AZT is an inhibitor of reverse transcriptase. I don't know about this chemotherapy claim of yours. I don't want the students here to get confused."

It looked like I didn't know what I was talking about, but *he* was the one who was confused... and confusing his students.

As we filed out of the classroom, I was approached by two classmates, one after the other. Each told me separately that they had seen the *60 Minutes* program, and that the physician had actually made a pointed effort to find a doctor who would treat him immediately and aggressively with AZT.

My professor had saved face by inventing claims that were false, and in the process misled over 100 future physicians.

## *Reappraising Web Sites*

HEAL United: thorup.com/HEAL/healindex.html
AIDS Authority: www.aidsauthority.org/library
HEAL-LA:
www.geocities.com/WestHollywood/1781/healfacts.html
AIDS Journalism Review: www.refuse-resist.com/iajr
HIV=AIDS Controversy:
alumni.umbc.edu/~akoont1/tmh/hivcont2.html
Rethinking AIDS: www.xs4all.nl/%7Eraido/index.htm

## HEAL (Health Education AIDS Liaison)

HEAL is an international network of independent groups challenging the validity of the HIV/AIDS hypothesis, the accuracy of HIV tests and the efficacy of HIV-based protocols as treatments or preventions for AIDS.

To obtain an information catalog, a complete list of HEAL chapters in 20 North American cities and three countries around the world, local seminar schedules or other information, call:

| HEAL-LA | HEAL-New York | HEAL-Seattle |
|---|---|---|
| (213) 896-8260 | (212) 873-0780 | (206) 391-6910 |

For a copy of the new expanded and revised edition of *What If Everything You Thought You Knew About AIDS Was Wrong?*, a concise and compelling introduction to the HIV/AIDS debate, send $7.95 plus $1.00 shipping to:
HEAL 11684 Ventura Blvd., Studio City, CA 91604.




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