

CONTINUUM



**Eleopulos
interviewed**



**Witchboy
confessions**



**Detoxifying
your liver**

CONTINUUM

changing the way we think about aids

why CONTINUUM?

The orthodox view on AIDS holds that it is caused by a virus known as HIV that is transmitted through the exchange of body fluids. Once infected, a person will remain well for a time, though infectious to others, before going on to develop AIDS and dying. Despite the huge sums of money spent on medical research, there is still no cure, just drug therapies said to slow the progress of the disease, and regular T-cell counts to measure health.

A whole industry has evolved around AIDS, on which many careers and businesses depend, but which offers little hope to those affected. It works on the premise that HIV=AIDS=DEATH.

CONTINUUM began as a newsletter encouraging those effected to empower themselves to make care and treatment choices. As we look further, anomalies in the orthodox view continue to appear.

Are you aware, for example, that the link between HIV and AIDS has never been more than hypothetical? That a growing body of scientists and doctors throughout the world doubt that HIV causes AIDS?

At the onset of the "epidemic", the hysteria that resulted from the linking of sex, death and an infectious virus created a climate where to question the "facts" was considered reprehensible. Many of those who dared to do so were silenced or ridiculed.

Since the growth of the orthodoxy, those who question have also had to contend with the weight of vested interests.

Twelve years after HIV was first associated with AIDS many predictions based on the viral hypothesis are failing to materialise.

CONTINUUM is a unique forum for those in the scientific community challenging the orthodoxy and those whose lives have in some way been touched by the hypothesis.

CONTINUUM is a voluntary organisation dedicated to providing information we believe is necessary for the fuller understanding of HIV, AIDS and immunity. All our workers are unpaid and the organisation relies on subscriptions and donations to maintain its work. Your

focus

INTERVIEW

Leading AIDS analyst and biophysicist **Eleni Papadopulos-Eleopulos** speaks to CHRISTINE JOHNSON about her group's scientific papers and their views on 'HIV' itself

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vol 5, no 1
autumn 1997



PHOTO: Mapplethorpe

The Wrestler: grappling with the implications as the body of evidence comes into focus.

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Dissident fogeys? asks JOAN SHENTON

a magazine by the living for the living

Staff drugs warning

An Information Sheet For Staff Receiving Post-Exposure Prophylaxis – combination therapy – from Chelsea & Westminster Hospital, London, says: "There is a risk of serious side effects associated with the drugs offered in this policy... [which] could be life-threatening or irreversible. The drugs lamivudine and indinavir ...[may have] side effects, including cancer, birth defects and other life-threatening diseases..."

HIV/GUM Directorate 4 Sept 96

Combos fail

A meeting of the American Society of Microbiology in Toronto has said combination therapy is failing in over 50% of patients. Data from San Francisco General Hospital and elsewhere is "far different" from drug company trials, they said. "Over the past year, we had a honeymoon period," said Dr David Deeks.

Associated Press 29 Sept 97

New legislation

A new German law would grant alternative medical treatments the same scientific status as orthodox medicine after an evaluation "according to the current state of scientific knowledge in that particular form of therapy". New alternative treatments would be evaluated by specialists from the relevant branch of alternative medicine, i.e. "peer recognition". Advocates say the law is necessary to promote "pluralism" in committees deciding the validity of new treatments.

New Scientist 20 Sept 97

Bad transmission

A new paper *Heterosexual transmission of HIV* (Padian *et al*) states: "We estimate that infectivity for male-to-female transmission is low, approximately 0.0009 [sic] per contact, and that infectivity for female-to-male is even lower". The figure agrees with previous estimates for heterosexual 'transmission', about 1 in 1000.

Am. J. of Epidem. 15 Aug 97

Or be damned

Medical researchers are allowing outcomes of studies to influence their judgments about worthiness for publication. Says Ian Roberts, a paediatrician at the Institute of Child Health, London, not reporting research is "serious misconduct on a grand scale. If you do experiments on living people and don't publish, you are guilty of serious wrongdoing". A global 'trial amnesty' will be launched in Prague this year by 100 science editors. Their message: send your unpublished trials and we'll register their existence in a central database – no questions asked.

New Scientist 13 Sept 97

Pictures explode isolation claims

Two historic papers in the leading science journal *Virology* in March this year provide astonishing new data on the purification and isolation of HIV. For the first time in the history of AIDS, elusive electron microscope images of 'HIV' collected or 'banded' at the official density required for retroviruses, 1.16gm/ml, have been published, by a research group in Germany. The electronmicrographs disclose "major contaminants" in "pure HIV".

HIV expert Hans Gelderblom of Berlin's Robert Koch Institute, whose photos of non-banded 'HIV' material

have been the industrial benchmark since 1987, co-authored the first paper which describes the contamination as "an excess of vesicles" – particles of cellular proteins, that may contain DNA or RNA. In a consecutive paper, a US research team from the AIDS Vaccine Programme in Maryland reveal carefully, "It is unknown how these cellular proteins associate with the virus" and warn, "The presence of microvesicles in purified retroviruses has practical implications": both teams discuss the resulting non-specificity of HIV tests, all of which are based on early

unchecked "purified HIV".

In an historic admission that it has never been established which proteins constitute 'HIV', the US scientists conclude, "The development of various purification strategies to separate microvesicles from HIV-particles ... will greatly enhance our ability to identify virion-associated cellular proteins." The imaging step in attempts at retroviral isolation was deemed essential when isolation procedure was discussed and decided at the Pasteur Institute, Paris in 1972, but it has never been published before in the 13-year history of 'HIV'.

Fresh UN Action

U.S.-based International Education Development Inc. (IED) and *Continuum* presented a second Urgent Appeal For Action to the U.N. Sub-commission on Human Rights in Geneva on 13th August, over combination 'antiviral therapy' for 'HIV/AIDS'. Under Agenda Item 5, Women and Children, representation was made that the anti-HIV drug AZT is being given to pregnant women and newborn babies especially in African countries without proper information on the drug's lethal effects: these include as reported by Britain's Medical Research Council a 25% higher mortality in people on AZT than in their untreated equivalents. The Subcommission heard withholding information regarding long-term effects of these drugs is a gross violation of the right to life, liberty and security under the UN Charter of Human Rights, Article 3.

The appeal speech was delivered by international activist and *Continuum* Executive Committee member Michael Baumgartner and was well received by other participating NGOs. Baumgartner sees alerting

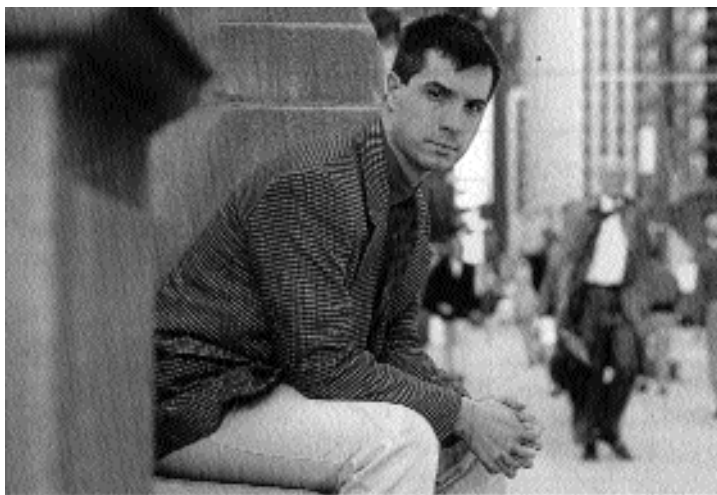
policy makers and populations in developing countries to the unethical global promotion of 'AIDS' drug-regimes as part of the value of the Geneva meetings. He told the Sub-commission, "The medical authorities violate the highest medical standard, the Hippocratic Oath, by prescribing AZT, discredited on several counts. Based on unscientific assertions and fraudulent drug licensing processes, women get exposed to treatment with AZT as a presumed way of preventing the suspected transmission of 'HIV' from mother to child. The treatment with AZT proves especially dangerous to pregnant women." The next Appeal will be made next March before the Human Rights Commission.

Remarkably, influential UK broadsheet *The Guardian* has reported that United States and European governments have been accused in the *New England Journal of Medicine* of unethical medical experiments on thousands of 'HIV-infected' pregnant women in Africa, Asia and the Caribbean – however not because they were being given AZT but because in most studies half were given placebo instead ('American

AIDS trials run into ethics fury' 19 Sept). Urging uniform prescription of AZT, Dr Peter Lurie of a Washington-based advocacy group Public Citizen is quoted as saying, "We have turned our backs on these mothers and their babies."

The highly contentious experiments are part of a programme of 15 trials which have been conducted for the past two years on more than 12,000 women in 11 developing countries. Nine studies have been financed by the US government, two by France and one each by Belgium, Denmark and South Africa. Another is funded by the UN AIDS programme. Most of the research is being conducted in Burkina Faso, Ethiopia, Ivory Coast, Kenya, Malawi, South Africa, Tanzania, Uganda and Zimbabwe. Further tests are being done in Thailand and Dominican Republic. Analysts note that as Glaxo-Wellcome's exclusive rights to make and sell AZT expire this year, future pharmaceutical profits require a market sufficiently expanded to support competition.

Copies of the comprehensive document *An Urgent Appeal for Action 2* are available from *Continuum*, £4 UK, \$8 US (inc. p&p).



José Zuniga, 28, of Chicago, is one of 50 healthworkers and activists offering to be injected with 'live HIV' vaccine. The NIH and FDA may delay approval of the experiment for up to two years. Swiss Dr Bernard Hirschel is relieved: "When I registered, it was more of an idea."

Protease hero dies

The *New York Times* reported on its front page on August 22 the death of celebrity Washington lawyer and AIDS-activist Jerry Roemer, whose much publicised "remission from AIDS" had been the public foundation for claims of a "Lazarus" effect with protease inhibitors. According to reporter Sheryl Stolberg, "Jerry Roemer was supposed to be the new face of AIDS".

After two years on sickness benefits, Roemer had started taking Saquinavir, and returned to his job as a lawyer for the US Department of Justice. Attorney General Janet Reno had called him an inspiration. In his final skeletal days in Georgetown University Medical Centre Roemer is reported as saying, "It wasn't supposed to happen this way." He died aged 32.

AIDS supremo Dr Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases in Bethesda, Maryland, currently estimates it can be supposed to happen this way up to 50% of the time. "People do quite well for six months, eight months or a year, and after a while, in a significant proportion, the virus starts to come back," he suggests. Stolberg reported Roemer's death is not an isolated tale: a year and a half after protease inhibitors came into widespread use in the USA, they already seem to be failing 25%-30% of the 150,000 people using them. Increasingly doctors are seeing people like Roemer – "diligent determined patients who tolerate the drugs and take them religiously, but for whom the apparent benefits do not last."

Roemer was diagnosed HIV positive in 1987. His partner since 1994 Mike Mancilla said of their three year relationship, "We lived our life in pursuit of accelerated joy."

Roemer is reported to have been aggressive about medication, moving from AZT monotherapy through ddI, ddC, d4T and 3TC before taking Saquinavir. His doctor, Mary Young, Acting Chief of the Division of Infectious Diseases at Georgetown's School of Medicine, explained, "We were doing what we knew at that time...There are two pieces to this whole HIV issue. One is trying to control the virus. But the bigger question is, what do we do with individuals like Jerry...The question is how do we restore their immune systems?"

New paper silences 'experts'

The British science journal *Current Medical Research and Opinion* (Vol 13, No 10, 1997) has published a paper *HIV antibodies: further questions and a plea for clarification* by Eleni Papadopulos-Eleopulos *et al* questioning the specificity of 'HIV' antibody tests. Citing references that antibodies to even the PCP organism itself can cross react with 'HIV' antigens, the peer reviewed paper also raises questions regarding 'HIV's putative viral identity. The authors conclude, "Since there is no such data proving the origin of either 'HIV' proteins or antibodies, and

since there is ample evidence that reactions between 'HIV' proteins and 'HIV' antibodies are non-specific...it is vital for the scientific community to utilise valid methods in order to prove whether the 'HIV' proteins and antibodies arise as a result of a new, unique, exogenously acquired retrovirus..."

Having received a copy of the paper from its authors, who include Glasgow University emeritus Professor of Public Health Gordon Stewart, Edward King, editor of the National AIDS Manual's *AIDS Treatment Update*, declined to comment.

The paper has also been sent to British 'AIDS' experts including Prof. Richard Tedder, Head of Virology at University College London, Derek Bodell, of the National AIDS Trust, Drs. Ian Williams and Ian Weller of the Mortimer Market Centre, UCL, and Simon Watney of the Red Hot AIDS Charitable Trust.

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Positively Drunk

A popular African alcoholic drink made from maize husk, allegedly can cause an 'HIV+' antibody result in consumers. The drink is in widespread use in the 'AIDS epicentres' of Africa. The fuanose sugars in this drink are said to mimic parts of the make-up of 'HIV', eliciting antibodies.

jlsalstrom@ucdavis.edu 16 Sept 97

Animal Suffering

Drugs giant Merck delayed marketing Protease Inhibitors for four years because the drugs killed laboratory dogs and rats, say press reports issued earlier this year. This ethically controversial data was not made available for those taking part in PI trials. Unexpected deaths amongst human PI consumers are rising in number.

Dayton Daily News /NY Times Aug 97

Virtually Positive

A report highlights one problem encountered in testing 'HIV' vaccines in clinical trials. The case involves a vaccinee, seronegative at entry into the study, whose PCR came back positive. It took a battery of tests – viral culture, nested DNA PCR, Western blot and ELISA – at a cost of US\$50,000 to confirm that the PCR test was detecting 'HIV' vaccine components and was false-positive for 'HIV infection'.

The Lancet 25 July 97

Home Tests Fizzles

In August, drugs giant Johnson & Johnson shut down the toll-free number for results from its home 'HIV' test, which was discontinued in June. Production of the Confide test stopped due to lack of consumer interest. Approved by the FDA in May '96, Confide was the first home 'HIV' test kit.

rethinkaids@uclink4.berkeley.edu Aug 97

Non-Hodgkin's Lymphoma

Studies have shown a big increase in cases of Non-Hodgkin's Lymphoma in white populations around the world. Between 1984 and 1993 the number of cases in England and Wales soared from 3,300 to 4,600 a year, an increase of 40%. Researchers say evidence is growing that the key to the trend is ultraviolet light from the sun. Non-Hodgkin's Lymphoma is an original 'AIDS' defining-illness.

The Guardian 17 Sept 97

Condom Riots

The Jamaican government sent police and troops to the country's two main jails in August after 16 prisoners died in four days of riots against inmates accused of being gay. The riots began when guards walked out in protest at a plan to give them and prisoners condoms "to stop the spread of AIDS". They said the proposal implied they were homosexual.

Guardian 25 Aug 97

For the first time an interview with arguably the most important scientist in the field of HIV/AIDS, Eleni Eleopulos, is made available. As time passes, the exceptional work of her group grows in significance. It's vital that people take the time and make the effort to understand the basis of their arguments.

So far this has been a revelatory year, giving both a sense of urgency and an expectation of a real presence for non-orthodox participants at and around next year's World AIDS Conference in Geneva, Switzerland.

Preparations are already under way to co-ordinate activists. Scientists are reminded that abstracts should be submitted by the end of January. 'HIV' theories of 'AIDS' and attendant pharmaceutical interventions must not be allowed unchallenged sway in the reporting of the meeting, or indeed in its proceedings.

In *Sound Mind, Sound Body*, Dr Kenneth Pelletier writes, "Transforming crises into a positive influence, either during childhood or adulthood, is not achieved through a naive conception of the 'power of positive thinking' or by denial. Crises need to be acknowledged and accepted as normal. Positive meaning and understanding can be derived from these experiences, if they are not repressed. It is possible to achieve a positive outcome even without professional help, self-help groups, or an extended family." If there has been an era of collective repression, it is certainly soon to end.

This issue marks the start of a seasonal timetable of four magazines per year. This change will make it possible to eke out resources, and for us volunteers to take time to develop our personal lives, as Mark Griffiths explained was his course in his powerful *Lust for Life* in this issue. We look forward to the winter issue with excitement, trusting this one will provide nourishment for a balanced diet of contemplation and action until then.

Huw Christie

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by
**Lesley Cooper
and Martin Walker**

In the last issue of *Continuum*, Alex Russell, AIDS activist and editor of *Death Camp* climbed into bed with Elaine Showalter, the populist post modern academic and author of *Hystories: Hysterical Epidemics*, Picador 1997. We think this was a big mistake. (Dissenting View: Communicable Dis-ease. *Continuum*, vol 4, no 6, June/July 1997).

Showalter is a member of a group of critics, historians and anthropologists informally known as the 'New Hysterians'. The thesis of her most recent much publicised book, is that throughout history hysteria has served as a form of expression for people who are unable to give voice to their feelings.

Whilst psychiatrists generally debunked the concept of hysteria in the post-freudian, feminist seventies and eighties, the New Hysterians of the nineties insist that the condition is still with us but like 'HIV' has cleverly taken on new forms. They argue that hysterics' conversion symptoms differ across time because individuals collage together manifestations drawing from a contemporary 'symptom pool'. According to Showalter, hysteria in the 1990s has coalesced psychological epidemics around contemporary archetypal themes, such as multiple personality syndrome, satanic ritual abuse, alien abduction, Gulf War Syndrome (GWS) and such 'new' illnesses as Chronic Fatigue Syndrome (CFS) or ME.

These cultural narratives of hysteria, Showalter says, have multiplied uncontrollably in the 1990s and, in the name of rationalism, must be stopped. A number of scientifically based, campaigning groups such as CSICOP (The Committee for Scientific Investigation of Claims of the Paranormal) and the American National Council Against Health Fraud together with its British sibling, HealthWatch, have historically fought this corner, transforming scientifically and industrially unpalatable illnesses into psychiatric disorders. Although Showalter does not mention these groups in her book, she offers the same solutions for the 'victim' or 'sufferer': 'good therapists', the countering of 'sensational news reports, rumour and fear', and a stern dose of taking responsibility for your own inadequacies.

In his dissenting voice article, Russell, like Schmidt in *The AIDS Cult* (Lauritsen & Young 1977, Asklepios, Ma. USA), argues that AIDS is an example of epidemic hysteria, or a psychogenic epidemic. He suggests that gay men are suffering from a 'group fantasy of a poison threat', of which the key poison, 'HIV' is posited as a 'demon' or irrational belief. Russell writes, 'many gay men become ill because their mental and emotional resources are depleted. Recreational drugs ... lead to depression and alienation which in turn induces psychosomatic conditions which in the presence of the bogus HIV positive results are absurdly nominated as 'AIDS' - compounding their 'condition'.'

It is wholly comprehensible that dissenting activists especially those who sail close to post modernism like Russell, in their desire to deconstruct the hysterical paradigm of HIV=AIDS = DEATH, would turn to Showalter. Showalter's theories appear at first glance to assist lay activists in regaining power and knowledge from a deeply tainted biomedical scientific establishment. Indeed, we empathise when Russell takes up Showalter's cry that 'knowledge is the cure' as a heartfelt response to the 'HIV' bone pointing of scientific medicine.

The real and the illusory phenomena of AIDS, however, exist on many levels, from its possible bio-medical scientific cause to the socially constructed illusion of a single disease epidemic, which epidemiologists projected would wipe out heterosexual

Whose hysteria?

America. It is important to separate the hysterical from the real in the different levels of narrating AIDS.

It may be the case that some gay men are tempted to take up AIDS as a tragic mask and act out a death wish choreographed by medical science. And it would be foolish to argue that psychological factors do not contribute to the overall outcome of those who suffer from AIDS-associated illnesses. It is also clearly the case that the medical model of HIV = AIDS = DEATH is a monster conjured up by the nightmares of virologists who have considerable vested interest in a chemotherapeutic solution to 'AIDS'. None of these dissident themes can, however, take precedence over an organic basis to the very real nature of AIDS-associated illnesses, or make believe AIDS is a 'psychogenic illness' – an illness created and passed on through the mind.

In reality the hysteria thesis ignores the complexity of the scientific and lay conflicts in 'AIDS' as it does in multiple chemical sensitivity, chronic fatigue syndrome and Gulf war syndrome. It disguises the multiple interaction of the political, industrial, ideological and psychological and throws a cloak over the interaction of the possible material, environmental, viral and psychological causes. The workings and the power of orthodox science are complex structural phenomena affected by a number of intrinsic and external factors. Political and social factors have heavily influenced the course of all AIDS research including claims about the origins, reality and causal nature of 'HIV'.

Irrationality and hysteria do clearly exist in the social perception of AIDS but belief in a vacuous 'theory of hysteria' is itself as hysterical as the unquestioned acceptance of 'HIV' as the cause of 'AIDS'. While knowledge is undoubtedly the cure, we have to ask, what kind of knowledge, engendered by whom? And we have to admit that dissenting views are sometimes adopted in desperation with a lack of critical rigour. While intellectual and theoretical dissent is a virtue, in the world of strategy, we have to be careful with whom it leads us to lie.

The hysteria thesis, just like the HIV hypothesis, disempowers rather than empowers those who wish to stay healthy: the only 'cure' for HIV is chemotherapy, while the only cure for a hysterical illness is a psychiatrist. Showalter treats all participants in her hysterical epidemics as 'cultural dupes'. The subjects' experience of illness and the insights of many sufferers into their own condition is ignored or belittled and its place taken by the condescending paternalism of the professional clinician, psychologist, psychiatrist or even academic. The latter live almost entirely in a perverted world of theory which never entertains its practical progenitors or casualties.

Showalter's theory is regarded by CFS and GWS activist-sufferers and multiple chemical sensitivity sufferers as a theory

which de-legitimizes their illness. Many activists who have chronic fatigue syndrome and ME feel that post modern psychiatrists, cultural historians and a number of leading physicians who associate with them have consistently misrepresented their illness, causing them anxiety, distress and sometimes financial suffering. Ironically, these activist-sufferers look to the biomedical sciences,

which have so let down the gay community, to save them from this irrationality. Activist-sufferers in the field of ME, MCS and GWS seem to understand that interpretive theories such as Showalter's are never free floating but always contextualised by political and social perspectives. Because he is himself an active AIDS dissident Alex should know that people with AIDS-associated illnesses are not just searching for any theory, but one which fits the social, political and scientific facts of their case.

We have all to be aware of how



LESLEY COOPER is writing her Ph.D. thesis on the politics of representation of myalgic encephalomyelitis (chronic fatigue syndrome) at the University of Essex, where she holds an MA in Medical Sociology

science, medicine and psychiatry and their links to industry and government, control discourses and disempower sufferers. AIDS activists especially, need to leave their 'one illness' isolation, and engage with activists involved in other environmentally caused, immune compromising, iatrogenic and contentiously diagnosed illnesses. By now they should be identifying common enemies and common orthodoxies, understanding the role which professions and disciplines play in the matrix of power which controls us all, healthy and dis-eased. Rather than trying on New Hysteria like a new jacket, activists could develop a more comprehensive analysis so enabling dissidents to sustain a distance from both the actual hysteria around 'HIV', propagated by a biomedical professionals, and the illusory hysteria wrought in words by Showalter around chemical sensitivity. ☐

The PWA's princess

by *Huw Christie*

*Imagine there's no heaven
It's easy if you try.*

John Lennon, 1971

The heart is a lonely hunter.

novelist Carson McCullers, 1940

The radical gift of the late Diana, Princess of Wales, to AIDS-pariahs was contact. Ten long years ago in a world terrorised by media fantasies of a vast sexually-infectious deadly AIDS pandemic in which millions could die in Britain alone, she stalked media attention opening Britain's first specialist AIDS hospital unit.

Moreover, she did it without prophylaxis. Went a contemporary report in *Today*, "Among those who caught Diana's attention was homosexual male nurse and Aids carrier Shane Snape, 28. Before the visit Shane had been worried that she would wear gloves to meet him, but when the moment came Diana was bare-handed. He said, "The Princess knew I was positive. But she still shook my hand without her gloves on. That meant more to me than anything else."

In her vivid 1995 TV interview for BBC *Panorama* Diana said as her private life deteriorated she understood better the pain of the vulnerable – the "...battered this, battered that". With AIDS-patients Diana's casual affection deconstructed the risk of casual infection. Kevin Corbett was a staff nurse during her visit to the AIDS unit in 1987: "She looked like she had AIDS



PHOTO: ALL ACTION

"Anywhere I see suffering is where I want to be..."

herself. She looked anorexic. She was so thin."

In George Bernard Shaw's poignant drama *Major Barbara* (1905) charity does not overcome deadly market forces – Barbara belongs to the Salvation Army, but is no match for the moral or economic prowess of the international arms industry in which her father is a major figure. Leaving aside landmines, and the refusal of the US and other nations to ratify banning them following her death, one might tell a similar story of Diana and 'AIDS'. Her reaching out to institutionalised AIDS patients and later lending herself to fundraising may after all have consolidated the establishment paradigms of HIV/AIDS, reinforcing a deadly industry in which, as in Shaw's play, secondary financial spinoffs palliate the real costs. In the *Panorama* interview Diana described taking her impressionable sons to

meet AIDS patients – "albeit I told them it was cancer", presumably to avoid discussing sex and homosex at that. Who could doubt that AIDS was sexually transmissible after such a tactful substitution? What might have happened had she fulfilled the post of UN Ambassador for AIDS reportedly being negotiated at the time of her death?

By June last year, columnist Nicola Tryer in the *Evening Standard* was not alone in asking, "Aids has failed to become the predicted plague...is it time she moved on to less fashionable fund raising?" In the month since her death, hovering in her inspiration, currently cash-strapped British 'HIV/AIDS'/gay institutions, matured over the years into vigilant harpies of the HIV orthodoxy, have circled Diana's remains, most not too polite to feed in public. Susie Parsons, Chief Executive of the high profile AIDS hospice London

Lighthouse, "took nine people on her tickets to the [funeral at Westminster] Abbey, including a member of staff, two management council members and a volunteer [and] five service users", squawked virophile monthly *Positive Nation*, marketing a luminous black-bordered cover shot of the princess. "Crying all the way to the bank", scoffed editor Graham McKerrow, secured by full page colour adverts from drugs giants Bristol-Myers-Squibb and Roche, and warning smugly of "pay rises and large gins all around". National AIDS Trust Director Derek Bodell, successor in that post to current Health Minister Baroness (Margaret) Jay, erstwhile AIDS-advisor to the princess, sent a letter to organisations: "Our Patron...made an enormous contribution...her compassion and loving commitment will be impossible to replace", and threatening to publish a new manifesto *AIDS 2000 - the next ten years*, urging paying advertisers to come forward.

Many gay men seem to have been deeply disturbed by news of the death. The mainstream gay *Pink Paper* reported the majority of recent calls jamming the London Lesbian and Gay Switchboard "were from gay men at various stages of Diana-related distress". Readers voted her their premier icon in a list of 500. "I was the girl who was supposed to be a boy," she once explained of her family's expectations.

Her identifications were resonant - sister/mother, virgin/whore, muse/slave, hunter/hunted: above all, the noble face of suffering. Wrote scholar Camille Paglia in *The Guardian* of Diana's death, "What was the point of it? Just give them some photographs. We're not talking about a private vacation. She's in Paris; she had dinner at a public place. Yet there was this kind of S & M game played with the pursuing paparazzi..."

"Anywhere I see suffering is where I want to be, doing what I can", Diana said. TV comedian Rory Bremner entertained millions impersonating her televised attendance in an operating theatre. What was she 'doing' there? Comforting the unconscious? Declaring the chest cavity open?

Yet was there anything specifically 'gay' in all this? Perhaps it's that with a woman, the disposition to bear pain may be as (mistakenly) taken for granted as the expectation of childbirth; in a gay man, it may be as intrinsic as the eroticising of St Sebastian, seen on the cross, shot from every angle.

Diana and HIV/AIDS as phenomena have particular features in common. Both were introduced to the world by the press. Consciousness of both grew to quasi-global dimensions by lodging in almost opposing regions of the collective psyche. Both had material realities substantially different from



Gay readers voted her their premier icon in a list of 500.

the public perception, consent to sustain which nonetheless disintegrates further and further over time.

It turns out for example it has taken thirteen hypocritical years for essential photos of purified HIV to be published, in *Virology* last March, so scientists could see purified HIV doesn't exist. At the time of the declaration of 'HIV', it was a politically incorrect revelation that such key confirmation was unobtainable. Vaccine developers now suggest we should research what proteins do make up actual 'virus', as if fraudulent antibody tests hadn't been administered all over the world for over a decade through lack of such work to date.

Extensive as it was in reporting Diana's last months romantically aloft with jet-setter Fayed as the happiest of her life, it

may likewise be years before the general media confirm what is discussed among journalists now - that a French police source said Diana's and Fayed's autopsies revealed they had been taking cocaine. One may wonder, so what anyway? There were numerous reports of the chauffeur's excess alcohol and anti-depressants - perhaps it's less of an issue if his passengers were high in the back seat. Editors who in the past would publish Diana's private telephone conversations are not reporting this news however. For one thing, it would put great holes in the public presentation of the government's new politically correct, and many argue short-sighted, War on Drugs - unless one was prepared to say the monarchy, and at least the people's favourite 'member' of it, was dissolute. Of course cocaine has never gone away since before the days when it was the stimulant in Coca-Cola. But at the recent annual Labour Party conference - the first for the triumphant new government of Prime Minister Tony Blair, who coined the mantra "the people's princess" after her death - Home Secretary Jack Straw reiterated a commitment not to legalise illegal drugs. A new Anti-Drugs Minister has been appointed. Any popularising of drugs is to be done by doctors, not princesses.

The most brutalising/disillusioning details of Diana's last hours are on the lips of London journalists, but may not reach the public ear for an equally long time: that she was "medically stabilised" for over an hour at the crash scene because both her legs had been severed - "thigh injuries", mentioned at first but later dropped from reports. A blanket of media silence nullifies this horror.

Thus some public fantasies are deemed important to maintain, 'necessary illusions': an ultimately killable AIDS-virus that teaches us more about medicine every day, not, when all is said and done, a slaughter; the sensuous embodiment of a princess we can invoke as the champion of humane and cohesive values, not, in some Leninist vernacular of history, a cokehead legless in Loveland. "The higher the media put you," she considered, "the bigger the drop." She need not have worried.

An often reluctant pioneer, in her own estimation a "free spirit", Diana may now become a legend. Subsequent generations might bring their own values and needs to what they see as her story. But who will dare continue in her name the now overt betrayal of fundamental human rights that is the 'HIV/AIDS' machine? □

EXCLUSIVE

IS HIV

*Interview by
Christine Johnson*



**ELENI PAPADOPULOS-
ELEOPULOS**

*is a biophysicist and
leader of a group of
HIV/AIDS scientists
from Perth in Western Australia.*

*Over the past decade and
more she and her colleagues
have published many scientific
papers questioning the HIV/AIDS
hypothesis. This interview looks at this
work and especially her group's views
on the AIDS virus itself.*

PHOTO: Joan Sheridan

the cause of AIDS?

CJ: Eleni, many thanks for agreeing to this interview.

EPE: My pleasure.

CJ: Does HIV cause AIDS?

EPE: There is no proof that HIV causes AIDS.

CJ: Why not?

EPE: For many reasons but most importantly, because there is no proof that HIV exists.

CJ: That seems a rather bold and incredible statement to make.

EPE: I suppose it is but nevertheless, that's where my research takes me.

CJ: Didn't Montagnier and Gallo isolate HIV? Back in the early eighties?

EPE: No. In the papers published in *Science* by those two research groups, there is no proof of the isolation of a retrovirus from AIDS patients.^{1,2}

CJ: They say they did isolate a virus.

EPE: Our interpretation of the data differs.³⁻⁵

CJ: Perhaps you should explain what leads you to this rather radical view.

EPE: I think the easiest way to begin is to ask the question, "What is a virus?". The answer is quite simple. A virus is microscopic particle that reproduces itself inside a cell..

CJ: Don't bacteria do that?

EPE: They may but there's a very important difference. Bacteria are not obliged to replicate inside a cell. Viruses must. You see, what bacteria take from the cell, or from an inanimate source of food and energy, is all turned into the next generation of bacteria inside the bacterial cell itself. That's also how our own cells replicate. But viruses can't do that. The virus particle is really no more than a few proteins strung around a piece of RNA or DNA but without the machinery needed to replicate.

CJ: So whereas a cell is a factory, a virus is a blueprint that must hijack a factory?

EPE: I can't better that analogy.

CJ: How does a virus replicate?

EPE: It has to get inside the cell. To do this the protective

envelope of the viral particle fuses with the cell membrane and then the particle passes inside. Once inside, using the cellular metabolic machinery, the virus particle is disassembled. Then, using the same machinery, separate pieces of new virus are synthesised. Finally, all the viral components are put together and out come the new virus particles.

CJ: Out of where?

EPE: The virus either destroys the cell or in the case of retroviruses the virus particles have a more orderly exit by budding out of the cell membrane. But that's not what happens with HIV. Unlike retroviruses, HIV is said to destroy the cells.

CJ: Well, what about HIV particles? Are you suggesting they're not a virus?

EPE: To prove the existence of a virus you need to do three things. First culture cells and find a particle you think might be a virus. Obviously, at the very least, that particle should look like a virus. Second, you have to devise a method to get that particle on its own so you can take it to pieces and analyse precisely what makes it up. Then you need to prove the particle can make faithful copies of itself. In other words, that it can replicate.

CJ: Can't you just look down a microscope and say there's a virus in the cultures?

EPE: No you can't. That's the whole point of putting the virus question. Not all particles that look like viruses are viruses. You have to prove that whatever particle you nominate can actually make copies of itself. No replication, no virus. I'm sorry but this is an extremely important point. No-one, especially virologists, can afford to ignore it.

CJ: That seems to make sense. I guess it would be hard to get sick catching a particle that could not make more of itself.

EPE: Exactly.

CJ: So where did AIDS research go wrong?

EPE: It's not so much a question of where the research went wrong. It's more a question of what was left out. For some unknown reason the decades old method of retroviral isolation^{6,7} developed to study animal retroviruses was not followed.

CJ: You better explain retroviruses before you go on.

EPE: I should. As you probably know, HIV is claimed to be a retrovirus. Retroviruses are incredibly tiny, almost spherical particles that...

CJ: How tiny are they?

EPE: One hundred nanometres in diameter.

CJ: How tiny is that?

EPE: One ten thousandth of a millimetre. Millions would fit comfortably on the head of a pin.

CJ: How do you actually see something that tiny?

EPE: You need an electron microscope. That's how we know the size and shape of retroviral particles. That they're almost round and they have an outer envelope covered with knobs and an inner core consisting of some proteins and RNA.

CJ: So, if it exists, HIV is an RNA virus?

EPE: Yes. Another important point is that retroviruses do not directly use their RNA blueprint to make more virus. According to retrovirologists, what sets them apart from nearly all other viruses is that retroviruses first make a DNA copy of their RNA. This DNA then moves into the cell nucleus where it becomes part of the cellular DNA.

This stretch of DNA is called a provirus and there it sits, hibernating, perhaps for years, until something activates the cell.

CJ: What happens then?

EPE: The proviral DNA is copied back into RNA and it is this RNA, not the original RNA, that instructs the production of the necessary proteins to make new virus particles.

CJ: Why are they called retroviruses?

EPE: Because for a long time biologists believed that the direction of information flow in the cells of all living things was from DNA to RNA, and thence to the proteins whose synthesis the RNA instructs. If we say this direction is "forwards" then what retroviruses do first is copy their information "backwards".

CJ: Understood.

EPE: There's one more thing. One of the proteins inside a retrovirus particle is an enzyme which catalyses this process. Not surprisingly, it's called reverse transcriptase.

CJ: And that's it?

EPE: Well, that's why they're called retroviruses.

CJ: You mentioned the decades old method of isolating retroviruses. How many decades are we talking about?

EPE: From the 1940s until the late 1970s. You see retroviruses were among the first viruses discovered. Dr. Peyton Rous at the Rockefeller Center in New York originally encountered them when he was doing experiments on malignant muscle tumours in chickens.⁸ Not that he could actually see them. That was back in 1911. It wasn't until the invention of the electron microscope and the high speed centrifuge that things began to be sorted out.

CJ: What was actually sorted out?

EPE: It was these that led to the method of identifying and purifying retroviral particles.

CJ: That's the same as isolating them?

EPE: Yes. To purify particles of any kind a scientist has to develop a method of separating out the particles he wishes to study from everything else.

CJ: How did electron microscopes and high speed centrifuges make purification of retroviruses possible?

EPE: The electron microscope enabled particles this small to be seen. The other part was played by the high speed centrifuge and was extremely important. It was discovered that retroviral particles have a physical property which enables them to be separated from other material in cell cultures. That property is their buoyancy and this was utilised to purify the particles by a process called density gradient centrifugation.

CJ: Sounds complicated.

EPE: The technology is complicated but the concept is extremely simple. You prepare a test tube containing a solution of sucrose, ordinary table sugar. But it's made so the solution is light at the top but gradually becomes heavier, or more dense, towards the bottom. Meanwhile you grow whatever cells you think may contain your

retrovirus and if you're right retroviral particles will be released from the cells and pass into the culture fluids. When you think everything is ready you decant a specimen of culture fluids and gently place a drop on top of the sugar solution. Then you spin the test-tube at extremely high speeds. This generates tremendous forces and particles present in that drop of fluid are forced through the sugar solution until they reach a point where their buoyancy prevents them penetrating any further. In other words, they drift down the density gradient until they reach a spot where their own density is the same as that region of the sugar solution. When they get there they stop, all together, or to use virological jargon, that's where they band. That band can then be selectively extracted and photographed with an electron microscope.

CJ: And do retroviral particles band at a characteristic point?

EPE: Yes. In the sucrose solutions they band at a point where the density is 1.16 gm/ml.

CJ: So, examination with the electron microscope tells you what fish you've caught?

EPE: Not only that. It's the only way to know if you've caught a fish. Or anything at all.

CJ: True. Did Montagnier and Gallo not do this?

EPE: This is one of the many problems. Montagnier and Gallo did use density gradient banding but for some unknown

Before March this year, no-one had ever published a picture of a density gradient

reason they did not publish any EMs of the material at 1.16 gm/ml which they and everyone afterwards call "pure HIV". This is quite puzzling because in 1973 the Pasteur Institute hosted a meeting attended by scientists some of whom are now amongst the leading HIV experts. At that meeting the method of retroviral isolation was thoroughly discussed and photographing the 1.16 band of the density gradient was considered absolutely essential.

CJ: But Montagnier and Gallo did publish photographs of virus particles.

EPE: No. Montagnier and Gallo published electron micrographs of a few particles which they claimed are a retrovirus and are HIV. But photographs don't prove particles are a virus and the existence of HIV was not proven using the method presented at the 1973 meeting.

CJ: And what was that method?

EPE: All the steps I have just told you. The only scientific method that exists. Culture cells, find a particle, isolate the particle, take it to pieces, find out what's inside and then prove those particles are able to make more of the same with the same constituents when they're added to a culture of uninfected cells.

CJ: So before AIDS came along there was a well tried method for proving the existence of a retrovirus but Montagnier and Gallo did not follow this method?

EPE: They used some of the techniques but they did not undertake every step including proving what particles, if any, are in the 1.16 gm/ml band of the density gradient, the density that defines retroviral particles.

CJ: But what about their pictures?

EPE: Montagnier's and Gallo's electron micrographs and every other electron microscope picture published up until March this year are of unpurified cell cultures. Not the gradient. Before March this year, no one had ever published a picture of a density gradient.

CJ: Which is what we need to do to prove isolation of retroviral particles?

EPE: Yes.

CJ: Can the 1.16 band contain material other than retroviral particles?

EPE: Yes. That's another reason why you need a photograph. To see everything that's going on. It was known long before the AIDS era that retroviral-like particles aren't the only material that may find their way into this part of the density gradient. Tiny cellular pieces, some recognisable as internal structures of cells, or just cellular debris, can band at 1.16 gm/ml. And some of this material can enclose nucleic acids and take on the appearances of retrovirus particles.

CJ: What are nucleic acids?

EPE: DNA and RNA.

CJ: Surely though, if retroviral particles are released from cells without disrupting the cells, it must be possible to guard against cellular contamination?

EPE: Well it is and it isn't. Certainly the animal retrovirologists were well aware of this problem and strongly advised handling the cultures gently and regularly topping them up with nutrients to keep the cells alive. So they don't disintegrate. But in the case of HIV there are additional problems. We are told that HIV is cytopathic meaning it kills cells. So one could hardly claim that putative virus particles are the only things likely to be floating around in culture fluids or at 1.16 gm/ml. The other confounding fact is that in many HIV experiments the cells are deliberately broken up by the experimenter as part of the experiment.

Knowing all this, it's a complete mystery why any HIV researcher could have omitted the crucial step of taking an EM of a density gradient.⁵

CJ: Could it be because electron microscopy is highly specialised and expensive?

EPE: It may have been in the early days but not anymore. For the past twenty years at least electron microscopy has been used daily in most hospitals to diagnose all kinds of diseases. Besides, there are plenty of EMs of HIV cultures.

It's just that until this year, for some unknown reason, there haven't been any of the density gradient.

CJ: All right. Let's talk about the pictures of the density gradient published this year. What do we see there?

EPE: Two groups, one Franco/German⁹ and one from the US National Cancer Institute¹⁰, published pictures of density gradients. In the Franco/German study the pictures are from the 1.16 gm/ml band. It is impossible to tell from which density the pictures in the American study are taken but let's assume it's the correct 1.16 density for retroviral particles. The first thing to say is that the authors of these studies concede that their pictures reveal the vast majority of the material in the density gradient is cellular. The authors describe all this material as "non-viral", or as "mock" virus or "microvesicles".

CJ: What are microvesicles?

EPE: Encapsulated cell fragments.

CJ: Are there any viral particles in these pictures?

EPE: There are a few particles which the researchers claim are retroviral particles. In fact, they claim these are the HIV particles but give no evidence why.

CJ: Are there lots of these HIV particles?

EPE: No. The band should contain billions and when you take an electron micrograph they should fill the entire picture.

CJ: So the banded material contains only a few HIV particles and from the HIV particles' point of view is rather impure?

EPE: Yes.

CJ: Do the experts comment on this?

EPE: They say the cellular material "co-purifies" with the HIV particles.

CJ: Tell me, the few particles they say are HIV, do they look like a retrovirus?

EPE: They bear only the vaguest resemblance to retroviral particles. For sure they look more like retroviral particles than all the other particles and material but even if they looked identical to retroviral particles you cannot say they are a retrovirus. Even Gallo admits to the existence of particles which band at 1.16 gm/ml and which have the appearances and biochemical properties of retroviruses but which are not retroviruses because they are incapable of replicating.¹¹

CJ: All right, but that aside, what's the difference between these particles and a real retroviral particle?

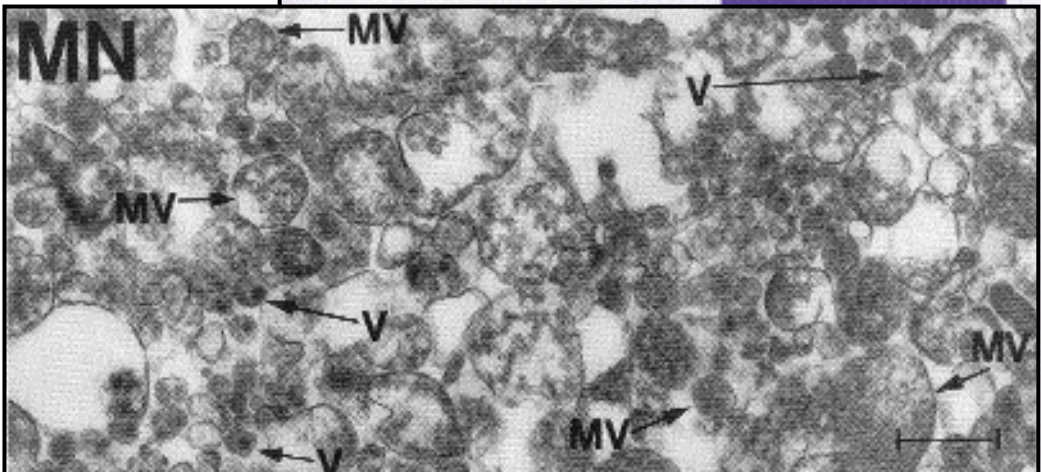
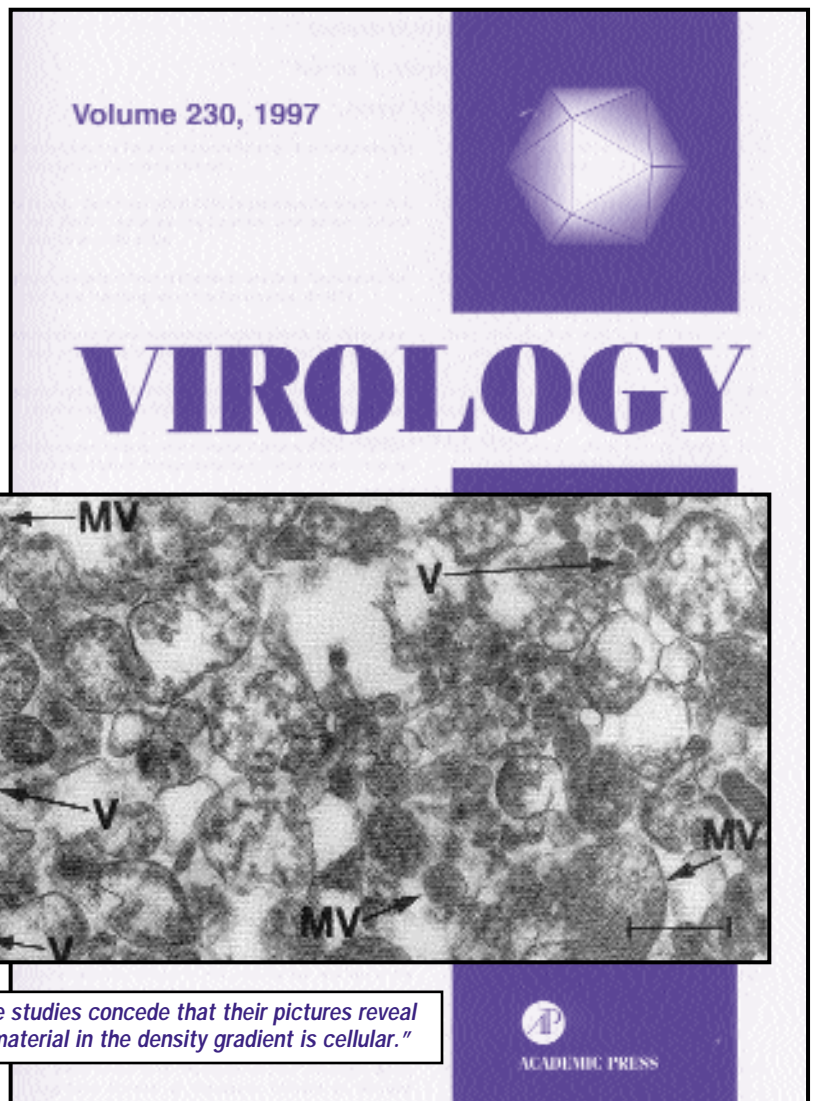
EPE: Gallo and all other retrovirologists, as well as Hans Gelderblom who has done most of the electron microscopy studies of HIV, agree that retrovirus particles are almost spherical in shape, have a diameter of 100-120 nanometres and are covered with knobs.^{12,13} The particles the two groups claim are HIV are not spherical, no diameter is less than 120nm, in fact many of them have major diameters exceeding twice that permitted for a retrovirus. And none of them appear to have knobs.

CJ: Surely size can't be that critical? Many things in Biology have a range of sizes. What about humans? There's plenty of humans twice the size of other humans. They're all still humans.

EPE: What's true for humans is not true for retroviruses. For a start, retroviruses don't have to grow up. They're born adults. So the correct comparison is between adult humans. There aren't too many twelve foot humans. In fact, the tallest human ever recorded was eight feet eleven inches. But there's more than size involved here.

CJ: What else?

EPE: If we assume both the Franco/German and US groups



"The the authors of these studies concede that their pictures reveal the vast majority of the material in the density gradient is cellular."

sought particles at the correct retroviral density then the particles found by both groups must have the same density, 1.16 gm/ml. If you measure the major and minor diameters of the particles in the EMs they claim are HIV and take the average diameters and for argument's sake, assume they're all spherical, then the Franco/German particles are 1.14 times larger than genuine retroviral particles and the US particles are 1.96 times larger. Now, to translate this into volumes, we have to cube the ratios of the diameters. So, if we take 120nm as the upper limit for the diameter of a retroviral particle and do the sums, the Franco/German particles have 50% more volume than a retroviral

particle and the US particles have 750% more volume. And the US particles are five times more voluminous than the Franco/German.

CJ: Which tells us what?

EPE: It tells us that the Franco/German and US particles must contain 50% or 750% more mass than genuine retroviral particles.

CJ: Why is that?

EPE: Because density is the ratio of mass to volume. If the volume goes up by a certain amount, to keep the same density, the mass has to go up by the same amount.

CJ: OK but what's your point?

EPE: The point is that any genuine retroviral particle contains a fixed amount of RNA and protein. No more and no less. If that's the case then these particles are made up of much more material than a genuine retrovirus. Which means that if these different sized particles are truly HIV then HIV cannot be a retrovirus. The only other explanation is that the electron micrographs are not from the 1.16 gm/ml band. If that's the case then we have no choice but to redefine retroviruses and more importantly, not to consider the 1.16 band as HIV. But if we do that then all the research done on HIV using this band cannot be used because this is what everyone uses as purified HIV. That would mean for example that this band cannot be used to obtain proteins and RNA for use as diagnostic agents to prove HIV infection.

CJ: You mentioned the particles lacked knobs. How serious a deficiency is that?

EPE: All the AIDS experts agree that the knobs are absolutely essential for the HIV particle to lock on to a cell. As the first step in infecting that cell. So, no locking on, no infection. The experts all claim that the knobs contain a protein called gp120 which is the hook in the knobs that grabs hold of the surface of the cell it's about to infect.¹⁴ If HIV particles do not have knobs how is HIV able to replicate?

CJ: You mean it can't get hold of the cell to get inside?

EPE: Precisely. And if it can't replicate, HIV is not an infectious particle.

CJ: That sounds like a serious problem to me. How do the experts respond?

EPE: They avoid it. And the knobs problem is not something new. The German group drew attention to it in the late 1980s and again in 1992.^{15,16} As soon as an HIV particle is released from a cell all the knobs disappear. This single fact has so many ramifications. For example, three quarters of all haemophiliacs tested are HIV antibody positive. And the claim is that haemophiliacs acquired this as a result of becoming HIV infected from infusions of contaminated factor VIII which they need to treat their clotting deficiency. The problem is that factor VIII is made from plasma. That's blood with all the cells removed which means if there are any HIV particles present in factor VIII they must be floating free in solution. But if cell free HIV has no knobs those HIVs have no way of getting into fresh cells to infect them.

CJ: Then how do you explain HIV antibodies and AIDS in haemophiliacs?

EPE: My colleagues and I have published several papers discussing alternative explanations including a detailed analysis of haemophilia in an invited paper in the 1995 special issue of *Genetica*¹⁷ devoted to the HIV/AIDS controversy.

CJ: I must confess I find it very hard to accept that haemophiliacs have not been infected through contaminated clotting concentrates. And I bet haemophiliacs do too.

EPE: Unfortunately that is true but perhaps I can persuade you with one quick and simple explanation. Tell me this. If someone HIV positive is cut and bleeds how long does the blood remain infectious? Outside the body?

CJ: According to what I've read, for only a few hours at the most.

EPE: And why is that?

CJ: Because HIV dries out and dies. Certainly that's what the

CDC says.¹⁸

EPE: OK. Let me ask you this. How is factor VIII made?

CJ: From donated blood.

EPE: Right. Have you ever seen a vial of factor VIII?

CJ: No.

EPE: All right I'll tell you. It comes as a dry, flaky, yellowish powder and by the time it's used it's at least a couple of months old. Do you see the problem?

CJ: I do. If it's dry and that old any HIV in it should be long dead.

EPE: Exactly. So how does factor VIII cause HIV infection and AIDS in haemophiliacs?

CJ: I don't know but I think I'm beginning to see why your group is not the toast of the town. Perhaps we'd better not get diverted into a discussion about haemophilia. Why do you think until now most HIV experts have been happy enough to regard the material at the 1.16 density as pure HIV?

EPE: I think it's premature to assume these pictures have changed anyone's minds about the 1.16 gm/ml portion of the density gradient being anything but pure HIV.

CJ: Well how does your group respond to these pictures?

EPE: On the evidence provided by these pictures there is no reason to claim that this material is pure or that it contains retroviral-like particles let alone a retrovirus or more importantly, a specific retrovirus, HIV. And this vindicates the position we have held ever since the beginning. And a position we long ago put into print that there is no evidence proving the isolation of a retrovirus from AIDS patients or those at risk of AIDS.

CJ: OK. Let's set aside the March pictures and talk about what we could deduce from what was known beforehand. How solid is the evidence prior to March that HIV exists?

EPE: Sticking to particles all the evidence comes from electron micrographs of whole cell cultures. Not density gradients. From this evidence it can be said that cell cultures contain a large variety of particles some of which are claimed to look like retroviral particles. That's all. None of the particle data has been taken further. No purification, no analysis and no proof of replication. In these cultures several research groups including Hans

Gelderblom and his associates from the

Koch Institute in Berlin who specialise in this area have reported not just one type of particle but a stunning array of particles.^{13,19,20} This raises several questions. If one of these particles really is a retrovirus experts call HIV, what are all the others? If the HIV particles originate from the tissues of AIDS patients, where do all the others come from? Which of these particles band at 1.16 gm/ml? If the HIV particles cause AIDS why doesn't one or several of the other particles also cause AIDS? Why don't all the particles cause AIDS? Or why doesn't AIDS or the cultures cause the appearance of the particles? And when it comes to HIV, the HIV experts can't even agree what is the HIV particle. There are three subfamilies of retroviruses and HIV has been classified by different research groups under two of these subfamilies as well as three different species.

CJ: Where does this leave us?

EPE: We still don't know what any of the particles are. We don't have a definite particle proven to be a retrovirus from which to take proteins and RNA to use in tests for infection in people or to do experiments to try and understand what is happening if there truly is a virus causing AIDS.

CJ: All right. Let's suppose that we do have a picture of a density gradient and it contains nothing but thousands of particles all the right size and shape, and with knobs, to be called a retroviral particle. Let's go over what should be done next.

EPE: The next steps are to disrupt the particles, find out what proteins and RNA are in them, prove one of the proteins is an enzyme which turns RNA into DNA and finally, take more of the density gradient and prove that when PURE particles are put



"Let me repeat, there is no question of isolation. Gallo did not isolate a virus."

into a virgin cell culture exactly the same particles made up of the same constituents come out.

CJ: *And has this been done?*

EPE: No, but perhaps I can explain things more clearly by talking about what has been done. Some of Gallo's experiments from 1984.

CJ: *Isn't 1984 a bit ancient?*

EPE: No because that's when the best research on HIV isolation was done. Those experiments are vitally important because everything believed and taught about HIV is founded on what happened back then.

CJ: *Everything?*

EPE: Yes every single solitary thing. Whether an HIV particle has been isolated and therefore any claim that it exists. The HIV proteins used in the antibody tests. The RNA used especially to diagnose children infected with HIV and now used to measure the so called viral load. And more. But the question is are they good enough?

CJ: *Good enough?*

EPE: Good enough to claim the existence of a unique retrovirus called HIV and that it causes AIDS.

CJ: *OK. Tell us about Gallo's experiments. Why was he interested in AIDS anyway?*

EPE: By 1984 Gallo had already spent more than a decade researching retroviruses and cancer. He was one of the many virologists caught up in President Nixon's decade of war against cancer. In the mid 1970s Gallo claimed to have discovered the first human retrovirus in patients with leukaemia. He claimed his data proved the existence of a retrovirus which he called HL23V.^{11,21} Now, just like he would later do for HIV, Gallo used antibody reactions to "prove" which proteins in the cultures were viral proteins. And not long afterwards others claimed to have found the same antibodies in many people who did not have leukaemia. However, a few years after that these same antibodies were shown to occur naturally and be directed against many substances that had nothing to do with retroviruses.^{22,23} Then it was realised that HL23V was a big mistake. There was no HL23V retrovirus. So the Gallo data turned out to be an embarrassment and HL23V is now extinct. What's interesting for us though is that the evidence used to claim proof of the existence of HL23V is the same kind of evidence said to prove the existence of HIV. In fact the evidence for HL23V was better than HIV.

CJ: *Better in what way?*

EPE: Well, unlike HIV, Gallo found reverse transcriptase in fresh tissue. Without having to do cultures. And he published an EM of density gradient material present at 1.16 gm/ml.

CJ: *But it still turned out to be a false alarm?*

EPE: Not even Gallo talks about HL23V anymore. But in 1980 he said he'd discovered another retrovirus. It was yet more of the same kind of data from leukaemia patients and this time he called it HTLV-I and claimed it caused a particular rare form of leukaemia which Gallo now calls adult T4 cell leukaemia, ATL. In fact, there are some very interesting parallels and paradoxes between HIV and HTLV-I.

CJ: *What are they?*

EPE: They're said to infect the same cells and to be spread the same way. Yet unlike HIV, HTLV-I has not gone beyond where it was discovered. The greatest prevalence of HTLV-I was reported from Africa and Southern Japan and that's where it's remained. That's longer than we've had AIDS and don't forget that although this virus is said to cause leukaemia, less than 1% of persons who test positive ever develop leukaemia. Even after forty years. But I digress. What I was about to say was that many of the first AIDS patients had a cancer known as Kaposi's sarcoma, as well as low numbers of the same T4 cells which are present in excessive amounts in ATL. This was known because the technology to count the different classes of lymphocytes came along about the same time that AIDS appeared.

CJ: *HIV was hypothesised to be killing the T4 cells?*

EPE: Well, this was too early for HIV but it was hypothesised that something was killing them. Later Gallo actually went through a stage of thinking that HTLV-I might be the culprit but that theory

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was a problem because HTLV-I allegedly causes leukaemia which is far too many T4 cells. Also, despite the high prevalence of antibodies to HTLV-I in Southern Japan, there were no AIDS cases. However, because gay men with AIDS had such a high incidence of the cancer Kaposi's sarcoma, and because something seemed to be affecting their T4 lymphocytes, Gallo persisted in trying to find a retrovirus to explain it all.

CJ: *What happened next?*

EPE: Gallo and his colleagues did a lot of experiments which culminated in four consecutive papers published in *Science* in May 1984. That was a year after the French published their paper also in *Science*. Gallo's group began by culturing lymphocytes from AIDS patients but apparently, none of the cultures produced enough reverse transcriptase to convince Gallo that a retrovirus was present. At that time Gallo had a Czech researcher called Mikulas Popovic working for him and so Popovic and Gallo agreed to mix up culture fluids from ten AIDS patients and add that to a culture of leukaemia cells. The leukaemia cells they used in this culture had been obtained years earlier from a patient with ATL. When they did this enough reverse transcriptase was produced to convince Gallo and Popovic they now did have a retrovirus.

CJ: *You mean a retrovirus would not grow in individual cultures from AIDS patients but did when the specimens were mixed up and cultured?*

EPE: Yes.

CJ: *Isn't that a little puzzling? How can a germ do that? Surely if it's present in one of the specimens, as long as the cultures are done the same way, it should grow no matter what?*

EPE: You would think so.

CJ: *And if you mix up all the specimens, how would you know who had the virus in the first place? It might have come from just one patient. Was Gallo ever questioned about this?*

EPE: He was and in a 1993 television documentary said he didn't care whether the virus came from a single patient or whether it came from a pool of patients.

CJ: *Did you not say that the leukaemic cells used in the cultures were originally obtained from a patient with adult T4 cell leukaemia?*

EPE: Yes.

CJ: *Then surely the cultures must have contained many T4 cells?*

EPE: That's true.

CJ: *If those cultures were made up from T4 cells and if HIV kills these cells, how could a cell killing virus be expected to grow?*

EPE: That's another of the problems with the HIV theory of AIDS. Even though HIV is said to kill T4 cells and make people immune deficient, that's what the "AID" in AIDS actually refers to, the leukaemic cell line as well as its H9 clone which Popovic eventually produced, are both immortal even when infected with HIV. That means rather than being killed by HIV the cells permit what is regarded as HIV to grow indefinitely. The H9 clone is

widely used in both research and commercially for producing what are regarded as the HIV proteins for use in the antibody test kits.

CJ: *OK. What did Gallo actually do to prove he had isolated a new retrovirus from AIDS patients?*

EPE: If you read the first paper, what was called isolation consisted of electron microscopic photographs of a few particles in the cultures, not the gradient, finding reverse transcriptase and observing that some antibodies present in a haemophilia patient as well as rabbits reacted with some of the proteins in the cells of the cultures.

CJ: *That was reported as isolation of a virus?*

EPE: Yes.

CJ: *Is that really isolation?*

EPE: No. Isolation means separation from everything else. Not just detection of some phenomena. The only way to prove the existence of an infectious agent is to isolate it. That's what this debate is all about.

CJ: *Yes, but isolated or not, how do you respond to Gallo's claim that his cultures grew a retrovirus?*

EPE: Let me repeat, there is no question of isolation. Gallo did not isolate a virus. There were no electron microscope pictures of a banded specimen that one would expect to show nothing but retroviral particles. How could there be? There were no EMs at all of a banded specimen. Just pictures of cells with a dozen or so particles lying nearby but no extraction and analysis and proof that these particles could replicate into identical particles. But what we must ask is whether Gallo had the proof to say he had even detected a retrovirus. In our view he did not. And it's vitally important at this point to state that finding particles and reverse transcriptase is not proof that a retrovirus is present.

CJ: *You said retrovirus particles contain reverse transcriptase.*

EPE: They do, in fact reverse transcriptase was discovered in retroviruses but there's a catch. The catch is two things. The way the presence of RT is proven and the fact that RT is not unique to retroviruses.

CJ: *RT?*

EPE: Reverse transcriptase. The existence of RT is proven indirectly. By putting some RNA into a culture and seeing if DNA bearing the corresponding sequence appears.

CJ: *You mean the presence of RT is implied by the ability of the culture to do this particular trick?*

EPE: Yes. It's measured by demonstrating the process of reverse transcription. Like many enzyme tests the test for reverse transcriptase measures what the enzyme does, not the actual enzyme itself. So in the case of RT it measures the production of DNA copied from a synthetic piece of RNA introduced into the cultures. The problem is that RT is not the only thing capable of doing this trick as you call it. Other enzymes, normal cellular enzymes can also do this trick. In fact they do it very well with the same synthetic RNA that all HIV researchers introduce into their cultures to copy into DNA²⁴ and to claim their cultures contain HIV RT and thus HIV. And what's more, when you read the AIDS literature, it becomes apparent that some researchers who publish claims to have isolated HIV have done no more than detect RT.

CJ: *That's quite disconcerting.*

EPE: There's much more to RT. For instance, according to Harold Varmus, Nobel Laureate and Head of the National Institutes of Health, RTs themselves are also present in normal cells. And bacteria have RTs. And it's known that some of the chemicals that are an obligatory component of these cultures cause normal lymphocytes to reverse transcribe. And leukaemic cells can also do the same trick unaided when not cultured with such chemicals or cells from AIDS patients.

CJ: *There are many possible reasons for RT then?*

EPE: Yes and there's yet another. Remember that Gallo and Popovic used H9 cells to demonstrate the existence of what they

claimed was a new retrovirus. But as I said before, if you trace the lineage of the H9 cell line it comes from the HUT78 cell line, a cell line which began life in a patient whom Gallo says had a form of malignancy caused by HTLV-I. If that malignancy is caused by HTLV-I then HTLV-I and its RT will be in the very cells Gallo used to prove the presence of HIV.

CJ: *But surely no one would search for a new retrovirus using cells that already contained another retrovirus?*

EPE: You would think not especially since a year earlier Gallo published a paper in *Nature* reporting HTLV-I genetic sequences in the cell line from which the H9 cells ultimately originated.²⁵

CJ: *So the evidence using RT does not look good?*

EPE: The problem with RT is the same problem with all the evidence. It's just like the particles Gallo photographed. They might be the particles of a retrovirus, the reverse transcription might be caused by the RT of a retrovirus but "might" is not scientific proof. You don't construct scientific theories from what "might" be going on.

CJ: *But even so Eleni, how can you dismiss particles? They're so convincing. How can you escape the fact that no matter how widely Gallo and everybody else deviated from the traditional method of isolating a retrovirus, there are particles in these cultures and a lot of very important people regard them as particles of a retrovirus.*

EPE: I appreciate your point but I think particles have to be viewed with a considerable amount of perspective. Retroviral-like particles are practically ubiquitous. In the 1970s such particles were frequently observed in human leukaemia tissues, in cultures of embryonic tissues and in the majority of animal and human placentas. This is of significance given that the H9 cell line is made up of leukaemic cells and also because Montagnier obtained his EMs from cultures done with umbilical cord blood lymphocytes. There's also a large group of retroviral particles classified as type-C particles that are found in fish, snakes, worms, pheasant, quail, partridge, turkey, tree mice, agouti, tapeworms, insects as well as mammals. And amongst its many official guises HIV has been described as a type-C particle, by both Montagnier and Gallo.²⁶ Also, there's an electron microscope study reported in 1988 by O'Hara and colleagues from Harvard.²⁷ They examined enlarged lymph nodes from both AIDS and non-AIDS patients and found "HIV" particles in 90% of BOTH groups. They had to concede that particles alone do not prove infection with HIV.

CJ: *All right. Let's leave particles. What about the antibodies that reacted with the cells in the cultures? Surely that must signify something that ordinarily isn't present? Wouldn't this fit with a retroviral infectious agent?*

EPE: It might fit but there's that word again. It's simply not possible to prove proteins belong to a retrovirus or antibodies are caused by a retrovirus, or to claim proof of the isolation of a retrovirus just because some things react together in a test-tube.

CJ: *Could you explain that a little more please?*

EPE: Again, let's not take the data any further than good science allows. The experiments reported in the first Gallo paper tell us that some antibodies present in a patient with haemophilia, as well as in rabbits, reacted with some proteins in H9 cells cultured with lymphocytes from AIDS patients.¹

CJ: *That's the data?*

EPE: That's the data we have to work on. What's important is how we interpret the data. Now, for what he called isolation of HIV Gallo regarded the antibodies as the crucial evidence. How do we know this? For two reasons. First, what we have already said. Gallo knew there are particles which look exactly like retroviruses, which band at 1.16 gm/ml and which contain RT but which do not replicate. So, whatever they are, no matter how they arise, they can't be viruses. Second, we know because in one of Gallo's papers he actually talks about the need to have specific



Luc Montagnier
"Montagnier obtained his EMs from cultures done with umbilical cord blood lymphocytes."

agents to identify a particle as a virus. And by that he means specific antibodies or proteins. The Gallo hypothesis is that there is a virus causing AIDS, it's foreign so when it infects a patient the patient develops antibodies to the virus.

CJ: So it works backwards as well as forwards? Virus produces antibodies and antibodies can be used to point to the virus?

EPE: No. That's the problem. Antibodies do not work backwards. We'll get to why in a minute. The important thing here is not to forget what question we're trying to answer. We're trying to define which proteins are unique constituents of a retroviral particle. For me, there's only one way to do that. And it's easy. We define viral proteins exactly the same way we define our arms and legs. Or our kidneys.

CJ: Meaning what?

EPE: My bits and pieces of anatomy are mine because they're part of me. Either inside or outside. If one of my kidneys is diseased and has to be removed the first thing the surgeon must do before I'm put on the operating table is to check and make sure it's me. It's no different with viruses. Viral proteins are the proteins that come out of particles proven to be a virus. It's that simple. If you want to define the proteins of a retroviral particle first you must prove you HAVE a retroviral particle.

CJ: Antibodies are too imprecise?

EPE: Antibodies are imprecise but that's not the issue here. Antibodies are irrelevant. You prove proteins come from a virus particle by isolating the particle and then doing a dissection. You don't prove proteins are constituents of a viral particle by performing chemical reactions on what is essentially a culture soup. It has nothing to do with it. So what if some proteins and antibodies react? There's many reasons why these reactions might take place.

CJ: Such as?

EPE: There are many antibodies and antibodies to one thing can and do react with other things.^{28,29} Immunologists call these cross-reactions. This is a fact of Nature and it causes problems because an antibody reacting with a protein in a culture could just as well be an antibody made to something totally unrelated. Quite possibly something not even in the culture. To put it into plain language, antibodies adopt other partners. My colleague Val Turner adopted the term "promiscuous" to explain this behaviour. The only way to prove a reaction you see is caused by the one antibody reacting with the one protein is to see how the reactions compare with what you think they signify. What we have to do is correlate the reactions against HIV itself. Antibodies are specific to HIV if and only if they are present only when HIV is present.

CJ: Not if HIV is absent?

EPE: One hundred percent specific means no antibodies reacting when HIV is absent. Now, as my colleagues and I see it, using antibodies to prove the existence of a retrovirus is the crux of the problem. This is a very important part of our argument so I hope to get this very important message across.

CJ: I'm all ears.

EPE: Think about what's happened so far. There's an old, logical, reliable, commonsense method of proving the existence of a retrovirus. It's based on nothing more than the definition of a retrovirus as a particle having a particular size, shape, appearance and constituents and the ability to replicate. But for some unknown reason this method has been abandoned in the HIV era. Don't ask me why but it has. In its place we have a disparate collection of data including particles not photographed in density gradients and some evidence for reverse transcription either in the culture or the material which bands at 1.16 gm/ml. Neither of these are proof that a retrovirus exists in the cultures. Gallo says so himself.

CJ: I'm following. Go on.

EPE: Then along comes the idea with antibodies. If there really is a virus then being foreign, it should induce antibodies in people it infects. Perhaps these antibodies are indeed specific meaning they are made solely in response to HIV and react with viral proteins and nothing else. OK. Let's assume this unlikely specificity is a fact

and let's make an even less probable assumption.

CJ: Yes?

EPE: Let's say what's considered true of the so called HIV antibodies is true for all antibodies. Every single antibody ever made only reacts with what stimulated its production and with nothing else. Antibodies to the tuberculosis germ only react with the tuberculosis germ. Antibodies to hepatitis virus only react with hepatitis virus et cetera. OK. We have some cultures of tissues derived from AIDS patients which react with antibodies present in the serums of AIDS patients. What next? We know that AIDS patients are infected with many different agents. So if these agents, or bits of them, are present in AIDS patients, they're also likely to be in their cell cultures. Isn't this why laboratory workers are believed to be at risk from handling these specimens? And we also know that despite being labelled immune deficient, everyone agrees that AIDS patients have myriads of antibodies to all manner of things. Including antibodies to human T-cells, the cells that make up the cultures. If you add some antibodies from the same kind of patients to these cultures, even if each antibody only reacts with its mate, wouldn't you expect to see lots of reactions between lots of different things?

CJ: I see your point. Since all you see is reactions you can't tell what is reacting with what.

EPE: Exactly. Antibodies react and things light up but who's got a finger on the switch? And for this argument we've agreed that every antibody is directed against one agent and only reacts with that agent. What if we bring back real life where antibodies cross-react as well?

CJ: I guess it's a big mess. It's difficult to tell where any proteins or antibodies come from.

EPE: That's absolutely correct. And one must not confuse origins with composition. For sure you can't prove the origin of a protein by an antibody reaction. Why should a reaction tell you that a protein comes from a particle any more than it comes from Mars? But you can't prove identity either. That's because antibodies do not work backwards.

CJ: Are there any germs in AIDS patients that could actually react like you've said?

EPE: Yes. A good example is hepatitis B virus. Many, and in the case of haemophiliacs, virtually all AIDS patients are infected with hepatitis B virus. And HBV doesn't just infect liver cells. It also infects T-lymphocytes. And strange as it may seem, hepatitis B virus has a reverse transcriptase enzyme. And people make antibodies to this virus...

CJ: OK. I get the drift.

EPE: But there's more to Gallo's experiments. For a start, the serum that Gallo used in this experiment came from a patient with the initials "E.T.". But ET didn't actually have AIDS. He had a condition known as pre-AIDS. That's enlargement of lymph nodes in many parts of the body. But pre-AIDS is caused by many infectious agents which are present for example in gay men, intravenous drug users and haemophiliacs even when there is none of what is called HIV present.

CJ: So ET might not have had HIV antibodies?

EPE: Exactly and the other puzzle is the rabbits.

CJ: Yes. I was going to ask about that.

EPE: Gallo claims he had a serum from rabbits that contained antibodies specific to HIV. Just imagine for a moment the scene in Gallo's laboratory. They've cultured H9 cells with lymphocytes from AIDS patients and when they come to determine which proteins in their cultures originate from a presumed virus they reach up on the shelf and, lo and behold, they pull down a bottle labelled "specific antibodies to HIV". How did they manage to get those antibodies? This was the first paper they wrote but they already had a bottle containing rabbit antibodies specific to a virus they were currently attempting to isolate for the very first time.

CJ: Well how did they do it?

EPE: They say they prepared rabbit antibodies by repeatedly infecting rabbits with HIV. But if they were preparing antibodies

Antibodies react and things light up but who's got a finger on the switch?

to HIV they would have had to inject rabbits with pure HIV³⁰ which again means they must have already isolated what they were now attempting to do for the first time. It doesn't make sense.

CJ: Well, if they didn't inject pure HIV into the rabbits what did they inject?

EPE: At the very best, if they used a banded specimen which they and everyone else regard as pure HIV, the evidence is that what they injected would have been something akin to what we see in the Franco/German and US National Cancer Institute pictures. Now any immunology book will tell you that proteins are the most potent antibody producing substances available. Even more so if they're introduced directly into the blood stream. So, by injecting their culture material into rabbits, even if they had used a banded specimen, Gallo and Popovic would have exposed their rabbits to a multitude of cellular proteins. The rabbits would have then produced antibodies to all those proteins and when they added these antibodies back with the material they injected of course there would be reactions. That's exactly what you would expect but that doesn't make the material you inject into a virus. And even less into a unique retrovirus.

CJ: OK. I understand what you're saying. Your argument is that, before he had a virus, there was no way Gallo could have known there were antibodies in patient ET or in AIDS patients or rabbits that would specifically recognise HIV proteins.

EPE: Yes. Before he had a virus there was no way of knowing that antibodies to HIV existed at all. Anywhere. To even begin to talk about specific antibodies to specific HIV proteins first you have to prove the proteins are constituents of a retroviral-like particle that is able to replicate. And the only way to do that is to isolate the particles and do everything else I've described. You need the virus BEFORE you go looking for proteins and antibodies.

CJ: Well what on Earth are these antibodies in AIDS patients which everyone calls HIV antibodies?

EPE: What my colleagues and I have been arguing all these years is that there is no evidence they are HIV antibodies. The only way to find out if they're HIV antibodies is to do the experiment comparing antibodies with virus isolation. That is what's meant by having a gold standard. Using virus isolation as a totally independent means

of determining whether there truly are specific HIV antibodies. You can think of HIV as being the adjudicator. If antibodies specific to a retrovirus called HIV exist they will reveal themselves by reacting only when a retrovirus called HIV is present. Nothing could be simpler. Now, although you may not realise, there's another problem. There might be specific HIV antibodies but what if there's non-specific HIV antibodies as well?

CJ: I can see people getting confused. Could you please elaborate?

EPE: All right. The problem using antibodies is that there could be two types of antibodies. One type is specific meaning antibodies caused by HIV and nothing else and reacting with HIV and nothing else. The other type is non-specific meaning they're antibodies caused by other agents or stimuli and sure they react with those agents but they also react with HIV. If you add a person's serum to some of the "HIV" proteins in a culture or in a test kit and see a reaction how can you tell which type of antibodies are doing the reacting? In fact there are three possibilities. All the antibodies might be the specific type or none of them might be. Or there might be a mixture. All you see is a reaction. Something changes colour. That's all. So how do you tell? Simple. You test for antibodies in all sorts of patients, some with AIDS, some who are sick but who don't have AIDS and in some healthy people as well. But in the same experiments, at the same time, you use HIV as the adjudicator. To judge what type of antibodies they

are. And if antibodies show up when there's no HIV then non-specific antibodies must exist.

CJ: What about the experiment to sort out the antibodies?

EPE: The experiment, which should have been done long before HIV antibody testing was ever introduced into clinical medicine, has never been done. And in fact it could not have been done because to date nobody has isolated HIV. But there's plenty of evidence that people who all the experts accept are NOT infected with HIV do have antibodies which react with what are claimed to be the HIV proteins. So there are non-specific "HIV" antibodies and if some are non-specific how do you know how many? Why not all of them? Even if it's only some how can you tell them apart? The answer is you can't and that means that not one single person can be diagnosed using an antibody test. It also means that scientists must question the existence of HIV for exactly the same reason scientists at the Sloan Kettering and National Cancer Institute questioned the existence of HL23V.

CJ: So your argument essentially boils down to "HIV" antibodies not arising because of or being directed against HIV in spite of the fact that everyone calls them "HIV" antibodies?

EPE: That's right.

CJ: What about proof that HIV causes AIDS? Did Gallo prove that in 1984?

EPE: To be fair, in his 1984 *Science* papers Gallo did not make such a direct claim. He said HIV was the probable cause of AIDS. But even this conclusion is questionable. Even if Gallo's evidence was incontrovertible proof he had isolated a retrovirus he only managed to isolate it from 26 out of 72 AIDS patients. That's only 36 percent. And only 88% of 49 AIDS patients had antibodies. And that was mostly using ELISA, the antibody test considered

the least specific. No one diagnoses HIV infection on a single ELISA. And if the virus was present in only 36% of patients why did 88% have antibodies? I mean there were more patients with antibodies without virus than there were patients with virus? And there was not even a hint of proof that HIV was killing T4 cells or that having low T4 cells could cause all the diseases diagnosed as AIDS.

CJ: The evidence in 1984 was light on?

EPE: There was no evidence. But two years later, when Gallo was

defending the accusation he had used the French virus to discover his version of HIV, he was much more definite about his 1984 papers. He said they provided "clearcut" evidence that HIV is the cause of AIDS. And his opinion was no different in 1993. Let me read you Gallo's own words from the 1993 TV documentary, *The Plague*:

"The compelling evidence that convinced the scientific community that this kind of virus is the cause of AIDS came from us. The proper growth of the virus came from this laboratory principally through Mika Popovic. The development of a sensitive, workable blood test. I don't think that we have to debate. I think the history speaks for itself."

CJ: Do the problems you see with the Gallo papers also apply to the tests used to diagnose patients infected with HIV when cultures are not done?

EPE: You mean the antibody tests?

CJ: Yes.

EPE: It's the same test. Can you see what's happened here? The HIV researchers have used some antibodies in the patients' blood to convince themselves that some proteins in their cultures are unique constituents of a particle which they say is a retrovirus and call HIV. That's the first thing. But having done that they've then



"They say they prepared rabbit antibodies by repeatedly infecting rabbits with HIV... which means they must have already isolated what they were now attempting to do for the first time."

turned around and said, "OK, if these proteins are from HIV then the antibodies must be THE HIV antibodies". So they've used the one and same chemical reaction to prove which each reactant is when in fact there's no way an antibody reaction can tell you even what one reactant is even if you know the other to start with. That's why you need a independent gold standard adjudicator. As far as actually doing the test is concerned, the difference from cultures is that the patient's blood is mixed with proteins extracted from H9 or other cell cultures and put either all together in a test tube or separately at discrete spots along a thin paper strip. The first is called the ELISA and the second the Western blot. If these proteins react with the blood, and in the Western blot the number and type of reacting proteins required to produce a positive test vary all over the world and that's yet another huge problem, then the patient is reported HIV positive.

CJ: So the HIV antibody test is really the same procedure that was used to prove the existence of HIV in cultures from AIDS patients in 1984?

EPE: Yes. And also by the French in 1983. And by Gallo and his colleagues to prove the existence of HL23V in the mid seventies. Our group find it intriguing that any scientist could regard antibodies reacting with proteins as proof of viral isolation. Is an antibody joined to a protein a virus? What would you expect to see under the electron microscope? A particle with a core and knobs?

CJ: Then is it fair to say that the HIV antibody tests are useless?

EPE: No, they're not useless. There is no doubt being in a risk group and having these antibodies is not a good thing.

CJ: How can that be?

EPE: Because empirically such people are more likely to develop the illnesses we classify as AIDS. In fact, there is evidence published in the *Lancet* that a positive test also predicts increased mortality from diseases which are not classified as AIDS.³¹ But what the tests don't do, or at least there is no proof that they do, is prove HIV infection. Or even less that HIV infection is the reason people develop AIDS. You may not appreciate that the only evidence HIV causes AIDS is these tests. If the tests are unproven for HIV infection then there is no proof that HIV causes AIDS.^{3-5,26,32-34}

CJ: What about a positive test in people who are apparently healthy and not in any risk group? Should they be worried?

EPE: There is no data to answer that question and I think it would be impossible to ever obtain that data. There would have to be an experiment comparing matched groups of healthy people with and without these antibodies. In other words, follow people with a positive test over a period of years and see who developed AIDS and who did not. The trouble is it would be very difficult for most people knowing they are HIV positive, as well as their physicians, not to believe that sooner or later they're going to get very sick and eventually die of AIDS. And that mindset may greatly effect the results of such an experiment. From both sides.

CJ: What do you mean from both sides?

EPE: I mean that patients' health will be affected knowing they are HIV positive and their physicians will feel compelled to offer treatments with drugs given in the belief they are necessary to kill a virus the patients do not have.

CJ: The drugs themselves might be harmful?

EPE: Well AZT, the original and still most widely used drug is certainly well known for its toxic effects and in fact some of these effects mimic AIDS.

CJ: What if we did this experiment, and we did it blind, and found that the HIV positives were more likely to develop AIDS than the HIV negatives? What would that tell us?

EPE: On our present data that would mean the same it means in the AIDS risk groups. Gallo and his colleagues serendipitously

discovered a test which for some reason predicts a tendency to get sick from certain diseases that are lumped together as AIDS. But it doesn't prove that the link to all these diseases is a retrovirus. That can never be proven unless HIV is proven to exist by isolating it first and then used to validate the antibodies as HIV antibodies. Even then, you can't say HIV causes AIDS just because it's present in AIDS patients. Association doesn't prove causation. You can be present at a bank robbery but not be the robber. You need other data to prove causation. In fact, according to the CDC AIDS definition, you don't even need to be HIV infected to be diagnosed as having AIDS.

CJ: That sounds really crazy.

EPE: It's written down in the literature. Under some circumstances the CDC AIDS definition requires a patient to be diagnosed as a case of AIDS even if the patient's antibody tests are negative.³⁵

CJ: What about the RNA tests. The PCR and viral load and like?

EPE: That's another huge subject but I can say just one thing. All these tests rely on matching a piece of the patient's RNA or DNA

Under some circumstances the CDC AIDS definition requires a patient to be diagnosed as a case of AIDS even if the patient's antibody tests are negative

to a test piece of RNA or DNA deemed to originate from a particle called HIV. You can think about this like the rabbit antibodies. There's another bottle on the shelf and the label on this one reads "HIV RNA". But if a retroviral particle hasn't been isolated and purified and shown to be a virus, how does anyone know where this

piece of RNA comes from? The HIV experts themselves say that there are about one hundred million distinct HIV RNAs in every AIDS patient.³⁶ With that much variation one would think that a virus is the most improbable source for such RNA. I mean, how can a virus have that much variation and still be the same agent? Still make the same proteins and induce the antibodies? Still perform all the same tricks?

CJ: Tell me Eleni, if there is no virus where do all the things Montagnier and Gallo found come from? I assume you do believe they did find something in their cultures?

EPE: Of course they found something. They found many things. All the things we've discussed. And your question is fair. In our view it is possible the RT and particles could be some reaction produced when cells from sick people are cultured. Or the result of the chemicals introduced into the cultures. We know that both normal and pathological processes can be associated with the appearance of retroviral-like particles. There's absolutely no doubt about that. What exactly are all these particles? Well, some may be no more than pieces of disintegrating cells. Others certainly look more uniform and might conceivably be viral-like or even retroviral-like but in the context of HIV what really matters is proof that at least one of these varieties of particles is a retroviral particle. Even if we had that proof, the RT and the particles and proteins could all come from an endogenous retrovirus.

CJ: What's an endogenous retrovirus?

EPE: Unlike the case for all other infectious agents, normal human DNA contains retroviral information which did not get there following a retroviral infection. The cell was born with it. So amongst all our DNA there are stretches made up of some retroviral information and that may sit there maybe all your life until something happens. The DNA starts to make RNA and hence proteins, and this may go even further and lead to the assembly of endogenous retroviral particles. They're called endogenous because they're not something that got in from the outside. Like HIV is supposed to do. Something that gets in from the outside is called exogenous. Long before the AIDS era everyone knew that in animal cells endogenous retrovirus production could occur spontaneously. You make a cell culture and do nothing else. Just leave it on the bench for a few days or maybe a few weeks and

then one day it starts to produce retroviral-like particles. They seemingly come out of nowhere and the process can be significantly accelerated and the yield of particles increased, sometimes millions of times, by conditions which induce cellular activation, the same conditions which are obligatory to obtain what is called HIV from cell cultures. Interestingly, up until 1993, neither Gallo nor Fauci who is another well-known HIV researcher,³⁷ accepted that humans contain the DNA to make endogenous retroviruses but now it's accepted that endogenous retroviral DNA forms about 1% of human DNA. For the record, that's about 3,000 times larger than what the experts claim is the size of the HIV genome. And what's more, new retroviral genomes can arise by rearrangements and recombination of existing retroviral genomes.

CJ: So HIV could be an endogenous retrovirus?

EPE: There are many explanations for the laboratory phenomena held up as proof for the existence of HIV. We went into all these in a very long article we wrote for *Continuum* magazine last October.³⁸

CJ: Can you tell endogenous and exogenous apart?

EPE: No. Endogenously produced retroviruses are morphologically and biochemically indistinguishable from exogenous retroviruses.

CJ: If HIV is an endogenous virus, why would AIDS patients produce such viruses when we don't?

EPE: Because the patients are sick. In fact they are sick before they ever develop AIDS. So their cells are sick and their sick cells find themselves in the right condition in cultures to be activated. That's what's needed to produce endogenous virus and that's been known for decades.

Either the agents to which the patients are exposed induce the right conditions or the culture conditions play a part. Perhaps a major part. I don't know which contribution is the greater but that might have been sorted out a long time ago if the first HIV researchers had included a few control experiments.

CJ: What are they?

EPE: When you do a culture of say lymphocytes from an AIDS patient with some H9 cells and all the chemicals which are added to make the culture produce "HIV", you really don't know if what you find is the difference that sets AIDS patients apart from everyone else. What if you were to find exactly the same thing in similar patients that don't have AIDS? So, to convince yourself that what you find and call HIV is present only in AIDS patients and therefore might have something to do with AIDS, you must use controls. They're experiments run in parallel with your main experiment conducted exactly the same way using exactly the same materials. The only difference is the one variable you're chasing.

CJ: Could you explain that further?

EPE: A control would be a culture of cells from some patients of the same age and sex and environmental exposures who are sick with diseases like AIDS but not AIDS. Even better if the cells came from patients who have low T4 cells and who are oxidised.^{3,32} AIDS patients have both these abnormalities but they're not the only patients to have them. And one must also not forget to add the same chemicals to all cultures. We already know that one of these chemicals causes reverse transcription in normal lymphocytes. Now, if you did all that you might well find that lymphocytes from men in New York who were sick with non-AIDS diseases also develop particles and RT and antibody reactions when cultured. That would mean that one would have to be very cautious interpreting that data as being something special to AIDS.

CJ: There weren't any controls?

EPE: This is yet another problem with so much AIDS research. Hardly any one uses controls and when they do they're often the wrong type.

CJ: Is it possible we've got AIDS back to front? You hinted at this before. Could the patients or the cultures be responsible for what is called HIV and not the other way around?

EPE: Right. Having AIDS may just be a prescription for developing those abnormalities. Retrovirologists themselves have argued that retroviruses may arise as the result of a disease and not vice versa. Getting cause and effect the wrong way around is not new to Medicine. The Nobel Prize has even been awarded under such circumstances.

CJ: It's almost time to finish up. I have several more questions.

First, how long have you and your colleagues held the view that HIV may not exist?

EPE: Ever since the first publication on HIV. In 1983.

CJ: So it's not something you recently came to?

EPE: No.

CJ: Have you published these particular arguments? I mean in a scientific journal?

EPE: Yes. In my first paper on AIDS in 1988. There I put forward a non-viral theory of AIDS and I also included some of what we've talked about today.

CJ: Where was that published?

EPE: In *Medical Hypotheses*.³

CJ: Not a well known journal?

EPE: It is a well known journal of ideas. There the discussion on HIV isolation is not as frank as we've had today but back then it was virtually impossible to question the existence of HIV. It was important to be subtle in order to get into print. Even so, it took a few years for that paper to be published. Initially I submitted it to a much more prominent journal but it was rejected. Twice in fact.

CJ: Which journal was that?

EPE: That's not important. Then in 1988 Val Turner and I wrote a paper which directly spelt out all the problems we've discussed today. We aimed that paper at clinicians and practising doctors in Australia.

offered it to a journal read by

CJ: No luck?

EPE: No luck.

CJ: So only the people who read *Medical Hypotheses* would have known what you thought ten years ago?

EPE: Yes.

CJ: You mentioned your non-viral theory of AIDS. Tell me a little about that.

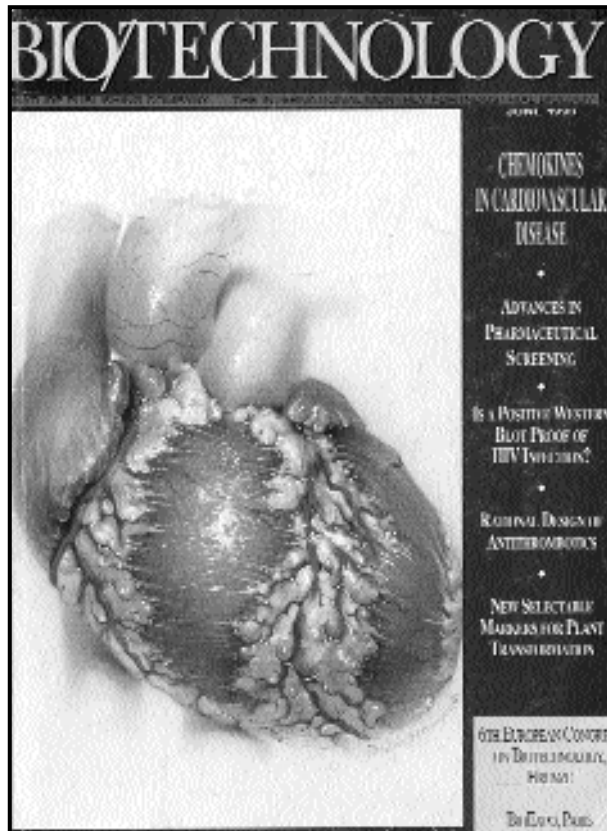
EPE: We were among the first people in the world to put forward the idea that non-infectious factors explain AIDS in gay men and the first to propose a non-infectious theory for all risk groups as well as a unifying mechanism. What's more, our theory predicts that the factors which cause the development of the AIDS diseases are also responsible for the phenomena which everyone else infers as the "isolation" of a retrovirus from AIDS patients.

CJ: How much reaction has there been to your theory?

EPE: Unfortunately very little but some research groups have confirmed some of our predictions including our prediction that antioxidants may be useful for treating individuals who are at risk for developing AIDS.

CJ: Have you managed to overcome the inertia to your ideas?

EPE: We haven't had much luck in the scientific press but some gay men and gay mens' organisations have become our greatest allies. If it wasn't for them I think our task would be almost impossible.



"That paper was certainly noticed but again, no-one responded to our views."

CJ: If you had to nominate a single obstacle hindering the resolution of the scientific problems with AIDS what would that be?

EPE: In our view the greatest single obstacle to understanding and solving AIDS is HIV.

CJ: That would explain why your group has written so many papers against HIV?

EPE: That's quite right. In fact we've written a lot more papers than we've had published. Unfortunately, we've only managed to get about a dozen or so papers into print in the scientific journals. One of the most important was a paper published in *Bio/Technology*⁵ which is now called *Nature/Biotechnology*. There we said straight out there is no proof of HIV isolation. That paper was certainly noticed but again, no one responded to our views.

CJ: So you remained a minority?

EPE: We aren't just a minority. We are still the only people to ever publish data in scientific journals questioning the existence of HIV and arguing that the HIV antibody tests are not proof of HIV infection.

CJ: Eleni, why, despite everything you have explained today, do virtually all the world's scientists and physicians appear extremely comfortable with the very evidence you find so hard to accept?

EPE: The problem is not a matter of accepting evidence. It's how evidence is interpreted. The way I see it is this. Most of the scientists and doctors who believe in HIV and that HIV causes AIDS do so because they accept the interpretation of a relative minority of experts. It's totally unrealistic to expect all the people who work in AIDS to analyse the data to the degree we have. As far as the HIV experts themselves are concerned, I don't know why they interpret the evidence as they do. I can only speculate. Perhaps it's because pictures are so powerful. There are pictures containing particles which look like a virus

and there's reverse transcriptase in the same cultures as the particles. It is possible mentally to connect particles, reverse transcription and proteins and the

antibodies that react with the proteins and make this into evidence for the existence of a retrovirus. Especially for a retrovirologist. I suppose that is the whole problem. We must not forget we are all subjective and we look at problems from our own perspective.

CJ: Well doesn't the same apply to your group's interpretation of the literature?

EPE: Certainly it does but don't lose sight of one very important aspect of all this that is not subjective.

CJ: What is that?

EPE: The definition of a virus and the method that follows for proving the existence of a virus. The same method that was endorsed by the Pasteur Institute in 1973. Nobody can deny that here is a method which constitutes absolute proof for the existence of a retrovirus. And what nobody can also deny is that HIV has never been accorded reality according to this method. In other words, in spite of AIDS being regarded as one of the gravest conditions ever to afflict the human race, no one has deemed it necessary to use a proven method to establish the existence of the putative cause of this dread disease. Instead everybody's opted for a set of non-specific criteria and appear to imagine that if you put all these together they must somehow metamorphose into the right answer.

CJ: Doesn't that have some merit? If they're all clues to a retrovirus surely the more you have the closer you get?

EPE: Certainly not. What if the true cause is something unexpected? Or something of which you have no knowledge or cannot even possibly imagine? In that case the more clues you have to what you are expecting, or what you want it to be, the more likely you will be misled. It all boils down to whether you would rather deal in probabilities rather than facts. That's what I mean about being subjective. It's like a physician seeing a patient with fever, diarrhoea, vomiting, weakness and shock and then declaring the cause is cholera. Sure it might be cholera but what about the dozens of other germs that cause a similar pattern? What if your life depended on it?

CJ: I see your point. Do you think now we've seen what's actually

in a density gradient, the tide will turn against HIV?

EPE: I would expect that data to be a turning point. Especially the more people get to see or know about it. And it confirms what our group has been saying for a very long time. In the introduction to the Franco/German paper the authors clearly affirm that before their pictures the 1.16 gm/ml density gradient was "considered to contain a population of relatively pure viral particles". That's our point. HIV has never been isolated and yet for the past fourteen years scientists and biomedical companies having been using this material to obtain proteins and RNA as if it is pure HIV. Pictures are powerful and that cuts both ways.

CJ: What do you think should happen now to AIDS research?

EPE: I think that the traditional method of virus isolation should be applied as urgently as possible using cultures with cells from AIDS patients as well as suitable controls. As I said, we must find out once and for all if there is such a thing called HIV. It's taken fourteen years to get a mere handful of electron microscope pictures of a density gradient and even if these had shown nothing but the right looking kind of particle, we're still missing all the other steps which are needed to arrive at a retrovirus.

CJ: Which steps are the most important?

EPE: All the steps are important. Establishing the presence of retroviral-like particles in cultures, purification and analysis of those particles, proof the particles can replicate and proof that the antibodies in patients' blood which react with the proteins taken from the particles are specific.

CJ: If this is not the case?

EPE: If these phenomena are also seen in control cultures, or if the particles which band at 1.16 gm/ml are of the wrong morphology or are not infectious, or if the antibodies present in

AIDS patients are not specific to those particles, then AIDS patients cannot be said to be infected with a unique virus HIV.

CJ: Which means HIV could end up similar to HL23V?

EPE: That is quite possible. The proteins said to belong to HL23V were defined in the same manner as the HIV proteins. By antibody reactions. So, when the antibodies were shown to be non-specific, HL23V disappeared. In the case of HL23V it was relatively easy because the antibodies occurred in so many people who were never going to get leukaemia they were bound to be something unrelated and that's what was eventually proven at Sloan Kettering and the National Cancer Institute. My group thinks that scientists will eventually accept that the same is true of HIV antibodies. You see AIDS patients are inundated with antibodies to so many different things a few of these could easily react with two or three of the ten proteins present in the "HIV" test. That's all that's required to be HIV positive. In fact, there's now ample evidence that antibodies produced as a result of infection with the two germs that infect ninety percent of AIDS patients react with all the HIV proteins. I mean the germs known as mycobacteria and yeasts that between them cause two of the commonest AIDS defining diseases. We have a paper on this in press in the British journal *Current Medical Research and Opinion*.³⁹ If that's the case how can anyone say these antibodies prove infection with HIV or that these diseases are caused by HIV?

CJ: Eleni Papadopulos-Eleopulos, many thanks for your time today.

EPE: My pleasure. ☐

Christine Johnson, July 1997

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REFERENCES are available from Continuum.

Choosing a doctor in the age of AIDS?

by *Michael Ellner*

Since 1982 tens of thousands of people have come to HEAL meetings in New York City to get an alternative view and approach to health and healing. HEAL provided the necessary resources to help them evaluate their actual health risks, and access alternative healthcare providers if they decided to use an alternative approach.

The 'AIDS Zone' is a mass trance that creates an imaginary hyper-desperation and helplessness in all who unknowingly slip into it. When participating and making choices within the Zone it is itself, in my opinion, the most dangerous and under-rated risk for developing AIDS-indicator diseases. For most people, primarily people who have tested 'positive', whenever discussing or even thinking about HIV or AIDS they do so unaware of their trance logic. The most important thing HEAL offers people is a way out of the trance; a way out of the Zone.

Could you be in the AIDS Zone? Take this simple test:

- Are you always afraid of getting sick and dying?
- Are you taking T-cell counts?
- Are you taking any conventional anti-HIV treatments?
- Are you taking any alternative anti-HIV treatments?
- Are you concerned about your viral load?
- Do you think every symptom and minor health problem is the beginning of the end?

If you answered yes to any of the above questions you are unknowingly operating with the Zone. This is dangerous because desperate people always make desperate choices.

Unfortunately, escaping from the AIDS Zone is not enough.



Rev. Dr MICHAEL ELLNER is a driving force in alternative healthcare. He has earned worldwide recognition as the President of HEAL - Health Education AIDS Liaison, New York City. A prominent hypno-healer, he has received many honours including the first International Association of Counsellors and Therapists' Mind/Body/Spirit Award and two Hypnosis

Humanities Awards from the U.S. National Guild of Hypnotists (1989, 1994). His significant new book *Quantum Focus* written with Richard Jamison Ph.D. explores self-healing and empower-



When choosing a healthcare provider one is wise to ensure that the practitioner you are considering is not him/herself stuck in the AIDS Zone. In the late eighties, a new breed of alternative and holistic practitioners began offering their services within the western allopathic context of treating 'HIV disease'. When HEAL talks about taking an alternative or holistic approach to maintaining or rebuilding health we are talking about practitioners who design a personalised protocol based on their patients' or clients' individual needs. This approach has been disregarded by these 'new' practitioners who instead treat 'HIV infection'. We recommend that people replace these practitioners with someone who practises classical alternative (or holistic) medicine, someone who views them as people with health problems and imbalances, rather than people with HIV or AIDS. Although many of these new 'alternative HIV' practitioners are well intentioned, they are best avoided and HEAL advises people to avoid any and all practitioners who treat "HIV infection." The task is to address genuine health risks and any problems people are actually experiencing.

We also recommend that people with or at risk for AIDS indicator diseases be aware of the special health risks that come with being viewed as being infected with HIV, which include: intense chronic fear and social isolation, relentless programming to get sick and die, and the fact that in far too many cases every problem they have will be blamed on HIV.

So before considering what kind of help you need it is important to calmly evaluate your health outside of the Zone. Because the tests for both HIV antibodies and the HI-Virus are simply not scientifically valid¹, if you haven't taken an HIV test - don't!

If you have already tested so-called 'HIV positive' it is best to consider all the risks associated with getting a false positive result and address the risks themselves. HEAL considers all positive results to be false positives in lieu of viral isolation. At most a positive result is, outside the Zone, a marker for possible serious health risks, and not the death sentence one gets within the Zone. As there is no specific evidence which demonstrates HIV has been properly isolated one may not think of oneself as HIV

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positive.

In order to help people better evaluate their prospective practitioner I offer you the Ellner test:

A) If you are otherwise healthy and have simply tested positive you must look the prospective practitioner in the eye and say: I am 'HIV positive' and am told that I'm at risk for AIDS. Do you think it is possible for me to live a long and healthy life? If the practitioner says anything but yes, find another practitioner!

B) If you have one or more AIDS indicator diseases or conditions, the test is a little different. In addition to eye contact, you must physically make contact with the doctor and say: I have 'AIDS'. Do you think it is possible for me to

regain my health and live a long healthy life? If the practitioner says anything but yes run for your life! Then calmly find another practitioner.

In certain situations conventional medical care can be and is life-saving. But, to do with 'AIDS', only in the context of actual diseases, i.e. the 'opportunistic' diseases themselves. In all other cases I believe AIDS specialists (both conventional and alternative) who are helping you wage a war against HIV can only hurt you and ultimately shorten your life.

Remember, educate yourself and then question, challenge and fire any and all healthcare providers who want to treat you inside the AIDS Zone. ☒

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From the following studies of HIV/AIDS survivors/non-progressors, adapted from a comprehensive list by HEAL Portland, Oregon, two important points emerge:

- (1) individuals did not use antiviral drugs;
- (2) they stopped all high-risk activity after testing positive.

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Inventing the AIDS Virus?

Truth or dare

by
Karl Krafeld

In July 1996, Californian molecular biologist Peter Duesberg declared he had the biological proof for the existence of what he calls a retrovirus and many call the AIDS-virus, HIV, and aired his right to *Continuum's* Missing Virus Reward of £1,000.

Argumentation with genetic sequences may conjure the idea of retroviruses, but it has never shown a scientifically proven, real, infectious one. To this day, who has proved that any retrovirus is more than an idea: a hypothesis – a reduced construct, manifest in HIV as a virulent obsession, of what's described as cognitive dissonance?

Years ago, Martin Irle, a German social-psychiatrist, described, in developing Festinger's theory, the psychological mechanism of reduction of cognitive dissonance. Festinger had proposed the dissonance between two troublingly irreconcilable cognitions is reduced by changing one cognition; Irle now proposed changing one cognition is not the only way: another is to build a hypothesis

which allows the two cognitions to coexist.

In 1970, deep dissonance emerged between the radical new cognition in genetics of reverse transcription (RNA transformed into DNA) vs. the established cognition that this 'reverse' direction of transcription had (apparently) been proved impossible. This clash of cognitions was reduced to the hypothesis of

**Gallo and Montagnier
announced the
discovery of a retrovirus
fully aware that there
was no proof for it**



KARL KRAFELD was born in 1949 in Salzbergen, Germany. He studied structural engineering, statistics and state law in Dortmund, and education with Prof. Paul Schwarzenau at the University of Dortmund. He worked for three years in an information service for handicapped people. In 1989 he received two prison warrants for disclosure of corruption in financial services, revealing actions by the German

government to concealed information on human rights, preventing them being known and making them therefore unthinkable. "When it is not allowed that reality becomes thinkable, it is not possible to find the right ways and means to solve problems. This would ultimately lead to global suicide." He reiterates the most shameful things are possible so long as they are carried out outside the thinkable.

His work against HIV/AIDS began in 1993 after the death of a friend, and he leads the challenge to the legal and constitutional bases for HIV/AIDS policy in Germany, stating "the uncontrolled dynamics of globalisation must be tied with the fetters of human rights."

"The situation is serious," he says, "because it is hopeful."

backwards-(retro)-viruses. With this idea of the marvel of retroviruses, the biologists' world was restored to harmony.

Although it later became accepted that reverse transcription is not an exceptional marvel at all, but a normal process in cells, no 'retrovirus' needed to explain it, few then questioned whether these marvellous viruses actually exist. Great retrovirologists had arisen, known worldwide, like Robert Gallo, Luc Montagnier and Duesberg. Retroviruses as a source of reverse transcription had still not been proven to exist as a biological entity, thus to exist at all. Did it matter whether they admitted they gained their reputation through adherence to an error, based on an understandable psychological reaction?

Then in 1983 Montagnier claimed the detection of a new retrovirus (LAV) in a pre-AIDS-patient, and in 1984 Gallo misused this 'detection' to celebrate worldwide with the US-government the discovery of the 'AIDS-virus HIV'. These reputed retrovirologists did not live outside the scientific world of reason in 1983/84. Gallo and Montagnier announced the discovery of a retrovirus fully aware that there was no proof for it. Keeping silent about this fundamental flaw, Duesberg countered "the retrovirus HIV is harmless".

Montagnier and Gallo in their fight over who discovered 'HIV' promoted the retroviral construct in a roundabout way. Peter Duesberg publicly claimed the Missing Virus Reward even after several scientists, including Dr Lanka, had published beyond reasonable doubt that there never was any discovery of such a retrovirus. Acting thus, was Duesberg mindless that with his collaboration millions of people would remain scared to death and

Inventing the AIDS Virus?



many people, including mostly homosexuals in the US and Europe and Africans, continue dying?

A scientist and even more a responsible scientist defines himself as willing to avoid the psycho-traps inherent in emotional pressures. Claiming the existence of retroviruses and HIV suggests to analysts only that a scientist has become a victim of a psycho-mechanism, of the reduction of the cognitive dissonance of a decade or so earlier. If in future Duesberg wants not to be named in the same breath as the scientific frauds Gallo and Montagnier he has to present the biological proofs, according to the fullest standards of biology, for the existence of retroviruses and HIV before he speaks about them, or claims "HIV is harmless" or even more, claims Missing Virus Rewards for the scientific proof of the existence of HIV. And if this is not possible...concur that belief in them is a psycho-product, an idea and a biological error.

Nobody forced him to claim *Continuum's* Missing Virus Reward. For all his AIDS-dissident campaigning, Duesberg faces an historic dilemma.

A scientist who wants to be respected must be able and willing to escape the influence of his own, and general, psychomechanisms. An individual who holds issues like personal cult higher than scientific rigour, be it Gallo, Montagnier, Duesberg, Papadopulos, Hässig or Lanka or any other is threatening lives, especially in the arena of HIV and AIDS. No scientist loses face when he or she admits an error of his or her own. On the contrary, such a scientist gains in reputation. "To err is human" – scientists who deny themselves this human characteristic declare themselves gods – and in the same moment suspect public figures.

With AIDS and HIV we are not dealing with scientific dust. Lives are definitely at risk. Scientific slopwork and lies are unacceptable. ☐

Escaping the AIDSZONE

by Frank Green

Reflections on The Scarlet Letters

I'd been HIV positive for years before I realized that widely accepted facts about the cause and treatment of AIDS were wrong. At first, I viewed my diagnosis as a death sentence, and the stress made me sick. I planned to take AZT until I read about its fatal toxicity in a countercultural magazine. I researched arcane sources and found dissident scientists questioning the role of HIV in AIDS. I quit going to HIV doctors, and began to trust my body. Ten years later, I'm healthy again. My friends who swallowed AZT to prolong their lives are all dead.

I wanted to counteract the victim mentality dominating art about AIDS by making a performance with a truly positive message. I wanted it to be both a self healing ritual and a political diatribe against medical nemesis. I wanted to rail against the prejudices I'd encountered, and the use of AIDS for sexual suppression. I wanted to examine the structures of medicine, challenge the authority of doctors, and provide alternative information. Above all, I wanted to honor the wholesome beauty and integrity of my body.

I made a performance with a structure based on the letters H, I, V, and +. The actions took place on a ritual cloth, a metaphor for my body as shamanistic healing circle. Slide projections showed my body progressing through made-up stages of skin disease, from red spots to lesions to solid red, the color of the warrior. I used make-up because I saw the HIV=AIDS=Death paradigm as artificially constructed. But it wasn't enough to show the surface; I had to get under the skin, where the virus supposedly lived, so I wallowed in scarlet paint as a metaphor for my blood.

Nathaniel Hawthorne's Hester Prynne is the prototype of the "high risk" sinner who transcends her punishment by embracing it. I constructed the text as correspondence to myself from characters in *The Scarlet Letter*, discovered in the labyrinth of my body. The epistolary form allowed me to step outside myself to speak objectively while remaining inside myself as subject of the ritual. Like Hester's embroidered "A", I elaborated my HIV brand with intricate art work.

The characters uncovered modern versions of mechanisms they'd embodied in the novel. Hester illuminates isolation, from the alleged separation of a virus in a test tube to the segregation of AIDS patients in prisons. Arthur Dimmesdale illustrated concealment, from the cult of confidentiality to the censorship of dissident scientists. Roger Chillingworth spoke for doctors whose false prophecies of doom were self-fulfilling. Pearl Prynne, pagan anarchist wild child, helped me reclaim my autonomy.

Some viewers were grateful for my life-affirming perspective, but others were angry with me for threatening the sacred cow of HIV prevention propaganda. Because the performance was grounded in my own self healing, I took it personally when presenters rejected it. So I made another performance about the folly of trying to change the world by clinging to my own rituals, and went on to other work.

Frank Green lives in Cleveland, Ohio. He began performing in East Village clubs in 1980 and has performed in galleries and theatres and throughout the U.S. and Canada.

Ventilating an AIDS Patient

Each generation of 'AIDS treatments' produces its own ethical dilemmas. KEVIN CORBETT describes how in the defining days of AIDS care treatment decisions were shaped by knowledge of antibody status.

I was working as a staff nurse on a medical ward for HIV and AIDS patients, having qualified as a nurse just over a year before. Previously, I'd gained experience in high dependency nursing on an intensive care unit (ICU).

I had trained in a very busy district general hospital which was also a local trauma centre before I came to work at a London teaching hospital. Thus, I found I was more clinically experienced in acute medical and surgical nursing than some other staff, even those more senior to me.

John was a 34-year old man admitted with a chest infection which his physician thought might be *Pneumocystis carinii* pneumonia. John had known his positive antibody status for two years. John was a gay man in a long term partnership with a guy called Mark.

John was running temperatures of 40° plus and was becoming increasingly short of breath. Just after admission he had expressed to the nurses that he wanted to live and fight this condition and wanted us to do "everything" to help him.

He was bronchoscoped and PCP was reported, confirming his physician's suspicion of AIDS. He was started on high doses of Septrin intravenously. John's veins were small and did not tolerate

cannulation very easily nor the toxic infusion of Septrin. It became necessary to insert a cannula into one of John's larger neck veins (a "central line").

Over several days his respiratory rate and his blood oxygen levels (gases) continued to deteriorate. When he started to become semi-conscious it was clear he would require assisted ventilation to support his breathing as the Septrin had not yet "kicked in" on his PCP.

The consulting physician decided John could not be mechanically ventilated (the usual option) as he had 'AIDS' and was continuing to be unresponsive to treatment. When challenged on this, the physician cited American research which "showed" that AIDS patients do not survive very long and that if an "active" treatment was pursued the patient would only "die on the ventilator" and it would become difficult to "turn the machine off".

We all challenged the physician many times about this series of decisions but there was suspicion of staff who questioned medical orders, especially those who were openly gay, such as myself. The

implication was always that as we were gay, we had a "problem" about HIV/AIDS. This physician had said to several staff that I was fearing what was happening to the patients would soon happen to me. He said to me he preferred that nurses "...make the beds and leave treatment decisions to the doctors" and that I was denying the "reality of AIDS" which is of course "death and dying", and he would only ventilate an "AIDS case" in "certain situations" which he couldn't really specify except that to do so would necessitate "acute deterioration" in such a patient. Those few of us who had worked in ICU knew this to be unsound practice.

I argued with this decision, as the research he quoted was pooled case report data only, with no control group, and had represented the very first efforts at ventilating PCP in the United States. The physician unwittingly revealed to several of us that there were concerns about admitting a positive patient to the ICU and he was "unsure" if the ICU anaesthetist would be willing to ventilate an "infected case".

On every shift the nursing staff were insisting more serious support be given to John's breathing. I remember thinking how surprising it was that no physician had thought of this eventuality, of ventilating an AIDS patient. This seemed unusual. No-one had thought through the clinical reality of ventilating.

I remembered the first day the unit was opened for admissions and a boozy group of doctors came up to see "the first AIDS unit in the UK". I felt now the significance of their joking about how if we put out a 333 call (cardiac arrest) for the ward, everyone would know it's us (AIDS) and wouldn't come. We didn't appreciate the joke at the time, but now it seemed like they were giving

The treatment decision was not clear, to us, John or his partner and the medical approach was fatalistic

us insights into what were the actual medical attitudes around the hospital to "our boys" – as they had referred to the patients that night.

Instead of sedating and mechanically ventilating John, the decision was taken to

set up a continuous positive airways pressure system (CPAP). Although this would offer some support to his gases, it is generally considered a less effective approach. It was used here as a sub-palliative. We nurses thought that the treatment decision was not clear, to us, John or his partner and that the medical approach was fatalistic in not offering mechanical ventilation, which can at least be tried and discontinued if unsuccessful.

Although the CPAP increased his gases for a time, John's condition steadily worsened. He became increasingly semi-conscious even on the CPAP device as his oxygen saturation became poorer. I remember the Tuesday afternoon of the Professor's ward round when it was first said John was "...dying..." and diamorphine should be prescribed to promote comfort. This was asked for by the nurses: in small titrated doses it has a calming effect.

However, we were all surprised about how much (a massive 15 mg) was actually written up on the chart to be given as a 'stat' (one off) dose, administered by the quickest route possible (intra-

venously). Several of us challenged such a high dose and the route of administration on the grounds of its likely fatal effect. As I was managing this shift of nursing staff I was liaising with the physicians. On presenting surprise at the dose, I was pretty promptly told by the attending physician to administer the drug as the patient was dying and was prescribed the drug which "he needed", and that the Professor had approved this course of action. Furthermore, he pointed out, the prescription was legal and who was I to question this medical order.

Although I was the most senior nurse on and had worked in ICU, I still was new to AIDS care. I asked a colleague from the ward opposite to come over and help me make sense of the situation. Marion had worked in AIDS for years and actually had nursed John on previous admissions. She was surprised at the dose and asked the physician didn't he know "...it would kill" John. I asked the physician if he was prepared to administer the prescription himself, which he legally could have, but he refused and quickly began to leave the ward.

Marion and I together administered the prescription in a much reduced dose (2.5 mg) by a slower and more sustained route (subcutaneously). We watched during the next half hour as John's respiratory rate went down from 60/minute to 9. I looked at Marion and knew she was wondering as indeed I was what could have happened if we'd given him the full amount.

Later on in the shift the nursing staff said they were worried that such a prescription left written on a patient's chart could prove

altered" by a nurse and she did not really want to "get involved" in what she saw as "doctor's" decisions "best left to the doctors". However, nothing further came of my changing the chart.

The physicians counselled Mark in preparation for John's death. Interestingly, just at this point, a laboratory culture of a specimen taken during John's bronchoscopy was reported to the us from the lab. The report confirmed that in addition to John having PCP, he also had well-established *Staphylococcus aureus* ('Staph') infection in his lungs, and needed to receive another antibiotic in addition to Septrin. An emergency chest X-ray confirmed a consolidation in both lung fields consistent with untreated Staph infection. When the new antibiotic was started John improved.

After several weeks it became clear John was surviving. Intensive physiotherapy was needed to correct muscle damage and wasting, due to his immobility sustained during treatment. I remember that many of the nurses felt angry John had not received intensive care protocol during the episode, and it served to remind us how such scenarios were in reality difficult. Several of the nurses became angry and wanted to know why there was no "dedicated" ventilator for our unit, and asked for money to be set aside for one. Some of the nurses felt responsible for the muscle loss as they said they had in a way expected him to die and had not performed the appropriate exercises and turning.

One year after this event studies were published which showed that "first episodes" of PCP could be successfully ventilated in ICU's and protocols were published for admission to ICU for AIDS patients.

Four years later on, as a nurse specialist attending a case conference at the hospital, I walked up behind John in the corridor. He was attending a clinic appointment (he had been taking PCP prophylaxis), and was walking with a stick on one side and his partner on the other. I remember recalling in that instant of recognition those events of years before and how it had shaken us and how many had felt John was "terminal".

John died at home a full four and a half years after the initial episode of "PCP".

This case showed me how arbitrary were the developing UK treatments in HIV and AIDS related conditions, but also proved to me how powerful medical opinion was in setting the "frame" for the treatment of the "case". Some were even angry that John hadn't died as expected. Even at the time of John's illness, protocols existed elsewhere in the world for ICU treatment of such a "case". For me the experience was one of coming up against an overwhelming sense of fatalism that John would die because he had "HIV" and "AIDS". It felt like the opposition between two sets of beliefs: between the wish fulfilment of the "terminal" medical prognosis and that of advocating an individual's right to attempt to survive.

This experience also served to remind me how orthodox medicine was treating AIDS patients differently because all AIDS patients are seen as inevitably "progressing": this was the model for "HIV/AIDS". I remember having fantasies about what I called "frame scenarios" for many of the patients and their clinical histories, which were a replay in my mind of their clinical events and histories but with another frame wrapped around it – a sort of control frame to use a research term. For example, I would think of John walking into a casualty ("Accident and Emergency" or "ER") department and not informing them about being diagnosed with HIV/AIDS and seeing the extent or limit of what could be enacted in order to salvage him, to see if what had actually been offered to John was indeed the artefact of a self-fulfilling medical prophecy which was really about orthodox medical convictions that HIV/AIDS patients are inevitably "dying". I was coming to see how powerful was medicine's view of the AIDS patient as "dying" and that this was shaping the clinical reality for the individual patient, and the nursing and medical staff. To me it seemed unjust, but in a sense very telling, that in John's "case" he had survived despite the medical "support". □

People's names have been changed and identities withheld to preserve confidentiality.



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South Bank and London Universities. In 1995 he began wide-ranging doctoral research at South Bank University into people's experiences of self help and empowerment, focusing on the complex discourses in "HIV/AIDS". Kevin would be glad to hear readers' experiences.

lethal. I paged the physician to change the prescription: agency nurses were on later that night who had no knowledge of the patient except he was "dying" with "AIDS" and we were concerned the overdose situation might arise. The physician did not respond and it was already past the end of the shift. Before going off duty I changed the prescription to ensure no overdose would occur.

The following day John's condition had stabilised – he had not deteriorated but wasn't really improving. Coming on duty that afternoon, I learned that the physician had complained to the senior nurse that the prescription was not given in full to a "dying man who needed it" and that John's medical chart had been altered by myself against the hospital's procedure. I could feel the procedural straightjacket tightening around me. I was interviewed by the senior nurse and reprimanded for changing the chart and formal discipline was threatened. I stressed that our concern was about the issue of John expressing his wish to live and his wish to have "everything done". I argued the physicians were "writing John off". They had been unwilling to offer any further medical hope but were themselves unwilling to administer this potentially final dose. The senior nurse accepted this dose, if given as medically instructed in a "bolus" i.e. in one go, was especially dangerous and would undoubtedly have proved lethal for John. Yet, her view was pragmatic: the chart should "not have been

'HIV' Witch

Confession, Possession, Obsession

by
Alex Russell

"The people need wholesome fear; they want to fear something. They want someone to frighten them and make them shudderingly submissive"
—Ernst Roehm, gay leader
of the Nazi SA Brownshirts.

"The demon threatened to kill me if I had refused co-operation."
—Interrogation of five year-old witch Andreas Forster
before Bamberg's Inquisition, 8 May, 1629.

A confession written at a witch hunt trial in Bamberg, 1629 uncannily resembles the typical interrogations of gay men suspected of being 'HIV+' by 'AIDS' counsellors. The inquisitors recorded the confessions of a child, referred to as 'Witchboy'. The court authorities said that the accused was being visited by his demon even in the presence of the inquisitors. The account of the Witchboy, consisting of a twenty-four page deposition, is a revealing testimony about the demonological belief of the time as shared by the accusers and accused alike. The document serves as a memorial to the uncounted multitudes of children murdered by the inquisitional machinery. My essay serves as a memorial to the thousands persecuted and executed as a result of the 'HIV' Witch Hunts.

The nine years old boy was brought before the interrogators and declared himself willing to confess, after having been encouraged to do so without the application of torture. The authorities named the boy a witch based purely on accusation and rumour. The boy was willing to go along with the accusation. A new identity emerged in the boy; he saw himself as a recruit of the Devil. Witchboy blamed the cunning and menacing demon for his wrong doings. Witchboy probably did believe in his own fantastic stories which were formed out of mythomania, brainwashing and the demonology embedded in Christian cosmology. The Witchboy trial seems like 'HIV' counselling sessions with their superstitious belief in a 'retrovirus' invested by pseudo science with virtually paranormal powers. Belief in 'HIV' is like the belief in the Holy Ghost or

the Devil – a prerequisite article of Faith. 'HIV' operates on three levels: the metaphysical as a 'demon identity'; the psychological as a fantasy object of desire and the bio-chemical as an amorphous constellation of non-viral material and non-specific proteins. Demonology now masquerades as virtual virology. 'HIV+' identity exactly equates with demonic possession, and today – as in the Middle Ages – the obsessive preoccupation is with how to cast out the demon, 'HIV'. 'HIV Witch doctors' cast the 'evil eye' on the 'cursed-diagnosed' which can induce a death-sentence in the naive and the gullible. Witchboy's experiences resemble those of today's 'HIV+ Witchboys'. Consider the transcript:

The Hearings, April, 3rd, 1629, Witchboy confessed:

"My friend George who stood beside my bed started to talk to me. He tried to persuade me to learn the art of witchcraft... I didn't want to get involved in witchcraft... George got very angry and would not leave me alone... It was George who later became my little demon lover. He grew two horns and had two goat's feet. He was usually in the company of three friends and flew on a pitchfork on which there was room enough for all three of them... George had already taught witchcraft to two other playmates and these two now demanded to have their own demon-lovers..."

Many 'HIV+ witchboys' form conversations with their 'demon HIV'; like Witchboy had done with his demon, George. The late Derek Jarman screamed vituperative abuse at his beloved 'HIV'. Jarman insanely accepted a death-sentence pronounced on him by the 'HIV' Inquisition and was slowly tortured to death by AZT-poisoning.

April, 4th, 1629; Witchboy confessed:

"Creek water was poured over me and I was baptised in the name of the demon and of the demon's lord, the Devil. After the baptism was over, my demon George tried to stab me in the left arm and in both eyes. But since I was scared that it would hurt, I didn't want him

boys...

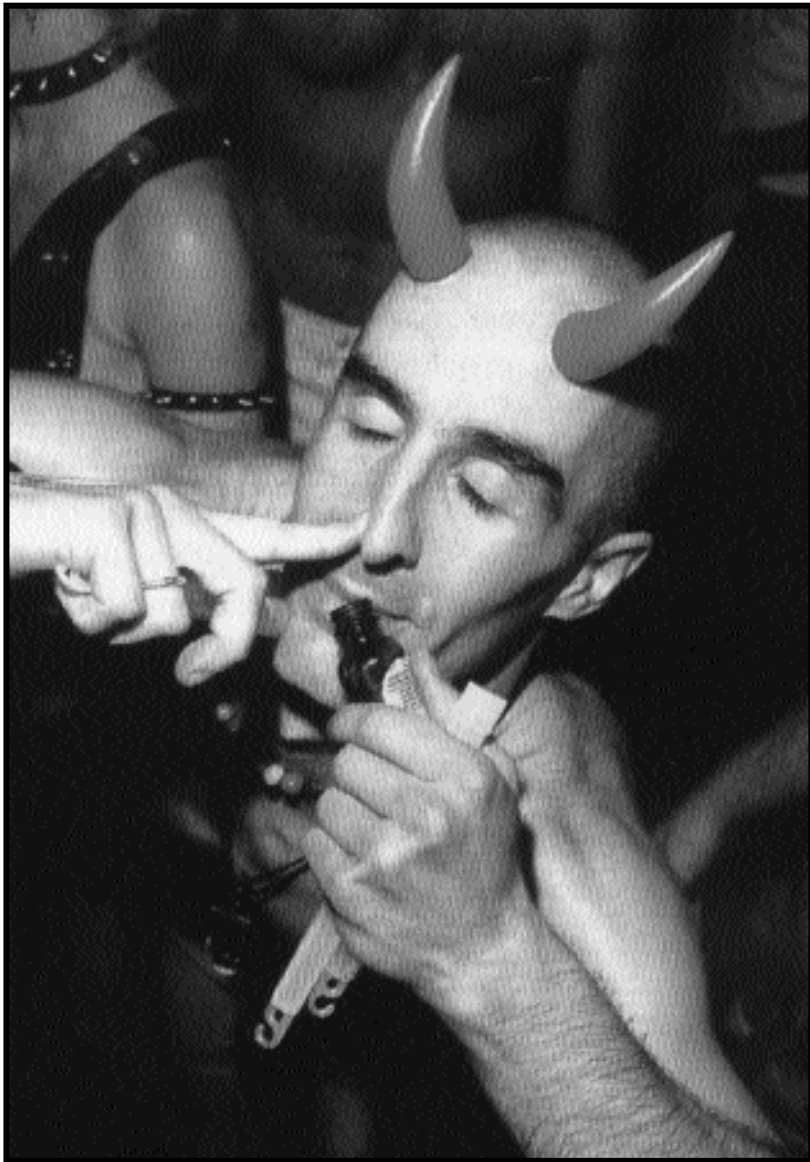


PHOTO: Gordon Rainsford

AZT can drive out Devils! The alchemic remedies brewed by 'HIV' witch doctors to purge the 'virus' are little better than their forbears who subjected their patients to a regime of emetics, leeches and laxatives – sometimes prophylactically – all too frequently resulting in the patients' deaths. 'Viral loads', the PCR 'HIV' tests and CD4 cell-counts are merely more 'sophisticated' forms of dealing with viral-demon possession and amount to little more than witchcraft masquerading as state of the art wizardry. Thus ironically, the patient and physician are both victims of possession, the former by the phantom 'virus', the later by scientific error. John Mellors of the University of Pittsburg proclaimed: "Viral load has nothing to do with infectivity!"

Like the 'HIV possessed' imagine their (demon) 'HIV' programmes them, Witchboy confessed that he had to be obedient to his demon:

"My demon George commanded me to stop calling God...Instead, from then on, I was to regard my demon as my God and pray to him- just as all witches were supposed to pray to their demons...My job in the cellar was to sit on top of the wine barrels and whip them with a leather strap, which my demon had given me for exactly that purpose."

to do it. That made my demon quite mad and he threatened to break my neck. Anyway, finally he got the upper hand and stabbed me in the arm and in the eyes with a tiny spear that was very sharp. The blood was then used to write my name into a secret book...I was to regard my demon as my God and pray to him...Whenever I made the sign of the cross, I had to do so in the name of my demon."

Witchboy's baptism is strikingly similar to the 'HIV' blood test and today the damned have their medical files stamped with the Sign of the Cross: 'HIV+'. The Demoniacal belief was conveyed to the general population by the church and the Inquisition who firmly believed that Witchboy was possessed by his demon while they were interrogating him. The Inquisitors were convinced of the reality of the nocturnal flight and the witches' Sabbath just as the 'HIV' researcher is blindly convinced that 'HIV' is a lethal pathogen and

witch, Andreas Forster, believed that they could fly and would 'lubricate' their 'pitchforks' for the flights. Contemporary interpretations have connected 'lubrication' to psychedelic drugs and 'flying' as analogous to 'tripping on ecstasy'.

In 17th century Germany, witchboys were implicated in the use of 'prohibited pharmaceuticals'; entire groups of youths were implicated in their use and were subsequently liquidated by the Inquisition. Gangs of 'sorcerer-boys' were executed in Styria (1678), Tyrol (1679), Salzburg (1678-90) and Bavaria (1690, 1698). The vast majority of these drug-trials consisted of witchboy gangs who were accused of killing people and livestock with their devilish lotions. Bamberg's prince-bishops demanded the banning of folk-pharmacopeia used in demon ritual (salves, ointments, greases, lotions). In 1617, Bamberg's Prince-Bishop Johann Gottfried von Aschhausen declared a war against drugs.

Many 'HIV+' witchboys practice pink-magic

pharmacopeia-cocktails: AZT with body building steroids, protease inhibitors with Ecstasy and poppers with everything. The Devil's Powder and Lotions were blamed for the spread of the Black Death by the Church; today's medical and street drugs spread the Pink Plague: *plus ça change...?* The role of narcotic-addiction and demonic-possession are the constant factors found in 17th century witchboys and 'HIV+' witchboys. The 'HIV+' Witchboys' coven is held at the 'circuit parties' where intoxication, orgies and substance use are rife. One advert for a circuit party sponsored by several Dallas 'AIDS' groups read: 'ABANDON HOPE ALL YE WHO ENTER HERE!' Witchboy's confession abounds with images of witchboy-gang members consuming urine, faeces and blood as the rituals belonging to their liturgy; just as many 'HIV+' Witchboys are into Yellow, Brown and Red; the ritualistic codes of The Scene. London's Dr Mike 'Let Them Eat Cack' Youle stated that it was safe to eat shit because there was not much 'HIV' in it. Moreover, Youle condones the lethal cocktail mix of protease inhibitors with Ecstasy.

Historically, the Devil's attempt to win the person for his evil purpose was invariably coupled with a sexual encounter; every witch accusation simultaneously was an accusation of sexual transgression; mainly sexual relations with the Devil. The old injunction – 'Thou shalt not suffer a witch to live' – is now adapted by the medical profession – 'Thou shalt programme an HIV positive to auto-destruct' – and they will be 'saved' by the purging of the 'virus'. Just as the Middle Ages believed in destroying the body to save the soul, contemporary doctors are set on eradicating the 'virus' even if it means killing the patient. The death of the patient is indeed the sign of the exorcism of the demon 'HIV'.

Possession, blood, death and an obsession with sex link medieval demonology with contemporary quasi-virology. Just as many believed that the Black Death was the doing of witches, so in the early 1980s 'AIDS' was dubbed as the 'Gay Plague'. Gay men now find themselves in the ironic position of promoting and acting out the homophobic fantasies of straight epidemiologists who have created a global panic-pandemic based on their own sexual fantasy that 'AIDS' is a sexually transmitted plague! The natural successor to Matthew Hopkins, the Witch Finder General of 17th Century England is Robert Gallo, the Virus Finder General, who described 'AIDS' as "the crucible in which the field of immunology would have its baptism by fire". Gallo proposes that gays and drug users are genetically predis-

posed to the encouragement of 'HIV mutation'; prompting his former colleague Peter Duesberg to remark: "According to Gallo's hypothesis most American homosexuals, haemophiliacs and intravenous drug users are mutants". Medieval-demonic possession, like 'HIV diagnosis', has always been equated with 'deviant' sexual activity. Once one is possessed with the Demon-'HIV' the only route to salvation is through confession, penitence and expiation. The Medieval mind was obsessed with how many angels could dance on the head of a pin; today's obsession is with how many 'HIV demon-particles' are present in a drop of blood: virtual-virology displaces theology.

German 17th century witchboys' fabricated mythomaniacal stories to please their interrogators; today bedevilled 'HIV+'s confess elaborate fantasies for their 'HIV' counsellors on how the demon 'HIV' possessed them often adapting their responses to meet expectations. This extends even to being able to pinpoint the moment of imaginary possession by the diabolic-'HIV' – from the night the condom broke or the exposure to 'bad blood'. Playing the role of the possessed can have a powerful physiological impact. Once the psyche of an 'HIV+' has been programmed to a certain role definition, the body may mimic the appropriate somatic symptoms. This is termed 'HIV virtuality-sickness'. Psychoanalyst Jacques Lacan argued that a radical break in one's psychological perception can trigger specific biochemical changes and immune system reactions.

Gary Null reconfirms this view: "The mind itself is able to manifest all the things that we call this 'AIDS' syndrome in the initial immune depression. I believe that any correlation between a positive HIV test result and a risk from immune suppression is purely psychic. It can be traumatic, and it can be lethal..." (*Zenger's*, August, 1997). The 'HIV+' test result can initiate the subconscious desire for 'AIDS-ing' which is so common amongst masochistic gay men (who are predisposed to the Freudian Death-Drive). Thus, testing 'HIV+' may catalyse repressed material, triggering the genesis of a psychosomatic-illness which is then accelerated by 'anti viral' drug regimes. The dividing line between sickness and health is always arbitrary and is drawn by our own desires. Lacan and Freud argued that there is 'pleasure' to be found in suffering and that psychosomatic response is the register of unconscious desire. Medical doctors fail to see that 'AIDS-ing' is also a psychosomatic condition; – by crudely reducing 'AIDSing' to the biological they fail to acknowledge that the mind and body are inter-dependent.

Inquisitors' initial questions focused on the circumstances under which the accused first met the Devil which invariably involved a sexual encounter.

The sexual activity described in the more lurid confessions merged into a phantasmagoria of orgiastic sex. The confessions were structured as narratives, around the succession of temptation, diabolical pact, Sabbath and harm done to neighbours. Just as the Inquisitors probed the soul to extirpate the demon, today the probing tongues of anally-obsessed 'HIV' counsellors penetrate the rectum as the zone of diabolic infection, applying proctology to demonology and declaring rectal sex to be anathema. This voyeuristic obsession with sexual diabolism blinds the 'HIV' witch doctors to the

Another Virus Finder General
Prof. Richard Tedder, of
University College London,
receives royalties for his
1986 patent (licensed to
Wellcome) for the first UK
'HIV' antibody test:

"I spend a lot of time chasing the virus, because I hate its guts. Alright? I may owe my professional career to a certain amount of working with this virus but I despise it. And anything I can do to stop it transmitting around the world I would gladly do. And that includes putting you [defenders of non-HIV hypotheses] in your place."

UP-Front, Granada TV, 1992

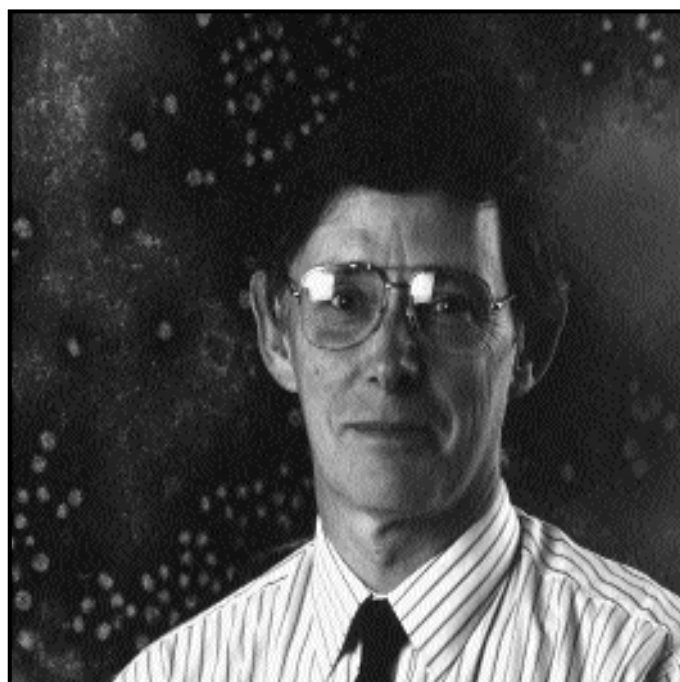


PHOTO: UCL

patients' real symptoms, or more frequently, the lack of them. Dementia and mental-illness were readily interpreted by 17th century Inquisitors in terms of demonic possession or obsession just as dementia in 'AIDS' patients is superstitiously and incorrectly attributed to 'HIV'.

The condition of being possessed by demons is recognised by outward signs: the ritual of exorcism was 'The Test' involved to determine whether a well-known set of symptoms had been identified, mainly whether the demon had taken over the body. The neuro-physiological and psychological signs that indicate Demonic Possession include: insomnia, dementia, fever, mania, abdominal pain, a change in facial features and auto-aggression up to suicide. Ironically, the demoniac-AZT also causes insomnia, dementia, fever, mania and a change in facial features!

And death.

Hysteria, agitation, convulsions, copious foaming saliva, eating faeces, screaming fits and grinding teeth are further symptoms of demonic possession.

Demoniac 'HIV Hysteria' has produced similar signs and symptoms in 'undiagnosed' and 'diagnosed' 'HIV' Witch finders: Martin Delaney, Robert Gallo, Anthony Fauci, Simon Watney, Duncan Campbell and Larry Kramer have been seen at public meetings ranting and frothing at the mouth when any heretic dares to challenge their dogma of 'HIV' obsession-possession. At the 'Transmission '96 Conference', Kramer, with the manic gesticulations of a rabid mongrel dog, snarled that Neville Hodgkinson's book *AIDS - The Failure of Contemporary Science* should be: "spoilt, spat at, and rendered unreadable". Kramer's retarded and reactionary actions typify the psychosis of 'HIV Hysteria'. During the Middle Ages and the Renaissance, hysteria was viewed as a sign of possession by the devil; today hysteria may be regarded as possession by the evil spirit 'HIV'. 'HIV Hysteria' is more common in the 'undiagnosed'.

Capuchin Jacques d'Autun, in 1644, criticised the ignorance of judges at witch trials which would seem to fit the blind bigoted prejudices of 'HIV' physicians and journalists:

"I am astonished by the behaviour of some judges, who tremble at the simple name of witches, and believe that all those suspected of witchcraft are already convicted: the opinion which preoccupies their mind is a coloured glass, which transfers its hue to all the objects which become before their eyes... Their readiness to believe the witnesses who accuse an idiot (who does not know how to defend himself) deceives them to such an extent that the stupidity of the accused passes for a confession."

The gullibility of the 'HIV+' cursed results in an inevitable death sentence and execution.

No witch-confession was complete without disclosing the other members of the 'coven'; this ensured the inquisition machinery kept moving. 'HIV' witch doctors will also ask how many sexual contacts a patient has had in order to co-opt them into the sexual cluster. This is called contact tracing and exactly echoes suspected witches pressured to denounce members of their coven.

Just as 17th century witchboys embroidered their

sexual experiences to satisfy the prurient cravings of their Inquisitors in the hope of better treatment so the post-modern 'HIV+' witchboys will embroider their virtual-reality 'HIV cripple-symptoms' to gain attention.

Some have even been taught by 'HIV' support-groups the lucrative charade of faking 'HIV-virtual-disabilities' - i.e. walking slowly - to qualify for higher benefit; thus milking the system in revenge for imagined persecutions. Avarice triumphant over paranoia. Many 'HIV+' witchboys have internalised the demonised mythology of the 'HIV' Inquisition that



PHOTO: Gordon Rainsford

rectal sex spreads the diabolic-'HIV'. Yet 'HIV Grand Inquisitor', Dr David Ho, gave 'evidence' that 'viral load tests' show that 99.8% of putative 'HIV particles' are non-infectious - which rules out sexual-transmission of the evil-'HIV'. 'HIV+' heretics that refuse to 'believe' in 'HIV' are said to be in 'denial' and may even have their 'HIV' benefits terminated; just as any religious heretic will be denied the sacraments. If you are cursed 'HIV+' and slavishly subscribe to the 'HIV' myth they will give you wads of cash and loads of drugs but you'll pay for it with your life.

'HIV' counsellors will even suspect an 'HIV' negative person from a high risk-group of harbouring a 'hidden' strain of 'HIV': possession by association. Moreover, for an 'HIV negative' to dabble with an 'HIV positive' is regarded as

fraternising with the possessed.

Don Mattia Bergamasco wrote to the Inquisitor of Aquileia in 1628:

"I accuse before the Holy Office Girolamo Cucchiul, my practitioner, as one who publicly professes to be able to identify the bewitched and heal them, to know who are witches and even their names, without ever having seen them. And he spreads this around with the danger that the relatives of the victims might try to kill a person who may very well be innocent."

How many 'HIV' witch doctors have accused and subsequently executed someone suspected of being 'HIV+' possessed?

On 21 May 1649, Michele Soppe, a travelling witch doctor (benandante) was arrested and incarcerated by the Holy Office on the charge of infanticide. The Inquisitor had been informed that Soppe: "always goes around from one village to another making signs over the sick, and plies them with remedies to cure them, and he also reveals who has been bewitched and how..."

Soppe confessed that he had killed children at devil's orders and confessed that even his cures had occurred through the direct intervention of the devil. Today, infanticide occurs through direct intervention of AZT-euthanasia.

Techniques used by 'HIV' counsellors could have been learned directly from witch trial inquisitors:

- 1) establishment of possession (an 'HIV+' diagnosis),
- 2) admission of sex with the Demon ('unprotected rectal sex'),
- 3) need to confess (outing one's self as 'I'm HIV+'),
- 4) channelling of guilt by identifying other members of your coven ('HIV' contact-tracing),
- 5) re-education or redemption (practising 'safe sex' /

- a lifetime of terrorised penitence),
- 6) progress toward a new harmony Gestalt ('living with HIV'),
- 7) final confession; I signed a pact with the Devil in my own blood ('I practised unsafe sex'),
- 8) ritual redemptive slaughter – auto da fe (iatrogenic-death by 'antiviral' drugs).

Unless they are able to break this psychic-stranglehold, persons processed by the above techniques will become indoctrinated into believing that they are 'possessed' by a demon – ('diagnosed' with 'HIV'). Those that failed to break free from this mind-set have allowed themselves to be ritually dispatched. 'HIV' witch doctors reinforce 'HIV virtuality-sickness' in their patients through voodoo-hypnosis and then execute them with 'antiviral' drugs. If you want to live avoid 'HIV' witch doctors like the plague.

John Lauritsen, in 'HIV Voodoo From Burroughs-Wellcome' (*New York Native*, 7.1.1991), quotes Dr Quentin Young's concept of 'iatrogenicide' as: "The systematic destruction of a large group of people by doctors".

Once the demon 'HIV' is cast into the group-tranced 'believers' they commit 'autogenocide': this echoes the miracle of the Gadarene Swine when Christ exorcised the demons of sick people by casting them into a heard of pigs who then dutifully killed themselves:

"So the devils besought him, saying, If thou cast us out, suffer us to go away into the heard of swine. And he said unto them, Go. And when they were come out, they went into the heard of swine: and, behold, the whole heard of swine ran violently down a steep place into the sea, and perished in the waters". St Matthew, Chapter 8.

Like Lemmings, the 'virus possessed' are leaping into the quick-sands of 'antiviral' drug-trials for an early-exit. People suffering from demonic possession often report that the demon wants to kill them by forcing them into a suicidal act. Suicide is the apex of narcissism.

Witchboy's final confession:

"Now I wish to receive the Holy Eucharist to be safe from the demon; so that the demon cannot reach me anymore".

Is this any different to 'HIV+s' being persuaded to receive AZT – for their sins – as the last rites? The Eucharist devotion of gulping AZT is the infantile desire to incorporate the Primal Father through the mouth. 'AIDS' researchers come out with idiotic nursery-talk: "Children with AIDS too often lose their minds. AZT can make them better...An 8-year old boy, once normal, was rendered practically autistic by HIV." (*Science*, 6.10.1989). Autistic 'HIV' Inquisitors and their captive cloned clients are drawn towards these childishly monstrous fantasies. This 'HIV belief' results in a regression to a second childhood and a retreat from the complex (intellectual/cultural) to the simple (mythomania/vegetative).

The 'HIV'-possessed are the Living-Dead, the Un-Dead. Held in a kind of living-death, the 'HIV tranced'

are like Antigone, entombed, buried alive, deprived of air and sustenance. The desire for the phantom 'HIV' is a desire to incorporate the absent Father. We are no longer ruled by the Father, but the ghost of the Father, the ghost of 'HIV'. These identificatory fusions help to give one a binding and relevance with an Imaginary Order: the 'HIV' Primal Horde of the Doomed. People will settle for any known set of identifications, however regressive, in order to remain fixed into the familiar symbolic order: 'HIV' as the cannibalised and internalised Primal Father. The need to identify with 'HIV' compensates for an impoverished and sterile existence. Desire to identify with 'HIV' is founded in 'loss'. It is 'loss' that drives life and 'HIV' denotes a filler of this 'void'. To compensate for their 'lack-in-being', many

gay men desire 'to be HIV'. Yet once they are 'diagnosed HIV', they become deluded, bored and then the gulf of 'lack' reopens and the gnawing sense of their nothingness returns. The paradox of 'HIV Identity' is that, because its origin is linked to desire, it is also non-identity – that is, the space where the sense of Otherness enters the world.

Human beings pursue objects that sustain fantasies, even though attaining an object of fantasy, such as 'HIV', can never completely close the void. The crucial function of the fantasy-object 'HIV' is that of filling up an actual void. While the desire for the fantasy-object 'HIV' can never fill up the gap of loss itself it can initiate a creative nexus of images and fantasies of plenitude and empowerment that can liberate the self from the 'curse' of an 'HIV+' diagnosis. Desire reveals

a power that disrupts any simple 'HIV self-identity', yet one that can also be the cradle for a new opening. Rather than succumb to the religious bigotry of the 'HIV Clergy', there are ever growing numbers of 'HIV diagnosed' who refuse to be sacrificed 'HIV Witchboys' by rejecting the group-delusion theology of the 'HIV Belief' system.

Like the multitudes persecuted and executed by the 'HIV' Witch Hunts, Derek Jarman, Rudolf Nureyev, Denholm Elliott, Freddie Mercury, Kimberly Bergalis, John Curry, Kenny Everett, Oscar Moore, Rebecca and Bonnie Handel died from the iatrogenic 'HIV' voodoo-curse put on them by the conclave of 'HIV' Inquisitors – counsellors, missionaries, doctors, journalists. These bewitched 'HIV+' martyrs died for 'HIV Belief'; they were abject willing slaves of the 'HIV Clergy'. Their willingness to enter into 'HIV Slavery' results from fear, guilt and ignorance coupled with a desire to subscribe to a 'movement', a 'belief-system'. Enslavement is always the final result of desire. The passionate devotion to the 'HIV Cause' means giving up one's critical faculty and succumbing to a persistent vegetative state. Freud noted that when people leave religions they see themselves regaining their critical faculties. Lacanian and Freudian psychoanalysis may help the group-tranced 'HIV' Witchboys reclaim their critical thought and autonomous being. □

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The Torments of the Damned. Terry Bouis (1420-75)

The Liver of the Matter



Once thought to be the seat of courage, love etc., the liver is central to our bodies' endless process of removing unwanted chemicals.

Leading British nutritionist and Director of the Society for the Promotion of Nutritional Therapy
LINDA LAZARIDES takes a closer look.

One of our body's most vital functions is to convert metabolic products and toxins into safe, soluble substances which can be eliminated via the urine or the gall bladder into the intestines. **The liver** plays an all-important role in this process – known as detoxification or biotransformation. Recent research has shown that many patients with chronic illnesses have a disordered liver biotransformation ability.

We simply don't know all the diseases and health disorders which may be promoted by a toxic overload resulting from such dysfunction, but progress is beginning to be made in looking at specific detoxification pathways and relating underfunctioning of these to the development of disease.

Pathways

A number of biochemical 'pathways' – sequences of chemical changes – are involved in liver biotransformation. These are normally grouped into **oxidation, reduction or hydrolysis** reactions (**Phase I**) and **conjugation** reactions (**Phase II**). **Phase I** reactions are catalysed by a group of liver enzymes scientifically known as cytochrome P450 oxidases (or P450 oxidases or cytochrome p450s). These enzymes introduce oxygen into the chemical structure of toxins or metabolites. Typically, by this process the toxins are converted into **intermediate substances** – alcohols and aldehydes – then into acids, which are water-soluble, and can be excreted via the urine.

Phase I detoxification

The intermediate substances created during **Phase I** detoxification, which include reactive oxygen species (free radicals), can be extremely toxic – far *more* so than the original toxins. Their harmful effects are primarily controlled by antioxidant nutrients/enzymes: a plentiful supply of these substances is essential. Apart from free radicals, intermediate metabolites include chloral hydrate (which is identical to the knock-out drug often known as a 'Mickey Finn'), epoxides, and endogenous benzodiazepines – substances similar to Valium and other tranquillisers and sleeping pills. This makes it easier to understand how chronic fatigue, for instance, can develop when a toxic overload is present.

The more P450 enzymes are induced in the liver, the more of the toxic intermediates will be present in the body. P450 enzymes are induced by caffeine, alcohol, dioxin and other pollutants, exhaust fumes, high

protein diets, oranges and tangerines, organophosphorus pesticides, paint fumes, steroid hormones, and a variety of drugs including paracetamol (acetaminophen), diazepam tranquillisers and sleeping pills, the contraceptive pill and cortisone.

Aldehydes

Substances which can *inhibit* the action of P450 enzymes include carbon tetrachloride, carbon monoxide, barbiturates, quercetin and naringenin (found in grapefruit). The oxidation reaction can also be blocked by an excess of toxic chemicals, a lack of enzymes, lack of nutrients and/or loss of oxygen.

Such blocking results in a build-up of more toxic substances such as formaldehyde and other aldehydes in tissue. This can in turn lead to a spreading phenomenon, with increasing sensitivity to more chemicals such as ketones and alcohols, and eventually even to natural chemicals occurring in foods, pollen and mould. A build-up of aldehydes can in severe cases lead to tissue cross-linking, causing vasculitis with possible seizures and brain damage.

Although most aldehydes in the body are thought to occur as intermediate metabolites, external sources include exposure to formaldehyde gas (which is given off by new carpets, curtains and other furnishings) and breakdown products of ethylene glycol and methanol.

Two known sources of aldehydes are intestinal overgrowth with *Candida albicans*, as well as the peroxidation of polyunsaturated fats. The fatigue, foggy thinking and 'brain fog' linked with candidiasis may be due to an overloading of the detoxification system with aldehydes, which can even lead to a reverse reaction of aldehyde to alcohol. Extreme intolerance to alcohol consumption may occur in these individuals, as it does in those diagnosed with ME or chronic fatigue syndrome.

Amines

Cytochrome P450 and other oxidizing enzymes also oxidize amines such as phenylethylamine found in chocolate, tyramine found in cheese, and adrenaline, noradrenaline and dopamine. These are oxidized into aldehydes by the enzyme mitochondrial monoamine oxidase (MAO) – if this enzyme is blocked, for instance by MAO inhibitor drugs used to treat depression, tyramine, for instance, cannot be metabolized and hypertension can develop as a chemical sensitivity reaction.

Glossary

acetylation – combination with acetic acid

alveolar macrophages – rounded granular phagocyte cells in the alveoli of the lungs that ingest inhaled particulate matter

aldehydes – a class of organic compounds containing the atomic group C(Carbon)H(Hydrogen)O(Oxygen)

amines – organic compounds containing nitrogen

amino acids – the chief constituents of proteins; the “building blocks” of life

biochemical pathway – a series of chemical enzyme reactions, that converts one biological material into another

Candida albicans – a quite common fungus in humans, which when unchecked can cause illness

catalyse – speeding up of a chemical reaction by a substance which remains after the reaction

conjugation – the joining together of two compounds to form another

corpus luteum – a yellow glandular mass in the ovary

dioxins – a group of chemicals present as trace contaminants in herbicides

endogenous – arising from within the organism

epoxides – compounds containing one oxygen atom bound to two different carbon atoms

ethylene glycol – a solvent used as an antifreeze

gall bladder – the reservoir for bile, on the surface of the liver

hydrolysis – the splitting of a substance’s molecules by adding water (H₂O): a hydrogen-oxygen molecule (HO-) being added to one fragment, and the hydrogen atom (H) to the other

hydrophilic – readily interacting with water

intracellular – within cells

ketones – a class of organic compounds containing the molecule C=O

lipids – fats and fat-like substances

lipophilic – readily reacting with fat

lymphocytes – an immune-system cell generated by lymph tissue

metabolic, -ism – all the processes which create and maintain, and use up, organised living matter

metabolites – any substance produced by metabolism

methanol – a solvent

methylation – the addition of a methyl, i.e. a molecule of C(Carbon) and three H(Hydrogen) atoms

mitochondria – small cell organelles, with their own nucleic acids, that through synthesis of adenosine triphosphate (ATP) produce most of the energy for cells

monocytes – cells formed in bone marrow that travel to tissues, e.g. lungs and liver, to develop into macrophages

oxidation – the removal of electrons from the atoms of a substance; often by combination with oxygen

pantothenic acid – a member of the vitamin B complex

peptide – a compound of more than two amino acids

peroxidation – a chemical reaction creating an oxide with more oxygen than any other

polyunsaturated – denoting a chemical compound, particularly a fatty acid, having two or more double or triple bonds in its hydrocarbon chain

reduction – the addition of electrons to the atoms of a substance; often by combination with hydrogen

thiol – the univalent – S(sulphur)H(hydrogen) group

vasculitis – inflammation of a (usually blood) vessel

xenobiotics – substances foreign to the body

Phase II detoxification (conjugation)

There are five main conjugation categories, including **acetylation**, **acylation** (peptide conjugation with amino acids), **sulphur conjugations**, **methylations** and **conjugation with glucuronic acid**. Some substances enter Phase II detoxification directly, others come via Phase I pathways.

Conjugation involves the combining of a metabolite or toxin with another substance which adds a hydrophilic (or water-reactive) molecule to it, converting lipophilic (or fat-reactive) substances to water-soluble forms for excretion and elimination. Individual xenobiotics and metabolites usually follow a specific path, so whereas caffeine is metabolized by P450 enzymes, aspirin-based medications are conjugated with glycine, and paracetamol with sulphate.

Acetylation

Acetylation requires pantothenic acid to function. It is the chief degradation pathway for compounds containing aromatic amines such as histamine, serotonin, PABA, P-amino salicylic acid, aniline and procaine amide. It is also a pathway for sulphur amides, aliphatic amines and complex hydrazines.

A proportion of the general population – perhaps up to 50 per cent – are slow acetylators. This rises to as high a level as 80 per cent among the chemically sensitive population. Their N-acetyltransferase activity is thought to be reduced, and this prolongs the action of drugs and other toxic chemicals, thus enhancing their toxicity.

Acylation

Acylation uses acyl CO-A, with the amino acids **glycine**, **glutamine** and **taurine**. Conjugation of bile acids in the liver with glycine or taurine is essential for the efficient removal of these potentially toxic compounds. Disturbed acylation by pollutant overload decreases proper levels of bile in the gastrointestinal tract, resulting in poor assimilation of lipids and fat-soluble vitamins, and disturbed cholesterol metabolism.

Toluene, the most popular industrial organic solvent, is converted by the liver into benzoate, which like aspirin must then be detoxified by conjugation with the amino acid glycine (glycination): large doses of glycine and N-glycylglycine are used in treating aspirin overdose. Benzoate itself is present in many food substances and is widely used as a food preservative.

Glycine is a commonly available amino acid, but the capacity to synthesize taurine may be limited by low activity of the enzyme cysteine-sulfinic acid decarboxylase. Damage can occur to this enzyme directly by pollutants, or by overload/over-use resulting in depletion.

Both taurine- and glycine-dependent reactions require an alkaline pH: 7.8 to 8.0. Environmental medicine specialists may alkalinize over-acidic patients by administering sodium and potassium bicarbonate in order to facilitate these reactions.

Glutathione conjugation, using the amino acid glutathione in its reduced form,

is used for the transformation of xenobiotics such as aromatic disulphides, naphthalene, anthracene, phenanthracin compounds, aliphatic disulphides – and the regeneration of endogenous thiols from disulphides. There is a cycle of replenishment for glutathione, allowing it to be reformed after conversion to glutathione reductase. Heavy metals can inhibit this cycle, thus preventing replenishment.

Sulphur conjugation (sulphation)

Neurotransmitters, steroid hormones, certain drugs and many xenobiotic and phenolic compounds such as oestrone (one of the forms of oestrogen), aliphatic alcohols, aryl amines and alicyclic hydroxy-steroids employ sulphation as their primary route of detoxification. Steventon at Birmingham University (UK) has found that many sufferers from Parkinsonism, motor neurone disease and Alzheimer’s disease as well as environmental illness, tend to have a reduced ability to produce sulphate from the amino acid cysteine in their body, and instead accumulate cysteine.

Sulphate may be ingested from food, but is also produced by the action of the enzyme cysteine dioxygenase on cysteine. This process is known as sulphoxidation.

The body’s ability to conjugate toxins with sulphate is ‘rate limited’ by the amount of sulphate present; if there is inadequate sulphate, toxins and metabolites can accumulate, perhaps building up to levels which cause degeneration of nervous tissue after several decades.

Steventon’s findings are a matter for serious concern. How many individuals are given the opportunity to find out whether they are poor sulphoxidizers and to reduce their chances of developing the above mentioned diseases by improving their sulphoxidation ability?

Methylation

According to environmental medicine specialist William Rae, the process most often disturbed in chemically sensitive people involves methylation reactions catalysed by S-adenosyl-L-methionine-dependent enzymes. Methionine is the chief methyl donor to detoxify amines, phenols, thiols, noradrenaline, adrenaline, dopamine, melatonin, L-dopa, histamine, serotonin, pyridine, sulphites and hypochlorites into compounds excreted through the lungs. Methionine is needed to detoxify the hypochlorite reaction.

The activity of the methyltransferase enzyme is dependent on magnesium, and, due to the frequency of magnesium deficiency, supplementation with this nutrient will often stabilize chemically sensitive patients.

Glucuronidation

Glucuronic acid is a metabolite of glucose. It can conjugate with chemical and bacterial toxins such as alcohols, phenols, enols, carboxylic acid, amines, hydroxyamines, carbamides, sulphonamides and thiols, as well as some normal metabolites in a process known as glucuronidation.

For most individuals glucuronidation is a supplementary detoxification pathway. It is a secondary, slower process than sulphation or glycation, but is important if those pathways are diminished or saturated. Obese people seem to have an enhanced capacity to detoxify molecules that can use the glucuronidation pathway.

However, damage to the capacity for oxidative phosphorylation which takes place in the mitochondria, is likely to diminish the capacity for glucuronide conjugation.

Overload

If the liver's detoxification pathways are excessively stimulated and overly utilised, they eventually become depleted or begin to respond poorly – being suppressed by toxic chemicals. Once breakdown of the main pathways occurs as a result of pollutant overload, toxins are shunted to lesser pathways, eventually overloading them, and disturbing orderly nutrient metabolism. Chemical sensitivity may then occur, followed by nutrient depletion and finally fixed-name disease. Depleted immunity is also a potential outcome of a toxic overload.

Interesting facts

• Dr William Rae of the Environmental Health Centre in Dallas says that the most severely ill chemically sensitive patients not only have abnormally low antipollutant enzymes, in addition to toxic suppression and nutrient depletion, but in some instances **antibodies** are produced against cytochrome P450 and these may inhibit or decrease its effectiveness.

• Environmental medicine specialists have found that almost 35 per cent of chemically sensitive patients are deficient in intracellular sulphur. Not only can this hinder the detoxification of some sulphur-containing and other toxic chemicals, it can enhance the harmful effects of exposure to cyanide from foods such as cassava and almonds as well as from tobacco products. The hereditary disease known as Leber's optic atrophy involves a defect in the ability to detoxify cyanide, and leads to sudden, permanent blindness on first exposure to cyanide in small amounts such as those ingested from smoking cigarettes.

• Many multimineral supplements in the UK omit iron and copper due to theories that individuals may already be overloaded with these nutrients. However if no overload is present, an unbalanced supplement may promote depletion of the minerals. The Environmental Health Centre in Dallas finds that intravenous

infusions to replenish iron stores brings dramatic improvements for the chemically sensitive patient as part of their detoxification process. Copper is also found to help catalyse the cytochrome systems. (NB: self-supplementation with iron and copper should be cautious, to avoid iron and copper overload conditions).

• Although the liver is the primary site for oxidation of xenobiotics, the cytochrome P450 system is found in other tissues that are exposed to environmental compounds like the skin, lungs, gastrointestinal tract, kidneys, placenta, corpus luteum, lymphocytes, monocytes, pulmonary alveolar macrophages, adrenals, testes and brain, in both the mitochondria and in the nuclear membrane.

• Always rinse your washing-up carefully. Pollutants in the form of solvents and detergents can damage and penetrate cell membranes and damage the contents of the cell.

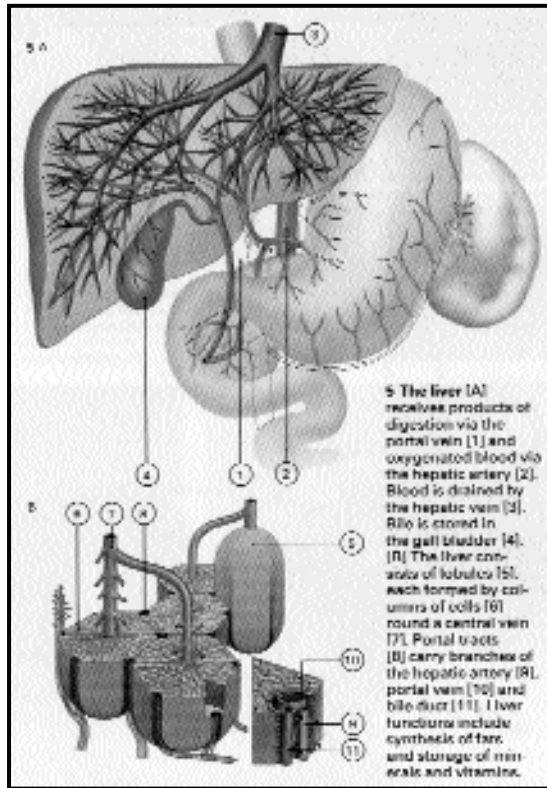
• Vitamin B3 has been shown to accelerate the clearance of aldehydes in some chemically sensitive patients.

• Molybdenum, although an essential element, competes with sulphate in its activation step to the important enzyme PAPS and can thus lower sulphate levels and impair sulphation ability. Environmental medicine experts warn that molybdenum supplementation may be contraindicated in individuals with poor sulphation ability.

• The substance naringenin, found in grapefruit, can significantly inhibit **Phase I** detoxification, as can grapefruit itself. This may prove clinically useful in some situations where **Phase**

I activity is too high, (as shown in liver function tests available from nutritional therapists).

• Persons who have been exposed to toxic chemicals, drugs and other xenobiotics, have increased requirements for some vitamins. Functional nutritional assays for vitamins B1, B2, B3, B6, B12 and folate, and serum levels of vitamins A, D, C and beta carotene were performed in a random sample of 333 environmentally-sensitive patients prior to treatment. 57.8% were found to be deficient in B6, 37.7% in vitamin D, 34.9% in B2, 32.2% in folate, 27.7% in vitamin C, 21.4% in niacin, 14.9% in B12, 5.6% in vitamin A and 4.6% in beta-carotene. (Ross GH *et al*: Evidence for vitamin deficiencies in environmentally-sensitive patients. *Clinical Ecology* 6(2):60-6, 1989.)



Adapted from the Nutritional Health Bible by Linda Lazarides (Thorsons, £9.99). Published September 1997. Available from all good bookshops or by mail order from SPNT Books (see address below).

For help with a liver detoxification programme, it is best to consult a nutritional therapist, who can arrange for (non-invasive) tests to determine which pathways need boosting. For a list of nutritional therapists and other natural medicine practitioners in your area, send £1 plus sae to: Society for the Promotion of Nutritional Therapy (SPNT), PO Box 47, Heathfield,

<p>Foods to aid detoxification</p> <p>Beetroot helps with liver drainage</p> <p>Broccoli, cauliflower and other cruciferous vegetables these aid cytochrome P450 activity</p> <p>Protein</p> <p>Radish, watercress rich in sulphur.</p> <p>Supplements to aid liver detoxification</p> <p>B complex vitamins</p> <p>Digestive enzymes may be necessary to ensure that protein is adequately digested and glycine is readily available</p> <p>Essential fatty acids</p> <p>N-acetyl cysteine (NAC)</p> <p>Reduced glutathione</p> <p>Selenium, zinc, magnesium and manganese possibly iron and copper if used with caution</p> <p>Taurine (a useful combination product is magnesium taurate)</p> <p>Vitamins C and E and beta carotene.</p>	<p>Liver herbs to aid detoxification (traditionally known as 'blood cleansing' herbs)</p> <p>Dandelion root cholagogue (stimulates liver secretions and bile flow)</p> <p>Globe artichoke leaf promotes regeneration of the liver and promotes blood flow in that organ</p> <p>Silymarin according to recent research, this herbal extract stabilizes the membranes of liver cells, preventing the entry of virus toxins and other toxic compounds including drugs. Promotes regeneration of the liver.</p> <p>Turmeric a cholagogue like dandelion, but may irritate the gastric mucosa. Its advantages are its cheapness and ability to be used in cookery.</p> <p>These herbs are best combined with wild yam, which helps to prevent liver spasms caused by gall bladder stimulating herbs.</p>
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AZT: AN AIDS DEFINING DRUG part 2

AZT

by
Martin Walker

INFLUENCING DEMOCRACY

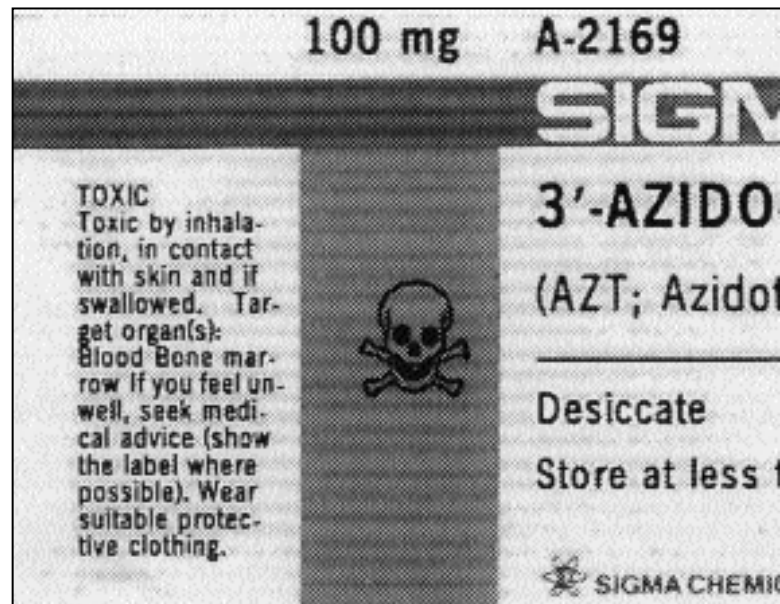
By the end of their term in office the last British Conservative government had become the 'government of sleaze'. To the public, 'sleaze' had come to be symbolised by brown paper envelopes filled with money for questions, given to MPs as payment for lobbying ministers.

In looking to pursue its marketing strategy for AZT inside the British parliament, Wellcome used two devices: first the science lobby and scientific institutions and secondly a small all-party parliamentary campaigning group, the All Party Parliamentary Group on AIDS (APGOA), which had until 1987 been more or less dormant.

In October 1988, just as Wellcome and the Medical Research Council were beginning the Concorde trials, the APGOA received sudden and quite substantial funding. This funding came in part from the Wellcome Foundation which in 1988 gave around £10,000. In later years, as well as the Wellcome donation, CRUSAID, a charity funded by Wellcome and responsible for distributing money to grass roots groups supporting people suffering from AIDS-associated illnesses, gave money to APGOA. Other contributors to APGOA were Roche and the London International Group, whose subsidiary, the London Rubber Company, produces condoms.

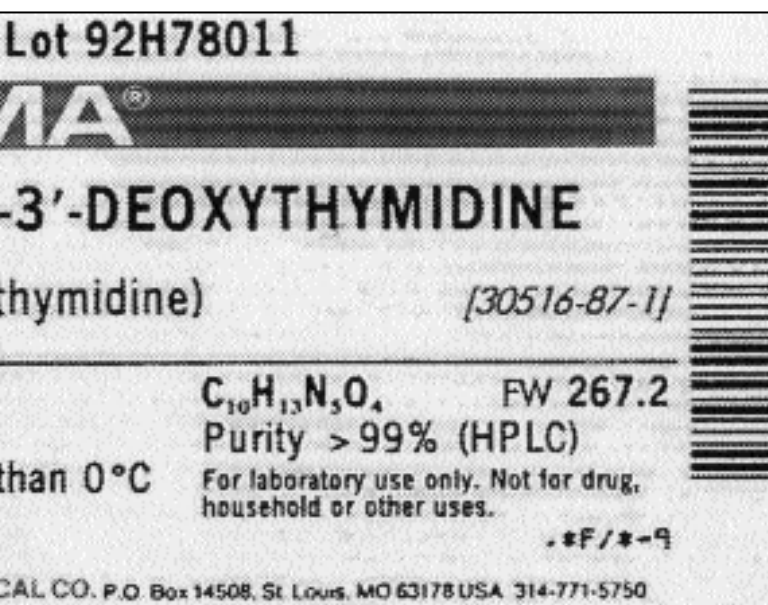
In November 1988, APGOA began regular publication of the *Parliamentary AIDS Digest*, a forty- or fifty-page journal published four or five times a year. The group funded two research workers who worked within parliament producing the Digest.

From the time that Wellcome began sponsoring the APGOA, doctors who wrote for the *Digest* and those who attended the all-party meetings were, in the main, doctors involved in the Concorde trials or another of Wellcome's grant-receiving projects.



From 1989 onwards, Wellcome had an input to government which was even more influential than contact with MPs in the House. In July 1989, Sir Alfred Shepperd, who was at the time Chairman of Burroughs Wellcome and who had been Chairman of the Wellcome Foundation up to 1985, was a member of the Advisory Council on Science and Technology (ACST). This body advises the government and the civil service on matters of science. Its meetings are attended by the chief scientific adviser to the Cabinet Office and departmental chief scientists and scientific advisers. Also on this committee in the late 1980s was Professor Roy Anderson, who at that time headed the department of Pure and Applied Biology at London's Imperial College of Science, Technology and Medicine. He was also a Wellcome Trustee. As a trustee he was one of a handful of powerful men who controlled the Wellcome funding empire. Throughout the time of his term of office with the ACST Professor Anderson was one of the most vociferous proselytisers for AZT.

A Seller's Market



SCIENCE AND INDUSTRY

In America it was the National Institutes of Health that controlled all the research around 'HIV and AIDS', ensuring that scientists kept to the beaten track. Research into 'HIV' was allowed but not into AIDS; research was allowed into anti-viral pharmaceuticals but not into natural health care for immune system disorders.

In Britain AIDS research funding and its direction were controlled by the Medical Research Council (MRC). The MRC was originally set up with a number of other Research Councils, so that government money could be equitably allocated to government-prioritised medical research projects.

Although scientific research had always had some identity of interest with industry, it was not until after the second world war that the dichotomy between the interests of citizens and those of industry began to be manifest. This dichotomy became evident in a number of different ways; with the advent of crop spraying with

pesticides for example.

From its inception, the MRC was superficially independent of industry. In the nineteen fifties, the organisation made various forays into such areas as the effects of chemicals on health. By the nineteen seventies, the MRC was constrained from any independent research by its links with industry. By the nineteen eighties, things had become much worse and as the government increasingly cut back on research funding their place was taken by industrial companies in partnership agreements, and the Wellcome Trust. By the late eighties and the era of AZT marketing, the MRC was the dog of an institution being wagged mercilessly by its pharmaceutical tail.

The results of many of these publicly supported projects were never published by the MRC. A clause in the research protocol ensured that Wellcome, or another company, had use of the research results before, or even instead of, the MRC.

In the Concorde Trial protocols, Wellcome managed to negotiate a clause of just this kind and consequently Wellcome were able to suspend the trial results while they organised damage limitation. During the waiting time, a number of Wellcome directors cashed in their own shares in the company. When the results were finally published they were written in 'scientese' which obscured their easy understanding.

A review of the MRC Committee on AIDS (MRCCoA), at the time when AZT was on the agenda, opens a window onto the intricate machinery of scientific vested interests that industry has created over the years. The individuals or their specific vested interests are not as important as the process which is involved; individuals and their interests change but the process continues.

In the mid eighties, MRCCoA consisted of a Chairman and eight members. The Chairman was Lord Jellicoe, who was also, at the time of Concorde, Chairman of the MRC itself. Lord Jellicoe was leader of the House of Lords from 1970-73 and during his time in the Lords he has been a member of the All Party Group for the Chemical Industry. At the time of Concorde he was also Vice Chairman of the All Party Parliamentary Group on AIDS. From 1978 to 1983 he was Chairman of the Board of Directors of Tate and Lyle, Britain's biggest sugar company. In 1993, he was Chairman of Booker Tate, the confectionery conglomerate. From

1985 to 1990 he was on the Board of the Davy Corporation, a company which makes plant for the pharmaceutical and food processing industries. Lord Jellicoe is also involved with Rockefeller interests through a Directorship of Morgan Crucible.

Sir Austin Bide, a member of MRCCoA from 1987 to 1990, was the chief executive of the drug company Glaxo from 1973 to 1980 and then became the first Chairman of the Board and in 1985 their honorary President. Sir Austin has been Chairman of the anti-socialist Adam Smith Institute since 1986 and from 1974 to 1985 he was a member of the Council of the CBI.

An interest in the promotion of processed food is the one thing which stands out in the career of Sir David Crouch, a member of MRCCoA in the late eighties and Conservative MP for Canterbury from 1966 to 1987. He was a member of the Society of the Chemical Industry and Chairman of the All Party Group for the chemical industry for almost twenty years from 1970 to 1987. He was a director of the pharmaceutical company Pfizer from 1966 to 1987.

Sir David's real interests, however, were in public relations; since 1964 he was chairman of David Crouch & Co, marketing and PR consultants, whose clients include Beechams. He was also a director of two other leading PR firms in the field of processed food marketing: Burson Marsteller Ltd, of which he was a director from 1972 to 1983, handle many of the large processed food and pharmaceutical accounts, including an account for Wellcome. In 1989, Sir David was a director of Kingsway Rowland the company which handled aspects of the PR account of AZT for Wellcome.

Of the scientists on the MRCCoA, Dr Joseph W.G. Smith is an interesting individual. Recently a Director of the Public Health Laboratory Service, in the 1970s he was head of bacteriology at the Wellcome research laboratories.

The most important of the MRC AIDS subcommittees throughout the time of Wellcome's Concorde trials was the AIDS Therapeutic Trials Committee. This committee was responsible for selecting and overseeing all government and industry sponsored trials into AIDS and HIV at the time Wellcome received its license for AZT. At least five members of this committee, the only committee in the country which could, during the late eighties, have furthered competitive research and drug development, had received funding through the Wellcome Trust.

The monopolisation and infiltration of 'independent' research facilities by commercial and industrial interests, represented, well before privatisation, a considerable shift in the control of public money. As happened at the Ministry of Agriculture, Fisheries and Food, over the years the base of both research and regulation which had always been in the industry, began to manifest an everyday policy which was against the interests of consumers. How, for example, could the MRC ever be involved in independent research into health and chemicals, chemicals and food, chemicals and cancer, when its committees are dominated by chemical company interests?

THE MEDICAL PROFESSION

Since the middle of the last century, first serving the new industrial bourgeoisie and later the working class as well, the general practitioner became the mainstay of the National Health Service. Until the 1960s, many general practitioners had a reputation for independence of mind. Over the last thirty years this independence has been eroded on the one hand by the drug marketing and the introduction of centralised high technology centres of scientific medical excellence and on the other hand by ongoing fiscal crisis.

From the beginning, Wellcome marketed AZT as a complex, high flying and very expensive drug. One of the advantages of this was that Wellcome did not have to depend upon general practitioners to dispense the drug. The ordinary doctor was, in fact, a serious problem for Wellcome as they entered the field of AIDS. What if general practitioners were to find other ways of treating HIV antibody positive patients?

Wellcome set out to educate general practitioners to the enormous dangers of HIV and AIDS, ensuring that most general

practitioners were so afraid of the highly contagious nature of the 'disease', that they quickly passed patients on to the hospitals. To reinforce this and strike further discipline into doctors, the General Medical Council ruled that it would be a disciplinary offence for general doctors to treat AIDS patients.

In 1987, the year that AZT was licensed, the British Medical Association (BMA), the professional trade union for doctors and an organisation which had substantial links with Wellcome, set up the BMA Foundation for AIDS. In March 1988, Wellcome gave a covenant to the Foundation, a sum of £36,000 annually for four years, totalling £144,000. This meant that at the very heart of the British medical profession, Wellcome had control of the information flow on AIDS.

In 1988, Wellcome helped fund a £150,000 educational package for GPs about HIV and AIDS. The package contained three videos. It was expected that Wellcome representatives, together with reps from Calmic, one of Wellcome's hygiene product companies, would show the videos and promote the free package in all 11,000 surgeries in Britain.

The Chairman of the BMA Foundation for AIDS was Dr John Marks who was also at that time Chairman of the Council of the BMA. Dr John Marks is the brother of Professor Vincent Marks, a leading member of a group which at that time was called the Campaign Against Health Fraud and later changed its name to HealthWatch. Professor Vincent Marks, with two of his colleagues at Surrey University, was also the recipient of a Medical Research Council grant of almost £120,000 to research 'monoclonal antibodies to HIV'. Wellcome's testing kits depended upon the efficient production of such monoclonal antibodies.

Another trustee of the BMA Foundation on AIDS was Dr Brian Gazzard, at that time, consultant physician at Westminster and St. Stephen's Hospital. Dr Gazzard had appeared on Wellcome's sales caravans and was also at the time one of the Concorde trial doctors. Dr Gazzard had also worked on research funded by the Wellcome Trust into so-called HIV, at the London School of Hygiene and Tropical Medicine.

THE VOLUNTARY SECTOR ORGANISATIONS

The 1968 Medicines Act makes it a criminal offence to advertise medical treatments directly to patients (vulnerably ill people). However, the sale of AZT directly to individuals who had tested 'HIV antibody' positive – using a Wellcome-produced testing kit – was from the beginning the cornerstone of Wellcome's marketing strategy.

Those who suffered AIDS-associated illnesses or who had been diagnosed 'HIV antibody' positive, mainly gay men, were an unknown factor. Pharmaceutical companies had no real experience of dealing with large, youthful, cultural identity groups.

The greatest potential for drug pushing was to be found in the plethora of self-help organisations which were springing up throughout the country. Here at these focal locations, not only gay men gathered but specifically those who had tested 'HIV antibody' positive.

Wellcome set out to buy up all the self-help groups which had contact with gay men who tested 'HIV antibody' positive in Britain and America. Where they were unable to fund them directly, they gave grants for journals, papers and magazines or for specific projects. There were no overt strings attached to such money but recipients had to adhere to the medical model of AIDS and act as conduits by which off-the-street gay men concerned about their health could be funnelled into the charnel houses of chemotherapy.

The grant funding of self-help groups in the field of AIDS, by vested interest organisations, is perhaps one of the greatest scandals of AIDS medicine. By bombarding newly tested gay men with partial information about AZT and other so-called anti-viral drugs, Wellcome had found a way round the Medicines Act and the perfect way to construct a drugs market. Wellcome adopted a strategy which has been known within politics for hundreds of years. Wellcome didn't need General Practitioners to sell AZT, they mounted their beach heads in the bourgeois sectors of the gay community and developed a colonial class which administered the medical model for them.

The use of self-help organisations was and still is a systematic marketing strategy, and while it is important to list the groups which received drug company money, it is more important to understand the strategy which Wellcome used.

Sally joined an organisation called Positive Life (PL) which had been set up by people who were HIV antibody positive. PL had been set up for five years by the time Sally joined in 1991.

Soon after starting work, Sally was asked to write a number of articles about AZT. Sally was nervous about writing the articles because she felt the need to be critical but responsible and she was worried she might upset people by suggesting AZT was toxic.

Not long after her first article came out she was contacted by the head of the Health Education Authority AIDS programme who suggested that her article might contain inaccuracies. She was insistent that Sally should have lunch with her. When Sally went to lunch she found that a media relations manager from Wellcome's Public Relations Department was also there.

The conversation over lunch centred upon Wellcome's relationship with voluntary sector organisations and the problems of marketing AZT. Not long after the lunch, the coordinator of PL received a phone call from a public relations company informing them that Wellcome wanted to fund their organisation. PL did not accept the money.

BIG SCIENCE RIDING OFF INTO THE BLACK HOLE

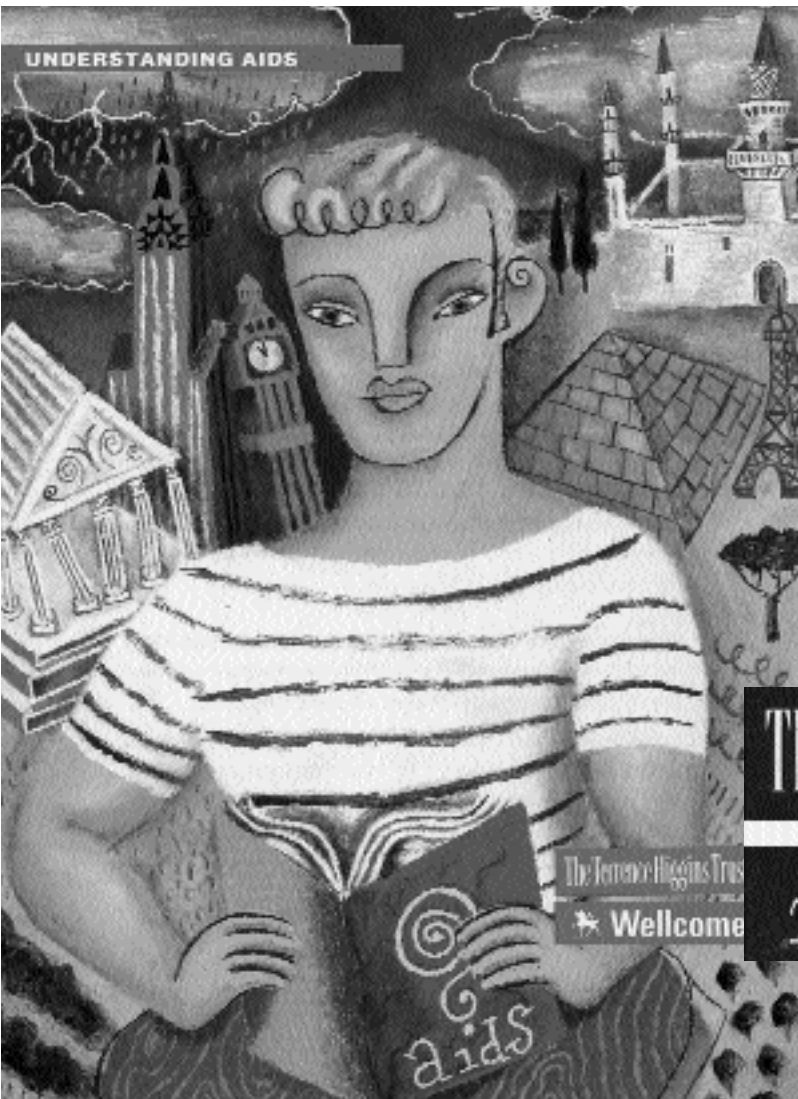
Much dissent especially in politics is based upon an intuitive and heart-felt sense of right and wrong; arguments take place around moral or ethical issues which are often impossible to prove. In AIDS, the principal orthodox proposition – that a Human Immunodeficiency Virus is the cause of AIDS – appeared to be based upon a scientific truth.

While it appears at first that only the idea of Gallo's retrovirus and its transmission has shaped our perception of AIDS and its social relations, it is more complex than this. Gallo and Gallo's idea are themselves a product of the social and commercial relations which exist inside science and the production of scientific knowledge.

Had Gallo presented his theory thirty years ago in a reputable scientific journal, rather than at a *fin de siècle* press conference in Washington, his proposal would have been tested by his peers. A focused and centralised authority which had responsibility for evaluating scientific knowledge would have made a judgment, its clinical basis would have been replicated and a dialectical process would hopefully have forged the truth. As it was, there was no proving, no dialectical process, no clinical proof and no biological proof, no peer review, no open public critique. Gallo's idea was passed down in tablets of stone and 'HIV' was found guilty without any kind of trial or search for the truth. Science by absolute decree of the idea. This is not how science has been practiced nor how truth has been arrived at over the last two centuries.

Karl Marx was the first important European philosopher to refute Hegel's contention that ideas themselves shape material reality; rather Marx insisted, social attitude and concepts are created by material reality; especially the material reality of contemporary production. Marx went on to posit a whole system, in which ideas are tested against material reality, where a continual struggle, a dialectical process, takes place between man and the natural world. This is how the creation of the material world has been understood for the last hundred years and it is how we now understand the processes of human production, whether of ideology or of scientific knowledge.

Gallo, of course, did not personally create this whole condition of science, with its thousands of aspiring scientists, its universal commercial subsidy, its proliferation of research journals and its incestuous intimacy between government and laboratory. But come the hour, cometh the man and Gallo and his idea were the perfect product of the productive relations within twentieth century science. In the first instance, the condition of science in the developed world – the relationships within science, the authority of science and its institutions –



Wellcome did not always have to make such direct advances to groups. From an early stage they managed to gain influence on the committees and boards of the major fund-dispensing bodies which acted as gate-keepers for voluntary sector funding. These strategically placed individuals, on the board, for example, of CRUSAID, an organisation which in the early nineteen nineties was controlling in excess of £4 million in funding, made sure that funds were channelled only to organisations which believed in the use of antiviral drugs.

ensured the passage of the Gallo's idea into a material reality.

Duesberg (1996) analyses this position. At first, when he describes the evolution of the virology industry in the United States throughout the 1980s, it reads a little like sour grapes. But what he is in fact analysing at the beginning of his book, are the conditions and relations, especially in the field of virology, which produce contemporary scientific knowledge. Given these relations and the structure of this kind of science, Duesberg points out that it was inevitable that the conclusion was reached that 'AIDS' was caused by a virus.

While Gallo's 'idea' that a retrovirus is the cause of AIDS was a product of contemporary science, its reproduction and transmission in turn has been a consequence of the social, economic and political relations which exist today within both science and the

medicine industry. For it was not simply the idea generated by Gallo, but a fluid series of material relations, which themselves have become an industry.

First there was the epidemiological approach, then the cell biology approach to research, the discounting of empirical qualitative research, then the pharmaceutical production of AZT. Then there was the long-standing relationship between the drug companies and doctors, between doctors and patients. Then there was the relationship between the drug companies and those who suffered from illnesses associated as AIDS. There was also the relationship between professional medicine and patients and the culture of the gay community itself. Between all these sets of relations, there developed relations, attitudes, views, which were initially based upon the production, distribution and exchange of drugs. These basic social relations around medical production were cemented together by the media, by fear of illness and a plethora of cultural and psychological networks.

The persistent clamour which surrounded the production of AZT and the very material reality of its production, left most people no alternative but to believe that the scientific community had first found the cause of AIDS and then with persistent logic and science found a cure for it. This construct was, however, a fantasy wish-fulfilment created by scientists who wanted to be seen able to respond effectively to what some of their number were already describing as a world plague.

The fact that people were ill with greater frequency and died more quickly when they took AZT, did not affect the the public perception that users of AZT got better, or lived longer lives of better quality than people who unfortunately did not have access to the drug. From a very early stage, the great, mysterious and very male-oriented adventure of science began to depart from the real record of absolute clinical failure of so-called antiviral remedies. This total failure was in part disguised by the increasing understanding of doctors, and their ability to treat the individual infections and other illnesses which made up the spectrum of AIDS.

Wellcome's strategy of hegemony, brilliantly orchestrated, was highly successful. In 1992, five years after AZT was licensed, the 44.7 tonnes of AZT produced that year returned Wellcome over £250 million profit. The profits for the following year were even higher.

Over the last few years, AIDS science, which has as its only aim the production of magic-bullet drugs, has moved further and further away from the conditions of people's living illnesses. The mad scramble of science to understand the intricacies of 'HIV' has given new meaning to the old axiom, 'The operation was successful but the patient died'. AIDS scientists are now openly declaring that clinical end-points are no measure of the success of their work. To protect their authority, they have created an impenetrable wall around themselves, and within this wall its practitioners discuss mutual ideas which over the years have come to develop their own inner logic.

To people knowledgeable about AIDS but beyond the pale of orthodoxy, it appears as if AIDS scientists are slipping deeper into some kind of group psychosis. Apparently considered statements by scientists take on the meaning and form of mantras or cultish utterances which are nonsensical to those outside AIDS science. Such statements as: 'If antivirals don't work it's because the virus is very intelligent and keeps mutating'; or 'Non-infectious HIV is pathogenic' or 'Protease inhibitors mean AIDS is over'.

At some point early on in the bang of big AIDS science and its widening galaxy of abstract theorising it became impossible to readdress fundamental ideas. At issue in this reluctance was not only the plausibility of science and the authority of individual scientists but the continuing production and the profitability of anti-viral drugs. AZT was undoubtedly one of the factors which pushed the handcart of early AIDS speculation over the hill, and transformed it into the juggernaut of premature consensus.

If any doubt did begin to creep like cracks through the cultural hegemony created around AZT, at the end of the Concorde trials, these cracks were quickly filled by the culture of pharmaceutical influence which stood ready with the cocktail of combination therapy. The 'combo' approach which after all still had AZT as its central support, quickly came to be reflected upon with gothic disbelief but even then, science and medicine was saved at the last minute by protease inhibitors. These miracle drugs, despite the fact that they had been trialed for only two years will, it was said, give

all those who are 'HIV antibody' positive, a happy and contented old age. The grim deception of that view is already apparent.

We are all in awe of science, especially medical science for it appears inarguable. What science does, is, and what science says can happen, scientists make happen. Like the stone masons and architects of the seventeenth century, scientists are constructing the everyday reality within which contemporary society lives.

When we look closely at the science of AIDS, and particularly at Gallo's hypothesis, we realise quite quickly that we are not dealing with scientific truth in the normal sense of the expression. The idea that an HIV is the cause of AIDS-associated illnesses, is just that – an idea – there is, even now, no evidence but only supposition to support it.

This idea, however, has achieved a materiality of considerable proportion, and it has spawned an industry. An understanding of how this happened is important – important because in understanding it, we understand not only how knowledge is reproduced

MARTIN J. WALKER

was born in 1947 and trained as a graphic designer. He has written books and articles while working as an investigator and researcher, including *Dirty Medicine*, his sixth book. His last book, *With Extreme Prejudice: a study of police vigilantism in Manchester*, was written following an investigation into the cases of two Manchester Students who were harassed by the Greater Manchester Police. His other books include: with Geoff Coggan, *Frightened for my life: an account of deaths in British prisons*, published by Fontana. With Jim Coulter and Susan Miller, *State of Siege: politics and policing in the coalfields. The miners' strike 1984*, published by Canary Press. He was chairman of the Steering Committee on AZT Malpractice (SCAM) and the AZT on Trial conference, 1993.



PHOTO: Nigel Luckhurst

in our society, but also how power is mediated. Without this information we can not know how to dissent. We have to have this intimate understanding of the way in which the power relations of orthodoxy shape the world in order that we can resist it.

We do not believe power resides in slogans and our dissent does not become real when we say 'HIV is not the cause of AIDS'. Nor does our dissent become real if we simply argue the opposing scientific perspective. We have to dissent with who we are, with our acts; this is why the intimate knowledge of the orthodoxy's power is important to us. To oppose them we must behave differently, resist their social and institutional relations and the way in which they produce and make material knowledge.

People have to empower themselves, in every area where industry and capitalist production have taken over the basic functions and interchanges of everyday life. People have to fight back by finding themselves and a better way of treating themselves. □

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Indian development

I can assure you that your magazine is being presented to people who are directly and indirectly connected with both AIDS and public health issues, with startling effects that a printed magazine actually exists which questions the HIV/AIDS hypothesis and (most important to me) presents the use of therapies to those actually affected and diagnosed as HIV+. Already there are individuals who are taking a new stand with regard to their causes of illnesses. I feel this is a catalytic source of information for those in a country like India, where traditional therapies have existed and justifies going back to them for people weaned away from such methods by rapid

industrialisation and the accompanying reliance on allopathic drugs.

I wish to strongly reinforce the comments of Dr. Ellner in his letter on page 31 of the last issue. In four years of attempting to present the ALTERNATIVE thinking on Aids, I have felt the need to shift the focus from AIDS as a scientific error to one where it is a booming social, political and economic success. This approach combined with the need to provide information about and access to effective, low cost, non toxic alternatives is definitely the way to get to people in the developing nations.

With regards,
Jethu Mundul
Mumbai, India

Subscriptions

I am enclosing a small cheque in response to your appeal in vol. 4, no. 6. I am sorry it is not larger but I am retired and have heavy demands on my limited reserves. I am only sorry that I am not still living in London where I might be able to help you in other ways. The work you are doing is very important and much appreciated. Whenever I give lecture/talks about the HIV/AIDS problem I mention

your periodical and urge people to subscribe or get their library to do so. What results this produces I don't know. But one can only try!

May I say how especially interesting I found vol. 4, no. 6; it seemed to have even more articles which I found useful than usual, which is saying a lot as I always find something of use in each issue.

With every good wish,
Ronald F. Price (Dr)
Melbourne, Australia

Bigger prize

Recently I subscribed to *Continuum*. It's a really good, professional work in regard to form and contents. In some articles I find allusions which make me suppose that there is not isolation of any retrovirus, neither 'HIV' nor any other. This is not precisely said. But I think it would be helpful to

end retroviral speculations, if the base for them doesn't exist. The retrovirology – a false way altogether? My idea is: *Continuum* enlarges the conditions for the Jody Wells Memorial Prize to any retrovirus.

Yours sincerely,
Hans Bernd Ashauer-Jerzimbek
Dusseldorf, Germany

The big lie

I just received my first issue of *Continuum* and it is clear that it is conceived in the spirit of vigilance and clarity that is so necessary to maintain in these times of what I call 'spin-crime'. I am old enough to remember WWII and Dr. Goebbels' words about the Big Lie; but of course since the *status quo* has never been healed of its dualism and duplicity, the new 'doctors' are even more refined in these techniques.

Although I am not ill or in any of the assigned 'risk groups', I have for over 30 years been visited by the various symptoms of life style that attend the life of a jazz musician (wilful ignorance). I also have paid attention to nutrition and behaviour modification techniques that have enabled me to reclaim a level of constitutional health that would otherwise not be possible. I have been a regular listener to Gary Null's radio

show since 1975 and count this as one of the best tools for true self-actualisation.

Getting my media-whipped fellow New Yorkers to re-examine the HIV/AIDS hypothesis as a preemptively assumed paradigm is an uphill battle. Many people don't see the connection between ALL big lie systems. When I tell Americans what happened at Waco and what it means for our future, all they can say is, "Oh, that could never happen here."

In conversation with thinking people I always stress the difference between science and technology; the confusion lies in the fact that aggressive can-do technicians have dazzled us with their manipulation of matter. That many of these achievements are bad science (e.g. splitting the atom) is either ignored or forgotten.

May your journal thrive.
Edward Diehl
New York

HIV STATUS IN QUESTION?

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Nominations to the Executive Committee, questions, discussions, experiences. Come and find out more about the Continuum organisation.

Thursday 6th October, 6:30 - 9:00 pm

at

Continuum, 172 Foundling Court, Brunswick Centre (door 3), Marchmont St, London WC1N 1QE (near Russell Square tube station)

Please call to indicate attendance on 0171-7137071

Lust for Life...

Do not believe in the strength of traditions even if they have been held in honour for many generations and in many places; do not believe anything because many people speak of it; do not believe in the strength of sages of old times; do not believe that which which you yourself have imagined, thinking that a god has inspired you. Believe nothing which depends only on the authority of your master or of priests. After investigation, believe that which you yourselves have tested and found reasonable, and which is for your good and that of others.

BUDDHA

I received an HIV+ diagnosis from the Pasteur Institute in 1986, six months after the sudden death of my wife, during a heroin detox in Switzerland after years of drug and alcohol abuse during my life as a rock musician. I was lucky enough to be told by some nurses at the time that many Americans had chosen to change their diet, take up sport and learn to meditate or relax in order to reinforce their health – and were living well. The seed of hope was sown, but it was not sufficient to prevent the fear that started to poison my life over the next three years although I learned different relaxation techniques and regularly consulted a psychologist for support.

In 1989 I met Dr. Christian Tal Schaller in Geneva – a pioneer holistic practitioner and health educator, co-founder of a flourishing health education foundation and publisher of many books related to natural health including a translation of *Roger's recovery from Aids* by Bob Owen and other testimonies of recovery. This courageous pioneer and two other doctor colleagues had just published a book called *Aids Hope* which was a synthesis of different holistic techniques used by HIV support groups and health practitioners around the world. There was a small paragraph about Peter Duesberg which did not hit home until a year later... The Geneva press, and the gay press ridiculed this book in subsequent reviews, but its contents provided an excellent basis for the apprenticeship which would change my life for ever.

After one year of meeting many new people and concepts I had learned that I was responsible for my health and discovered the philosophy of "treating the whole man", searching for the causes and reinforcing natural immunity rather than repressing the separate symptoms of illness. I recovered physical fitness and discovered a real sense of global well-being for the first time in my adult life.

by
Mark Griffiths

During this period I started to change so many things in my life. I basically learned a lot of new tricks that had been around for a long time but were mostly hidden from general knowledge and were totally absent from the curriculum of my Public School education. Accepting that a strategy of change was essential and possible was perhaps the most difficult thing for my ego to swallow. Healing in its deepest sense is not a nice clean aseptized process like taking a pill or undergoing surgery behind closed doors. A friend who self-healed from cancer described the healing process as being like putting her life through a washing machine; it is a process where we cannot hide the dirt that comes out and we need courage and humility to create support for ourselves and develop the love of ourselves and the patience that is vital. Fear of change and the unknown is always difficult to vanquish but is essential to growth. Are we perfectly formed human beings the day we leave home, school, apprenticeship, university or formal medical training for that matter, or is life a continual process of growth and learning – this is a choice that anyone may take. This is the grid of reference that I used to undertake some serious "work on myself" and how I published it in 1991.

During this earlier period of apprenticeship I observed an interesting phenomenon that I feel is worth sharing with you. From 1986 to 1993 I underwent six-monthly blood tests and check-ups through an Aids doctor in Geneva. By 1990 I was feeling in excellent

health after a year of change and effort. But my T4 cells were at 250 – well down from the initial 1250 in 1986. What should I believe? My own feeling of well-being and a real improvement in physical fitness and endurance – or the medicine which told me that I was advancing towards Aids symptoms because my T4 cells were diminishing? I decided to trust my intuition and my new-found confidence in life.

In 1991, 1992 and 1993 I went to the USA to undergo detoxification by three week living food health education programmes in specialised centres in California and Florida. I used these stays to do blood analysis before and after while still continuing my bi-annual check-ups.

Returning each time I observed the following phenomenon: I felt wonderfully well – lucid, reoxygenated and fully fit. The T4 cells had diminished! The first time a well-intentioned classic doctor friend in Paris tried to frighten me by saying "yes but your T4 cells have gone down – so natural medicine doesn't work". Six months later the T4 cells were higher than the initial count before the cure. The next two years I repeated the same scenario – with the same result. Only that each time the T4 cells were higher than the year before! By 1993 I was up to 850 T4 cells. While meditating in a church in Paris somebody stole a bag containing all my medical papers since 1986. Please excuse my using such a cosmic joke to my own advantage, but I have never undergone "HIV analysis" since. I am quite confident in my own ability to listen to my body's own messages, although I will occasionally ask a doctor for (non-HIV) advice; this has worked well for me ever since. I believe that *Continuum* have carried out their own research into the non-specificity of T4 counting.

During the summer of 1990 I discovered an article in *Policy Review* entitled "Is

Mark's suggestions for a holistic approach to health

Illness is a warning signal that one's way of life has deviated from a natural balance. Like a car that leaves the main road to join a progressively bumpy, muddy farm track that may lead to a precipice. This gives the individual the choice of identifying and ceasing the activities that have caused the imbalance. Combining both age-old and modern holistic techniques, one may learn to detoxify, regenerate and rebalance the human organism.

Another key to health is understanding that illness is caused by a breakdown in communication, both interior and exterior – becoming disconnected with our "soul", our very source. This creates toxicity and deficiency. This is the result of inadequate elimination of excess substances and emotions that the body, mind and spirit have accumulated through a lifetime of ignorance of other alternatives and of the means of nourishing the human being globally. In the light of self-discovery and research into the fundamental

gardening and learning to grow sprouts at home; contemplating the perfection of the seasons which do not deny natural death during winter.

Emotional: learning to identify, express and release the pent-up emotion which impedes healthy co-habitation with other human beings and our environment. These emotions are often stocked from past trauma in both our bodies and our psyche thus diminishing our vital and creative energy. Learning to trust the support of a group, fire-walking, bungee-jumping and solitary ten day fasts in the French Alps and the Californian desert were some of the means I used to confront fear and fear of being alone.

Mental: changing negative thought patterns through conscious positive thinking, creative visualisation and affirmative statements of well-being. Our conscience today is the result of all our accumulated thoughts. Saying "I love you" in the mirror and sticking meditation inspired positive thinking labels all round my flat for a couple of years.

Spiritual: accepting to relax and meditate in order to find one's own inner "still small voice" which bears authentic wisdom and guidance for more conscious living. Discovering how to feel "one" with life, and meditating on this rather than feeling separate and isolated. Learning and experiencing the power of prayer. Learning to take the time to discover that time does not exist!

These aspects need to be kept in harmony to create the dynamic we call health. Health is not a certificate or linear state that we earn at some point in life and then forget about: it is a constantly moving evolutionary dynamic; the ability to live fully in the present moment while appreciating the joy of learning incessantly to know oneself more fully.

I believe that the natural state of the human being is health and balance. After some three hundred years of materialistic development we have

simply forgotten that nature provides us with a magnificent self-healing organism with which we transit and learn from the human experience. It is our destiny and birthright to awaken to the beauty of our authentic potential by learning to master our own health and lives and thereby discover our true place in nature.

This is a very basic guide based on my own experience that I hope will be of use to you. Use your imagination to adapt it to your own needs. Read the opening quotation and take responsibility for your own life choices. There is not enough space in these lines to elaborate more fully. I hope to find the time soon to write a book about my experience.



the Aids virus a science fiction" by Peter Duesberg and Bryan Ellison. This article was the last piece of the puzzle I needed to create a documented synthesis of survivor testimonies, successful therapies and philosophies of health, critical science and the point of view of many wise men such as Ghandi or Illich. The result was named *Aids : The Apprenticeship*, and this document became the cornerstone for five years of public conferences about the "survivors of Aids", the apprenticeship of health and the "dissident" science that was being ignored and scorned by the establishment and the media. At the time I was the only HIV+ person in France to stand up and speak in public about the importance of health education for Aids patients and the first to translate the dissident science

similarities in the self-healing approach of fellow survivors, I discovered a positive holistic approach to restore health which is based on the understanding that the human being is more than just a physical body. So for example, four basic aspects may be developed and harmonised as follows:

Physical: learning and experiencing optimum nutrition, fasting, exercise, breathing and adequate elimination. AMAROLI or auto-urine therapy cuts out the (pharmaceutical) middle-man as our own body creates exactly the right medicine for each individual. Getting close to nature – long walks in the forest, the mountains, the desert, the sea and the ocean;

and point of view into French. Among the "scoops" were Peter Duesberg and Bryan Ellison's 1990 *Policy Review* article, Neville Hodgkinson's "Aids: Can we be Positive?" in the *Sunday Times*, the translation of Robert Willner's early 1992 manuscript *The Ultimate Deception* which we renamed "The Aids Rip-off", Stefan Lanka's "HIV – Reality or Artefact" (*Continuum*, vol. 4, no.1) and a mass of other relevant material.

The work continues today with the translation of certain important articles from *Rethinking and Reappraising Aids*, *Continuum*, HEAL and other sources, and *L'Apprentissage* has become the most up-to-date dissident publication in the French language. All this work has been voluntary and many people have rallied to the cause with their excellent translations and computer work. Only the French natural

Lust for Life...

health press have dared to publish some of the material.

During this period I have also learned to take the time for a private life full of experiences far removed from the crazy world of the Aids dissident, and having the satisfaction of seeing old wounds within my family and my own life beginning to heal. Running round Europe and the USA giving conferences and looking after a full-time unpaid research and information network has not stopped me from undertaking many projects and fulfilling many dreams. Today I live with my girlfriend Sylvie (both of us HIV and healthy) and Sylvie's five year old boy Arthur (HIV+ to HIV- at one year old by avoiding fear and medication) on a beautiful domain in S.W. France. We look after a large vegetable garden, several cats and help out on a 40-acre domain. We have been taking in HIV positives, their families, friends, caretakers, and a number of therapists who are seeking an alternative view of Aids and responsible holistic health in general. It is important to us to take good care to gradually become integrated into the local community rather than creating a revolution by trumpeting "the Aids scandal" – despite the fact that this is my profound conviction. We created a non-profit association on November 15th 1996 with myself and Sylvie, doctors, therapists, psychologists, priests and many supportive friends, some of whom are "HIV", who see that we are living well despite "HIV". We have also created the first French-language AIDS health newspaper which has been inspired by *Continuum*, *Reappraising Aids* and *HEAL* – although allowing a platform for personal testimonies of recovery remains our priority. We have held conferences, debates and screened some of the dissident videos here, and I have even taken up my trusty Fender bass again to play rock and blues with friends to raise money. By the time you read this we should be in India for a three month stay.

On a personal note I have done my best to keep "working on myself" with different approaches and groups of people dedicated to self-development – this approach has transformed, and continues to transform my life since 1989. In the beginning my motivation was fear of Aids, but around 1990 through my research – personal and exterior – my motivation became love of life. Today I have acquired a number of self-help tools which permit me less discipline (letting go) and more freedom than during the initial apprenticeship. In my opinion it is the incapacity to change which is the principal cause of illness – by this I mean that any rigid system that does not allow for the diversity of all life may eventually damage our health and well-being. Many of the means for detoxifying and regenerating the body are essential to restore lost health, but if they subsequently impede the freedom and adventurousness of the individual, I believe that they may then become a new source of dis-ease. Quantum physics demonstrates that out of order chaos is born, and that out of chaos order is born. Learn to love yourself, love others, stay loose and stay alive.

Love to you all and long life and success to *Continuum* and all those selfless and dedicated beings who give so much to bring an end to a tragic period in the history of medical "science". My hope is that the Aids shambles will become a motor to create harmony between medicine based on treatment and preventive, education-based medicine. Authentic health education would reduce the amount of intervention due to degenerative disease which is the ultimate result of immune breakdown. Both are complementary and it is mainly financial criteria which are the obstacle – not because of the cost but from the loss of pharmaceutical profits. The war between the two forms of medical practice must cease if we are to survive this incredible period of explosion in human knowledge and consciousness.

Science without conscience is ruin of the soul.

–Rabelais.

*Everything that happens to you is your teacher.
The secret is to learn to sit at the feet of your own life
and be taught by it.*

–Polly Berien Berends. ☐



Joan Shenton
of Meditel Productions



WHAT IT IS TO BE A DISSIDENT FOGGY

I found myself not only snarling this morning but actually biting. A perfectly nice young journalist from Italy rang up and said he was making a programme about the AIDS debate. He did not want to cover the AIDS dissident scientists. He had made a programme on them already for Italian television and it had caused him a lot of grief. Besides, didn't I agree that Duesberg and the other dissident scientists in his wake were now sounding a bit ridiculous? Their ideas were flawed, they didn't hold water any more. But, he said, there was obviously something wrong with AIDS science, so this time he was going to make a programme about AIDS drugs – AZT and the new triple therapy cocktail. Could I help him with some contacts?

I started to feel hot under the collar. Who was this young upstart encroaching on my territory? Hadn't we struggled for ten years to tell the world about the enormity of the AIDS fraud? Didn't he know about the seven documentaries we had made on the subject? Didn't he know about the brave programme on the AIDS debate made in 1992 for RAI2 in Italy by a colleague of ours, Stefano Gentilone, to which we had contributed our footage from the Amsterdam Alternative AIDS Conference? Impossible, said my caller (sounding crestfallen), it couldn't have been transmitted. (He had to have been the first to break the story on television in Italy).

Then I realised that I was behaving like an AIDS dissident foggy. Of course there is a new generation of young journalists wanting to take a bite at the apple. And so they should. The fundamental problem is that the word dissident and all the discomfort that goes with it seems to stick in their throats.

So why do we call ourselves dissidents? After all, if we were behaving "properly" scientifically, we would simply look objectively at the subject and coolly find the evidence to prove the orthodox hypothesis wrong. And – Hey presto! – the world would see reason. Unfortunately it just doesn't work that way.

The truth is all the big debates in the scientific world are political, whether we like it or not. There are so many billions of pounds, tied up in the surrounding technology and in therapeutic approaches to disease management, that to steer the boat in a different direction would not only rock it but cause it to capsize, taking down fortunes in patents, research grants and pharmaceutical stock market share values with it. Moreover, the reason we have become dissidents is because we have seen the views of dissident scientists systematically censored and suppressed over the years and a kind of partisan rage sets in. Sooner or later anyone who challenges the prevailing orthodoxy has to roll their sleeves up and get their hands dirty. The word campaigning takes over from the any attempts to adhere to the beacon of objectivity. We end up crossing the line.

I remember in 1993 planning to film our dissident assault on the Berlin World AIDS Conference. No TV Channel at that stage would commission us. It was Professor Alfred Hässig who said, "Do it like 'samizdat' (the name given to the underground press in the Soviet Union). "Do it anyway and it will get shown in the end." It did, thanks to the generosity of several other benefactors. *Diary of an AIDS Dissident* was eventually transmitted on Sky News and WLIW PBS Channel in America.

So we become dissidents – and now we are behaving like dissident foggy. Good luck to the new generation of "post AIDS-dissident journalists" who will take up the baton. We need them. From now on I shall try to greet them with a smile not a snarl...

Copies are available for all back issues of the magazine. Where we have no stock of original copies, articles reproduced from these issues are available individually. The index below details the contents of recent issues (available as complete magazines). A list of contents of earlier issues is available on request. To order please use the form overleaf.

Recent back issues

Vol 4, No 6 June/July 1997 40pp

FOCUS: Antibiotics:

Geoffrey Cannon looks at the magic bullet concept
 Micro-ecology: Heinrich Kremer asks some evolutionary questions
 Antibiotic alternatives discussed by Leon Chaitow
 Interview: Immunologist Prof. Alfred Hässig on politics, risks and therapies
 Immune Suppression in Hypercatabolic Diseases, by Alfred Hässig
 Conference Report on the Chemotherapy of AIDS, by David Rasnick
 Nutrition: The vital role of minerals
 FEATURE: HIV, AZT, big science and clinical failure: Martin Walker on the history of an AIDS-defining drug
 Escaping the AIDSzone: a new column
 Dissenting View: the provocative work of Elaine Showalter

Vol 4, No 5 February/March 1997 40pp + 24pp Supp

FOCUS: Protease inhibitors (PIs):

PIs in Provincetown: John Lauritsen wonders how hope can exact such a price
 From Hype to Hesitation: Recent research has led to serious caution
 SUPPLEMENT: Peter Duesberg and David Rasnick's The Drugs-AIDS Hypothesis
 Conference report: Alternative therapies in France
 Interview: Holistic doctor Leon Chaitow, on wide-ranging health
 Counterculture: part 2 of Ian Young's The AIDS Cult and its Seroconverts
 Virus isolation:
 - Near enough is good enough? Peter Duesberg defends existence of HIV
 - Why no whole virus? Eleopulos et al. argue Duesberg's claims are unsubstantiated.
 - No viral identification - Stefan Lanka says human rights are the issue
 Nutrition: Vitamins, how and why
 Review: The AIDS Cult, editors Lauritsen and Young
 Dissenting View: Innocence is no defence - Nigel Edward's story from prison
 Workshops for Change: Michael Baumgartner on the process of personal growth after diagnosis
 PLUS: News, HIV Watch, Lust for Life etc

Vol 4, No 4 November/December 1996 40pp

FOCUS: Pneumonias & Lung Diseases:

Acquired Iatrogenic Death Syndrome: Dr. Heinrich Kremer examines the real causes of PCP and other lung diseases that are usually labelled "HIV-associated"
 Counter Culture: Ian Young's The AIDS Cult and its Seroconverts, part 1
 Sexual Health: Anal Sex and AIDS examined by Fred Cline
 Conference Report: 2000 without AIDS? Barcelona's dissidents meet
 Lifestyle: E for Ecstasy or 'ealth? Club culture from a sociopsychological perspective
 Nutrition: Knowing your Immune System
 Science Speak: Prof. Alfred Hässig on Hepatitis viruses
 Viral Load & the PCR: Christine Johnson explains why they can't prove "HIV" infection
 Review: Toxic Sludge is Good For You! Lies and the public relations industry
 DrugEffects: Corticosteroids
 SNARL: World AIDS Day hype and MDR-TB
 Dissenting View: The UK's long-term survivors study under the microscope
 PLUS: News, HIV Watch, Live, Live, Live, Lust for Life, etc.

Vol 4, No 3 September/October 1996 36pp + 24pp Supp

FOCUS: Animal Experimentation:

Animal Rights & Bad Science: Peter Tatchell questions the value of vivisection
 Human Wasting: Human guinea pigs are not the exception (by Michael Baumgartner)
 Rights & Wrongs: Alex Russell says we confuse animals & people at our own risk
 Interview: Noam Chomsky speaks out for the first time on HIV and AIDS
 Virus Isolation: Neville Hodgkinson summaries our scientific supplement
 SUPPLEMENT: Possibly the most important scientific paper, arguing the case against the isolation of HIV, presented by Dr Eleni Papadopulos-Eleopulos and colleagues
 Collective Fallacy: Dr Stefan Lanka responds to Prof. Peter Duesberg on virus isolation
 Sense & Sensuality: Three articles on different perspectives of gay sex
 Healthy Options: Information on the healthy German Kanne Bread Drink
 Nutrition: What is Nutritional Medicine? First in a new series
 Alternatives: The DNCB Files - a review of an immunity booster
 DissentingView: Whose antibodies are they anyway? - the extent of cross-reactions
 Review: Artist Keith Haring's Journals
 Conference Report: The Green Network's "Human Health & Toxic Chemicals"
 DrugEffects: Sulphonamides
 SNARL: Vancouver International AIDS Conference
 PLUS: News, HIV Watch, Live, Live, Live, Lust for Life, etc.

Vol 4, No 2 July/August 1996 36pp

FOCUS: Global Concern on Virus Isolation:

Prof. Peter Duesberg responds to our challenge
 Open Questions concerning the specificity of anti-HIV antibodies
 Interview: Lord Baldwin, of the Parliamentary Group for Alternative & Complementary Medicine, speaks out on medicine and AIDS
 AIDS & Decadence: Camille Paglia on the historical development of AIDS
 Alternatives: Mopping up the Microbes - allicin
 AIDS Activism - no thanks!: Michael Baumgartner's essay, part 2
 Nutrition: A Spoonful of Sugar - all about blood sugar levels
 Sexual Health: Safer Sex - seeking a new definition
 Review: Neville Hodgkinson's AIDS: The Failure of Contemporary Science
 DissentingView: Protease Inhibitors
 DrugEffects: Poppers
 PLUS: News, HIV Watch, Live, Live, Live, SNARL, Lust for Life, etc.

Vol 4, No 1 May/June 1996 36pp

FOCUS: Tuberculosis:

TB examined: characteristics, cures and drug-resistance
 False Positive: Neville Hodgkinson looks at immune deficiency & TB
 Natural Treatment of TB: alternative & complementary approaches
 Looking for AIDS in Haiti: Joan Shenton found poverty and malnutrition
 Why gay men needed "HIV": Michael Baumgartner's revealing essay
 Nutrition: Facing the Fats - essential fatty acids and why we need them
 Nutrition: Hemp seeds - a useful source of essential fatty acids
 Virus Challenge: A response to NAM's dismissal of our isolation prize
 CounterCulture: AIDS-related Kitsch - influences behind AIDS imagery
 False Negatives?: The great Easter test scare - no need for alarm
 HIV Watch: BBC Panorama's 'A Ray of Hope' reviewed
 Review: Natural treatment for candida
 DrugEffects: TB treatments
 PLUS: News, DissentingView, Live, Live, Live, SNARL, Lust for Life, etc.

Vol 3, No 6 March/April 1996 32pp

FOCUS: Kaposi's Sarcoma:

KS: New Perspectives - the latest thinking says it's not infectious
 Highway to Health - Marshall Smith overcame KS by visualisation
 Other Options - alternative therapies that work for KS
 Blind Alley - looking at the holes in linking HHV8 and KS
 Think Big, Act Quick: Stefan Lanka's call for unity in demanding answers to fundamental problems in the HIV theory
 Sunshine and Stress: Matthew Probert finds Jamaican life very stressed
 CounterCulture: For and Against Poppers:
 Hellbent... - Ian Young charts the history of poppers use as a gay drug
 ...Or Heaven Scent? - A look behind the US ban on the sale of poppers
 Nutrition: Antioxidants help regulate the effects of oxidation (rusting)
 HIV Watch: Nigel Edwards on censorship on AIDS issues in the gay media
 Interview: The Healing Circle comes under the spotlight
 DrugEffects: Protease Inhibitors
 Review: Dissident sites on the Internet
 PLUS: News, DissentingView, SNARL, Lust for Life, Enquire Within

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SPECIAL FEATURE: Where have all the T-cells gone?

Interview: Prof. Hässig on the work of Dr Fauci, head of NIAID
 Science: The depletion of CD4s explained
 Report: The New York Times on stress
 HIV Watch: review of World AIDS Day on BBC TV
 Testing Times: 1) Does antibody testing prove infection?
 2) Why has the UK changed its testing policy?
 Report: The 2nd Complementary Medicines Conference in Spain
 DrugEffects: DaunoXome
 CounterCulture: Designer Science, Virtual Virology & Dodgy Crystal Balls
 Health: Allicin - the secret of garlic
 Addiction: AA/NA - a personal testimony
 PLUS: News, Book Review, LifeStory, Letters