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Why I Quit HIV

By Rebecca V. Culshaw

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As I write this, in the late winter of 2006, we are more than twenty years into the AIDS era. Like many, a large part of my life has been irreversibly affected by AIDS. My entire adolescence and adult life — as well as the lives of many of my peers — has been overshadowed by the belief in a deadly, sexually transmittable pathogen and the attendant fear of intimacy and lack of trust that belief engenders.

To add to this impact, my chosen career has developed around the HIV model of AIDS. I received my Ph.D. in 2002 for my work constructing mathematical models of HIV infection, a field of study I entered in 1996. Just ten years later, it might seem early for me to be looking back on and seriously reconsidering my chosen field, yet here I am.

My work as a mathematical biologist has been built in large part on the paradigm that HIV causes AIDS, and I have since come to realize that there is good evidence that the entire basis for this theory is wrong. AIDS, it seems, is not a disease so much as a sociopolitical construct that few people understand and even fewer question. The issue of causation, in particular, has become beyond question — even to bring it up is deemed irresponsible.

Why have we as a society been so quick to accept a theory for which so little solid evidence exists? Why do we take proclamations by government institutions like the NIH and the CDC, via newscasters and talk show hosts, entirely on faith? The average citizen has no idea how weak the connection really is between HIV and AIDS, and this is the manner in which scientifically insupportable phrases like "the AIDS virus" or "an AIDS test" have become part of the common vernacular despite no evidence for their accuracy.

When it was announced in 1984 that the cause of AIDS had been found in a retrovirus that came to be known as HIV, there was a palpable panic. My own family was immediately affected by this panic, since my mother had had several blood transfusions in the early 1980s as a result of three late miscarriages she had experienced. In the early days, we feared mosquito bites, kissing, and public toilet seats. I can still recall the panic I felt after looking up in a public restroom and seeing some graffiti that read "Do you have AIDS yet? If not, sit on this toilet seat."

But I was only ten years old then, and over time the panic subsided to more of a dull roar as it became clear that AIDS was not as easy to "catch" as we had initially believed. Fear of going to the bathroom or the dentist was replaced with a more realistic wariness of having sex with anyone we didn't know really, really well. As a teenager who was in no way promiscuous, I didn't have much to worry about.

That all changed — or so I thought — when I was twenty-one. Due to circumstances in my personal life and a bit of paranoia that (as it turned out, falsely and completely groundlessly) led me to believe I had somehow contracted "AIDS," I got an HIV test. I spent two weeks waiting for the results, convinced that I would soon die, and that it would be "all my fault." This was despite the fact that I was perfectly healthy, didn't use drugs, and wasn't promiscuous — low-risk by any definition. As it happened, the test was negative, and, having felt I had been granted a reprieve, I vowed not to take more risks, and to quit worrying so much.

Over the past ten years, my attitude toward HIV and AIDS has undergone a dramatic shift. This shift was catalyzed by the work I did

as a graduate student, analyzing mathematical models of HIV and the immune system. As a mathematician, I found virtually every model I studied to be unrealistic. The biological assumptions on which the models were based varied from author to author, and this made no sense to me. It was around this time, too, that I became increasingly perplexed by the stories I heard about long-term survivors. From my admittedly inexpert viewpoint, the major thing they all had in common — other than HIV — was that they lived extremely healthy lifestyles. Part of me was becoming suspicious that being HIV-positive didn't necessarily mean you would ever get AIDS.

By a rather curious twist of fate, it was on my way to a conference to present the results of a model of HIV that I had proposed together with my advisor, that I came across an article by Dr. David Rasnick about AIDS and the corruption of modern science. As I sat on the airplane reading this story, in which he said "the more I examined HIV, the less it made sense that this largely inactive, barely detectable virus could cause such devastation," everything he wrote started making sense to me in a way that the currently accepted model did not. I didn't have anywhere near all the information, but my instincts told me that what he said seemed to fit.

Over the past ten years, I nevertheless continued my research into mathematical models of HIV infection, all the while keeping an ear open for dissenting voices. By now, I have read hundreds of articles on HIV and AIDS, many from the dissident point of view but far, far more from that of the establishment, which unequivocally promotes the idea that HIV causes AIDS and that the case is closed. In that time, I even published four papers on HIV (from a modeling perspective). I justified my contributions to a theory I wasn't convinced of by telling myself these were purely theoretical, mathematical constructs, never to be applied in the real world. I suppose, in some sense also, I wanted to keep an open mind.

So why is it that only now have I decided that enough is enough, and I can no longer in any capacity continue to support the paradigm on which my entire career has been built?

As a mathematician, I was taught early on about the importance of clear definitions. AIDS, if you consider its definition, is far from clear, and is in fact not even a consistent entity. The classification "AIDS" was introduced in the early 1980s not as a disease but as a surveillance tool to help doctors and public health officials understand and control a strange "new" syndrome affecting mostly young gay men. In the two decades intervening, it has evolved into something quite different. AIDS today bears little or no resemblance to the syndrome for which it was named. For one thing, the definition has actually been changed by the CDC several times, continually expanding to include ever more diseases (all of which existed for decades prior to AIDS), and sometimes, no disease whatsoever. More than half of all AIDS diagnoses in the past several years in the United States have been made on the basis of a T-cell count and a "confirmed" positive antibody test — in other words, a deadly disease has been diagnosed over and over again on the basis of no clinical disease at all. And the leading cause of death in HIV-positives in the last few years has been liver failure, not an AIDS-defining disease in any way, but rather an acknowledged side effect of protease inhibitors, which asymptomatic individuals take in massive daily doses, for years.

The epidemiology of HIV and AIDS is puzzling and unclear as well. In spite of the fact that AIDS cases increased rapidly from their initial observation in the early 1980s and reached a peak in 1993 before declining rapidly, the number of HIV-positive individuals in the U.S. has remained constant at one million since the advent of widespread HIV antibody testing. This cannot be due to anti-HIV therapy, since the annual mortality rate of North American HIV-positives who are treated with anti-HIV drugs is much higher — between 6.7 and 8.8% — than would be the approximately 1–2% global mortality rate of HIV-positives if all AIDS cases were fatal in a given year.

Even more strangely, HIV has been present everywhere in the U.S., in every population tested including repeat blood donors and military recruits, at a virtually constant rate since testing began in 1985. It is deeply confusing that a virus thought to have been brought to the AIDS epicenters of New York, San Francisco and Los Angeles in the early 1970s could possibly have spread so rapidly at first, yet have stopped spreading completely as soon as testing began.

Returning for a moment to the mathematical modeling, one aspect that had always puzzled me was the lack of agreement on how to accurately represent the actual biological mechanism of immune impairment. AIDS is said to be caused by a dramatic loss of the immune system's T-cells, said loss being presumably caused by HIV. Why then could no one agree on how to mathematically model the dynamics of the fundamental disease process — that is, how are T-cells actually killed by HIV? Early models assumed that HIV

killed T-cells directly, by what is referred to as lysis. An infected cell lyses, or bursts, when the internal viral burden is so high that it can no longer be contained, just like your grocery bag breaks when it's too full. This is in fact the accepted mechanism of pathogenesis for virtually all other viruses. But it became clear that HIV did not in fact kill T-cells in this manner, and this concept was abandoned, to be replaced by various other ones, each of which resulted in very different models and, therefore, different predictions. Which model was "correct" never was clear.

As it turns out, the reason there was no consensus mathematically as to how HIV killed T-cells was because there was no biological consensus. There still isn't. HIV is possibly the most studied microbe in history — certainly it is the best-funded — yet there is still no agreed-upon mechanism of pathogenesis. Worse than that, there are no data to support the hypothesis that HIV kills T-cells at all. It doesn't in the test tube. It mostly just sits there, as it does in people — if it can be found at all. In Robert Gallo's seminal 1984 paper in which he claims "proof" that HIV causes AIDS, actual HIV could be found in only 26 out of 72 AIDS patients. To date, actual HIV remains an elusive target in those with AIDS or simply HIV-positive.

This is starkly illustrated by the continued use of antibody tests to diagnose HIV infection. Antibody tests are fairly standard to test for certain microbes, but for anything other than HIV, the main reason they are used in place of direct tests (that is, actually looking for the bacteria or virus itself) is because they are generally much easier and cheaper than direct testing. Most importantly, such antibody tests have been rigorously verified against the gold standard of microbial isolation. This stands in vivid contrast to HIV, for which antibody tests are used because there exists no test for the actual virus. As to so-called "viral load," most people are not aware that tests for viral load are neither licensed nor recommended by the FDA to diagnose HIV infection. This is why an "AIDS test" is still an antibody test. Viral load, however, is used to estimate the health status of those already diagnosed HIV-positive. But there are very good reasons to believe it does not work at all. Viral load uses either PCR or a technique called branched-chained DNA amplification (bDNA). PCR is the same technique used for "DNA fingerprinting" at crime scenes where only trace amounts of materials can be found. PCR essentially mass-produces DNA or RNA so that it can be seen. If something has to be mass-produced to even be seen, and the result of that mass-production is used to estimate how much of a pathogen there is, it might lead a person to wonder how relevant the pathogen was in the first place. Specifically, how could something so hard to find, even using the most sensitive and sophisticated technology, completely decimate the immune system? bDNA, while not magnifying anything directly, nevertheless looks only for fragments of DNA believed, but not proven, to be components of the genome of HIV — but there is no evidence to say that these fragments don't exist in other genetic sequences unrelated to HIV or to any virus. It is worth noting at this point that viral load, like antibody tests, has never been verified against the gold standard of HIV isolation. bDNA uses PCR as a gold standard, PCR uses antibody tests as a gold standard, and antibody tests use each other. None use HIV itself.

There is good reason to believe the antibody tests are flawed as well. The two types of tests routinely used are the ELISA and the Western Blot (WB). The current testing protocol is to "verify" a positive ELISA with the "more specific" WB (which has actually been banned from diagnostic use in the UK because it is so unreliable). But few people know that the criteria for a positive WB vary from country to country and even from lab to lab. Put bluntly, a person's HIV status could well change depending on the testing venue. It is also possible to test "WB indeterminate," which translates to any one of "uninfected," "possibly infected," or even, absurdly, "partly infected" under the current interpretation. This conundrum is confounded by the fact that the proteins comprising the different reactive "bands" on the WB test are all claimed to be specific to HIV, raising the question of how a truly uninfected individual could possess antibodies to even one "HIV-specific" protein.

I have come to sincerely believe that these HIV tests do immeasurably more harm than good, due to their astounding lack of specificity and standardization. I can buy the idea that anonymous screening of the blood supply for some nonspecific marker of ill health (which, due to cross reactivity with many known pathogens, a positive HIV antibody test often seems to be) is useful. I cannot buy the idea that any individual needs to have a diagnostic HIV test. A negative test may not be accurate (whatever that means), but a positive one can create utter havoc and destruction in a person's life — all for a virus that most likely does absolutely nothing. I do not feel it is going too far to say that these tests ought to be banned for diagnostic purposes.

The real victims in this mess are those whose lives are turned upside-down by the stigma of an HIV diagnosis. These people, most of whom are perfectly healthy, are encouraged to avoid intimacy and are further branded with the implication that they were somehow dreadfully foolish and careless. Worse, they are encouraged to take massive daily doses of some of the most toxic drugs ever manufactured. HIV, for many years, has fulfilled the role of a microscopic terrorist. People have lost their jobs, been denied entry into

manufactured. HIV, for many years, has fulfilled the role of a microscopic terrorist. People have lost their jobs, been denied entry into the Armed Forces, been refused residency in and even entry into some countries, even been charged with assault or murder for having consensual sex; babies have been taken from their mothers and had toxic medications forced down their throats. There is no precedent for this type of behavior, as it is all in the name of a completely unproven, fundamentally flawed hypothesis, on the basis of highly suspect, indirect tests for supposed infection with an allegedly deadly virus — a virus that has never been observed to do much of anything.

As to the question of what does cause AIDS, if it is not HIV, there are many plausible explanations given by people known to be experts. Before the discovery of HIV, AIDS was assumed to be a lifestyle syndrome caused mostly by indiscriminate use of recreational drugs. Immunosuppression has multiple causes, from an overload of microbes to malnutrition. Probably all of these are true causes of AIDS. Immune deficiency has many manifestations, and a syndrome with many manifestations is likely multicausal as well. Suffice it to say that the HIV hypothesis of AIDS has offered nothing but predictions — of its spread, of the availability of a vaccine, of a forthcoming animal model, and so on — that have not materialized, and it has not saved a single life.

After ten years involved in the academic side of HIV research, as well as in the academic world at large, I truly believe that the blame for the universal, unconditional, faith-based acceptance of such a flawed theory falls squarely on the shoulders of those among us who have actively endorsed a completely unproven hypothesis in the interests of furthering our careers. Of course, hypotheses in science deserve to be studied, but no hypothesis should be accepted as fact before it is proven, particularly one whose blind acceptance has such dire consequences.

For over twenty years, the general public has been greatly misled and ill-informed. As someone who has been raised by parents who taught me from a young age never to believe anything just because "everyone else accepts it to be true," I can no longer just sit by and do nothing, thereby contributing to this craziness. And the craziness has gone on long enough. As humans – as honest academics and scientists – the only thing we can do is allow the truth to come to light.

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The Best of Rebecca V. Culshaw
