THE MISCONCEPTION ABOUT AIDS

This article may, to some readers, present radical views or prejudices. Healthmap does not endorse these. We are publishing this article because it contains valuable information and a view on AIDS research that is not often publicly discussed.

Ten years ago Dr. Peter Duesberg was a lone voice in the world of AIDS research. At that time, the molecular biologist, world-renowned virologist, and U.C.L.A. professor began asking a question that seems like heresy to this day: Is it possible that we were wrong when we equated HIV with AIDS?

By Gary Null, Ph.D.

Is it possible that we were wrong when we equated HIV with AIDS? While any scientific discussion should allow such a challenge, many have tried to silence Dr. Duesberg. AIDS research continues to be driven by the hypothesis that HIV is its cause, with virtually all our medical and scientific resources invested in this hypothesis. But several outstanding scientific voices are joining Dr. Duesberg in denouncing this approach. Witness the report published in mid-1993 by a group of Australian researchers led by Dr. Eleni Papadopoulos-Eleopulos. In this breakthrough report, the scientists raise serious questions about the accuracy of HIV antibody tests and, more importantly, the very relationship between HIV and AIDS. They show that the HIV tests produce inconsistent results, both within one laboratory that tested a sample twice, and between two labs that tested the same sample. What's more, it's nearly impossible to determine the rate of "false positives" because there is no "gold standard" to independently verify test results, as reported in the *New York Native*.

And that's not all. Among other things, the researchers also found that HIV cannot be isolated in all AIDS patients, but HIV *can* be found in people who are HIV-antibody negative. They found that people with non-AIDS diseases have antibodies that can register a positive result on the HIV-antibody test. They found that the p24 antigen is not, as is widely believed, an indicator of HIV infection or AIDS. Indeed, people with multiple sclerosis, T-cell lymphoma, generalized warts, and other diseases have the p24 antigen.

In short, it's time to face the disturbing notion that much of what we've been told about AIDS is incorrect. Here are some of the factors that have led scientists to challenge the well-entrenched hypotheses that HIV equals AIDS:

AIDS remains in high-risk groups. The claim that HIV is the sole cause of AIDS has a lot of holes, says Dr. Robert S. Root-Bernstein, a professor of physiology at Michigan State University and the MacArthur Prize-winning author of *Rethinking AIDS: The Tragic Cost of Premature Consensus*. The most striking flaw in the logic is that AIDS has not spread to the general population; it continues to be concentrated in high-risk groups such as subsets of the homosexual population, I.V.-drug users, and their sexual partners.

In the heterosexual population, the percentage of people with HIV or AIDS who are not drug users is "extremely low," according to figures from the Centers for Disease Control and Prevention, points out Dr. Charles Thomas, president of the Helicon Foundation in San Diego, a former Harvard professor, and a member of the Group for the Scientific Reappraisal of the HIV-AIDS Hypotheses.

"Two thirds of the people who come down with AIDS admit to being homosexuals. One third do not," says Dr. Thomas. "To date, the C.D.C. lists almost 300,000 people with AIDS. That leaves 100,000 people over an 11-year period, not a very great number. And within this group, a very large proportion are drug users and, in particular, intravenous-drug users."

The scientific proof is lacking. According to Dr. Thomas, proponents of the HIV-AIDS connection have yet to offer any "genuine scientific proof" that the virus causes AIDS. "Any time scientists propose that a microorganism causes a disease, it's incumbent upon them to prove that it does. So far they have to supply that proof," he says.

Remember, it's been over a decade since HIV was first deemed the cause of AIDS, so scientists have had plenty of time to offer compelling, foolproof evidence. "It was on April 23, 1984, that Margaret Heckler announced to the world that the cause of AIDS had been found, namely, HIV. Robert Gallo's colleagues said that his research made possible a blood test for AIDS and that a vaccine could be ready for testing in two or three years. That was in 1984, and nothing has happened in more than ten years."

IT IS FINALLY TIME TO FACE THE DISTURBING NOTION THAT MUCH OF WHAT WE'VE BEEN TOLD ABOUT AIDS IS INCORRECT.

In addition, certain rules of science must be followed for any agent to be considered a causative factor in disease, adds Dr. Roger Cunningham, an immunologist, microbiologist, and the director of the Ernst Witsky Center for immunology at the school of Medicine at the State University of New York at Buffalo.

"The first rule is that an agent that's going to be blamed for a disease should be able to be isolated from each and every case of the disease," says Dr. Cunningham. "That is not true in HIV and AIDS. It's very, very difficult, in many cases of AIDS to isolate the virus at all from these individuals. The second step is that you should be able to transmit the agent that is [causing] the infectious disease to another animal and have that disease developed in that animal. To the best of my knowledge, that has never been done with the agent we call HIV. The final step, of course, is to remove the agent from the animal which has been infected, put it into another animal, and transmit the disease in this fashion. This, too, has not occurred with HIV."

Dr. Arthur Gottlieb, chairperson of the Department of Microbiology and Immunology at Tulane University School of Medicine, agrees that too little is known about HIV to conclude that it causes AIDS on its own. "This is a very complex disease that is poorly understood, at best," states Dr. Gottlieb. "We know a lot about the HIV virus; it's probably been the most extensively studied virus ever. But in spite of that, we know relatively little about how the virus acts to cause disease."

Continues Dr. Gottlieb, "when HIV was isolated from people who had the disease we call AIDS, the immediate presumption was that this was the causative agent. It became a very popular idea that this 'new virus' must be causing the disease *by itself* because it was isolated from patients with the disease, and caused damage to cells in the test tube. This ignores the likelihood that there are many other factors involved in determining how this virus causes disease.

Says Dr. Gottlieb: "The viewpoint has been so firm that HIV is the only cause and will result in disease in every patient, that anyone who challenges that is considered 'politically incorrect.' I don't think—as a matter of public policy—we gain by that, because it limits debate and discussion, and focuses drug development on attacking the virus rather than attempting to correct the disorder of the immune system, which is central to the disease."

Professor Richard Strohman, a biologist for thirty-five years and professor emeritus of cell biology at the University of California at Berkely, believes that HIV may be completely unrelated to AIDS, but that we have no way of knowing this because scientists will not even entertain the idea that their HIV theory is incorrect.

"In the old days it was required that a scientist address the possibilities of proving his hypotheses wrong as well as right. Now there's none of that in the standard HIV-AIDS program with all its billions of dollars," says Strohman.

Dr. Gottlieb concludes that it's best to keep an open mind when so little is yet known. "If you firmly believe that HIV is the sole causative agent, you're going to try your best to show that it's true. I think, at the moment, we're all best off if we keep our minds open. Nothing has been ruled out at this point."

Being antibody-positive protects against disease. No infectious agent causes disease in every person who's infected, assuming natural immune responses are at work, says Professor Steven Jonas, professor of preventive medicine at the State University of New York at Stony Brook. "Native American Indians in the seventeenth, eighteenth, and nineteenth centuries were decimated by smallpox because their immune system couldn't produce antibodies to the virus. But that's a different situation. With HIV, the only way we know that people have been infected is because they develop the antibody—a chemical that the body makes to fight off an infectious agent, such as a virus, bacteria, or fungus—to HIV.

'WHEN YOU WATCH WHERE THE MONEY FLOWS, YOU CAN SEE WHY THE DEFINITION WAS EXPANDED.'

"When the body produces an antibody to a disease, there is no historical precedence for it spreading uniformly throughout the population and killing everybody that gets infected," Jonas continues. "For example, look at the Black Death that hit Western Europe. What they don't consider is that two-thirds of the population *didn't* die. They survived despite the fact that no measures were taken to prevent infection or treat disease."

Jonas concludes that when the average healthy person is infected with HIV, he or she is highly unlikely to develop AIDS in the absence of cofactors. The basis for his reasoning comes from his own personal experience with tuberculosis bacillus.

"As a medical student in the late fifties and early sixties, he says, "I was exposed to tuberculosis. Although I became infected with the tuberculosis bacillus, I never got tuberculosis and I never will get it. The only thing that changed was that I developed the antibody to the tuberculosis bacillus. Otherwise, my body functions in a healthy way. Similarly, when people become HIV-positive, all that means is that they've got the antibody on board. If their immune system functions in a healthy way, it kills off the virus.

"When Magic Johnson announced that he was infected by HIV," Jonas continues, "I wrote him a letter saying that assuming he didn't have any other disease or condition that compromised his immune system, and assuming he didn't take AZT, I would wager $10,000 that he would not die of AIDS. I advised Magic Johnson to unretire and go back to playing in the N.B.A. He took that advice, although I'm sure it was not because I sent him a letter. I think it was highly unfortunate that he was forced to retire. I'm sure that there are any number of players in the N.B.A. who are HIV-positive, and none of them will get AIDS either, unless they have some other disease or condition which compromises their immune system."

AIDS is politically, not medically, defined. Why haven't we examined the role of HIV cofactors? Jonas believes it is because we applied a political, rather than a medical, definition to the syndrome's pathophysiology. AIDS was first defined during "the radical-right Reagan administration, which was filled with homophobes," he says. "They saw a disease which appeared to be developing only in the gay-male population—a population which, for whatever internal psychological reasons, they greatly feared. It wasn't until 1987 that Reagan could even bring himself to say the word AIDS. First they tried to ignore the existence of this calamity. They tried to find something very specific to confirm their view that this particular disease was the property of gay men as a group.

"At the same time," Jonas adds, "there were people who felt that a single-virus theory would be useful in helping to raise public awareness about the 'disease.' It would help them get the research they thought was necessary and public funding for its treatment by scaring people into believing that while the disease was affecting gay men now, it was eventually going to spread throughout the heterosexual population. This political definition of the disease has proven to be inaccurate and inconsistent with its real medical nature."

Adds Dr. Charles Thomas, "the reason that the whole shabby story of HIV is being held in place is there's so much money riding on it. The federal government is spending about $4 billion on just this single subject, and all that $4 billion is predicated on the idea that HIV causes these diseases. If HIV does not cause these diseases, then that money is being wasted. And I believe it is being wasted. But the people who are the recipients of that money don't want to stop."

Indeed, Dr. Thomas believes that the definition of AIDS has been expanded to generate more funding for AIDS-related diseases. "When you watch where the money flows," he says, "you can see why the definition was expanded. If you are diagnosed with AIDS, your medical bills are picked up by the Ryan White bill, which supplies $150 million to AIDS treatment and education. Most of the people getting AIDS were males, and females felt left out, so they applied very great pressure in order to open up the definition of AIDS to include women. As a result, they added cervical dysplasia to the definition, and HIV-positive women with cervical dysplasia are now allowed to have their medical bills picked up. The whole thing stinks."

Dr. Thomas concludes, "I often wonder what would happen if all federal money for AIDS—education, research, treatment, and so forth—was suddenly turned off, instantaneously dropped to zero. It's my belief that AIDS would go away. In other words, the AIDS disease that we see today would be reassigned to their former categories—pneumocystis carinii pneumonia, Kaposi's sarcoma, and the other twenty-five or so different diseases, now including cervical dysplasia and so forth. Any individual who died of these various causes would add to the statistics in each of these individual categories and would disappear in the profile of mortality of normal disease. AIDS has been a disease of definition. If we said that it didn't exist and didn't pay for it with taxpayers' money, it would disappear in the background of normal mortality."

AIDS exists without HIV, and HIV exists without AIDS. At an AIDS conference in Amsterdam, scientists reported cases of AIDS in people who did not have HIV. Dr. Root-Bernstein notes that such cases have been reported since the onset of the condition. "A small percentage of the population has been manifesting all the symptoms of AIDS without HIV," he states. "The C.D.C. has always recognized this. They call the condition idiopathic CD-4 T-cell lymphopenia, a fancy term meaning HIV-free AIDS. The number of cases is fairly small, less than one percent, but they do exist. These people get all the symptoms of AIDS and never show any signs of an HIV infection.

"What then, is the role of HIV?" he asks. "The only way to explain these cases is that the people have other high-risk factors associated with AIDS, such as malnutrition, multiple infections, exposure to symptoms, and

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drug use. In sufficient quantity or combination, [these factors can] cause the same immune suppression—and therefore the same consequences—that everyone says HIV causes."

Dr. Thomas agrees that thousands of people with no evidence of HIV in their system are dying of the syndrome we call AIDS. "43,000 to 44,000 people listed by the C.D.C. as having AIDS in the past eleven years have never been tested for antibodies to HIV. You can be sure that there will be a large number of antibody-negatives among them," Dr. Thomas says. "Secondly, there are about a million people who have been exposed to the virus, as evidenced by the fact that they have antibodies to the virus in their bloodstream, yet only a trivial portion—approximately three percent—come down with AIDS in any one year. I think these two things are damning evidence against the HIV theory."

HIV spreads like an infectious disease. Contrary to popular belief, says Dr. Root-Bernstein, HIV does not appear to be spreading sexually throughout the heterosexual population. The data to support that connection simply isn't there.

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"There is a famous case of [a woman] who said she got AIDS from having vaginal sex just one time," Dr. Root -Bernstein adds. "As a researcher, I cannot validate that because I have no access to her medical records to see that she was, in fact, healthy prior to having sex. And I have no way of knowing that she only had vaginal intercourse. Many studies show that unprotected anal intercourse is the highest risk factor [in the spread of HIV and AIDS]. Penile or vaginal bleeding, or both together, is also highly dangerous.

"Most doctors never ask about these things, and most patients will not respond," he adds. "There are all sorts of possible mitigating factors. Even if HIV could be [sexually] transmitted, in every case where there is good medical evidence, there are always a whole series of other risk factors involved as well."

Of course, no one should take this as an endorsement of unprotected sex. Until all the medical evidence is finally in, all physicians and experts agree that "better safe than sorry" is the best practical sexual advice available.

But people often assume that if HIV equals AIDS, then they can catch AIDS, says Dr. Hans Kugler. And the medical profession does nothing to correct that faulty logic. "If I tell you that two plus two equals five, you will be able to disagree because you know some math. If I tell you that HIV is sexually transmitted and causes AIDS, you should know this to be untrue if you are in the medical profession. In medical school, one of the first things everybody is taught is that if you have an infectious disease, you have to show the infectious agent 100 percent of the time in people with the disease. With AIDS this is definitely not the case. Yet the medical profession doesn't see anything wrong with [believing] that [HIV causes AIDS]."

AIDS also discriminates against age and sex, supporting the logic that it is not infectious. "Normally, when we get older, the immune function decreases. That's why diseases like cancer tend to increase," explains Dr. Kugler. "This disease focuses on people between the age of twenty and forty-four. And while no infectious disease ever discriminates against sex, this one is found mainly in males."

Dr. Casper Schmidt, a psychiatrist who published his first AIDS-dissenting paper in 1984, offers further evidence that AIDS is not an infectious disease. "Figures put out by the C.D.C. in February 1993 showed that of the nearly 13,000 needle-stick injuries that were examined and followed over the prior twelve years, the percentage of people who then became HIV-positive amounts to a total of 0.013 percent. That is statistically insignificant. It's just a little bit greater than chance. Consequently, on the basis of this evidence, there is no way that AIDS can be an infectious disease. Something else must be going on. The more likely interpretation is that HIV and immune dysfunction—rather than HIV being the cause and immune dysfunction being a consequence—are both consequences of something else."

WHAT CAUSES AIDS?

Professor Steven Jonas says, "I think that when a person who already has a disease or weakened condition becomes infected with the HIV virus, the virus further compromises the immune system and makes it difficult or impossible for the immune system to produce antibodies in significant quantities over a period of time. [It may be] unable to produce antibodies to diseases such as Kaposi's sarcoma and other recurrent infections. Keep in mind that AIDS is a collection of recurrent infections, not a disease, and that these infections are what kill people."

Professor Jonas became interested in the role of cofactors being necessary for the development of AIDS when, in 1987, he was examining weekly morbidity and mortality statistics from the public-health service. "The reports were based on the original HIV developmental AIDS studies in San Francisco, which said that despite a long latency period, everybody who has HIV is eventually going to get AIDS and die. [But] nine or ten years into the study, twenty-five percent of people in study groups still hadn't developed any signs of AIDS at all. That's a very, very long latency period."

Dr. Root-Bernstein and other AIDS researchers say that the immune-suppressive factors most closely linked to AIDS in studies of high-risk groups include the following:

•Drugs. Any abuse of illicit drugs—particularly such intravenous drugs as heroin—will suppress the immune system. Malnutrition is also associated with drug abuse, since most drug addicts would rather have their drugs than eat well. Drugs can also interfere with metabolism.

•Antibiotics and therapeutic drugs, such as AZT and ddI, which are meant to treat AIDS prophylactically (to prevent worsening of HIV and AIDS), actually cause a deterioration of the immune system when taken for long periods of time.

•A promiscuous, fast-track gay life-style. Gay men that are at high risk for AIDS not only abuse drugs, but also have a tremendously high incidence of sexually transmitted and other infectious diseases. They are known to be frequent intravenous-drug users, and are also known to trade sexual favors for drugs. In addition, they may use antibiotics prophylactically to prevent sexually transmitted diseases. These antibiotics remove key nutrients from the immune system and prevent it from functioning properly. Semen that gets into the bloodstream or the immune system—fairly common in unprotected anal intercourse—can also result in immune suppression.

•Multiple concurrent infections. Multiple infections are quite common among high-risk groups and they are much more difficult for the immune system to handle than any single disease.

•Blood transfusions and blood-factor products. Unfortunately, both blood transfusions and such products as Factor 8, taken by hemophiliacs, can cause immune suppression and make one more susceptible to any infection,

including HIV.

Dr. Root-Bernstein says that once the immune system is weakened, HIV may trigger a continued loss of the immune function. "The whole system is extremely complicated," he says. "It's certainly not as simple as, 'if you get HIV you get AIDS.'"

AIDS TREATMENTS: CURE OR CAUSE?

Conventional AIDS treatments, which incorporate such drugs as AZT and ddl, are supposed to slow down or stop the spread of HIV and AIDS. But research suggests that such drugs may have the opposite effect, hastening the degenerative process. Two studies—one performed by the Veterans Administration in the United States and another conducted in Europe—confirm this belief. These studies found that AIDS patients who were using AZT fared no better than those who were not.

In fact, after a few years of treatment, the immune system of AZT users deteriorated much more quickly than that of people not using the medication. As a result, the European medical establishment suggested at an AIDS conference in Berlin that AZT no longer be given to people who are diagnosed with HIV but who exhibit no AIDS-like symptoms.

Perhaps the most striking evidence against AZT, says Dr. Root-Bernstein, is a comparison of AIDS survivors to people who succumb to the disease: The long-term survivors of AIDS or HIV infection are clearly not AZT users. "Those people who have had the HIV infection for ten or fifteen years now or who have survived full-blown AIDS for five or ten years, have not used AZT for more than a week or two because they found the side effects to be so bad. Most of them never used any of these drugs at all," he says. "This suggests that survivors don't use anything that can cause immune suppression. They eliminate drugs, including antibiotics and AZT, and simply try to lead a healthy lifestyle. So they may have the HIV infection, but it doesn't do anything to them."

Dr. David Berner, a physician and a hemophiliac, was infected with HIV more than ten years ago. He has refused to take AZT, and remains healthy today. His account: "My last surgical experience was in 1983, making it my last possible exposure to the HIV virus. Being very healthy, my wife and I ignored the potential problem It wasn't until AZT was heralded as a great treatment for AIDS in 1988 that I decided it would be prudent to be tested for HIV.

"I was found to be positive, and immediately wondered what the hell to do about it. My decision [not to take AZT] was aided by several factors, one of which was my age. Being in my late sixties, I viewed my eventual demise as less pressing. I had a very close, happy family. And I was educated to be skeptical during my twenty-five years of general practice about newly heralded grand cures. Reflecting back on the numbers of diseases I treated in the fifties and the sixties which now could be grounds for malpractice, I became skeptical about AZT, knowing it to be a cytotoxic agent. The other thing that helped me not panic about my decision was my excellent health and healthy lifestyle.

"At about that time, I had been introduced to an article by Peter Duesberg. I had the temerity to give him a call. I'll never forget his initial remark. I told him my plight, and he said, 'if you take AZT, you'll be dead.' I read his work and got introduced to other people who were skeptical about AZT.

"I decided early on to add some vitamin therapies to my already healthy lifestyle, particularly the antioxidants beta-carotene, ascorbic acid, and vitamin E. Despite my continuing excellent health for a sixty-nine year old—I do a lot of hiking and mountaineering in the wilderness—I have still been pressured by well-meaning clinicians to start AZT 'before it's too late.' I think it's very difficult for these people to admit that they're either partially or completely wrong."

AIDS IN AFRICA

Over the years, AIDS researchers have pointed to sub-Saharan Africa—Uganda, in particular—as the epicenter of the so-called AIDS epidemic. It has been estimated that one in forty Africans will die of AIDS, and that AIDS will account for 500,000 deaths a year by the year 2000. But in recent years, some AIDS researchers have come forward to question not only the validity of those projections, but the very notion that AIDS is pandemic in Africa.

The makers of "AIDS in Africa," one of the "Dispatches" series of documentaries, investigated AIDS in sub-Saharan Africa, and reached some startling conclusions. Dr. Harvey Bialy states that there is "absolutely no believable evidence of immuno-deficiency disease in Africa." Likewise, Professor Gordon Stewart, the only researcher to accurately predict AIDS statistics in the United Kingdom, found no evidence of an AIDS epidemic in Africa, and believes that statements of doom should be avoided.

Their reasoning? No one in Africa receives a blood test for AIDS, so diagnoses of the disease—and thus statistics on the rate of AIDS—are based purely on patients' symptoms. Those who have the three main symptoms of AIDS stated in international guidelines—a persistent fever, diarrhea, and a dry cough for a month or more—are classified as AIDS cases. The problem is, these symptoms are indistinguishable from those of malaria and tuberculosis, says Dr. Okot-Wang. Therefore, many cases of malaria and TB are being incorrectly classified as AIDS, reports Sam Mulondo, a journalist who has covered the AIDS crisis in Africa.

AZT AND DDL, THAT ARE SUPPOSED TO SLOW DOWN OR STOP THE SPREAD OF HIV AND AIDS, MAY HAVE THE OPPOSITE EFFECT.

The irony is that much of the money from international relief efforts is being channeled into AIDS education and treatment rather than being used to treat such rampant diseases as malaria, which is curable with drugs. Doctors and community leaders—anxious to get any money they can into the public-health pipeline—have no choice but to take money targeted for AIDS and do the best they can in combatting the illnesses they encounter.

Michelle Cochran, who has studied AIDS in Uganda and Kenya on a research scholarship, also reports that the data on AIDS in Africa is riddled with contradictions. "I think there are a lot of problems with the way we define AIDS cases in Africa," she states. "The majority of Africans diagnosed as having HIV or AIDS have never had an ELISA or Western blot test to confirm their diagnosis. They're diagnosed according to a clinical criteria which says that if you've lost ten percent of your body weight or have a fever or a cough for over a month, you have AIDS. Malaria can cause you to have an HIV-positive test. Flu can cause you to have an HIV-positive test. It's also possible that someone will test positive for HIV but have HIV-2 instead of HIV-1, which is not considered to be the cause of AIDS. We're going to need to see more confirmed tests in order to get any real data.

"There are no mortality figures for the cases in

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Uganda," Cochran continues. "The official caseload of 38,000 is anything but a massive pandemic. Five million people die of malaria every year in sub-Saharan Africa, making 38,000 cases of AIDS-related diseases far below the number one would expect, given all the attention to the epidemic. Africa presumably has the same number of HIV-positive cases as the U.S.—one million. They have at least the same number of AIDS cases that we do in the U.S."

Meanwhile, these figures are used to promote monetary aid for educational and counseling programs. Yet of the money raised under the guise of the AIDS epidemic, says Cochran, very little finds its way into treatments for tuberculosis or malaria. Little goes to AIDS patients, prenatal care, more food supplies, or the drug needed to treat opportunistic infections. "Most of it goes to bureaucratic or other political purposes that really don't benefit the health of the population," she says.

"The most interesting thing I learned [on my visit to Kenya] was that they do have HIV and AIDS, but it's all within the same high-risk groups we have here in the West," Cochran adds. "This is something we simply never hear about. We continually hear that there are no such things as African homosexuals and no such thing as drug trafficking, but it's simply not true. The cases along the coast are all concentrated within indigenous homosexuals who have no contact with Western homosexuals—in prostitutes, and in drug addicts."

SOME SENSIBLE APPROACHES

Professor Strohman says we are wasting energy by looking only at biological causes and cures for AIDS rather than environmental ones. "Ninety-eight percent of diseases in the U.S. are non-infectious and totally preventable. They can be traced to factors that are post-fertilization. Only two percent of diseases are genetically induced, yet our biomedical enterprise is spending ninety-eight percent of its money to support a paradigm which is molecular and genetic. We've got the whole thing standing on its head.

"The possibilities for a robust, diversified research program which would put us in touch with information having to do with drugs and other causes of immuno-deficiency are enormous. Yet our bio-medical establishment, by and large, is not funding them. You can't get money to do AIDS research unless you're doing some viral, molecular, magic-bullet approach. It's typical of everything that's gone on in the last twenty years. It's all genetic and molecular; the environment is never considered.

"The environment has always been enormously important in fostering health and increasing life expectancy," Strohman continues. "If you look at public health in the U.S. and other Western countries in the last 100 years, you'll see that the life expectancy has increased and that the death rate has dropped, mostly due to the elimination of infectious diseases. But this elimination hasn't come about from a molecular approach; it's come about from feeding people and from providing them with proper shelter and proper sanitation.

"[In fact], refrigeration was probably one of the most enormously important public-health measures contributing to increased life expectancy. Only in the very rare [instances] have molecular cases produced anything that comes even close to the impact that environmental manipulation has had on our population."

As Strohman points out, the same is probably true of AIDS. The problem is, we haven't been able to find out because research money isn't being channeled to Dr. Duesberg and others who want to explore the link between environmental factors and immune suppression. Meanwhile, immune system weakening may be causing specific diseases—such as wasting disease, Kaposi's sarcoma, and pneumonia—that have nothing to do with immune dysfunction.

Another vital part of any prevention treatment program is the strengthening of the immune system. A strong immune system maintains homeostasis and prevents the outbreak of an adverse condition. Even if the potential for an outbreak is there, it will not manifest. Dr. Gottlieb offers this example: "The herpes virus resides in the nerve roots on a long-term basis. If it doesn't come out and cause genital or oral lesions, no one is really concerned that the virus is there. Those breakouts usually occur in relation to decreases in immune function, whether as a result of steroids, recurrent infections, or whatever. Similarly, if one could put the HIV virus back in the box by maintaining a normal level of immune function, that might conceivably be a very good therapeutic approach based on the herpes model."

Dr. Thomas believes we must learn to recognize the different things that can impair the immune response. "The consumption of all kinds of drugs, including antibiotics and AZT, is immuno-suppressive," he says. "They prevent a normal immune response to a challenging viral or bacterial infection. Malnutrition causes overinfections, which I call hyperinfections, that wear out the immune system. And just being the recipient of a pint of blood is an immuno-suppressive event. That's why receiving blood of any kind is not a good idea unless there are overwhelming reasons to do so. But a hemophiliac, of course, is obliged to do so, and he suffers immune system suppression as a consequence."

Dr. Raphael Stricker, a hematologist and the associate director of the division of immunotherapy at California Pacific Medical Center tells of his success with dinitrochlorobenzene (D.N.C.B.), a type of immune-enhancing agent made of natural compounds. "D.N.C.B. stimulates the immune system to fight viruses and other infections," he says. "We have been following [HIV-positive people] who have been doing D.N.C.B. for three years on a continuous basis, and the results have been quite encouraging. We have been looking at patients with early HIV disease, not necessarily with advanced disease or AIDS. We've found these patients to have a stable course when they use D.N.C.B. on a regular basis. They do not progress to AIDS, and their immunologic studies are either stabilized or improved. The toxicity is really minimal. There may be some local irritation from the application site on the skin, but this usually clears up in a couple of days.

"D.N.C.B. is available through the Healing Alternative Foundation In San Francisco," Dr. Stricker adds. "Since it is a simple compound, it is not subject to patent rules or FDA control. It can be obtained for a very low price, also due to the fact that it is not patentable. It costs about twenty dollars for a six month supply."

Dr. Hans Kugler offers this general outline of immune-building steps HIV-infected people can take if they feel they are at risk of getting AIDS. "At first I would definitely not take the AIDS drug because it is immune-suppressive. This was shown in a recent publication of *Pharmacological Therapeutics*. I would stimulate the immune function. I would certainly emphasize a good and healthy lifestyle.

"The next step would be to move toward super nutrition," Kugler says. "The important thing to remember is to practice quality nutrition. Eat foods as Mother Nature makes them, not foods treated with chemicals. Then you would probably need a good supplementation program. Once you have started these basics, you put your mind to work. *Love, Medicine and Miracles* is a magnificent book to help teach you how to get your mind aligned.

"Then you can focus on stimulating the immune system into greater action," Kugler continues. "Since I served in the air force, I compare the immune system's function to the way the military acts during war. You activate all parts of it—the navy, marines, air force, and so on."

Once you've built up a strong defense, you can begin the move toward recapturing your health and your life.

Gary Null, Ph.D., is a nutritionist, consumer advocate, and author of over twenty books. In addition he hosts a series of nationally syndicated one-minute health-and-nutrition radio spots, ***Total Health****, as well as a television show carried in ninety-seven cities across the country. He lives in New York City.*