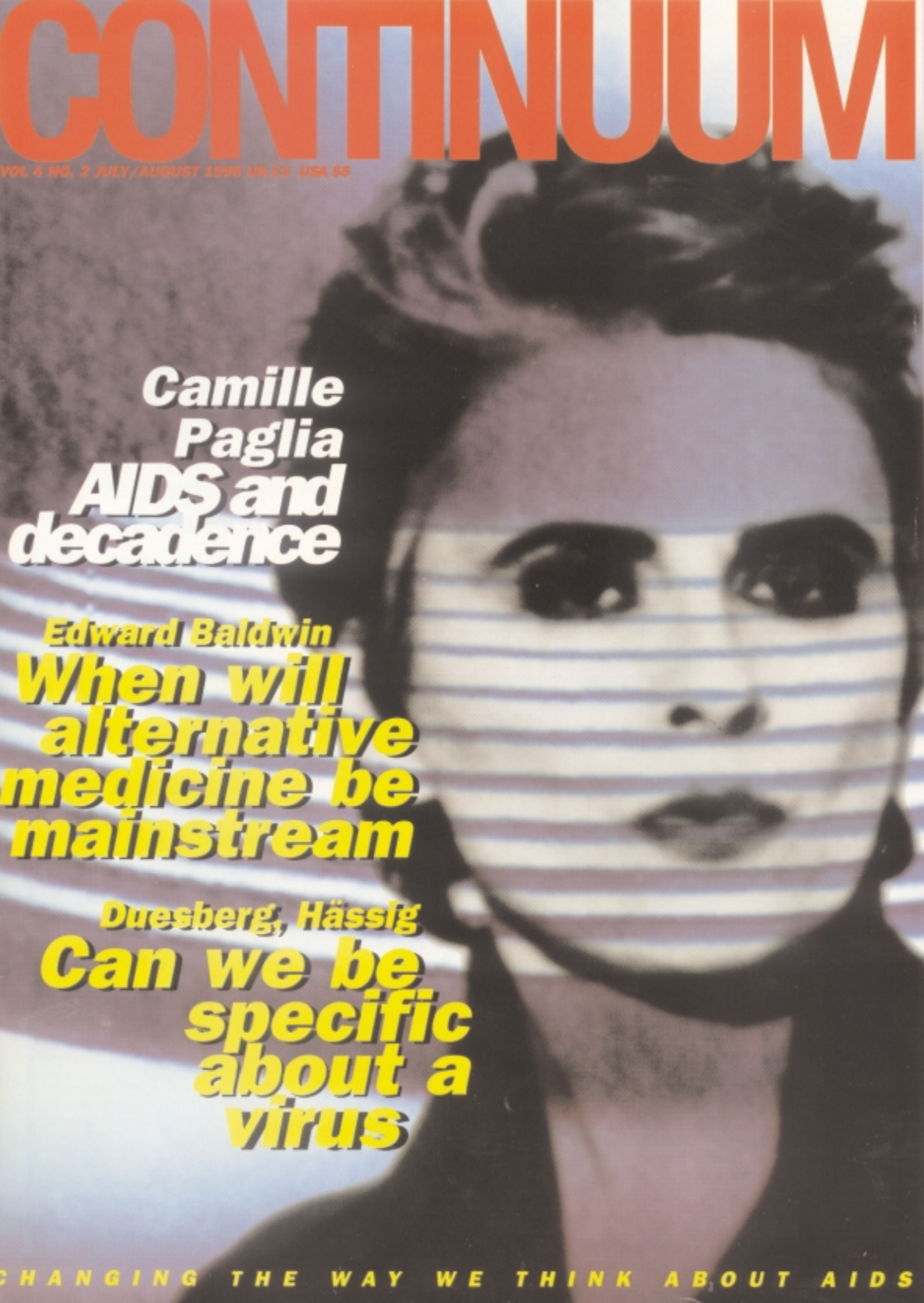
CONTINUUM

VOL 4 NO. 2 JULY/AUGUST 1996 UK £3 USA $5



Camille Paglia
AIDS and decadence

Edward Baldwin
When will alternative medicine be mainstream

Duesberg, Hässig
Can we be specific about a virus

CHANGING THE WAY WE THINK ABOUT AIDS

CONTINUUM

VOL 4, NO 2
JULY/AUGUST 1996

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.

FOCUS

FEATURES

Living exhibit at London's Gay Pride '96

PHOTO: BRIAN PARKIN

NEWS

REGULARS

CHANGING THE WAY WE THINK ABOUT AIDS

COMPLAINT UPHELD

The UK's Advertising Standards Authority has asked the free HIV magazine *Positive Nation* to stop running an advertisement implying combination drug therapy improves the health of T-cells and increases their number. The ASA upheld a complaint by *Continuum*, saying the advertisers "did not supply evidence to support the implied claim".

SALIVA TEST

The US Food and Drug Administration has approved an unvalidated saliva test for HIV called Orasure. The method eliminates the supposed needle-stick risk to medical staff while taking blood, since cotton wool is pulled between the gums and cheek.

STANDARD REPLY

Officials from the Department of Health's Communicable Diseases Branch have been sending out standard replies to *Continuum* readers who wrote urging the Government not to waste money on combination therapy. The replies assert that "the majority of scientists accept that HIV exists and cause AIDS" and "isolates are available". Dissatisfied readers have sent more probing follow-up letters.

NEW CURE

Therapists at London's Maudsley Hospital say they are prepared to deal with homophobia as a problem requiring treatment. But they accept that, as with racism and sexism, those affected rarely realise they need psychological help.

SWEDISH MEDITATION

Fifty people gathered in Rålambshov Park, Stockholm, to meditate and join their thoughts on HIV while using a bowl of flowers as a symbol of life. Claiming the power of thought could transform the virus, this is expected to become a yearly event in Sweden each June 16th.

SURGERY SURVEY

Surveys of HIV-positive patients in the Kensington, Chelsea and Westminster areas of London show that more than a third fear discrimination at their local surgery. The report recommends the introduction and display of non-discrimination policies.

FRENCH LESSON

Paris Gay Pride coincided with a row at Sidaction, France's AIDS research telethon on six TV channels over six hours. There were fifty percent fewer viewers than last year, and 75 percent less money raised.

UK holistic charities unite

Three of Britain's leading holistic HIV and AIDS charities have joined forces to create a national branch of a Europe-wide organisation.

Equilibrium, the Heal Trust and Positively Healthy have united to form NATC-UK, the British branch of the Natural Alternative Traditional Complementary Medicines Caucus Europe.

They hope the move will promote greater awareness of alternative therapies by:

- promoting the institution of good clinical practice;
- ensuring internationally acceptable standards for study and research;
- the integration into orthodox clinical practice of scientifically validated alternatives;
- establishing a pan-European database to collect and collate data on therapies currently under investigation and in use by people diagnosed with HIV and AIDS;
- instituting a pan-European practitioner and user questionnaire survey;
- hosting a major pan-European conference in 1998 to examine the issues surrounding the use of alternative and complementary therapies in HIV and AIDS healthcare management.

Trust backs dissident MPs

An HIV charity is promising not to blacklist any General Election candidates holding dissident views on AIDS.

The Manchester-based George House Trust, supporting people with HIV in the North West of England, plans to canvass the views of all candidates from the three main political parties and circulate them to their 4,000-strong mailing list.

The trust hopes to make adequate funding, discrimination and support for developing countries HIV issues in the forthcoming election.

But spokesperson Tim Pickstone said that provided candidates broadly supported the idea of helping people diagnosed as HIV-positive, it would not matter if they did not believe in HIV as a virus, or that it was the cause of AIDS.

AIDS book sparks row at seminar

US playwright Larry Kramer opened Salford University (UK)'s three day Transmission '96 conference in early July. The international event included seminars and presentations involving workers in the press, TV, film, radio and community projects.

Kramer told an audience including AIDS activists Edward King and Simon Watney that the new book AIDS – the Failure of Contemporary Science by former Sunday Times Science Correspondent Neville Hodgkinson [see Review] should be "spoilt, spat at, and rendered unreadable." Dr Stuart Derbyshire, of the Rheumatic Disease Centre, Manchester University, who also attended, described the comment as "intellectually vacuous and censorious."

Other speakers included Huw Christie, Nick Partridge and Hodgkinson himself, who was well-received on the third day. Former Nature editor Sir John Maddox cancelled his appearance at short notice.

Heterosexual AIDS threat shown to be just a myth

Claims that Britain was threatened by a heterosexual AIDS epidemic have been exposed as a myth by latest Government figures.

Gay community leaders now admit they deliberately hyped up the fear of AIDS among heterosexuals in order to attract maximum funding.

The figures reveal that of 12,565 people who received an AIDS diagnosis in Britain since 1982, only 161 were heterosexual. The Department of Health claims this low figure is a direct result of its £1.5 billion campaigns aimed at the majority, but does not explain why figures remain so high in the gay community which received the same message.

Some critics have accused the Government of wasting millions of pounds when smaller sums could have been spent aiming campaigns mostly at the gay community instead. But Jamie Taylor, of the London-based Gay Men Fighting AIDS (GMFA) admitted on Radio Four's Today programme that the gay community deliberately hoodwinked the Government.

"The type of money we needed to combat the epidemic in the gay community would only be forthcoming if the disease appeared likely to affect Middle England," he said.

The figures sparked off a row among national newspaper columnists with Ann Leslie, of the Daily Mail, explaining how experts, doctors and politicians had conspired to create a myth "wasting £1.5bn of your money". She pointed out that the Mail had spent ten years saying the threat never existed and that heterosexual AIDS in Africa was now being questioned.

Former Sunday Times editor Andrew Neil seized the opportunity to remind readers that during his tenure the paper, through its science correspondent Neville Hodgkinson, had continually challenged the claim that heterosexuals were at risk. He claims the establishment refused to listen at that time because "AIDS had become an industry, a job-creation scheme for the caring classes". Neil points out that if the establishment has now admitted it was wrong about a heterosexual spread, it ought to look at other areas, such as the link between HIV and AIDS, where it remains dogmatic.

The Guardian's Francis Wheen, who devoted several hundred words to insulting Neil without answering his points, clearly demonstrated how little such columnists understand the complex science surrounding the HIV and AIDS debate.

A similar lack of knowledge was shown by Princess Diana and AIDS activist Aileen Getty, daughter of billionaire art patron Paul Getty, who made it clear they were continuing to cling to the heterosexual threat idea and would campaign for funds accordingly.

Test case implications for pubs and sex shops

Selling poppers is now unlawful

The sale of poppers by clubs, pubs and sex shops in the UK has been clearly demonstrated as illegal after a test case was brought against a London shop in the Crown Court.

The Government has now promised to crack down on anyone, other than doctors and chemists, selling the drug and has revealed that several other investigations are already under way.

But the judge refused to grant the £47,000 costs of bringing the case to court because he said the shop should have been warned first. He did, however, fine the Camden-based Zipper Store £100 after its owners, Millivres, admitted illegally supplying medicines for human consumption.

The case against Millivres, which also publishes the magazine Gay Times, was brought by the Royal Pharmaceutical Society (RPS) after its inspectors, working undercover, bought a bottle of Hi-Tech poppers from the Zipper Store in March 1994. The society said it was not seeking to punish the store, but to bring a test case that would firmly prove alkyl nitrite (poppers) and its various forms – amyl, butyl and isobutyl nitrites – were to be classed as medicines under the 1968 Medicines Act.

PHOTO: BRIAN PARKIN

Pride, July '96: a large outdoor festival of celebration in London. The newly ratified South African Constitution is the only state constitution in the world in which the legal rights of gay and lesbian citizens are specifically guaranteed.

The society claims the successful prosecution of Millivres, despite Judge Finney's reservations about the way the case was conducted, proves poppers to be a medicine. The maximum sentence for illegal supply is two years in prison or an unlimited fine.

Immediately afterwards, a spokesman for the Department of Health confirmed it was now clearly an offence for anyone not a doctor or a pharmacist to supply poppers to the public.

"Any case of improper sales should be reported to the Medicines Control Agency and there are several investigations in progress," he added.

Poppers, once marketed by Wellcome as a medicine for heart conditions, are claimed by many researchers to be not only harmful but a possible co-factor in AIDS, and have been specifically linked to Kaposi's Sarcoma. [see Drug Effects]

Susan Sharpe, RPS director of legal services, said: "Poppers are increasingly widely used, and our concerns are that this open availability means people are ignorant of the possible dangers of use to their health. This will, I hope, result in poppers dropping from sale."

Manufacturers and suppliers of poppers have now begun to assess the legal implications of the case.

But Terry George, of telephone chatline operation GayXchange, whose Leeds-based mail order firm Aromas Direct makes three of its own brands – 100% Amyl, Pure Gold and Ice Diamond – while supplying several other brands, said he would continue to sell them.

"We don't sell it as a medicine – we sell it as a room odouriser with clear instructions on its use," he said.

At the same time, shops in London's Soho, and pubs and clubs throughout the UK have continued to sell poppers, most of them unaware of the case.

EARLIER DRUG USE

Luc Montagnier, discoverer of "HIV", has set up a new £1.8 million AIDS research centre in Paris to study early use of anti-viral drugs. While drug therapy usually begins when CD4 counts fall below 200, he intends to find out whether treatment at counts over 500 will affect AIDS.

EXPANDING MARKET

The Japanese have approved the drug ddC but remain under pressure to allow a further 15 drugs already available in the US. Japan, which has displayed a conservative approach to drug therapy, had only previously approved AZT and ddI.

POSITIVE MILESTONE

***Body Positive Newsletter's* 200th issue was produced last month. Originally one-page, it has steadily grown. In May 1987 BP achieved charity status, the BP Centre in Earls Court was opened in November 1988, and in July 1994 their survey showed a readership of over 14,000. Recent reports say they have accepted new computers from Glaxo-Wellcome.**

TESTING TIMES

The Terrence Higgins Trust is to hold a conference in London on September 13th to debate views on HIV testing. Key note speakers, discussions and open workshops will look at the controversial question of whether THT should actively encourage people to get tested.

DRUGS BOOST

Renewed stock market confidence in Glaxo-Wellcome anti-HIV drugs has greatly increased share prices. Managing director Sir Richard Sykes also told a Swedish newspaper that AZT would "never disappear". Cumulative worldwide sales of AZT stand at $2.5 billion to date.

SWEET CHARITY

Manchester's Village Charity is to hand out large cash rewards to those of its employees who have done outstanding work. The move is being criticised by those who believe the money should be spent only on providing services.

DIFFERENT STROKES

Researchers in Toronto are studying children told they have the "AIDS virus". "Boys seem to put the information in their back pocket. They...carry it back *there.*" Girls become "more tearful...as if (they) have new lenses for their glasses, and see the world in a different way." The study "is at a very preliminary stage".

COMMENT

We've not paid much attention to the recent Vancouver AIDS conference. The *Economist* (June 29) summed up its major article on triple-drug-therapy – the thrust of the Canadian pharma-sponsored gathering – with "For the first time since 1981, when a few inquisitive doctors noticed the outbreak of a strange and rare cancer in gay American men, there is hope". Has no-one told them Kaposi's Sarcoma has been taken off the list of AIDS-defining illnesses by some leading institutions because it is not associated with immune deficiency? Or that Robert Gallo thinks poppers may be its principal cause? The new anti-"HIV" drugs for AIDS are a marketing triumph and a human nightmare: chemicals to block proteases – enzymes which the body needs for normal functioning. A new round of experiments is about to begin, and no prizes for guessing the outcome.

Instead this issue celebrates the voices of dissent, the critical thinkers who keep enquiry alive, embracing the need to think for ourselves, in today's world more than ever with our mass communications, mass production and mass graves. Despite the best efforts and huge budgets of the "HIV" movement, now more than ever independent thought and clear analysis are finding a place in the general discourse. As Celia Farber of *Spin Magazine* has said, "Truth is like an aeroplane, it has to land somewhere." Bring your sense of humour and enjoy the ride!

Published bi-monthly by:

CONTINUUM

Founder: **Jody Wells** Editor: **Huw Christie** Administrator: **Tony Tompsett** News: **Nigel Edwards, Huw Christie** Cover Design: **Musimbi Sangale** Design & Layout: **Tony Tompsett, Malcolm Manning** Research: **Alex Russell, James Whitehead** Advertising: **Tony Tompsett** Administrative Assistant: **Rafael Ramos**

172 Foundling Court, Brunswick Centre, London WC1N 1QE
Tel: [+44] (0)171 713 7071 Fax: [+44] (0)171 713 7072

Continuum is grateful for support received from the Study Group on Nutrition and Immunity, Bern, Switzerland

Affiliated to the Harrow Association of Voluntary Service,
The Lodge, 64 Pinner Road, Harrow HA1 4HZ. Regd. Charity No: 294136

Printed by: Calvert's Press Workers Co-operative,
31–39 Redchurch Road, London, E2 7DJ. Tel: 0171 739 1474

DISSENTING VIEW

AIDS: death by prescription

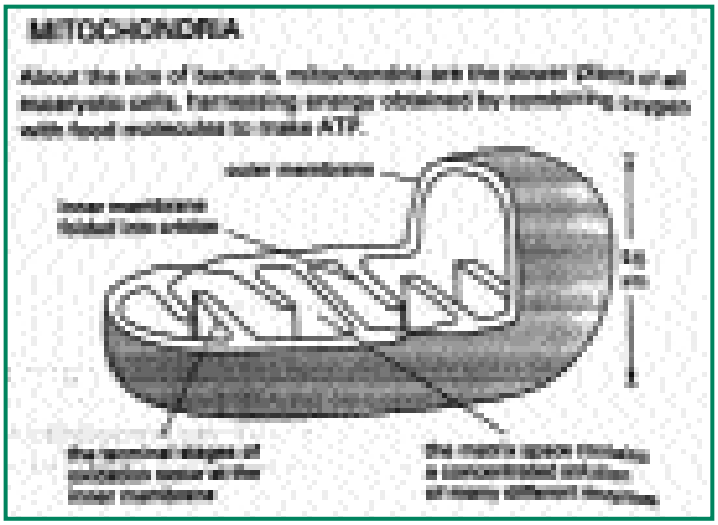
Protease inhibitors and antiviral drugs with mitochondrial toxicity: AIDS treatment with consecutive death.

by H. Kremer, S. Lanka and A. Hässig

The advertising drums are beaten hard all over the world today. The same doctors are calling for obedient candidates for their experiments and holding out the same promise of a cure who have poisoned countless AIDS patients by administering the DNA blocker AZT for the past ten years in an attempt to hunt down the phantom HI virus.

The same doctors are now trying to conjure up a substance from the test tube under the magic name of 'protease inhibitor' and to market it as having a limitless cure potential, although nobody in fact knows what long-term reactions this molecule, which has never been tested on man, may cause in the living organism.

The victims and perpetrators have only recently come to realise that AZT (also known as Zidovudine or Retrovir) has, in countless cases, brought about the inevitable and slow asphyxiation of the patient's body cells, which are in particular need of oxygen and hence the equally inevitable death by poisoning of those persons who are stigmatised as HIV-positive or diagnosed as suffering from AIDS and who trust their doctors. Despite that realisation, new test candidates are already being sought who will be voluntarily prepared, through fear of death suggested by the

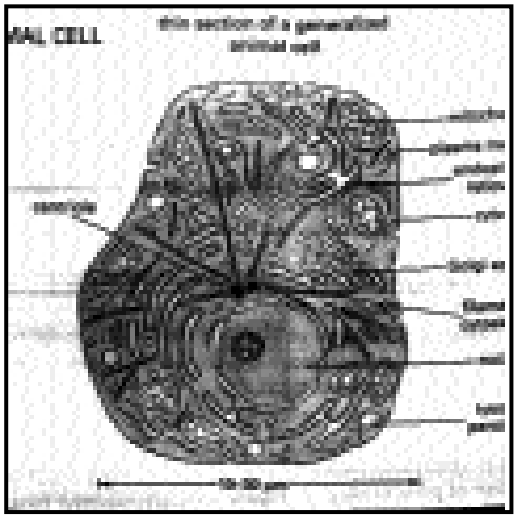


medical profession, not only to swallow AZT in combination with allied toxic substances, but in addition to take an inhibitor which has an incalculable impact on cell metabolism.

A guarantee of success is secured in advance, as with AZT, because any fatal 'secondary effects' of the mixture are described as an outcome of the phantom HIV infection. These are the self-same laboratory doctors and clinical practitioners who for years abused the confidence of anxious AIDS patients with the assertion that AZT would reliably, and with total certainty, prevent the proliferation of their 'phantom' HIV.

In reality the substance AZT is absorbed by a primary route through the DNA gamma-polymerase into the energy centre of all body cells, the mitochondria. Without the activity of the mitochondria as former bacteria, no body cell can produce the necessary energy from oxygen and make it available for the whole cell metabolism in the bound state in adenosine triphosphate (ATP).

The doctors who prescribe AZT have, however, denied this established fact and wrongly diagnosed the fatal consequences of AZT medication as the sequels of AIDS following a prior "HIV infection". For example, clinical manifestations such as the wasting syndrome, HIV encephalopathy, cardiomyopathy, atrophy of the skeletal muscular system and opportunistic infections of all kinds affecting the patients are declared to be tragic consequences of AIDS.



AZT manifestly also damages the mitochondria of the same microbes (protozoa and fungi) which have become adjusted to the cellular metabolism of the body in the course of evolution without being normally pathogenic. In the case of serious damage to their energy production they may, however, undergo mutation into aggressive pathogens and may, under certain conditions, cause what are known as opportunistic infections. The true opportunists therefore are the AIDS doctors who prescribe AZT. They have sought to drive out devils with Beelzebub!

And by doing so they demonstrate their ignorance of fundamental biological processes in the human organism.

But the dogmatic AIDS doctors have invented new tricks. Although, despite all the assertion to the contrary, no scientist has ever demonstrably produced a genome of the imaginary HIV which would be capable of causing infection they announce that they have traced minute fragments of the genetic material of HIV in RNA form and enriched these fragments; now they claim to be able to determine the precise quantity of HIV in the individual patient's blood serum. It remains a secret of the AIDS doctors to explain how they are able to identify the part as a whole, without ever having seen the whole. By the same token, researchers could conclude from the sight of a footprint on the banks of Loch Ness that the monster of the same name really does exist.

But they go on to develop a destructive logic on the basis of such arbitrary definitions. As the doctors claim on the pars pro toto principle that they can quantitatively determine the active amount of the HI virus in the individual stigmatised patient, they now prescribe "appropriate" quantities of AZT and similar toxic substances as a cocktail for the patient. A sufferer who is purported to have many fragments of the messenger substances of the genetic material of the HIV phantom in his or her blood serum, is described as an unfavourable case and receives the poison cocktail in correspondingly high doses; sooner or later the patient will be unable to escape his or her predicted fate because of the fatal toxic effects of the "medication", especially as, depending on the individual patient's reaction, the poison cocktails are varied and supplemented by protease inhibitors.

The purported "viral load" hides nothing but the measurement of particular messenger substances (RNA) in the blood plasma of selected patients. Sequences which resemble those that are defined as HIV-specific are then demonstrated. But it must be realised that such messenger substances occur in thousands of different variations, reflecting perfectly normal biochemical processes in the body, thousands of which take place simultaneously and in coordinated fashion in the metabolic interplay. Fluctuations, i.e. the increased or reduced occurrence of the sequences, are perfectly normal in this complex interplay of thousands of simultaneous metabolic processes. In the case of persons with a heightened cellular metabolism, e.g. persons under cell-destructive medication (AZT, ddI etc.) and those suffering from multiple infections, these molecules may sometimes occur with a higher degree of probability, precisely because of the metabolic acceleration. The isolated presentation of measurements of a particular kind of sequence, which remains in any case totally impossible to quantify, is therefore clinically irrelevant in the absence of comparison with other molecules of this kind. There are also no comparative values which would enable any significance whatever to be attributed to these relative measurements.

Proteases are in fact protein enzymes which split protein molecules into the length required in each particular case by the metabolism. They are naturally rendered inactive within and outside the body cells by special inhibiting molecules until they are recovered by complex interactions between many different molecules. The body constantly produces such protease inhibitors, e.g. heparin and the heparinoids. The HIV hunters now claim to have produced protease inhibitors in the test tube which will specifically only inhibit those proteases that are said to be responsible for the proliferation of the hypothetical HIV. They want to measure the success of these protease inhibitors by a quantified reduction of the arbitrarily defined viral load (see above) and the relative increase of the T-helper cells.

In other words, one fiction (virus blocking) is legitimated by another (virus quantification). The temporary increase of T-helper cells is brought about by the partial displacement of cells of this type from the bone marrow and other compartments into the bloodstream through temporary inhibition of the catabolic metabolism, which predominates in "HIV positive" patients.

However, in reality it is to be feared that sooner or later the unphysiological intervention in the complex interplay of body cell growth factors through artificial protease inhibitors will disturb equally vital functions of the basic tissue and cells, together with their mitochondrial energy centres, as is already the case when AZT and allied nucleoside-analogues are administered. However, as no animal model is available for preliminary clinical testing, the "HIV-positive" patients and "AIDS-sufferers" who go in fear of death must put their life on the line. Every test subject should therefore be aware that treatment with cocktails of AZT and allied toxic substances plus protease inhibitors may be equivalent to joining a suicide squad with a time fuse.

Finally, attention is drawn to the healthy organism where proteases and antiproteases are in equilibrium. Heparinoids at the cell surface are the normal antiproteases. An imbalance can be corrected by oral administration of heparinoids in the form of extracts of cartilage (chondroitinsulfate) and agar extracted from seaweeds. We suggest that anti-"HIV"-positive individuals take advantage of this simple and cheap possibility to correct a possible deficiency of antiproteases.

WARNING!

At a recent AIDS meeting, an important announcement was made concerning protease inhibitors. The FDA will make a similar announcement soon, with letters and faxes to all AIDS healthcare providers.

DO NOT MIX ANY OF THE THREE PROTEASE INHIBITORS WITH ANY ANTIHISTAMINE (including Claritin).

Two known deaths from cardiac arrhymthia have already occurred because of the combination. Apparently, the protease inhibitors cause concentration of the antihistamines to increase to possibly lethal levels. Because antihistamines are so common, the danger is widespread. Antihistamines are used as treatments for hay fever, in some cough medicines, for motion sickness, and bites and stings, etc.

Body Positive Newsletter (UK, July 1996) lists a further 14 specific drugs with which the protease inhibitor Ritonavir must not be mixed.

JOHN MADDOX is the recently retired editor of *Nature*, which flatters itself to be the best scientific journal in the world, and the occasion was marked by the bestowal of a knighthood on him. While the circulation of *Nature* has increased impressively under his leadership, its treatment of one of the greatest scientific bungles of our time has been anything but impressive and has, despite the vast erudition of its editor, followed convention (almost) to the bitter end

Is Maddox mad or is he just pretending?

Or is his greatest hour yet to come?

by

VOLKER GILDEMEISTER

The bitter end seemed finally to have arrived when, to everybody's great relief, Sir John out of the blue announced: "Professor Peter Duesberg from the University of California at Berkeley is probably sleeping more easily at night now than for five years, since he first took up the cudgels against the doctrine that AIDS is caused by the retrovirus HIV. Duesberg has been pilloried for his heterodox views, and faced the threat that his research funds would be snatched away."(AIDS Research Turned Upside Down, 26 Sep 1991).

The reformed Sir John went on to observe self-pityingly: "Now there is some evidence to support his long fight against the establishment among which, sadly, he counts this journal." Duesberg will be saying "I told you so". How's that for an apology?

Could anyone reading this be under any illusion that Maddox in his wisdom had decided that enough was enough, Duesberg's period in the scientific wilderness should come to an end? Maddox had expressed regret at the enormous blunder committed in 1984, when that scientific joker, Robert C Gallo, announced he had discovered HIV to be the cause of AIDS. It was always surprising that a polymath like Maddox, with a truly wide overview of contemporary science, should have fallen for the American fanfare lauding the wonders of their medico-scientific establishment, given the absence of any evidence worthy of the word to support it in the first place: and by Gallo of all people, mention of whose name should have provoked only smirks of derision, given his impressive record of self-glorifying mistakes.

With hindsight, Maddox must just have been cleverly biding his time, and used the figleaf of the rubbishy results of Stott et al and Hoffman & Kion to highlight just how dumb things had become. Stott's group of researchers used two groups of four monkeys, and inoculated one lot with SIV [supposedly the monkey equivalent of HIV] -infected white blood cells and the other with the same cells but without SIV, as controls. Guess what happened: three out of the four SIV-infected monkeys developed antibodies to SIV, but so did two out of the four that were never infected with the stuff! How could that be? Answer: they had no idea what they were doing; what antibodies they were measuring or even whether they were antibodies at all – probably they were just stress proteins.

Hoffman and his henchwoman found something equally zany. They treated one type of mouse with T-cells from another type, and found parts of HIV (sic) proteins in the treated mice. How can mice that have never been near HIV show antibodies to it, as if they had successfully overcome attack by it!

Maddox expressed regret at the enormous blunder

These findings were good enough for Maddox to launch his long overdue strike against the HIV/AIDS orthodoxy. So by September 1991, 4 1/2 years after Duesberg first blew the whistle, and hundreds of thousands of needless deaths later, old Maddox finally had enough of all these harmless viruses which had earned nothing but derision for much of medical research, with its retroviruses that did not cause cancer, Epstein-Barr virus that caused neither Burkett's lymphoma, nor herpes, nor warts nor cervical cancer etc. It was high time to add harmless HIV to this roll of dishonour.

As far back as 1988 Maddox had voiced his misgivings about the way molecular biology was just measuring things which amounted to nothing at all. "Finding wood among the trees: is the reductionist ambition for molecular biology in danger of being thwarted by the volume of the data it produces?" he asked, and concluded this perceptive piece by observing: "...the data will get so far ahead of its assimilation into a conceptual framework that [they] will eventually prove an encumbrance. Part of the trouble is that excitement of the chase leaves little time for reflection. And there are grants for producing data, but hardly any for standing back in contemplation." (5 May 1988)

Sir John had clearly decided it was time to do some serious reflection of his own. Soon after launching his attack on the AIDS orthodoxy he cast his net even wider by asking "Is molecular biology yet a science?", in which he correctly noted that: "there is now an army of people called molecular biologists whose published papers are innocent of references to whole plants and animals and which may have little to say about their physiology either." (16 Jan 1992)

But the dawn of a new realism in the value of molecular biology was short lived. As if he had taken leave of his senses, he published two long papers early last year (12 Jan 1995) which claimed that HIV caused "virological mayhem", by replicating several billion times per day. Didn't he stop to think how this could be, since it contradicted everything previously known about HIV? The manifest nonsense Wei & Ho had

churned out must be obvious to anyone.

To explain, just in case anyone has failed to see "the wood for the trees": how can HIV have been latent for the first 15 years of its existence, yet all along have been replicating furiously without ever having been noticed? Is this not the clearest example of what Maddox had complained about back in May 1988?

In his short period of enlightenment Maddox also asked: "Should molecular biologists mend their ways by resurrecting the Law of Mass Action (now conspicuous by its absence)? ... It would be a worthwhile precaution against the quantitative days that lie ahead that people should make sure that published data are capable of quantitative interpretation by those who have the zeal for that. As things are, that is far from true." (16 Jan 1992)

Tut, tut! What delicate, polite terminology to tell these overbearing Yankees from the NIH, NCI, NIAID etc. to stop churning out meaningless data. But who else than Maddox himself is responsible for this deplorable state of affairs! Or will he shuffle the blame off on Rupert Murdoch, the Yankee convert and owner of Maddox's rag, pleading force majeure. That would be a bit rich, since Nature's out and out American stablemate Bio/Technology is under no such constraint. Its scientific editor, Harvey Bialy, rightly prides himself on having kept his journal completely free of all the current AIDS alchemy.

No journal would have published such a bad paper

So, what was the bottom line of Sir John's short-lived uprising against HIV on 26 September 1991? Well, er, nothing much. On the grapevine it was said he planned to give Duesberg the opportunity to state his case properly. Instead Sir John commissioned a paper entitled Does drug use cause AIDS? (11 March 1993)

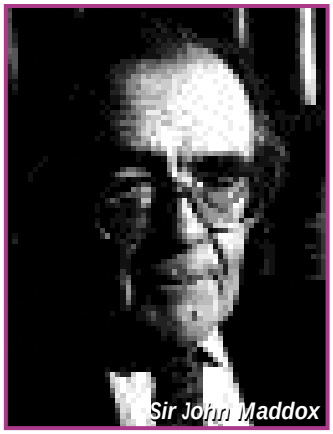
No half-way decent journal would ever have dreamt of publishing such a bad paper – it was embarrassing. How could any serious scientist even attempt to quantify drug use based exclusively on self-confession (as opposed to independent verification – who would believe a drunk to tell the truth about how much he drinks, all the more so if what he did were illegal, as drugs are)? The paper lumps together drugs as disparate as marijuana, nitrites (poppers), cocaine and amphetamines (ecstasy). Marijuana is so obviously different from the others, to anyone with an ounce of common sense, because only the gaseous components (as opposed to the impurities and adulterants) are inhaled, whereas with the other three, not only the drug but also the contaminants (which will be many and varied and toxic) are ingested. Therefore, such quantitative assessment of consumption must be one of the most foolish gestures ever made. But not too foolish for Maddox to publish.

To cap it all, no mention whatever is made of AZT, although it is crucial to the Duesberg case. Without people having been inadvertently killed in their hundreds of thousands by AZT, AIDS would by now have largely disappeared, the whole theory dismissed for its failure to produce anything useful. Without lashings of Wellcome money driving the blunder along, the AIDS bandwagon would have ground to a halt long ago.

As if the Maddox cup of self-betrayal were not full enough already, he then tries to discredit the Duesberg explanation of HIV infection in haemophiliacs, with equally ludicrous results. Someone like Maddox would know in his sleep that DNA, being a very large molecule, is sensitive to shearing (even by stirring in solution), and would certainly not survive the shear stresses occurring during freeze-drying to make Factor VIII. This would inevitably cause the DNA to be broken into smaller pieces, thereby destroying any biologically active structures which might have been present. He clearly never even considered the implications of the risible Oxford Haemophilia Study. It is so riddled with internal inconsistencies that I have known a semi-literate/numerate shop assistant fall about with laughter.

Its main finding is that HIV-positive haemophiliacs have a 10-fold greater death rate than HIV-negatives. The authors calculate a death rate of 0.8% for uninfected haemophiliacs; but they are so silly not to realise that this implies an average life-span of 100÷0.8 = 125 years – not bad going for people, who even a generation ago, generally did not reach 20! Maddox pretended not to notice and called it "A thorough study ... which for most people will be sufficient proof that the infection leads to AIDS". (7 Sep 1995)

To complete this grisly charge sheet, Maddox has recently disgraced his organ even further by publishing that most dismal scientific enterprise – the Delta Trial.


Sir John Maddox

Untroubled by the insolence of Wellcome's denial of Concorde (implying that the MRC and the French had cheated) Maddox did not bat an eye-lid at one of Delta's most ridiculous conclusions. Although everybody (except Wellcome) now agrees that AZT itself kills people (or more diplomatically does 'no good'), Delta claims that adding 1/1000 of the amount of ddC to it changes everything. But only if you have not previously attempted to administer AZT alone: as they impishly call that, patients are AZT-naive. The naivety of claiming that 1000 molecules of toxic AZT are changed from harmful to beneficial by just one molecule of ddC, might strike a chemist more forcefully than a physicist like Maddox, except that Maddox has at least 1000 times more savvy of contemporary medical research than an ordinary chemist has. It was the same Maddox who lectured molecular biologists that it was time for them "to mend their ways by resurrecting the Law of Mass Action conspicuous by its absence from what they publish". Whose fault is it that they do not?

For the benefit of those unfamiliar with the Law of Mass Action (and others who have forgotten) it means that one molecule

Maddox pretended not to notice

of ddC can never in a million years nullify the effect of 1000 molecules of AZT. It would be like saying a tiny amount of cyanide is lethal to man, but a single molecule cannot be – everything has to be in proportion. Stupendous stuff this ddC, you might wonder: in point of fact it is like AZT, just a dummy nucleotide, synthesised in the lab to stop DNA chains from being formed.

Since Maddox is known to prefer whiskey to pills, what quirk of human nature might be at work here–

(i) personal antipathy to Duesberg?

(ii) blind loyalty to Wellcome and all its works?

(iii) a case of cherchez la femme – Brenda, Lady M?

(iv) a delayed Strohman effect?

[Richard Strohman was until recently for more than 30 years Professor of Cell and Molecular Biology at Berkeley, funded throughout by the NIH, a measure of his scientific rectitude. For the last 20 years he tried to unravel the intricacies of muscular dystrophy, caused by a single defective gene. Not until he retired did he have the time to stand back and think, and realise that as a classical molecular biologist he had been labouring under completely false preconceptions of how genes work.]

Come on Maddox: collect your thoughts for a few hours and rattle off that article which will re-establish your integrity and credibility, and blow HIV right out of the water. Lots of people, especially in America, will say "the old sot has lost his marbles", but the elegant way in which you will say it will make them squirm. All the current pointless research on "how, why, perhaps, latently/billion-fold, directly/indirectly, overtly/covertly, this strain/that mutant, with/without this/that co-factor", this futile activity called 'AIDS research' will cease. Countless people will be saved, by not having to bother with a virus that cannot do anything anyway, and which does not even exist.

In classical mathematics one form of proof is reductio ad absurdum, ie. if a theory leads to an absurd conclusion, it must be wrong. How more absurd can you get, Sir John, than an average lifespan of 125 years, or that one molecule can cancel out 1000?

FOCUS: GLOBAL CONCERN ON VIRUS ISOLATION

After Robert Gallo with Margaret Heckler, the Reagan administration's Health and Human Services Secretary, held a press conference in 1984 to announce HIV as the "probable" cause of AIDS, he succeeded in publishing an unprecedented four papers on the subject in the journal *Science*. No other scientists had had time to respond to his opinions before he made them public; but Gallo had written to the editor of *Science* concerning the virus-like particles his French competitors had presented which he was later convicted of having misappropriated, and which today are the benchmark for HIV, "no-one has ever been able to work with [the Montagnier team's] particles. Because of the lack of permanent production and characterisation, it is hard to say that they are really 'isolated' in the sense that virologists use the term".

To this day, a vitally important debate with enormous implications continues over whether a virus can be said to exist if it can't be unambiguously isolated. Proteins and genetic material (DNA and RNA) may be viral or cellular in origin. Californian AIDS dissident Professor Peter Duesberg, historically a leader in virology and genetics, has argued brilliantly for nearly a decade that HIV cannot cause AIDS; here he responds to the challenge by *Continuum* for proof of the isolation of HIV. In the next issue, the Perth group led by biophysicist Eleni Papadopulos-Eleopulos, and German virologist Stefan Lanka, will respond.

Also in this issue, the latest paper from Professor Alfred Hässig and colleagues of the Study Group on Nutrition and Immunity in Bern, Switzerland raises serious doubts about the alleged specificity of HIV-antibodies, conventionally used not only as diagnostic markers but as an argument for the presence, and hence existence, of HIV. At least a good part of the positive reactions, they argue, are auto-antibody reactions against non-viral structures of the body.

Because Prof. Duesberg's preferred technique for retroviral isolation does not fulfil the Pasteur Institute methodology (1973) which was the criterion of the *Continuum* isolation prize, it has not been possible to grant his claim to the prize, albeit he argues that other isolation techniques exist.

The reward is still available.

245 DAYS...

The Jody Wells Memorial Prize

MISSING VIRUS!

£1,000 Reward

Blind romantics still believe HIV causes AIDS. But if 'HIV' has never been isolated, what *is* AIDS?

Never isolated? You bet! A cash prize of £1,000 is offered to the first person finding one scientific paper establishing actual isolation of HIV.

If you or a friendly 'AIDS expert' can prove isolation, £1,000 is yours. In cash. In public.

Interested? Pledge the money to your favourite AIDS charity, why not?

We bet you'll be surprised to discover the truth.

continuum

CHANGING THE WAY WE THINK ABOUT AIDS

...and still waiting!

Peter Duesberg Responds

In 1983, Montagnier et al isolated a retrovirus, now termed Human immunodeficiency virus (HIV), from a patient with lymphadenopathy and proposed that HIV may cause AIDS. Antibody against this virus has since been found in many, but not all AIDS patients[1] and in 17 million healthy people[2].

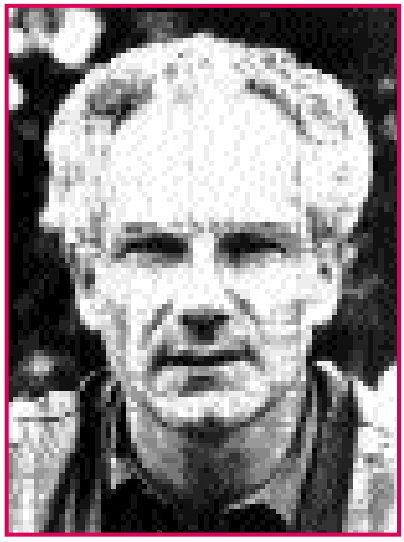
Eleni Papadopulos, Val Turner, John Papadimitriou, David Causer, Bruce Hedland-Thomas & Barry Page[3] and Stefan Lanka[4] maintain that the very existence of HIV is dubious because (i) HIV has not been properly isolated and thus could not have been properly identified (according to Papadopulos et al: "HIV has never been isolated as an independent particle separate from everything else"[3]); and (ii) antibodies against HIV are not specific[5]. They submit that the following evidence is not "specific" for HIV: identifying in the growth medium of infected human cell cultures either the existence of virus-like particles with the electron microscope, or of reverse transcriptase associated with such particles, or of certain HIV antigens or proteins associated with particles, because each of these could be cellular materials or could be from cell-borne (endogenous) retroviruses other than HIV.

Indeed, each of these criteria could reflect another retrovirus, and some of these criteria, eg. particles and proteins, could reflect non-viral material altogether.

However, the Papadopulos-Lanka challenge, that HIV does not exist, fails to explain (i) why virtually all people who contain HIV DNA also contain antibodies against Montagnier's HIV strain – the global standard of all HIV tests – and (ii) why most, but certainly not all people who lack HIV DNA contain no such antibodies. The presence of HIV-reactive antibodies in some uninfected people reflects an inherent limitation of tests for antibodies against viruses and other microbes. Since even the simplest microbes display thousands of antibody docking sites, termed "epitopes", antibodies against a given microbe may cross react

with an otherwise unrelated microbe if the two share some epitopes.

In view of the current controversy about the identification of HIV, the British AIDS magazine Continuum has offered in its Jan/Feb 1996 issue a "Missing virus! £1000 Reward"[6] for proof of the isolation of HIV, and the reward was reposted "105 days later...we're still waiting"[7] in the March/April, 1996 issue together with my preliminary "Reward claim... Cordially yours, Peter Duesberg"[8,9]. The stakes have since been raised considerably by a private reward of £10,000 from Alex Russell from the DMS Watson Library, University College London[10], and have now been raised even further by a £25,000 reward from James Whitehead from the International AIDS Freedom Network (IAFN), London[11,12].



Prof. Peter Duesberg

Here I take up these challenges. I will argue that HIV exists, and has been properly identified as a unique retrovirus on the grounds that (i) it has been isolated – even from its own virion structure – in the form of an infectious, molecularly cloned HIV DNA that is able to induce the synthesis of a reverse transcriptase containing virion, and (ii) that HIV-specific, viral DNA can be identified only in infected, but not in uninfected human cells. In view of this I can base my case for the isolation of HIV on the most rigorous method available to date, i.e. molecular cloning of infectious HIV DNA, rather than only on the much less stringent, traditional "rules for isolation of a retrovirus ... discussed at the Pasteur Institute, Paris, in 1973" that were stated criteria of isolation in Continuum's missing virus reward[6]. Indeed I will show that molecular cloning of infectious HIV DNA exceeds the criteria of the old "Pasteur rules".

(I) ISOLATION OF HIV

The existence of the retrovirus HIV predicts that HIV DNA can be isolated from the chromosomal DNA of infected cells. This prediction has been confirmed as follows: Full-length HIV-1 and HIV-2 DNAs have been prepared from virus-infected cells and cloned in bacterial plasmids[13-15]. Such clones are totally free of all viral and cellular proteins, and cellular contaminants that co-purify with virus. These clones produce infectious virus that is neutralized by specific antisera from AIDS patients. For example, virus produced by infectious HIV-2 DNA is neutralized only by antiserum from HIV-2 but not from HIV-1-infected people[15].

Since infectious HIV DNA has been isolated from infected human cells that is free of HIV's own proteins and RNA as well as from all cellular macromolecules, HIV isolation has passed the most vigorous standards available today. In other words these infectious DNA clones meet and exceed the isolation standards of the traditional "Pasteur rules". Isolation of infectious HIV DNAs is theoretically the most absolute from of isolation – it is the equivalent of isolating the virus' soul, its genetic code, from the virus' body, the virus particle. Thus HIV isolation based on molecular cloning exceeds the old standards defined as "Pasteur rules" by Continuum.

(II) IDENTIFICATION OF HIV

The existence of HIV predicts that infected cells contain a unique, virus-specific DNA of 9150 nucleotides that cannot be detected in DNA of uninfected human cells. The probabilities that cellular DNA and other viral DNAs would contain the same sequence of 9150 nucleotides is 1 in 4^{9150}, or 1 in 10^{4500} – extremely close to zero! Since the odds that a given nucleotide of any DNA is either A,G,C or T are in 1 in 4, the odds that any DNA has the same sequence of 9150 nucleotides as HIV-1 or HIV-2 are only 1 in 4^{9150}.

Thanks to the outrageous interest in HIV as the hypothetical cause of AIDS, many investigators have sought specific HIV DNA in humans with and without AIDS in an effort to confirm the rather unreliable HIV antibody-test.[1,5].

But because only 1 in 100 T-cells are ever infected in humans, virtually all such studies use Kary Mullis' polymerase chain reaction, a technique that is designed to amplify a DNA-needle into a DNA-haystack. Such efforts have confirmed the existence of HIV-specific DNA in most (not all) antibody-positive persons with and without AIDS – but not in the DNA of antibody-negative people. For example Jackson et al have tested blood cells of 409 antibody-positives including 144 AIDS patients and 265 healthy people. In addition 131 antibody-negatives were tested. HIV-specific DNA subsets – defined in size and sequence by HIV-specific primers (start signals for the selective amplification) – were found in 403 of the 409 antibody-positives, but in none of the 131 antibody-negative people[16].

The high sequence specificity of HIV DNAs is translated into the specificity of their proteins, eg. antibodies against HIV-1 do not neutralize HIV-1 and vice versa[15].

IN CONCLUSION

HIV has been isolated by the most rigorous method science has to offer. An infectious DNA of 9.15 kilo bases (kb) has been cloned from the cells of HIV-antibody-positive persons, that – upon transfection – induces the synthesis of an unique retrovirus. This DNA "isolates" HIV from all cellular molecules, even from viral proteins and RNA. Having cloned infectious DNA of HIV is as much isolation of HIV as one can possibly get. The retrovirus encoded by this infectious DNA reacts with the same antibodies that crossreact with Montagnier's global HIV standard, produced by immortal cell lines in many labs and companies around the world for the HIV-test. This confirms the existence of the retrovirus HIV.

The uniqueness of HIV is confirmed by the detection of HIV-specific DNA sequences in the DNA of most antibody-positive people. The same DNA is not found in uninfected humans, and the probability to find such a sequence in any DNA sample is 1 in 4^{9500} – which is much less likely than to encounter the same water molecule twice by swimming in the Pacific ocean every day of your life.

The existence of an unique retrovirus HIV provides a plausible explanation for the good (not perfect) correlation between the existence of HIV DNA and antibodies against it in thousands of people that have been subjected to both tests. The Papadopulos-Lanka challenge fails to explain this correlation.

Ergo: The Papadopulos-Lanka challenge is rejected. HIV exists and has been isolated.

References

1. Duesberg PH: The HIV gap in national AIDS statistics. Bio/Technology 11:955-956 (1993).
2. World Health Organisation: The current Global Situation of the HIV/AIDS Pandemic. Geneva (Jan 1995).
3. Papadopulos-Eleopulos E, Turner VF, Papadimitriou JM, Causer D, Hedland-Thomas B and Page BAP: A critical analysis of the HIV-T4-cell-AIDS hypothesis, Genetica 95:5-24 (1995).
4. Lanka S: HIV reality or artifact? Continuum, 3/1:4-9 (April/May 1995).
5. Papadopulos-Eleopulos E, Turner VF and Papadimitriou JM: Is a positive Western blot proof of HIV infection? Bio/Technology 11:696-707 (1993).
6. The Jody Wells Memorial Prize: Missing Virus! £1,000 Reward. Continuum 3/5:4 (Jan/Feb 1996).
7. Christie H: 105 days ... we're still waiting. Continuum 3/6:5 (March/April 1996).
8. Duesberg P: Reward Claim (letter). Continuum 3/6:18 (Mar/April 1996).
9. Christie H: Letter to Peter Duesberg (1996).
10. Alex Russell: Letter to Peter Duesberg (2/28/96).
11. Letter from Fred Cline, San Francisco, Representative of the IAFN (2/4/96).
12. Alex Russell: Letter to Fred Cline, undated (April 1996).
13. Fisher AG, Collalti E, Ratner L, Gallo RC and Wong-Staal F: A molecular clone of HTLV-III with biological activity. Nature (London) 316:262-265 (1985).
14. Levy JA, Cheng-Mayer C, Dina D and Luciw PA: AIDS retrovirus (ARV-2) clone replicates in transfected human and animal fibroblasts. Science 232:998-1001 (1986).
15. Barnett SW, Quiroga M, Werner A, Dina D and Levy JA: Distinguishing features of an infectious molecular clone of the highly divergent and noncytopathic human immunodeficiency virus type 2 UC1 strain. J. Virol. 67:1006-1014 (1993).
16. Jackson JB, Kwok SY, Sninsky JJ, Hopsicker JS, Sannerud KJ, Rhame FS, Henry J, Simpson M and Balfour HH Jr.: Human immunodeficiency virus type 1 detected in all seropositive symptomatic and asymptomatic individuals. J. Clin. Microbiol. 28:16-19 (1990).

HIV - can you be more specific?

Open Questions Concerning the Specificity of anti-HIV Antibodies: Do they belong to the group of autoantibodies against cellular structures?

by Prof. A. Hässig, Prof. Liang Wen-Xi, Dr. Kurt Stampfli and Dr. H. Kremer

Two years ago the working group of G M Shearer demonstrated that autoantibodies in the serum of patients with lupus erythematosus (an autoimmune disease), and in the serum of mice with experimentally induced lupus erythematosus, are capable of reacting specifically with glycoprotein (gp) 120 and peptides of the HIV-1 envelope.[1] The formation of antibodies with anti-HIV specificity against gp120 and the associated peptides in lupus erythematosus disseminatus is an indication that the anti-HIV antibodies can be formed within the framework of B-cell activations in systemic autoimmune diseases. Thus the question arises whether anti-HIV antibodies should generally be classified in the large group of autoimmune antibodies against cellular structures. These are described as antinuclear autoantibodies.[2,3]

Lupus erythematosus disseminatus is the prototype of a systemic autoimmune disease with widespread involvement of the different organ systems. This group of diseases also includes rheumatoid arthritis, Sjögren's syndrome, scleroderma and mixed forms of inflammatory diseases of the connective tissues. In these diseases, as a result of an activation of polyclonal B-cells, one finds a large number of humoral autoantibodies against cellular and extracellular structures.

HUMORAL AUTOANTIBODIES IN AIDS

In their review of chronic infections and autoimmunity, M Abu-Shakra and Y Shoenfeld mention that the following autoantibodies have been found in AIDS patients: antinuclear autoantibodies, rheumatoid factors, antibodies against erythrocytes, platelets, granulocytes and lymphocytes (T-cells), as well as antibodies against sperms[4]. In fact, there is extensive literature available on humoral antibodies in AIDS patients, in which autoantibodies against actin, myosin, trinitrophenol and thymosin have also been described[5-7]. In addition, in many works attention is drawn to the close connection between retroviruses and autoimmune diseases, without it being possible to explain the pathogenic mechanisms of these relationships[8].

HORIZONTAL TRANSMISSION OF HIV STRUCTURES AS TRIGGERING FACTORS FOR AUTOIMMUNE REACTIONS

RNA viruses which are transcribed by reverse transcriptase into the DNA of the host genome, where they are integrated as endogenous self-structures, are known as retroviruses[9]. For this reason the horizontal transmission of retroviruses may be considered as the transmission of genetic structures between individuals of the same species. The immunological reactions occurring in retroviral infections are therefore to be considered as alloimmune reactions and thus have to be classified as regularities of transplantation immunology. In this respect it is seen that immune-competent recipients of transplants react with an effective cellular immune response and thereby reject the transplant. Moderately immunosuppressed recipients of transplants, such as those under long-term treatment with cyclosporin, for example, are able to live with their transplant for long periods without problems. In contrast, transplant recipients with pronounced suppression of their cellular immune reactions are as a rule adversely affected by the activated immune system of the transplant, within the framework of a "graft versus host" reaction, which at worst can lead to the death of the patient[10]. In blood transfusions, the elimination of alloreactive genetic structures of the donor through cellular immune reactions of the recipient is the norm. "Graft versus host" reactions (GVHRs) are extremely rare.

ACUTE AND CHRONIC "GRAFT VERSUS HOST" REACTIONS (GVHRs)

The study of GVHRs in mice that were injected with lymphocytes from the parent animals has provided important insights into the mechanisms involved in acute and chronic GVHRs. With the injection of donor lymphocytes which show differences in MHC loci of Classes I and II, from the recipient animals, an acute lethal immunosuppressive GVHR occurs in the receiver animals, characterised by anaemia and hypogammaglobulinaemia, with increased mortality due to increased susceptibility to infections. If the difference between the donor lymphocytes and the recipient lymphocytes is limited to MHC loci of Class II a chronic GVHR develops, with stimulation of the polyclonal B-cells and the formation of humoral autoantibodies within the framework of a lupus-like syndrome. The stimulation of the formation of autoantibodies is due to the long-term persistence of alloreactive T-4 cells[11].

THE SIGNIFICANCE OF THE SHIFT IN THE TH-1/TH-2 EQUILIBRIUM IN SYSTEMIC AUTOIMMUNISATION

As we have shown in our previous studies, an acquired suppression of the cellular immune reactions is the leading factor in the pathogenesis of AIDS[12]. In this, the opposing behaviour of the humoral and the cellular immune reactions plays a decisive role. Characteristic for this is the behaviour of the cytokine profile of the Th-1 and the Th-2 cell-groups of the CD4+ helper cells. The Th-1 cells produce primarily IL-2, IL-12 and IFNg and through them stimulate the cellular immune reactions. The Th-2 cells produce mainly IL-4, IL-6 and IL-10, and through them stimulate the humoral (antibody) immune reactions. The Th-1/Th-2 equilibrium of the cytokine production of CD4+ lymphocytes is subject to the stress-induced neuroendocrine control of the immune system. Here, the relationship between cortisol and dehyro-epiandosterone (DHEA) plays the decisive role.

As explained earlier, the study of alloimmune reactions in rodents has shown that systemic autoimmunisations are associated with a shift in the Th-1/Th-2 equilibrium of the CD4+ lymphocytes. Chronic "graft versus host" reactions show an MHC Class-II-induced activation of the B-cells with increased IL-4 and decreased IL-2 activity. The excess of T-2 cells triggers the formation of antinuclear autoantibodies within the framework of lupus-like inflammatory reactions[11].

Extensive literature is available on the activation of autoimmune reactions within the framework of infectious and toxic inflammations[4]. We are grateful to A Schaffner and B Rager-Zisman for an excellent review on virus-induced autoimmunity[13]. Of special interest for the pathogenesis of AIDS in haemophiliacs are recent works on the activation of autoimmune reactions in hepatitis C[14]. The toxic induction of autoimmune reactions has for several years been the field of research of E Gleichmann who, with his working-group, has shown that toxic-induced autoimmune reactions behave in the same way as alloimmune diseases, whereby in both cases a Th-2 profile of the CD4+ helper cells plays the central role[15].

The close connection between our retroviruses and autoimmune rheumatic diseases gave rise to discussions as to whether endogenous retroviruses play a role in the aetiology of these diseases. However, no conclusive results were obtained in this respect[16]. The contrary idea, that antiretroviral antibodies should be classified in the large group of the autoimmune antibodies has to our knowledge not been considered up till now.

YIN-YANG SHIFTS OF MACROPHAGE ACTIVITY AS TRIGGERING FACTORS FOR AUTOIMMUNE DISEASES

As already mentioned, during the last ten years it has been recognised that in immune reactions a state of equilibrium exists between B-cell-dependent humoral and T-cell-dependent cellular immune reactions, which in all stress reactions is shifted in favour of the humoral immune reactions and to the disadvantage of the cellular immune reactions. Immune competence is defined as a state of equilibrium between humoral and cellular immune reactions[17].

The processing of the cell fragments resulting from the continuous cell metabolism is a permanent physiological task of the immune system. The human organism consists of about 10^{14} cells[18]. The around 10^{12} apoptotic cell fragments that are produced daily are recognised by the cytotoxic T-cells originating from the thymus and by the natural killer cells, and are transmitted to the macrophages, which process them without any signs of inflammation. The macrophage activity corresponds to the Yin situation. It is trophotropic and anabolic (such reactions involve the formation of body constituents).

In contrast, every stress-induced adjustment of the immune system to the elimination of exogenous "non-self" structures by humoral antibodies produced from B-cells is a special, temporary task of the immune system. It is always associated with an inflammatory activation of the macrophages. In this process the stress-induced hypercorticolism causes a reduction of the Th-1 lymphokines IL-2, IL-12 and IFNg. In the macrophages this causes an increased release of 0_2 radicals and inflammation mediators such as IL-1 and TNFa. At the same time this neuroendocrine situation weakens the containment capacity of the macrophages towards their intracellular micro-organisms. In addition, their defence against opportunistic micro-organisms is impaired. This macrophage activity corresponds to the Yang situation. It is ergotropic and catabolic and is generally described as an acute-phase reaction.

The Th-1 cytokine profile of the CD4+ lymphocytes corresponds to the Yin situation of the macrophage activity, while the TH-2 profile corresponds to the Yang situation of this activity[19].

According to what has been said, autoimmune diseases are to be understood as being the pathological effects of a continuous inflammatory macrophage activity, in which the increased performance of the immune system is directed towards endogenous structures.

In systemic autoimmune diseases such as lupus erythematosus disseminatus the persistent hyperactivity of the B-cell functions is the principal factor responsible for these conditions.

From what has been said, it emerges that there is much that speaks for the fact that the close association between retroviral diseases and autoimmune diseases is due to the same mechanism of a continuous hyperactivity of the B-cell functions. It should therefore be worthwhile to seriously address the question whether the anti-HIV antibodies can retain the individual identity accorded them up until now, or whether they should be classified in the large group of humoral autoantibodies against cellular structures. In this respect, clarification of the relationship of the retroviral proteins to the endogenous proteins plays a central role.

RELATIONSHIPS OF THE GLYCOPROTEIN GP120 OF THE HIV ENVELOPE TO ACTIN

In their work on the occurrence of anti-HIV antibodies with specificity against gp120 and the accompanying peptides in patients with lupus erythematosus disseminatus, the working-group of G M Shearer has shown that these antibodies differ from the anti-DNA autoantibodies of these patients[1]. As a result of this the question of the specificity of this autoantibody population remained unanswered. The following arguments serve to indicate that these could be anti-actin autoantibodies. Glycoprotein 120 and protein 41 are generally considered to be fission products of protein 160, which is found in virally infected cells but not in the infectious virus itself. Protein 120 is found only on the surface of protrusions occurring with the exocytosis of virus-like particles, but not in the released particles themselves[20]. Thus the question arises whether these glycoproteins, which are described as envelope proteins of the retroviruses, are endogenous proteins. In the first description of the human immunodeficiency viruses (HIVs) by the working-group of L Montagnier, they mentioned the possibility that "the 45k protein may be due to contamination of the virus by cellular actin, which was present in immunoprecipitates of all the cell extracts"[21]. In fact, the oxidation of cellular sulphydryl groups leads to the polymerisation of actin, so that the binding of anti-actin autoantibodies has been suggested as a sensitive method for the indication of a lymphocyte activation[22-25].

Anti-actin antibodies are found in healthy individuals, but also especially in patients with autoimmune diseases. In the latter cases their antibody profile speaks against cross-reactivity with viral antigens. In all probability they are natural autoantibodies[26]. They are particularly common in patients with chronic forms of hepatitis, where they play the same role as disease indicators as do the anticardiolipin antibodies in syphilis[14].

In order to explain the relationship of the demonstration of anti-HIV antibodies to viral or non-viral endogenous structures it seems to us to be essential to address, on a sound basis, the question of the anti-actin activity of anti-HIV antibodies against the envelope proteins of HIVs.

Based on these considerations, the sine qua non of an HIV infection in a case of AIDS is in our opinion invalid. Pathogenically, stress-induced suppressions of the cellular immune reactions are to be placed at the beginning of the process. Besides the weakening of the defences against latent infections and opportunistic micro-organisms, the impairment of the thymus-dependent immune functions causes an activation of the polyclonal B-cells, which in turn gives rise to autoimmune reactions with increased production of humoral autoantibodies. The increase in the anti-HIV antibody level is to be understood as a marker of this activation of the polyclonal B-cells. Therefore efforts aimed at the prevention of AIDS have to be directed primarily towards the correction of stress-induced suppressions of the cellular immune reactions, whereby suppression of the inflammatory activation of the macrophages is the most important objective[27].

Finally, we would like to draw attention to the fact that at the time when the working-groups of L Montagnier and R C Gallo were developing the anti-HIV antibody test, it was widely believed that any synthesis and release of reverse transcriptase was an indication of the active production of retroviruses. Today, however, we know that RNA-controlled DNA polymerases fulfil certain physiological functions, for example as telomerases in the stabilisation of the extremities of chromosomes[28]. It is therefore of impor-

est to consider this particular viewpoint in a critical examination of the development of these tests at that time.

SUMMARY

Two years ago the working-group of G M Shearer demonstrated that antibodies in the serum of patients with lupus erythematosus and in the serum of mice with experimentally induced lupus erythematosus are capable of reacting specifically with glycoproteins 120 and peptides from the HIV-1 envelope. On the basis of these observations we put to ourselves the question whether this group of anti-HIV antibodies are to be considered as autoantibodies against cellular structures.

A literature search has shown that humoral autoantibodies occur frequently in patients with AIDS and display the same specificities as in patients with systemic autoimmune diseases.

We would further point out that the horizontal transmission of HIV structures can act as the trigger for alloimmune reactions, whereby in recipients with severely suppressed cellular immune reactions "graft versus host" reactions can appear, with the development of humoral alloimmune reactions.

Furthermore, we have shown that autoimmune reactions have to be considered as pathological effects of a continuous inflammatory macrophage activity, whereby the increased performance of the immune system for the elimination of exogenous "non-self" structures is directed against endogenous structures. In this connection, in systemic autoimmune diseases such as lupus erythematosus the principal factor involved is the continuous hyperactivity of the B-cell functions.

Finally, we have shown that many observations point to the fact that anti-HIV antibodies with specificity against gp120 and the associated peptides are autoantibodies against cellular actin.

The authors are grateful for the support given to this work by the Hans Eggenberger Foundation in Zurich.

References

1. Bermas BL, Petri M, Bergofsky JA, Walsman A, Shearer GM, Mozes E. Binding of Glycoprotein 120 and Peptides from the HIV-1 Envelope by Autoantibodies in Mice with Experimentally Induced Systemic Lupus Erythematosus and in Patients with the Disease. AIDS Res. Human Retroviruses 10:1071-1077 (1994).
2. Tan EM: Autoantibodies to nuclear antigens (ANA): Their immunology and medicine. Adv. Immunol. 1982; 33:167-240.
3. Tan EM: Antinuclear antibodies: Diagnostic markers for autoimmune diseases and probes for cell biology. Adv. Immunol. 1989; 44:93-151.
4. Abu-Shakra A, Shoenfeld. Chronic infections and autoimmunity. Immunol. Ser. 1991; 55:285-313.
5. Matsiota P, Chamaret S, Montagnier L. Avrameas S. Detection of natural autoantibodies in the serum of anti-HIV-positive individuals. Ann. Inst. Pasteur/Immunol 1987; 138:223-233.
6. Calabrese LH. Autoimmune manifestations of human immune deficiency virus (HIV) infection. Clinics Lab. Med. 1988; 8:269-279.
7. Papadopulos-Eleopulos E, Turner VF, Papadimitriou JM. Is a positive Western blot proof of HIV infection? Bio/Technol. 1993; 11:696-707.
8. Krieg AM, Steinberg AD: Retroviruses and autoimmunity. J. Autoimmunity 1990; 3:137-166.
9. Levy JA: The Retroviridae Vol 4 (Ed0 in the Viruses: Series Eds Fraenkel-Conrat H and Wagner RR. New York Plenum 1995.
10. Roitt OI, Brostoff J, Male D: Immunology, 4th ed. London: Mosby 1996.
11. Rozendaal L, Pals ST, Gleichmann E, Melief CJM. Persistence of allospecific helper T cells is required for maintaining autoantibody formation in lupus-like graft-versus-host disease. Clin. exp. Immunol. 1990; 82:527-532.
12. Hässig A, Liang Wen-Xi, Stampfli K. Ueberlegungen zur Pathogenese und Prävention von AIDS. Schweiz.Zschr.GanzheitsMed 1995; Nr. 6:298-306.
13. Schaffner A, Rager-Zismann B: Virus-induced autoimmunity, Rev. Infect. Dis. 1990; 12:204-222.
14. Clifford BD, Donahue D, Smith L et al. High prevalence of serological markers of autoimmunity in patient with chronic hepatitis. Hepatol. 1995; 21:613-619.
15. Goldman M, Druelt P, Gleichmann E. TH-2 cells in systemic autoimmunity: insights from allogeneic diseases and chemically induced autoimmunity. Immunol. Today 1991; 12:223-227.
16. Venables P, Brookes S. Retroviruses: Potential aetiological agents in autoimmune rheumatic disease. Brit. J. Rheumatol. 1992; 31:841-846.
17. Hässig A, Liang WX, Stampfli K. Stress-induced suppression of the cellular immune reactions. Med. Hypothes. 1995; im Druck.
18. Lehner CF: Zellteilungen in mehrzelligen Organismen. Wie viele, wann und wo? Neue Zürcher Zeitung, 15 November 1995; Nr. 266:65.
19. Clerici M, shearer GM. Is HIV associated with a Th-1 to a Th-2 switch? Immunol. Today 1993; 14:107-110.
20. Pinter A, Honnen WJ, Tilley SA et al. Oligomeric structure of gp41, the transmembrane protein of human immunodeficiency virus type 1. J. Virol. 1989; 63:2674-2679.
21. Barré-Sinoussi F, Chermann JC, Rey F et al. Isolation of a T-lymphotropic retrovirus from a patient at risk for acquired immune deficiency syndrome (AIDS), Science 1983; 220:868-871.
22. Papadopulos-Eleopulos E, Turner VF, Papadimitriou JM: Oxidative stress, HIV and AIDS: Res. Immunol. 1992; 143:145-148.
23. Hinshaw Db, Burger JM, Beals TF, Armstrong BC, Hyslop PA. Actin polymerization in cellular oxidant injury. Arch. Biochem. Biophys. 1991; 288:311-316.
24. Bach MA, Lewis DE, McClure JE, Parikh N, Rosenblatt HM, Shearer WT. Monoclonal anti-actin antibody recognizes a surface molecule on normal and transformed human B lymphocytes: Expression varies with phase of cell cycle. Cell. Immunol. 1986; 98:364-374.
25. Damsky CH, Sheffield JB, Tuszynski GP, Warren L. Is there a role for actin in virus budding? J. Cell. Biol. 1977; 75:593-605.
26. Girard D, Senécal JL. Anti-microfilament IgG antibodies in normal adults and in patients with autoimmune diseases: immunofluorescence and immunoblotting analysis of 201 subjects reveals polyreactivity with microfilament-associated proteins. Clin. Immunol. Immunopathol. 1995; 74:193-201.
27. Hässig A, Liang WX, Stampfli K: Can we find a solution to the HIV-AIDS controversy? Med. Hypotheses: in print (1996).
28. Greider CW, Blackburn EH. Telomere, Telomerase und Krebs. Spektrum der Wissenschaft, April 1996:30-36.

HAVE YOU TAKEN AZT?

Joining the court cases will keep litigation costs down

Graham Ross, of the Ross Park Legal Partnership specialising in medico-legal, product liability, environmental, personal injury and group action cases, explains the developments in the pursuit of justice around AZT. The more people join the process, the more likely a successful outcome.

We are acting in a small number of AZT-related cases, some of which are now in court. These cases all relate to the prescribing of AZT to persons who were asymptomatic at the time and have subsequently become severely ill and, in most cases, died. The allegation is that significant damage was caused by the drug as opposed to the virus.

The allegation that the drug can play a major role in causing illness is no longer as controversial as it may originally have been. The Concorde study showed that there was no benefit in providing AZT to asymptomatics, in the sense that it did not delay the onset of illness, and now the Concorde follow-up study will reveal, according to the paper presented at Copenhagen last year by one of the Concorde team, Janet Darbyshire, that they have seen a significant excess of deaths in the group studied who had taken AZT whilst asymptomatic.

All these cases are covered by Legal Aid. An important consideration for the Legal Aid Board is to be satisfied that the cost of this litigation is not so excessive as to make the litigation unjustifiable. Whilst the cost in respect of the running of the general issues in these cases is high (on account of the complex medical and scientific issues) they are divided amongst all clients. The more cases, the lower the cost per case.

However, there is still a rather small number of cases so far going forward with the result that the proportion of costs borne by each client is higher than it ought to be. It is possible, and this has happened in other group-type actions, that the Board may decide that, whatever the merits of the cases, the pro rata share is too high and, as a result, withdraw support. If this were to happen then the litigation could not be taken forward and the opportunity to examine these important issues would be lost.

In view of this I would like to say to anyone who considers that they may wish to take action but have remained on the sidelines on a "wait and see" basis, that they make a decision to instruct a solicitor as soon as possible. Quite apart from the fact that the delay could prejudice claims (time limits do apply) we need more people to come forward to help share the cost burden. As part of a network called ALERT we have organised a team of twenty four solicitors around the country and clients can be referred to a local member firm. We are very happy to talk through cases on the telephone at no cost or commitment.

If anybody wishes to discuss this they can contact me or my team on 0151 284 8585.

AIDS: The Failure of Contemporary Science

(How a Virus That Never Was Deceived the World)

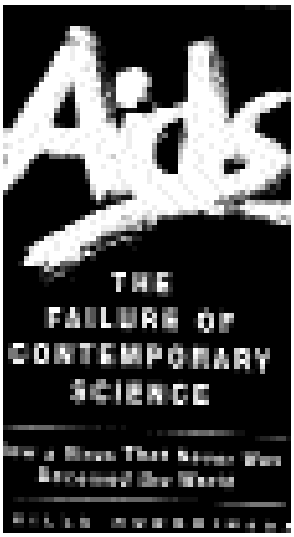
by Neville Hodgkinson

Published by Fourth Estate, 420pp, £17.99

Neville Hodgkinson's paradigm-shifting investigation into the mass-illusion that has become known as the 'HIV/AIDS' hypothesis will have a devastating effect on maintaining such a belief-system. This is the first book to be published stating the arguments of researchers who propose the non-existence of 'HIV'. Hodgkinson states, in the most important chapter in his book, 'The Virus That Never Was': "In Perth, Australia, a small group of scientists have been preparing themselves for what may prove to be the most remarkable role of all in the AIDS saga....They question the very existence of the entity that has become known as 'HIV'. Their standpoint is so radical that most of their published work to date has only hinted at the potential bomb shell that underlies it".

In 1986, Hodgkinson, like the majority of health and cultural journalists, subscribed to the 'HIV' belief system, duly reporting the official consensus party line on 'HIV' as being the cause of 'AIDS'. Hodgkinson states: "Ten years of reporting on HIV and AIDS, and three years of deep involvement in a controversy over AIDS causation, have led me to the conclusion that a decade ago we became ensnared in a mass illusion surrounding the issue.... As a medical correspondent of the Sunday Times during the second half of the 1980s, I was responsible for many articles that accepted and promoted the prevailing view of HIV as the universally accepted cause of AIDS, and reported warnings that almost everyone could be at risk". It was not until 1992 that Hodgkinson, now as Science Correspondent, became aware that a scientific challenge had been mounted to the orthodoxy by 'AIDS dissidents'. The chapters on dissidents John Lauritsen ('Drugged'), author of The AIDS War and Death Rush, and Professor Gordon Stewart, ('A Conspiracy of Humbug') present cutting arguments against the HIV/AIDS hypothesis.

Hodgkinson noted that when he tried to engage in critical debate with the defenders of the 'HIV' hypothesis, he did not get a reasoned argument, just emotive abuse. The followers of the 'HIV Belief' behaved like a theological freemasonry/protection racket defending the 'faith' rather than engaging in objective scientific debate. Hodgkinson reiterates this in a quote from Michael Callen in



1987: "Belief that HIV has been proven to be 'the cause' of AIDS has many characteristics of religion: as 'revealed truth', it's not wholly rational, but emotionally reassuring and certainly influential. I often compare my attempts to generate debate on the cause(s) of AIDS to walking into a fundamentalist revival meeting and asking those present at least to consider the possibility that God doesn't exist.... It came as quite a shock to discover that the true discourse of AIDS is theological. There are received truths; papal bulls (papal bullshit, more like it), and various sects and denominations. It's an unholy war..."

Hodgkinson reveals that Dr Eleni Eleopulos and colleagues have been sceptical about the very existence of 'HIV' from the mid '80s onwards and in Bio/Technology, 1993, they finally nailed the 'HIV' myth by exposing the non-specificity of all 'HIV' testing procedures.

Eleopulos presented her own oxidative stress theory that extended Duesberg's drug/AIDS hypothesis (which was too limited and reductive) by including multifactorial elements, seeing AIDS as a collection of biological phenomena associated with an overstressed immune system. Eleopulos argued that the assault on the body by oxidative agents (like sperm and nitrites) could account for general viral activation, AIDS-related conditions such as KS and lymphoma and loss of immune cell activity. Hodgkinson asserts that sperm itself may be considered a causative factor: "Several studies had shown that homosexual men who took an exclusively 'active' (sperm-donating) role in sex did not develop AIDS, whereas immune suppression was common in promiscuous anal sperm recipients". The oxidative stress theory attributes the decline of the immune-system to stress caused to the cells by repeated toxic and microbial assault, which can include anally deposited semen from multiple partners, repeatedly taken medical and recreational drugs, and impure Factor VIII concentrates. Added to this, many antibiotics/agents used for treating STDs were oxidising and immunosuppressive. Also, viruses such as CMV and EBV – (universally active in AIDS patients) – caused oxidation of their host's tissue.

Hodgkinson observes that in the 1980s Eleopulos wrote six papers on this oxidative stress theory of AIDS and from 1986 had been offering a multifactorial theory of AIDS causation. In 1989 she wrote a detailed letter to the Lancet, arguing for the non-existence of 'HIV' – it was not published.

Dr Eleopulos says that: "...to me, the presently available evidence does not prove even that it is an endogenous retrovirus, because what we see, the phenomena collectively known as HIV, are non-specific. RT is non-specific; virus-like particles are non-specific; the antigen-antibody reactions are non-specific; PCR is non-specific. You can't even say you have a retrovirus there". Prof. Papadimitriou, Eleopulos's collaborator, states: "They have not proven that they have actually detected a unique, exogenous retrovirus. The critical data to support that idea has not been presented. You have to be absolutely certain that what you have detected is unique and exogenous, and a single molecular species. They haven't got conclusively to that first step. Just to see particles in the tissues, and fail to look for evidence that it is an infectious virus, is wrong. Are these particles that cause disease? There is no evidence, ten years on, that the particles are a new infectious virus".

Hodgkinson's book constitutes an historical moment in 'AIDS' discourse; all other 'HIV Belief' coffee-table books become Neanderthal relics to be placed under a glass-case in a folk-lore museum, and sniggered at.

While journals such as Nature, Science, New Scientist and the Lancet uncritically propagate the multibillion dollar 'HIV' fraud, Hodgkinson's book will become the catalyst in deconstructing the mass-illusion of the 'HIV' trance. It is worth noting that the most hostile reviews so far of Hodgkinson's book have been written by some of those very journalists who have merely re-hashed the official hand-outs and who now have a vested interest in trying to ensure that their shoddy journalism of some 15 years should not come to light. As mere propagandists for the HIV Mafia, they must be shitting their pants with fear that the balloon is finally going up, despite their best efforts to deflate it.

ALEX RUSSELL

INTERVIEW

LORD BALDWIN

is the Joint Chairman of Britain's Parliamentary Group for Alternative and Complementary Medicine. HUW CHRISTIE went to Westminster to meet him

There's a distinction between complementary and alternative isn't there? Is that an important distinction?
It's rather like Catholics and Protestants, arguing as to how important these distinctions are. I don't think myself it's as important as some people do. There is one school of thought who maintain very strongly that complementary therapists are those who are subservient to doctors, and will never diagnose, and can't stand as therapists in their own right, and the alternatives are the full primary care providers like homoeopaths, acupuncturists or whatever. And that the latter should be trained up to a much higher level. I think I would go along with that latter. As to how important that distinction is, as I say some people feel very strongly about it. It's not generally accepted, there's no acceptable definition within the field, from the Department of Health or anywhere, even though some people think there ought to be. There's always a search for a good word – the Parliamentary Group for Alternative and Complementary Medicine: from time to time we think, should we change it? Natural Medicine, perhaps, but is osteopathy natural, is acupuncture natural? It's difficult finding the right word. When I initiated a debate in this place in January, it was called eventually The Benefits of Non-conventional Medical Treatment for the Health of the Nation. The Americans tend to call it Non-conventional. So what's in a name really?

At least the definition of non-conventional will always be relative to what convention is.
What I think one always has to bear in mind is there are some places in the world

We wanted the therapy that worked best, and not a toxic one

as you probably know where homoeopathy is mainstream, osteopathy is mainstream. It's always relative to the culture that you're talking about.

There are studies that dissuade people from bothering with complementary therapies or alternative therapies. The problem is that when it's complementary, in AIDS for example, it's usually that people are taking let's say AZT with Chinese herbs, and because the primary drugs are so toxic, little benefit is seen from the herbs, and people are told they're not effective. With an alternative therapy things would be different.
Yes. It may be the same as my wife and I found in deciding to use a nutritional approach rather than conventional drug treatment for her recent breast cancer; and having gone beyond that to establish that the two don't mix very well, we wanted to keep to the one that worked best and not use something toxic which detracted from it. For example Gerson has much fewer successes with people who've had chemotherapy because the aim of Gerson [cancer therapy] is to clear out the body and if you've got a lot of toxic stuff within, what they find is you've got to go terribly gently and slowly, otherwise the person gets overwhelmed as it starts coming out. They die of liver toxicity if you don't watch out. So you have to go a lot slower and that's not strong enough to cope with the cancer. So we had this dilemma really. Pressed to go for chemotherapy, we said "No, no, no", because we knew Gerson would not be so effective.

If the therapy is powerful one can think of presenting it as an alternative rather than as a complementary therapy.
Yes, it's whether they're contra-indicated in a sense. And with Gerson they are, and we had the devil of a time getting our orthodox doctors to get their minds round that particular problem, because they couldn't see how it could be so under their model of health and sickness and wellness. So we had to keep marching on. It's difficult. We were extremely lucky in a sense – being in this position here obviously it's much easier. Being able to quote studies back at them. If you can't do that... A consultant can browbeat people.

Can you give a brief history of the Parliamentary Group and your own involvement in it?
What is a Parliamentary Group? It exists primarily for MPs, peers and MEPs, and if it's called a Parliamentary Group as opposed to an All Party Group, paradoxically it can have outside members, associate members. So although it exists primarily to brief MPs and help formulate policies there, one of the strands of that with all these groups is to have meetings in committee rooms at which we get speakers along to talk. There's about half a dozen of those a year which we've had on a variety of topics, for the last few years. We've had a fairly good programme. I'm not a member of many groups, but I'm a member of the Parliamentary Food and Health Forum, and you can get perhaps fifteen, twenty people coming to their meetings. We reckon we have some forty, fifty, sixty to ours. I became more or less active in this place when I semi-retired from the education field in 1988. I came along and joined this group, but it was fairly moribund. There was Bill Cash and Peter Ross, two MPs, who were jointly in the Chair. MPs are a lot busier than a lot of us up this end and there wasn't a great deal happening. There were occasional meetings and so on. Then Peter Ross retired at one of the elections, and I was put into the Chair with Bill Cash. My having a bit more time and I think a bit more hands-on interest meant we've had a more active programme since 1992. And it's given us about six open meetings a year.

Is the purpose of the group to raise awareness amongst members of the houses?
Yes it is really.

In the expectation that that will add wisdom to legislation?
Absolutely.

Are there examples of legislation where you've felt this has come into play?
Yes. I mean I have to say that MPs are pretty rare attenders. That's true of all these groups. They're very busy and there's a great conflict of meetings and it only needs something happening down at the Commons end for them to be unable to come at the last minute, even if they've sworn they'll come. So you don't pull in very many of our members. We have more peers coming actually than MPs to our meetings. But we do send out briefings on the meetings, with the idea of keeping them in the picture. Examples? Well, we had a very interesting one in 1990/91 – the Health Service and Community Care Bill, when one or two of us put forward amendments. Lord Colwyn's a stalwart on this, and he and I together backed an

amendment to try and get some complementary medicine on the NHS. And we very nearly carried that. We only missed by four votes getting that. And that certainly had an effect and was noticed by the Department and very soon after that in, I think December '91, Stephen Dorrell, who was a junior minister for Health, issued a circular letter opening the doors to complementary medicine, under certain conditions, in GP's clinics. So I think there was cause and effect with that one. Then there was the Osteopaths Act and the Chiropractors Act. That wasn't specifically anything to do with the Parliamentary Group but obviously we were in there. You may remember that herbal hoo-ha the Christmas before last, when all of a sudden from Europe through our own dear Department of Health, an edict came that all herbal remedies had to go through the full pharmacological rigmarole and so on, and do it by the New Year, when this is a sort of twenty year programme. It was just plainly ludicrous. There was an outcry all through the country and again as the Group we were able to be a focus there, demanding meetings with ministers and so on, saying this is not on. So we were very much in the thick of it, though it was people power that did it in the end.

There's a directive called MAL-8, a Euro-directive, which limits what supplement companies can say. Is that the same thing?
That had ramifications but not so much on the herbal side. It's more on the supplement front. It may come originally from Europe, but now it's a Medicines Advisory leaflet from the Medicines Commission. They are refining the distinction between supplements and medicines, that grey area: what is a medicinal product, and therefore what claims can it make and what tests it goes through and so on.

Was it Hippocrates who said, "Let food be your medicine"?
Absolutely. I know.

Do you think this is an artificial distinction?
I do actually. I'm glad you raised that. It's not something I've had a chance to say publicly but would like to do so. It won't cut any ice I think for a long time but I think it has to be made philosophically. The whole thing's one big continuum. I do think it's an artificial distinction. You see papers in the medical press these days about broccoli and garlic. Well, where do you draw this artificial line?

In whose interests is this distinction?
I suppose, not being cynical, there are safety issues, because if you've got a continuum from say carrots down at one end and say AZT up the other, you need to distinguish somewhere along the line at what point what testing can be done. So it's a question of arguing about where the line comes and the safety tests get done. My feeling is on the herbal thing that they've probably got it about right at the moment, which is that they have these Licences of Right on the basis that they've been around for hundreds of years, there are monographs written on them, there's very little evidence of danger from them, and therefore they have a sort of cheap and modified procedure costing a few thousand pounds which herbal remedies go through. It seems to me that something herbal and natural is somewhere down near the carrot end rather than the AZT end. If you ask me exactly where the dividing line is...I have a feeling that once you start modifying things, synthesising them and so on, you're in a new ball game, however close you think you've got to the original.

You've mentioned AZT. You said in one of your speeches in the House of Lords: "The immense financial power of the pharmaceutical industry is now distorting our whole perception of medicine to a degree that is positively unhealthy." You were speaking in Britain – is that applicable to Britain?
I think it's fairly worldwide isn't it? I mean it's no less true of America. It's the dominance of one particular view reinforced by huge, huge money which prevents one seeing, as I think I said later in that speech, that one is inside a virtual monoculture. Another speaker in that debate

The limitations of the drug-based approach are very clear

picked up that point later on. Lord Desai the economist, from India originally – the Ayurvedic tradition – said it certainly struck him too, the monoculture within the western nations where, when there's a health threat, the immediate thought, the knee-jerk reaction is, "Right, let's get a drug."

Health is to do with maximising the strengths, not zapping whatever you arbitrarily may decide is the cause, because very often it's the symptom anyway.
Absolutely. It's a whole alternative view and I find it terribly hard to persuade doctors to get their mind round that possibility. They've never been taught it in medical school, they've never really come across it, and then I'm sometimes astonished, to take Gerson again as it's something I know well, at the simple thing of trying to explain to them what it's about. You can see them wrestling with the idea of strengthening the body as a first line approach. I think that's sad. We've really lost something important. And that's got to come back in. They've lost sight of the power of the body to regenerate itself.

You're aware that AZT's made by Glaxo-Wellcome. They obviously don't fund your group. There is an All Party Group on HIV and AIDS – do they come to some meetings of your group?
We had a joint meeting actually at our suggestion when the Bestyr College people – do you know who I mean? I think they're hot stuff – were presenting their Stage One report and they came over and unfortunately at the last minute I was called away and couldn't come to the meeting. I was told that it wasn't a terribly happy marriage of the AIDS Group and our Group on it. But that's the only one we've had. It'd be a super idea if some time in the future our Group had a presentation perhaps from the AIDS side – long-term survivors who have done well with complementary methods – and we asked the Parliamentary AIDS Group along to listen to that. But they at one stage certainly had some quite heavy funding from Wellcome. It seems to me you can't have that degree of input and not have an influence. That's why a lot of the ways these things are set up bothers me, like the interlocking interests in the Medicines Control Agency – the people who sit on that and on the boards of drugs companies and so on. Ok, they do not take part in decisions where their interest comes up but it skews the attitude. You don't have a judge sitting on a case when it's someone he's related to. He stands down and pulls out.

So in drug licensing there seems to be just not the same professional standards there are in other areas?
That's how it seems to me. It bothers me. It means essentially just one view gets heard. If you try and put a view across, such as that of empowering the immune system and targeting that, then you meet blank stares. What I object to is it's not as if all these things have been thoroughly tested. The public probably does believe these doctors, these big names, have had a thorough look at all these other things and put them through stringent tests. Nothing like that has happened at all. So it's a belief system that says it can't work, before you actually get down and look at it. Now if they say, this is an untried remedy and so on, then fair enough, I don't disagree. In the article in the Daily Mail that my wife wrote, they put an expert's view, somebody from the Royal Marsden. Well, expert he may be in his own medicine, but not in this. At the same time I couldn't quarrel with what he wrote there: "This is unproved." True. But that's not the same as disproved. In a realm like cancer, and even more so AIDS, where the success rate is so lamentable, I would have thought that any promising line should be embraced.

Glaxo-Wellcome have adverts on TV now, purporting to show "live" HIV, and saying their company is the greatest enemy disease has ever known.
This is despite Concorde? And despite the Panorama programme?

And despite the fact that you cannot get a moving picture through an electron microscope! People are not aware of simple facts like that. But people believe.
We're into belief systems a lot aren't we? One of the really difficult ones, and I guess it appears with AIDS stronger than any-

thing else, is the feeling that if all these big names, the Royal Colleges, have said it is so, then obviously it must be so. And the older I get the more I tend to distrust experts. There was an interesting thing here in one of our debates on education, Lord Skidelsky, a bit of a free thinker, was talking about nursery education. If just about all the experts agree something's a good thing then he's almost certain it must be wrong. Having said that, just to redress the balance a little bit, certainly my wife's experience of this cancer thing has tempered our view to some extent in that while resisting the chemotherapy she found that except when she was out at the Gerson place itself, where we could watch the little tumour nodules disappearing from her chest as the weeks went by – visibly vanishing – when we got back under less than optimum conditions, they came again. I'm convinced that the Gerson had stopped any distant spread. On the other hand nothing we could do could stop little nodules from reappearing in the chest area, until Tamoxifen, and that's a drug, though not a terribly toxic one. So I have to say, but for Tamoxifen, she would be worse off than she is. It's just possible the co-enzyme Q10 she was taking at that stage in high doses was beginning to bite as well. Given the timing I would put my money on the Tamoxifen having done that. So I would love in a sense to have been a purist and say we did it entirely by natural methods and that's what we wanted to do. She was always a difficult case anyway – the nature of the cancer and the stage it had got to. Certainly we bless the help we have had from that direction, while regarding the other natural approach as perhaps the main line one.

What do you think the future for complementary and alternative therapies is going to be in this country? Does your group have these questions in mind?
I don't know to what extent we really worry about the very long term. It has to be said we're a poorly funded group. We don't have any Wellcome Foundation behind us. We scratch around, we keep going on a part-time secretary and so on. We would love to get together some means of legislating for natural medicine but that I think is beyond us.

What would that involve, such legislation?
In Australia they've got something which has put some natural medicine on a firm statutory footing, so that it can't be got at and undermined, so that it has a legislative basis. We've got that at the back of our minds, but we haven't got the resources to actually do that. For the long-term future, well it's extremely difficult to predict. I'm thinking back to the turn of the century when for example homoeopathy was very strong, particularly in America – something like half the medical colleges taught it there. Then came new developments in drugs and so on, and the high-technology, quick-fix idea took over with its obvious simplicity and attraction, and homoeopathy became marginalised. So we've got these nutriceuticals coming and functional foods and so on which may tip the balance, I don't know. What I'm saying is that new scientific things may appeal popularly and may undo a lot of good that's being done for the complementary medicine movement. There's a surge at the moment in favour of complementary medicine largely because the limitations of the drugs-based approach are becoming very clear. The things they can't treat, the things they can't cure, their costs in terms of side-effects, and sheer monetary costs. We're on an upswing at the moment. My dream would always be – my ideal place – would be to have natural medicine as the mainstream and to have what is now the mainstream as the complement to it when natural medicine couldn't do the trick. You'll sometimes need a bit of surgery, and there are times when you'll need the drugs and so on. I would never rule them out. But I would like to see them subservient. Having said that one recognises this will not come in my lifetime.

What are the therapies in this country that it would be acceptable to legislate for?
Perhaps it's more useful to look at what might actually happen here for the various therapies. We already have the Osteopaths

My dream would be to have natural medicine as the mainstream

Act, three years ago, and the Chiropractors Act, whereby those professions were put on a statutory basis with Protection of Title, meaning that nobody else can call themselves an osteopath or a chiropractor. They can claim to use osteopathic techniques, but no more than that. That ties them in to ultimately the Privy Council, and so on. It's wonderful in terms of prestige, having arrived there. It's very cumbersome and expensive for them all. They've arrived, they've got their place in the sun. In a sense they're now unassailable, and that is great. It doesn't mean it's going to be right for every therapy. There was a time when the government was saying: "Get your house in order. Get together and then come and speak to us." But they were soon persuaded, five or ten years ago, that some of the therapies were so disparate there was no way they could come under one umbrella. So they said: "OK, therapy group by therapy group, come forward. Get your houses in order, get yourselves regulated and then come forward." Neither the government nor the complementary medicine movement necessarily thinks that statutory regulation is going to be right for everybody, because it has some of the drawbacks I've said. Probably the next in line would be the acupuncturists. I also chair the British Acupuncture Accreditation Board which is bringing some harmony into the training of acupuncturists. Even with them it's too early to tell whether statutory regulation is what they're going to want or not. One of the dangers of statutory regulation is you might end up finding yourself subservient to doctors, and you might not want that. Sometimes they're urged to go down the route of the Professions Supplementary to Medicine. Not everybody wants that. All the thinking hasn't yet been done on that and we're some distance away certainly from the next therapy coming forward to statutory regulation. Meanwhile the major ones are all beavering away now trying to bring their differing groups and approaches together, to get a unified register of practitioners, code of conduct and ethics and so on, governing body, complaints procedure, and all that. A number of things are necessary, including the approval of the medical profession before legislation. The government's not going to get legislation through if its medical advisors say, "We object." It's very interesting to see how the medical profession is beginning to swing round and become much more favourable to complementary medicine. It's a wonderful development. Within the Department of Health even they're bending over backwards to be helpful. There's an old guard that still sticks to the old beliefs and regards alternative and complementary medicine as magic but by and large there's a quite powerful shift. It's been growing over recent years. It's been hand-in-glove with popular demand. They've had to respond. I think if I were a GP I'd be quite embarrassed at some of my patients coming and telling me about homoeopathy and whatever and assuming I knew when I didn't. I think doctors are feeling disadvantaged and thinking, "Gosh, I need to learn about it".

What do you feel about the genetic approach in medicine?
I have great reservations about some of the assumptions about viruses and genes anyway. There is a big question mark. It may all turn out to be very different from what is currently supposed.

You've written about the obsession with the germ theory of infection. Do you think the idea of viruses is a publicly emotive concept?
I do indeed. I quite see, in Neville Hodgkinson's book, his argument that a killer virus strikes a chord in everybody and everyone wants to believe. I can easily go along with that. It's the sort of drama that journalists and medics and all of us frankly like. It's a concept that's easy to latch onto. We go on a great hunt for this thing. I can quite see how that touches the collective imagination.

People can find it hard to leave an orthodoxy unless they know what they're going to.
I'm a great believer in looking at people's track record. The track record of the drug approach to AIDS is absolutely abysmal. The drug approach to cancer is not a great deal better, though they've convinced themselves it is. You look at the people who've done hard epidemiological work on this and they say that the battle against cancer is a, quote, qualified failure. I don't know how many billions we've given them to do the job. What other group is so unaccountable in public? There is something wrong with a society that abdicates so much power to scientists who are going round in circles. If you look at the track record of these things it is very very bad. Commonsense says it's time to look in other directions. At one level it's as simple as that.

Poppers

The group of chemicals called poppers are all variants of alkyl nitrites – amyl nitrite, butyl nitrite, and *iso*butyl nitrite. These old drugs have been reported as popular in recreational use among homosexuals and some heterosexuals since the 1970s as it is alleged their effects include enhancing sexual pleasure, facilitating anal penetration through their properties as smooth muscle relaxants, and prolonging orgasm.

A recent successful prosecution by Britain's Royal Pharmaceutical Society against a company marketing *iso*butyl nitrite resulted in clarification that it is illegal to supply the drugs except as a medicine, through a doctor or pharmacist. A UK Department of Health statement said in their view the volatile nitrites currently considered recreational "poppers" – an allusion to their early packaging as capsules that were "popped" open for inhalation – included the full range of known close chemical analogues.

These medicines were first used in the 1860s (*sic*) by inhalation to treat angina pectoris, a condition of the heart in which blood flow is diminished causing severe pain. They are seldom if ever used for this purpose now. They may be employed by inhalation in the immediate treatment of patients with definite cyanide poisoning, to induce formation of methaemoglobin – an oxidised form of haemoglobin, the molecule transporting oxygen in red blood cells – which then combines with the cyanide to form non-toxic cyanmethaemoglobin, but the value of this treatment has been questioned. They have also been suggested for use in the management of hydrogen sulphide poisoning.

Poppers are clear yellow inflammable liquids with a pungent odour. Their volatility can lead to explosive mixtures with air or oxygen. "Recreational" samples usually contain around 96% eg. *iso*butyl nitrite, with small amounts of *iso*butyl alcohol and vegetable oil to make the liquid less volatile.

Amyl nitrite is absorbed into the blood circulation from mucous membranes by inhalation, the rate of absorption being most rapid in the lungs. It is rapidly inactivated in the body, probably by hydrolysis (reacting with water). Amyl nitrite is the fastest in action of the nitrites, the effect being evident within 10 seconds. The blood vessels of the neck and head are most rapidly affected by vasodilation (widening of blood vessels) and within 30 to 40 seconds after inhalation the face flushes, the head and neck perspire and the heart-rate increases. The action is of short duration and usually lasts about five minutes.

*Iso*butyl nitrite is inhaled more often than swallowed, and induces profound though transient vasodilation, with blurred vision, headache, flushing, a "warm feeling", and a widespread throbbing sensation. Reflex vasodilation follows, with tachycardia (heart rate of greater than 100 beats per minute). Other reported effects include nausea, burning in the nose, syncope (fainting), facial dermatitis, eye irritation, cough, bronchitis, coma and respiratory distress.

At the molecular level, the nitrites are potent oxidising agents and may cause oxidative stress to the red blood cells which manifests as methaemoglobinaemia. Methaemoglobin cannot serve as an oxygen carrier and high methaemoglobin concentrations are associated with significant hypoxia (decrease in oxygen uptake); without antidotal treatment concentrations greater than 70% may be fatal. The likelihood of a fatal outcome will be influenced not only by the rate but also the duration and frequency of exposure, the person's genetic complement of reducing (the opposite of oxidising) enzyme and the presence of ischaemic (blood deficiency) heart disease, or anaemia, which may limit the body's ability to withstand oxygen deprivation. It has also been suggested that as frequent users of nitrites tend also to be heavy cigarette smokers, the presence of carboxyhaemoglobin (the compound formed when carbon monoxide instead of oxygen reacts with haemoglobin) may compound the *iso*butyl nitrite-induced tissue hypoxia.

Several scientists point to the oxidative, and therefore cancer-causing, effect of volatile nitrites on the tissue of blood vessel walls, one of the primary sites of the effect of these drugs. The blood vessel cancer, Kaposi's Sarcoma (KS), was first described in the 1870s in Europe, some ten years after the introduction of volatile nitrites in the treatment of angina, though certainly not all risk groups for KS – which include elderly Sicilian men and West African teenagers – will have used poppers. Other oxidising factors may affect these people. Professor Peter Duesberg once calculated that inhalation of 10ml of poppers would result in some seven oxidising molecules in every cell of the body.

Treatment of short term toxic effects is as for fainting, keeping the person lying down with head lowered. Severe poisoning should be treated in hospital with stomach pump and oxygen. If methaemoglobinaemia occurs, give methylene blue 1 to 4 mg per kg bodyweight by intravenous injection. The circulation may be maintained with infusions of plasma and/or electrolytes.

A letter in the *Journal of the American Medical Association* (1976) suggests, "The use of amyl nitrite is then, like so many drugs used for hedonistic purposes, safe and pleasurable for most, unpleasant for some, and dangerous for a few. The dangers of abuse of the drug will be multiplied if its popularity increases and "street" amyl nitrite surfaces, bringing with it problems created by use of adulterants and even more toxic substitutes." The advent of these latter occurred long ago, and the illegal nature of any future recreational use of nitrites probably means consumers will be increasingly unlikely to know the exact contents of any such product.

Sources

Oxford Textbook of Medicine, 2nd edit., Weathrall DJ, Ledingham JGG, Warrell DA. Oxford Med. Pubs. 1987
British National Formulary, Alternative Edit., 1957
Martindale 21st edit. 1977
Martindale 31st edit. 1996
J. Am. Med. Assoc. Vol 236, No.14 Bradberry SM et al: Fatal Methemoglobinemia Due to Inhalation of Isobutyl Nitrite.
Clinical Toxicology, 32(2), 179-184, 1994
Papadopulos-Eleopulos E, Turner VF, Papadimitriou JM: Kaposi's Sarcoma and HIV. *Med. Hypotheses* 39:22-29, 1992

HUW CHRISTIE

Natural Highs

Two non-toxic legal "highs" have recently been given attention in the gay and straight press. The Energy Bomb is a herbal drink containing guarana (presented as an adrenal tonic, rather than a stimulant), muir puama, lapacio, ginseng and fresh Royal Jelly. It gives a sustained energy boost allowing long work and play. The Cama sutra is an aphrodisiac variation. They seem to work! Any adrenal activator may be contra-indicated for people with cellular immune suppression, as stress hormones deplete levels of circulating T-cells. No energy is free – nutrition and rest are necessary. [*see Nutrition*] £1.99/15ml vial from various outlets, including the main suppliers, Human Nature, 25, Malvern Road, London NW6 5PS.

CAMILLE PAGLIA is Professor of Humanities at the University of the Arts in Philadelphia. Her books *Sexual Personae, Sex Art and American Culture* and *Vamps and Tramps* have caused quakes of delight and controversy. An outspoken critic and theorist on cultural, social and sexual issues she experienced first hand the historical development of the AIDS discourse. She spoke with HUW CHRISTIE in this exclusive interview.

You've written, "My admiring memory of [gay men's] revolutionary, philosophe-like iconoclasm makes me most regretful about recent infringements of free speech by a few overzealous AIDS activists, who made themselves the arbiters of a new dogma and enforced it with terrorist tactics." What do you see as the dogma and what have been the tactics?

Well, I think it's somewhat better now, OK. But when I came on the scene, which was not very long ago – I mean it seems like centuries, but when my first book [Sexual Personae] was finally published it was only 1990 so it's really 1991 that I started encountering these people – ACT-UP in its earliest incarnation was an absolutely fascist organisation. I know that they did do some good, but I have felt very directly the irrationality of AIDS activists, at one of my first appearances. The most insane and vicious and intolerant people I have ever met in my life are AIDS activists. I came into direct confrontations with them. If I would be speaking, sometimes lecturing, these people would pop up and be screaming, I mean screaming at me, OK? The way they controlled the discourse, their arrogance – they were like little Hitlers, stormtroopers, who believed that they had the truth, and anyone who tried to have a different view of AIDS, or the origins of AIDS, or anything like that, that we should not be permitted to speak.

It took me quite a long time, even a number of years, before I was even able to speak openly. My god, Sexual Personae, which is a great scholarly book for Heaven sakes, Sexual Personae was treated, was called...let me give you an example of this: in the MLA (Modern Language Association) Gay and Lesbian Newsletter, so overcontrolled was the discourse on homosexuality and AIDS that I got a review there of Sexual Personae that called it the most evil book ever written, compared me to a Nazi, compared me to Hitler, OK? This was going on constantly, in fact it happened in London – with one of your prominent gay activists on the stage of the Institute of Contemporary Art. You know these people, they're enamoured of [French gay cultural theorist] Foucault, enamoured of the most rigid kind of post-modernist discourse, which I believe comes from their own discomfort with their own sexuality, their early alienation from their bodies. There again it's much much better now. As I say I was constantly compared to Hitler. The Advocate did it. And now of course, the changes are so much abroad that I am a columnist for the Advocate.

The speed with which the discourse has opened up has really amazed me. Let me give you an example. When I was reviewing these books on classics, on Greek antiquity, that the scholarly journal Arion asked me to do – I would have been doing it late 1990, 1991 and these books which came out from Routledge had on their cover, "Half of the profits from this book will be donated to the San Francisco AIDS Organisation", something like that – now I spoke out against that. I felt that that was absolutely outrageous. You cannot have advertisements for charities on the back of scholarly books. There should be no political agenda attached to any scholarly book of any kind. Plus I thought it was the worst kind of Pharisaism, saying, "Look how charitable I am – half my profits." Now why not 100% of the profits, why only half of the profits? And in effect also it was coercive of the reviewer, saying in effect, "If you give this book a bad review, you are letting people die. You will reduce the profits of this book and fewer monies therefore will go to the care of the sick and so on, the terminally ill." So I spoke out against it. But the thing is, I remember at that time, to even dare to do that, to even dare! I remember I went through agonies about it, knowing how I was setting myself up for the worst. As it happens there were a few voices like mine that would not tolerate this kind of overcontrol of the discourse: people were absolutely intimidated to silence.

There was only one view of the epidemic. Only one view. And that was that this was an accident that happened, it just fell out of the sky, OK? The people who really caused AIDS? Ronald Reagan, Ronald Reagan caused AIDS, OK? He is the cause of the AIDS. There would be no AIDS if Ronald Reagan had given much much more money for AIDS. There was never any connection with behaviour, OK, and if you said, "Gee, there was a connection between the sexual revolution and the sudden upsurge in promiscuous sex , gay and straight. That that is the reason for this epidemic," you were called every name in the book. There was absolutely no connection whatever. You must not allege there was any such connection. At this point it became ridiculous. So many gay voices have now come out and said, "Well of course you have a situation where people are having forty men per night, in the baths and so on, in that period, or on Fire Island." For Heaven sakes there are houses on Fire Island where [people were] vacationing at that time, where everyone is dead! Everyone is dead now. Thirty people who were at one weekend are totally dead. At this point it's hard even to imagine what it was like in the early 1990s in America in this question of the AIDS discourse. So now it's much much better. So my writing, whatever the date was that I wrote those things, that was true at that moment.

But I will never forget one of the first times I went out, one of the very first times I was invited to a conference, at the State University of New York at Purchase, and I saw for the first time the incredible pressure. There's this fellow who's very active still in gay activism in New York city, a prominent gay activist there, I'd never heard of him, I had never had this experience before, and I gave my presentation whatever it was, it was on various topics, it wasn't on AIDS, it was on things like feminism, there was this screaming. I have never in my life seen a character out of Dostoevsky

right, this man burning with rage! This man mentally occupied the borderline between rationality and irrationality. I, as a person who is very keyed to psychology could clearly see that his rage, you know, had nothing to do with me, had nothing to do with AIDS, had nothing to do with homosexuality, it had to do his own problems with his own family, OK? I say this again and again: these fanatics who took over the political discourse are in fact trying not to think about themselves, not to analyse themselves, and they're projecting outward all their rage against Mommy and Daddy and everything else. But it was unbelievable, you could not believe the poor people in that room. The academics in that room, the people who came to the conference, were shrinking. No-one would speak. That man effectively silenced an entire auditorium of people. I will not tolerate that, because I have been out there. I was out there before Stonewall! Before Stonewall was, I was openly gay when it cost me something in my career. I was the only openly gay person, male or female, at the Yale Graduate School from 1968 to 1972! I will not tolerate that! I have been out there. I was madly unpopular for years! Now it's much much better.

I don't know what the situation is in England of course. All I know is that obviously one of the main reasons you're calling me, is that even the scientific discussion on AIDS has been very much crippled by this kind of intimidation, so that truly neutral and rational scientists have stayed away from this entire area. You want to talk about counterproductive!? People have fled this field of research, because there's no way to conduct yourself in a dispassionate scientific manner in it because of its overpoliticisation. The attitude is: it's due to homophobia. The reason why there was not

The AIDS activists over-controlled the discourse

enough money? Homophobia! Excuse me? This was a brand new disease. What are they talking about? It's only recently people have started to realise how many more deaths occur yearly among women from breast cancer, and how little there was research in that area for Heaven sakes. It was like, "Me, me, me! We demand, we demand! We want an entire rearrangement of the apportionment of money for other diseases! Now! This minute! Us! We, we! We middle class men, who have this one disease. If you don't listen to us immediately then you are homophobic, you are this, you are that."

All that did was, yes there was more money, but the investigation of this disease was very much held back by the flight from it of truly, it seems to me, talented scientists, the most talented scientists, the ones, especially later, the ones who would have been most likely to come up with working theories, working hypotheses, they have fled. Any rational people would flee from the craziness OK, and the solipsism and the infantile, infantile attacks on science itself. The AIDS activists would say simultaneously, coming with their stupid Foucault ideas, post-modernist ideas, "We demand that science think only about us." At the same time, "Science is completely ideological and science is meaningless." How can you simultaneously be attacking science and demanding that it produce an instant cure for you? Everyone knows we can't even solve the common cold.

You wrote, "Science and society are our frail barriers against the turbulence of a cruel indifferent nature." Careful scientists, particularly Dr Eleni Papadopulos-Eleopulos and her group and others, are saying HIV doesn't exist, its proteins and enzymes are products of toxified cells. If a big mistake has been made what hope is there for science and how reliable are these barriers against nature?

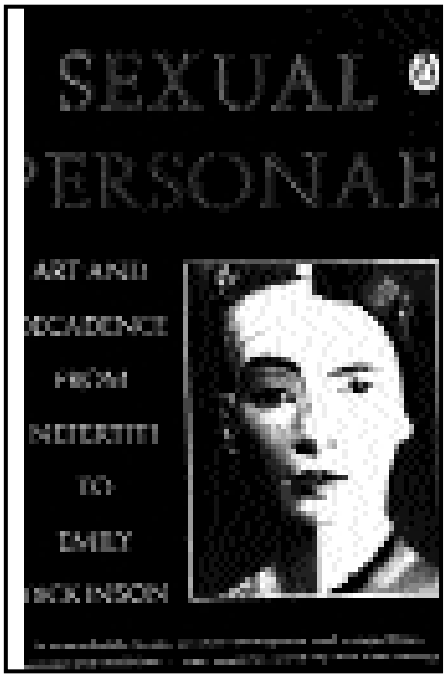
Well the point is we are just at the very beginning of understanding what AIDS is, much less what causes it or how to cure it or anything of that sort. Now without committing myself to any of the hypotheses that have been put forward, I as a scholar have been completely sceptical right from the start about everything.

It's not that I'm saying HIV does or does not exist. It's just that whenever I would see reports in the news media, even in the New York Times, in the news magazines and so on, I would say, "There's something madly wrong with the way this material's being gathered." I have been always sceptical about it. I have never accepted anything, anything about this, at any point from the beginning. And the way in which you almost immediately got a kind of received opinion and a received attitude about this disease seemed to me just a form of superstition.

You have the idea of an integration of science and history going way back.

Well I feel that I'm a product of the Graeco-Roman side of Western culture and I feel that is the fount of our thinking about the world. What I see in the fifth and the fourth centuries coming out of Greece is an extraordinary kind of virtuosity of artistic thought and scientific thought – our whole idea of the scientific method, of gathering evidence, examining it. I think that to be a great scientist or to be a great doctor you have to be a kind of artist. That is, you have a series of suggestions merely in the evidence and it's up to you to come up with a hypothesis that is only a working hypothesis. It lasts only until someone has a better hypothesis, which is usually a more economical explanation of the available evidence.

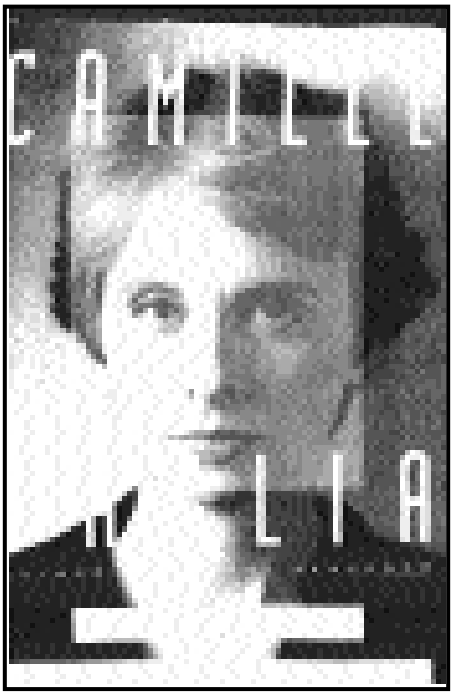
I've always been interested in internal medicine, which is definitely artful. A person presents with a series of symptoms, and I've seen again and again, in my own experience and among people I know, the way a doctor can be madly wrong. Totally wrong about something. Whereas it might be a lay person might be able to guess better. It's like a policeman coming to the scene as well, where a crime has been committed, and you have clues, and you have a whole number of speculative scenarios that are in your head. And there could be twenty different possible scenarios and you're always comparing them. The idea that we're going to immediately find a cure for AIDS, and the only reason that we haven't found a cure is because of homophobia and insufficient money is absolutely crazy!



People seem too ready to allege homophobia.

The reason why Sexual Personae upset people was just a few remarks in there about AIDS that were declared to be politically incorrect and unacceptable. I stand on the remarks in there and I believe in a hundred years from now, people will look back and realise that I knew what I was talking about. I said that the idea that this disease came out of nowhere, that all of a sudden in 1981 it was like, "Oh, my god, what happened here?" – I believe that the signs that something bad was happening were already there in the mid-seventies.

I have written and spoken about this. That period just after Stonewall when the men's bars exploded suddenly in number and in luxury – the women's bars always remained much poorer compared to that – I describe



this moment when I had been used to going with my male gay friends into bars and I suddenly was no longer welcome. And this was a tragedy for me, it was like a break in my life, when male gay friends who had been my confederates in anguish and in questing, you know, for love and so on, all of a sudden I as a woman was persona non grata in the men's bars, and it was exactly the moment when the orgy rooms came into existence, and when there were only now these black or dark rooms with people rolling around with very poor sanitation there, OK? You began to have sex shows, and fist fucking was coming in, men in swings, that kind of thing. I was no longer welcome. That's how I remember it, very accurately, I suddenly had this sense of abandonment by my male friends who went off into this paradise garden of earthly delights.

And almost immediately, this was in the mid-seventies, I remember reading this in the New York Native or something like that, and it reported – now also, my friends started talking about having this – trouble with amoebas, these parasites that would not go away. I started hearing about this from my friends. And then I saw this – this is the mid-70s – this article that said a parasite had been identified in the intestines of gay men in New York that had never been identified in human medicine before. Only veterinary medicine was able to recognise it. It was an animal parasite. A chill went through me. This can not have been more than six or seven years after Stonewall. I'm saying that the signs that something terrible was about to happen were already obvious within a few years after Stonewall. The idea that this came out of nowhere – this is a piece of historical nonsense.

You're saying the pagan promiscuity of the 60s was responsible?

Yes, yes. What I did say was, "OK, I don't want to blame gay men. Let's go back to the Mamas and the Papas!" It's my generation, the free love, which I myself tried to practice, and indeed was not very good at particularly. This sudden upsurge in promiscuity – I compared it to the Roman Empire. People said, "Oh that's terrible! You shouldn't be doing that!" Well, of course! The social conditions and historical changes were similar.

What happened in my generation, the sexual revolution, was the biggest thing in terms of numbers of sex acts by the greatest number of people since the time of the Roman Empire. And if we do not look back at that and realise that there are parallels there! Normally it's only conservatives who talk like that. I, however, am a student of history. I am an admirer also of decadent phases in history.

It was a tremendous experiment attempted by my generation, and I'm still committed to all the great principles of my generation, that's the subject of my work. But I'm saying, "Wow! We hit the wall!" We hit the wall of reality in a lot of ways, and AIDS is one of the ways we hit that wall. There's been an absolute slaughter of the talented men of my generation.

You're saying that the moral responsibility should be accepted?

I've constantly said of the gay men of my generation that they challenged Nature and lost. But I'm saying that that is noble and worthy! It's like the great Romantics. It's like Keats, Byron and Shelley. It's like Captain Ahab, I constantly say, in Moby Dick, who shakes his fist at the heavens. That's fantastic, that's the way the human imagination gains. Humanity gains from risk-taking. But then, accepting the consequences of your risk. This idea of blaming what happens to you on Ronald Reagan, blaming it on homophobic authority figures, is infantile! We must take responsibility for our gambles, OK? We gamble and we lose, we must take the cost to ourselves and not blame it on others.

I think in Europe there's been less tendency to blame the paternalistic figures perhaps because the paternalistic figures aren't so overwhelming. I think it's complex. There is more than one book coming out now showing that are at least very serious questions about whether a human immunodeficiency virus exists.

Well I'm not at all surprised. I think there has been a rush to judgment in terms of the working hypothesis they had. The working hypothesis about this disease was accepted as confirmed fact, and the people who were doing that in the media and among AIDS activists are just incompetent in terms of science or how science works.

There's something potent about the fiction of invisible transmission that almost helps a community define itself in the absence of other parameters.

I do feel what we see here in point of fact is repeated insults to the immune system. The original theory about poppers, amyl nitrate, was excluded! First people suspected it, then they excluded it. And I thought, "Why are they so quickly excluding this?

Just two days ago, poppers were confirmed illegal in this country. There was an important case, and the medical case against recreational amyl nitrate is tragically convincing.

Absolutely. It really happened at that very moment. Poppers were coming into the scene at that very moment when the bars suddenly went wild. Men were staying up all night, and drinking. I think that women, just by virtue of the menstrual cycle and so on, learn very early on how to conserve the body. I've always felt that gay men were pushing the limits of the human body throughout that period, also keeping thin and trim at that period, eating very little and drinking a lot. I would see this manic lifestyle. And now we hear more and more – people used to whisper this – how they would get gonorrhoea or whatever they might get, and they would go get penicillin month after month after month. These infections were signs that something was going wrong in their bodies.

Now women seem to have this instinct for preservation. You have an infection? Wow, pull back, conserve the body, save the body. I have no idea whether there's something biological or cultural here, but I who have defied every possible cultural pressure in terms of my identification as a woman and so on, I have this sense about the body. There's like a little signal, something's wrong, pull back, OK? Go slow. Conserve. And I notice men don't seem to have that. There was this wild, wild scene. It was like the Masque of the Red Death, and the wild party scene in that play, it was very much like that. And the band played on, as Randy Shilts says.

What did you mean when you said of Michel Foucault that if what you'd reliably heard of his public behaviour after he knew he had AIDS is true then he should be condemned by any ethical person?

People say this was not true, blah blah blah. I'm sorry, I happen to believe it. This information came to me very reliably. There were only two people between me and Foucault. Foucault told a famous gay writer, who told my close friend, who told me, that when he realised he

had AIDS, he was so angry that he determined he would take as many with him as he could. He would take as many to death as he could. That he deliberately went to bars and would deliberately have sex with people and not tell them and try actively to take them with him.

I've heard this about other people and I don't think it's an uncommon response. If there's no virus it's absurd however. You're on the record as being pro-pornography, pro-prostitution, pro-drugs. I think one of the things Foucault did before the end of his life was use a lot of drugs. What practical social measures could bring about responsible drug use?

Well now I'm someone who doesn't take drugs, you see. My view of drugs is that it's an age-old privilege of humankind to alter the mind for expanded consciousness or for a sharper perception about existence. Priests have done this in rituals from time immemorial. I myself do not take drugs merely because of a physical antipathy to it, but I regard liquor, which is the ancient drug of my people, as equivalent to other people taking marijuana or LSD.

Now, I'm very committed to the psychedelic view of reality even though I have never taken LSD myself. And I feel that the international war on drugs is the biggest waste of money of states in the world. Any attempt to deny people what they really want in sex or in drugs simply leads to an underground economy and drains the world's resources. It's destroyed the inner cities in America because obviously young people can earn a thousand dollars working the drug trade as opposed to like $3.95 an hour, or whatever it is, working in MacDonalds flipping hamburgers. I think this is just a massive delusion to ever imagine that we can stop what is clearly a human craving to alter consciousness.

At the same time I think we all must face the reality that drugs can destroy. They can indeed destroy. I think that LSD did indeed destroy a lot of my generation. Many people, their brains are pudding after too much taking of LSD. I think that similarly heroin is of tremendous concern now in the music industry. In fact there's a rising pressure about that in America after Kurt Cobain's suicide. I don't want to minimise that. I do think that drugs play their role in weakening the immune system in some way that also is related to what appeared to be such a sudden emergence of AIDS in the early 1980s.

In Britain recently, the Medical Research Council has come under the auspices of our Ministry for Trade and Industry. What do you think that means about the future of independent research?

Well that's been the case for a very long time in America where the pharmaceutical companies invest heavily in research and they're only interested in drugs which are essentially synthetic and that therefore they can control. Whereas things that come from natural plants, like marijuana and so on, they have no interest in.

In gay activism, and in AIDS activism, what may be the effect of the dramatic resignations and realignments were are now seeing?

I think that AIDS activism has pretty much lost its steam here in America anyway. It's staggering. The principal AIDS organisations like AMFAR and so on are trying to revive themselves. They've got Sharon Stone now to be a spokesman and so on. I think that they were pretty much set back on their heels in the last few years. I think there's a kind of dispirited vacuum that's occurred here in the last few years. I don't think it's going to be as big a change here. People are just not as arrogant. There was a moment when the AIDS organisations had a kind of a stranglehold on the media . They were able to coerce the media . There was a lot of media attention given to AIDS and it's really receded here I think.

Liza Minnelli in the States has built a career on it. Liz Taylor, Princes Diana, now Sharon Stone. And yet the CDC is saying that there was a conscious attempt to encourage people to believe there would be a heterosexual problem far beyond what there ever would have been or has been.

There was a period of absolute hysteria, cover stories just constantly in the public eye. And that would have been in the late 1980s and early 1990s. I think there's been a slow decline in the attention paid to the issue at all here. Part of it was that ACTUP was very very active at that time. The turning point may well have been the election of Clinton. The AIDS groups were very politically partisan. That's another way I think they damaged themselves. They were very politically partisan and they were ways to mobilise against Republicans, and the gay activist organisations in general were of course 100% behind the Clinton election when he was a fairly unknown figure.

So the thing is with the election of Clinton everyone thought, "Oh, now there's going to be Nirvana for the liberal organisations," and so on. Within two short weeks there was the gays in the military controversy that was mishandled by Clinton. Very badly mishandled. And suddenly everything fell apart. I think that the morale of the gay organisations in America never recovered from that. We're talking about two weeks after the inauguration of Clinton. Let's see, that would have been in January 1993 then. He was elected in the fall of '92. That's when everything started to unravel. The arrogance of the media, leading up to that election in the fall of 1992, their arrogance, the prancing around, the parading of the gay activist organisations, they all felt that they had mobilised the gays to vote for Clinton and they felt they had maximum power over politics and they felt it was going to be a tremendous change.

And then what we had was a rapid disintegration of all the gay organisations

And then when the gays in the military thing was a fiasco – [David] Mixner [Clinton's number one gay advisor] had given very bad advice to Clinton in terms of how to handle it and so on – they essentially became exiles, they all became exiles. The administration then realising the damage, the fallout from this, from the gay issue, how flawed their information was coming from the gay activist organisations, the whole administration turned its back on the gay establishment, OK?

And then what we had was a rapid disintegration of all the gay organisations here. That is, the leadership. There was this woman whom I despise, Urvashi Vaid, who's written a recent book, terrible book, and so on, these people were like Stalinists but in charge of these organisations and they all lost power so fast in that one year when they lost their access to Clinton. There have been a lot of articles in the gay press here about that. The way that gay leaders here in America, all the ones that were very prominent in that period leading up to Clinton's election, have lost status. This is the very period in which I have gained. I mean I'm in no way a gay leader. I mean there's no way. I'm a very controversial thinker. I have many followers, but there are many people who hate me and so on. But there is no strong leader who has emerged.

So that's what's happened here. AIDS, the way AIDS has gone to the back burner here in America, is simply a part of the general loss of prestige of the gay leaders. We don't have a Martin Luther King. There's been no figure who's been particularly talented. And I think again it's because of the ignoring of the cultural aspect of human lives by the gay political leadership.

With multi-drug-resistant strains of various microbes on the increase as an ever-widening range of pharmaceutical drugs is being prescribed, perhaps it's time to look for natural alternatives that really work. Allicin is one of the most effective remedies for treating a number of opportunistic infections, as homoeopath GARETH JAMES reports

MOPP-ing up the

Over the last few months, an increasing number of articles on the potential benefits of using allicin in the treatment and prevention of AIDS related conditions have been appearing in the HIV/AIDS media. Allicin itself, (also known as diallyl trisulfide or DTS) is one of the active ingredients present in garlic and has been used in China to treat a wide variety of complaints for over twenty years. John Stevens, editor of Equilibrium, has taken the lead in increasing awareness of allicin therapy for people with HIV/AIDS and first reported on its benefits in April 1995. Since then, the Heal Trust has made this product available at trade prices from its Buyers' Club for people in the UK wanting to use it as part of their treatment protocol.

Dr. Qing Cai Zhang, an AIDS physician and Chinese medical practitioner working at the Sino Med Research Institute in New York, has been pioneering work with allicin in his practice for a number of years. Zhang has no reservations in claiming that "Allicin is one of the most effective Chinese herbal remedies for treating and preventing the OI's (opportunistic infections) of AIDS."

The reason Zhang has become so excited about the use of allicin in the treatment of AIDS is that he believes it points to a whole new class of AIDS treatment medications. Because AIDS is multifactorial in its origins and multi-faceted in its expressions, Zhang believes we need to find treatments which reflect this complexity. In this context he refers to Allicin as a 'MOPP' – a multiple opportunistic pathogen prophylaxis. His criteria for a medicine being termed a MOPP is that the treatment must be safe enough for long-term use and therefore have a low acute and cumulative toxicity, it must have a very wide anti-infectious spectrum in its application and it must be affordable. The beauty of allicin is that it meets all the above criteria.

Apart from the strong odour of allicin (which lingers less as use is established) and the corrosive taste, the only reported side-effects are mild gastric discomfort. Some people suffering with sensitive oral or oesophagal thrush and ulcers, have reported pain on swallowing. Aside from these, there are no other reported side-effects. Allicin use is not recommended orally when these conditions are present.

In terms of its ability to inhibit a wide range of microbes all at the same time, allicin appears unrivaled by its pharmaceutical counterparts. As Zhang points out: "Most chemical drugs are designed specifically for one kind of infectious agent, necessitating that the patient has to consume an arsenal of different drugs. The cumulative toxicity of these drugs makes this regimen unsafe and therefore unacceptable. Sometimes conventional antibiotics which suppress bacterial infections are made from fungi, which then promote the growth of fungus. In the same way, Western anti-fungal drugs sometimes encourage bacterial infections. Instead of solving a problem a new one is created. Pharmacological studies have found that allicin has a very wide spectrum of anti-infectious ability. It is ideal to use for multi-agent co-infections."

Allicin has shown effects against many protozoa which cause infections during AIDS

Hi-tech, Western pharmaceutical use is also increasing the number of multiple-drug-resistant strains of AIDS-related microbes at an alarming rate (e.g. MDR-TB, MDR-Staph. aur., MDR-Candida). As Zhang found bacteria which were resistant to penicillin, streptomycin, chloramphenicol and chlortetracycline were still sensitive to allicin, the need for more research in treating these 'superbugs' with allicin therapy becomes self evident.

Coupled with existing studies, Zhang's research at the Sino Med Research Institute has found allicin to have anti-bacterial, anti-myco-bacterial, anti-fungal, anti-viral and anti-protozoal properties. Zhang found Allicin to be significantly bactericidal (bacteria killing) against many of the microbes involved in AIDS-related conditions: Staphylococci (causes folliculitis, boils, carbuncles, abscesses and fluid filled blisters), Neisseria meningitidis (causes meningococcal meningitis), Streptococcus pneumoniae (causes pneumonia), Shigella dysentry (causes fever, abdominal pain and tenderness and bloody diarrhoea), Escherichia coli (causes infections in the gall bladder, bile ducts and urinary tract), Salmonella (causes fever, chills, sweats, weight loss, diarrhoea and septicaemia), Mycobacterium tuberculosis (causes tuberculosis) and Mycobacterium avium intracellulare (causes high fevers, severe anaemia, night sweats, chills, weight loss, loss of appetite and weakness, chronic diarrhoea with malabsorption of nutrients and abdominal pain).

Allicin's anti-fungal repertoire includes Candida albicans (causes oral and vaginal thrush, chest pain, difficulty in swallowing, malabsorption and can infect lungs and brain) and Cryptococcus neoformans (causes cryptococcal meningitis and can infect the lungs). Zhang also comments

microbes with allicin

that he found the inhibitory dose of allicin for Cryptococcus to be the same as for amphotericin-B but demonstrated no toxicity.

As an anti-viral agent, a number of studies have reported inhibitory effects against cytomegalovirus (CMV, can cause inflammation and detachment of the retina leading to blindness and ulcerative colitis as well as some lung infections). There is also some, albeit minimal, evidence showing allicin has some anti-viral effects against the herpes simplex viruses.

Allicin has also shown inhibitory effects against many of the protozoa which cause infections during AIDS. Allicin has been shown to be effective in the treatment of microsporidiosis and infection with Cryptosporidium parvum, both of which are responsible for diarrhoea and weight loss and against which there is no established effective orthodox medical treatment.

The doses of allicin required for inhibitory effects against all these microbes are far from standardised. However, for the direct treatment of clinical symptoms Zhang recommends 30mg per 30 kilos of bodyweight per day and for prophylactic treatment, the same dose reduced in frequency to 1-3 times per week – this roughly equates to 2 vials per day or 2 vials 1-3 times per week respectively. Allicin can also be taken into the body through a number of routes: orally, anally as a retention enema or intravenously. Most clients using allicin from the Heal Trust choose to drink it. Zhang is currently developing an enterically coated, time release capsule containing 20 mg of allicin. This form spares the mouth and throat direct contact with the 'battery acid' taste and keeps the levels of allicin in the blood far more stable.

Zhang recommends allicin therapy as the primary prophylaxis for all his patients with CD4 counts below 200. Zhang uses allicin in a similar way to pentamidine inhalation through a nebuliser to protect the lungs as well as an aerosol spray carried by most of his patients to prevent against airborne infections.

For the clinical applications of allicin in AIDS, Zhang states: "If we protect the respiratory and digestive tracts, most infections can be prevented. From my observation, all patients who complied with these treatments, rarely complained of any dangerous new infections, such as Pneumocystis carinii pneumonia (PCP). I have a few patients whose CD4 count is less than 10, but as long as they adhere to these treatments on a regular basis, they can remain in a very stable condition for years."

One of Heal's clients, Tony, had been suffering with Cryptosporidium parvum for a number of weeks before finally being admitted to Ealing Hospital NHS Trust with debilitating diarrhoea and dramatic weight loss. He was prescribed anti-diarrhoea drugs and Gabbroral, neither of which, Tony said, made any significant difference to his condition. His CD4 count was <50 at this time. After six weeks in Ealing hospital he decided to change tack. At his request and in cooperation with consultant physician Dr. Stephen Ash, Tony started using allicin through his drip feed. His diarrhoea stopped within 48 hours and Tony was discharged from hospital two weeks later. Before leaving Ealing, repeat tests on Tony's stool samples found that he had completely cleared the protozoal infection from his gastrointestinal tract and tested negative for Cryptosporidium. Over the following three weeks Tony's appetite increased and he put on one and a half stone.

John was diagnosed HIV-positive at the end of February this year after suffering from constant diarrhoea for about a month. His CD4 count at that time was <50. Six weeks later, after some insistence that his diarrhoea was becoming steadily worse, his doctor tested him for Cryptosporidium parvum which gave a positive result. About one week later John was admitted to the Chelsea and Westminster hospital as his diarrhoea had become debilitating and he had lost about a stone in weight. He was also started on the drug Gabbroral which did stabilise his condition, preventing his symptoms from becoming worse, but despite a one month course showed no real improvement. After finishing the course, John came to the Heal Trust and immediately started on 2 vials of allicin a day. After one week, his stools had returned to normal and his appetite started to improve. After four weeks, he had put on just over a stone and aside from a short trip abroad when he stopped using allicin, has had no return of the diarrhoea.

Despite such impressive results, allicin has, in the main, been ignored by the majority of the orthodox medical profession as a potential treatment for Cryptosporidium and other microbial conditions. The greatest obstacle to furthering research into allicin stems from the hardy reluctance of the orthodox medical establishment to provide funding for trials. As allicin can no longer be patented by the pharmaceutical companies, their interest in researching a product from which they can make no direct profit is shamefully lacking. Zhang made an official proposal to the Office of Alternative Medicine at the National Institute of Health (NIH) and although in his words he received a 'courteous evaluation', no funding was forthcoming.

Despite some positive reporting on garlic in the National AIDS Manual's HIV and AIDS Treatments Directory, their pharmaceutical-friendly, bi-monthly publication AIDS Treatment Update (which must surely be renamed Pharmaceutical Treatment Update owing to its disappointingly narrow focus) has also been predictably sceptical regarding favourable reports on allicin.

Although Dr. Mike Youle at London's Kobler Centre has recently become interested in the possibility of some allicin trials, to date only AIDS ReSearch Alliance have conducted Phase I Pilot trials with Cryptosporidium parvum. The encouraging results which were published in the Spring edition of Searchlight this year concluded that "the use of high dose garlic concentrates appears to be a feasible therapeutic regimen to consider for HIV-positive patients with CD4 counts <100."

Dr. Qing Cai Zhang MD is also co-author of AIDS and Chinese Medicine (1995), Keats.

For more information on allicin or to purchase allicin in the UK contact:

The Heal Trust
Heal House
375 Kennington Lane
London, SE11 5QY

Tel: 0181 265 3989, fax: 0181 265 3973

Postal service available throughout the UK

Sources and further reading

Dr. Qing Cai Zhang. The Applications of Allicin in Preventing and Treating Opportunistic Infections of AIDS. Sino Med Research Institute, 141 East 44th Street, Suite 712, New York, NY 10017, US. (1996) (available from the Heal Trust)

Stevens J. Allicin: The Goodness of Garlic. Continuum. 3/5: 25 & 30.

Donnelly P. Got The GI Blues? Equilibrium. Issue. 1, Spring 1996.

Fareed G et al. The use of a High-dose Garlic Preparation for the Treatment of Cryptosporidium parvum Diarrhoea. AIDS Research Alliance, 621 N. San Vincente Blvd, West Hollywood, CA, US. (8/1/96) (available from the Heal Trust)

Guo-Nai Lan et al. Demonstration of the Anti-Viral Activity of Garlic Extract against Human Cytomegalovirus in vitro. Chinese Medical Journal. 106(2): 93-96 (1993).

Passwater R. An Interview with Professor Eric Block: The Chemistry of Garlic's Health Benefits. Whole Foods. 22-26 June 1992.

Yen T et al. Anti-viral properties of garlic: in vitro effects on influenza B, herpes simplex and coxsackie viruses. Planta Medica 5: 460 (1985).

Davis L. Garlic as an anti-fungal agent: Laboratory studies. First World Congress on the Health Significance of Garlic Constituents, Washington DC, August 28-30 1990.

Cai Y. Anti-viral and Anti-cryptococcal properties of garlic: clinical studies. First World Congress on the Health Significance of Garlic Constituents, Washington DC, August 28-30 1990.

Sandhu K et al. Sensitivity of Yeasts Isolated from cases of Vaginitis to Aqueous Extracts of Garlic. Mykosen. 23: 691-698 (1980).

They were not willing to address other issues,

What did we gain in the 15 years of AIDS? In this second part of his essay on the effect of "HIV"-dogma on homosexual life MICHAEL BAUMGARTNER examines gay men's attitudes towards sex, survival and society

To AIDS-activism – thanks for

The gay movement coming out of the sexual liberation movement, tired of the constant fighting for gay rights, became worn out with having to defend its achievements in a persistently ignorant society, leaving space for growing numbers of homophobic fascist groups like the Moral Majority founded by Jerry Fallwell in the late '70s. Outspokenly hateful, these groups sought to deny us the basic right to life. "Kill a queer for Christ!" became the credo of self righteous religious groups campaigning for a totalitarian shift from the previous liberal political leadership. When few came to the defence of homosexuals, even many of us started believing that "Only a dead homosexual is a happy homosexual".

This growing underlying group depression was nurtured by the occurrence of AIDS, the new deadly threat to the gay community, offering an end to the increasingly unbearable gay life. The received shame of being a homosexual combined with guilt around promiscuity led, with a certain sense of relief, to the "HIV"-dogma. AIDS released the oppressed tension of depressed emotions into hysterical outbursts much like the cries of concentration camp maids once the gas was dropped, having silently entered the camouflaged chambers. Decorated with the pink triangle, we were now socialised into red ribbon-wearing by the "HIV" establishment, adding another symbol of victimhood to our kitschly decorated sacrificial lives.

After 10 years, "HIV" has become the new identity of gay men and the new identity crisis. We came out of the closet introducing ourselves proudly to the world with "I am gay" – we now introduce ourselves equally proudly with "I am HIV". In common with all identity crises it seemed to leave us with no future but the confrontation of death. The reality for many homosexual men unable to identify as "I am HIV" was equally devastating. Since homosexuality is not inherited and many of us experienced abandonment by our physical families, we had been building our own gay families over many years. Suddenly "HIV+" challenged those ties, leaving the touched on one side and the untouched on the other – identified ironically by blood testing, the very fluid that does not bind us to our biological families. Much like in those families, friends now started isolating themselves on the grounds of a reality that the "not HIVs" could not relate to. While some moved into another even more isolating stage of being, others were simply left behind.

The effect of a negative "HIV-test" on many homosexual men is devastating. Depressed, having to cope with survivor guilt and feeling left out, many dive into the night with the unspoken desire of becoming "HIV". A positive diagnosis gives the victim the chance to be vindictive: inviting victimisation of ourselves over and again on the grounds of one's own homosexuality, we could get our own back on the "negatives", both homo- and heterosexually oriented – albeit on the grounds of an unspecific, unreliable blood test.

Rather than understanding the presumed deadly disease, dumped on us, we started to enjoy the grapes of death-mongering: unbearable life coming to a glamorous end. Kitsch pictures of "HIV+" individuals carried away by their suffering, or accusingly facing the bad world, became the staple of "HIV" -fundraising art exhibitions.

While the "infected" – I should say the indoctrinated – became preoccupied with their death career, the "uninfected" "HIV"-parasites mostly focused on the career of their homosexuality. Re-setting the political agenda became the powerplay of the AIDS '90s. AIDS activists at the beginning of this tragedy gave importance to making AIDS an all-endangering epidemic – the queer agenda was now to "re-gay" AIDS. It was the fear of the homosexual AIDS leaders that they would lose out to mainstream interests and could be forced into supporting rather than leading roles in this dance of decay.

The mainstream political agenda did not intend to spend more money on AIDS anyway, because after so much time there was so little incidence. There were so few straight nice white upper-class families affected. The homosexual interest in death-by-diagnosis had to be officially re-installed or the homosexual playground would vanish. Of course this latest discourse of the self-appointed "HIV-leaders" could attract little interest. How many "AIDS edicts turned upside down" can one take and still be trustful and obedient to authority?

Books by former closeted homosexuals, now wanna-be-gays, about their fucked up emotional lives and "HIV" enlightenment collected like flies around rotten fruit, claiming pieces of the AIDS-celebrity-cake with this suffering-justification-document, their biography. While gay life-stories seem to attract only an insider readership, the On-top-of-it -"HIV"/AIDS-diagnosis text seems to find a chink in the mainstream mind. To a n abnormal life belongs an equally illustrious death, and then the unconscious morals of the straight self-identified open mind can buy into the homosexual experience. While being gay was simply

because there would not be a simple cause

a non-status in Hollywood, being "HIV" could get you an Oscar. Just what does that tell us?! Our living is not interesting enough to be addressed or even accepted but our dying due to bad luck is glamorous!? AIDS became the key for apparent homosexual interests to enter the world of celebrity and superficial power. But there was little besides de-homoeroticised movie portraits of sacrificial death rites and victim dramas: some were entertaining but most not at all enlightening. It is less threatening to the self image of the plain homosexual man in America to fight death in a macho way, or give in to victimisation to the extent that all you

nothing!

can come up with is a blue screen by which the world can remember you as a rebellious queer artist.

While the medical AIDS-czars still stressed the lie that "HIV" is inevitably fatal, the great conquest of AIDS, sponsored with blood money, has always been built on sand, failing to stage the promised great heterosexual AIDS epidemic amongst non-IV-drug addicts. Once that fact was publicly known, the sources of money started to dry up fast. It seems that as far as the establishment was concerned, AIDS stayed where it might as well be, in the homosexual world, reducing gay power by numbers, getting rid of perverts and druggies. Therefore an increasing number of these overpaid AIDS-lords, both hetero- and homosexual, and including some charity bunnies, began grabbing their hats and coats and started leaving the party – the more queer, the more flamboyant their departure. Other homosexual men, doomed to death and still needy of support, got fed with wrong, even dangerous information and burdened with

Many dive into the night with the unspoken desire of becoming "HIV"

dubious comradeship. Pharmaceutical company Wellcome, by now married to the even bigger pharma-giant Glaxo – probably through fear of losing its capital to litigation claims for health damage from AZT – saw the market diminishing as AZT finally fell from grace with suspicious gays who realised AZT users are the ones dying fast and painfully. With more and more consumers turning their back on AZT, Glaxo-Wellcome now uses television to aggressively market its poison, pure or as cocktails, into the already well-exploited homosexual market.

With AIDS activists increasingly clear about the flaws in the "HIV"/AIDS-myth or at least about the toxicity of treatments, the average homosexually active man was left to their mercy to find his way through the "HIV"/AIDS jungle with its thousands of publications and suggestions about "HIV"'s dangers and possible powers. The self-appointed queer experts realised that whatever they had learned would only be good in the era of "HIV"/AIDS. They reached a dilemma. Should they advise their fellow gay men to stop listening to the nonsense of "HIV" science and start doing what they themselves felt best about, the only reasonable course in this disaster created by pseudo-science? Or should they continue to urge them to listen to their equally stressed MDs and take whatever the latest outcome of "HIV" research is? While the road to the self-responsibility and independence of others would leave these "experts" jobless, the other road would keep them as mediators in power. Mostly the second decision was made by the reckless queer AIDS-careerists. After all, some sacrifice seems to be needed to stay in power. A homosexual AIDS-foundation director once told me, "Let's face it, AIDS is the best thing that ever happened to us. We are important now. Where would we be without AIDS? Unimportant homosexuals doing unimportant work?...And there are very few affected anyway, mostly drug-addicts!" – the last remark made with a rather negative undertone.

How many homosexual men really were affected by AIDS? According to the epidemiological statistics – to date the only "proof" for the "HIV/AIDS hypothesis – in the US about 3% of the male homosexual population is directly affected by HIV and even less by AIDS. Since diagnosed "HIV+" cases usually get registered more than once, this is most likely an overestimate. This figure is less than die every year of other causes and less than the 20% of gays and lesbians affected by alcoholism. However after 10 years, the "HIV"- dogma diminished all other gay-relevant issues, regardless of their importance. This is not about making a hit-list of our issues of concern, yet when we simply drop our engagements in such issues to get involved with the latest flame of homosexual life, we have to accept criticism for being neglectful. Just because AIDS was created out of the pool of homosexual experiences and established as the latest and ultimate threat to all human life by the CDC and the WHO (wishful thinking?) does not mean that we can afford to neglect our other burning issues. The CDC today reveals that as early as 1987 it was clear to them that AIDS would be insufficient to do the damage they had proposed. They deliberately abused a health concern of a disenfranchised group in order to fund their mostly useless careers, and created a disaster. Instead of waking up to such abuse of power, revealing medical science's true face, we embraced their manipulations and counted on them as our supporters. At what deadly cost?

The young community was left with homosexual-related alcohol abuse, drug addiction, suicide and poverty, while our leaders attended brainwashing sessions learning how to handle AIDS pseudo-scientifically correctly. They did not seem willing to address these other issues, probably because there would not be a simple cause and answer as had been proposed for AIDS. "Early intervention" – a popular expression for prevention – seems so easy in AIDS, just drop the latest claimed-to-be beneficial "HIV"-poison. Prevention strategies for the real issues of homosexual and therefore gay-related health/life threats are more difficult to come up with, far more complex and hard to get funding for because they are of no interest to the straight health police, the CDC and the WHO (when did we last hear of a nationwide gay-sensitivity-campaign in schools to combat gay-bashing?). The homosexual policy seems still, "Let us not ask for too much and stay with what seems easy and fundable" – even if it leaves just one possible outcome for us, death!

Up to the present, with one exception – the New York Native – the press geared to male homosexual and gay culture pushes a "just-listen-to-your-doctor" approach as if they are initiated gay "Fuhrers" camouflaged in white drag, telling us to "use a rubber when you fuck and you'll be just fine." In the face of death anything else becomes unimportant anyway! Even the truth.

HIV=AIDS=Death became the excuse for many of us to nurture the subconscious incapability for living. Giving in to the forces of life, growing gaily older (for those who know of Quentin Crisp), in this society seems to some more difficult and less attractive than dying young and rather glorified. Homosexual life-style encouraged living fast, doing "it" all, not worrying about the consequences, forgetting the future. Living fast, meaning unhealthily, and dying

young became the reality for many homosexually active men in the AIDS era. "HIV positivity" as a consequence of "liberated" misunderstood gay living was worn as an emblem to the world.

What did we gain in the 15 years of AIDS? Towards the end of the twentieth century sex is seen again as a danger to human life, a threat to society, like some moral mediaeval curse. No reformation of religion, no understanding of nature, no liberation of the human mind prevented this backlash! What value is human growth and the development of science, when the outcome is new dogmas cast in an old-fashioned way, and fascist attitudes?

"HIV"/AIDS has been established as a fatal disease in people's minds. The homosexual link persists. Fighting for AIDS to be of general concern made us visible and connected with it, as well as its premier target. Homosexual awareness today has most likely to do with fear of AIDS in both the homo- and heterosexual mind. AIDS gave us a reason to be out: the ones most affected by it, we might as well die loud and angry. But many of us were ill-prepared for what hit them once they came out. Little ego structure left many vulnerable to questionable opinions and dangerous advice e.g. by doctors and/or the media. It was not only the sudden experience of homophobia nurtured by the homosexual-

Sex is seen as a danger to human life like some mediaeval curse

plague-carrier-myth, but also peer pressure leaving many in a state of constant confusion. Nevertheless we became more visible. Just let us not waste time focusing on our living – instead get ready for extinction through AIDS!

Stereotypical gay flamboyance and macho male homosexual AIDS death made the big screen. Would Hollywood and therefore the rest of the public world be "gay sensitive" if it weren't for AIDS? I doubt it. Identified we are, as the living end of AIDS. "HIV" still diminishes every other gay-relevant issue, like gay bashing, gay-related substance abuse, suicide, neglect and poverty, even domestic violence. One might argue that visibility does not achieve much when we are caught in the "HIV" trap. Homosexual recognition has most likely more to do with exploitation than concern. After all, we laid the financial ground for "AIDS research", demonstrating the power of the "pink dollar". Political power should be measured by achievements through arguments and not achievements through manipulation and piteous generosity. That "straight" politics is no better is no consolation.

In the AIDS era homosexual rights became a political issue, as if governments wanted to make dying homosexuals at least legal before death carries them off. Other political forces bound homosexuality with AIDS to punish the dangerous plague-carriers by reinforcing or trying to reinforce fascist homophobic laws. In many parts of the world same-sex partnerships have become legally recognised, while HIV+ individuals, mostly homosexuals, can no longer travel freely, much less emigrate e.g. to the US or Japan. Understanding that these laws are not based on science might just show that homophobia in liberals' minds has gone underground. Legally too we would be better off without the "HIV" dogma.

How much freedom has "HIV" brought to us, gay and homosexually active men? It is quite trendy to be "gay" – in loose usage either a stereotypically flamboyant queer or a plain homosexual – we even have our own disease now! Yet "gay awareness" today is not enough anymore, you have to bow your head from estranged orthodoxy and confess to "HIV"-fundamentalism, called "HIV" awareness. Young men and women drawn to homosexuality are coming out at a much younger age than many of the older generations did. The newer generations however have a burden to carry: there is not much freedom in how to be gay. Superficial political awareness is as trendy as the simulation of safe sex. Partying is expensive these days because the "pink economy" has to have a big turnover. We all know, only with money can one be really "gay"! And we need company, to feel connected with gays or gay-friendly crowds, especially for those who are young and new to the queer world.

It may be harmful for a healthy emotional life of young humans to be constantly reminded of an intimate, inevitable "deadly threat" that will catch you when you don't stay vigilant. In claiming to know how to be protected against AIDS, we don't only give out false information to the young but make them feel guilty when they do get an "HIV+" diagnosis. Of course we continue having "HIV+" diagnoses and AIDS in a group where uninformed drug use is part of the good vibe, the culture. While fearful of blame from straight parents for being gay, the younger generations now fear blame from their older peers for not playing "it" sexually safe enough. "Safer sex" is not irrelevant, but there is no such thing as "safe sex" unless it means no sex. The only freedom there is in being "gay" today is: to be out, never mind the real risks and to behave stereotypically, never mind the dangers. Isn't it just that stereotype, well exploited by organised commerce and corrupted by pharmaceutical money, that keeps the myth of the "gay community" alive?

The creativity surrounding AIDS, mostly by flamboyant queers, is notable. I personally am not impressed with celebrities finally coming out to "rescue" us from AIDS now that we are "doomed to death". Where have they been, when we marched for legal rights and struggled without role-models? Who needs that sentimentality dumped on us by Elton John and co. like rice after a wedding ceremony?

Taste aside, the psychosocial support networks we created are impressive and deserve credit. Too bad that too many of them were and still are absorbed with making people feel good about their mostly unnecessary and far too early death. We learned to care and came up with often very good quality help for our people in need. Why not put these energies, strategies and efforts (including the perception of one's death) into living, for all of us, rather than just fiddling in the shadow of death?

There is something to cherish however, something gay spirits have achieved in the midst of the AIDS-genocide: the survival of critical voices! Along with many courageous scientists – well-hated by the AIDS establishment – there were and still are a growing number of wise gay men and women speaking up and fighting the deadly, but for some very convenient, lies. It is finding these people and being impressed with how much just one person's courage can achieve that makes me continue raising my inconvenient voice, despite the hatred we get from fellow homosexuals just for raising appropriate questions and reaching even more appropriate conclusions after 15 years of nonsense.

Looking back to the many homosexual and gay men who I have known who believed they had been invaded by "HIV", it saddens me how stubbornly many held onto a nonspecific diagnosis, how they took the most toxic substances to kill something inside them that has never been verified, as if they were trying to kill their very being. Their death then seemed the ultimate victory, successfully destroying the "evil" inside, which was not "HIV" but some metaphor – most likely their negative self-image and the lifestyle that has grown our of that. It saddens me that they succeeded in killing something called gayness that made them different from normal, something I came to cherish and nurture over the years. We have lost many wonderful people, lovers, friends, colleagues, etc., people of potential that is lost due to unnecessary suffering and early death.

If even just one person has to die for others to wake up, was it worth it? We have lost many more than just one member of the fabric that might deserve to be called a "gay community".

This essay is dedicated to Michael Verney-Elliott, Jerry Terranova and Huw Christie for their love, inspiration and friendship and Connie Hartquist, Pansy-John Bradshaw and Judy Grahn for their loving guidance;
in memory of the late Michael Callen, Caspar G. Schmidt, Jody Wells and Mark Alampi, and all the others who raised their
necessary yet often ignored voices, to their inspirations and achievements;
and with thanks to the work done by gay men like Darrell Yates Rist and Ian Young, encouraging me to put together my own thoughts and observations.
And finally thanks to Continuum for publishing my controversial essay and Huw Christie for taking trouble to edit it!

TB or not TB: John Kennedy's unnecessary death

His partner TOM ASHFORD tells the real story

This is indeed an honour for both Continuum readers and myself – an opportunity to tell the uncut version of the latest fuck-up at St Thomas' Hospital, London.

If you've never heard of this establishment, unlike in other abattoirs, the patients are given a mycobacterium (drug resistant, of course) so that they are not only left untreatable, but can spread it around to as many people as possible before they die, weak,
wasted and confused.

When the fuck will there be an end to this appalling catastrophe? When will the "HIV specialists" realise that actually they have bitten off more than they can chew? They really are pumped up with a sense of their own importance. I can write these words, St Tommy's: you boobed, and you killed my partner. While he was in your care, he picked up multi-drug-resistant tuberculosis (MDR-TB). Because of your negligence, I don't have a partner and three people are fighting for their lives. You are irresponsible, you got it wrong and I hope that it redefines your whole treatment strategy. You could start with diagnosing correctly, and get off being so specialist. An "I am sorry" phone call a month after your patient dies, from a senior consultant confirming that John caught MDR-TB in November whilst being treated by her is diagnosing a little late in the day.

John first got ill in August when we returned from holiday in Greece. His chest was tight, sore and restricted, so he went to see his GP who told him he was suffering from pollution, prescribed an antihistamine drug and advised him to get out of London. He went straight to Ireland. Three days later he was in hospital fighting for his life.

PCP was diagnosed, without a sputum test, a bronchoscopy or any explanation as to why John's chest was so painful – such pain is not usually associated with PCP. DF118s were prescribed, along with steroids, two antibiotics and oxygen therapy. Well, the X-ray "said" PCP – not TB, not another chest infection, but PCP – well, it's an AIDS-defining illness, this patient has HIV, it's a logical conclusion and we know best.

Radiographically John was clear after three weeks. Literally, he was still very unwell and still had a searing pain in his chest which the consultant could not explain. Steroids mask infection and DF118s are Dihydrocodeine, strong pain killers given to drug addicts when they're coming off heroin. John's treatment on Ireland was a fair cover-up job.

So to London, and St Tommy's a week later, where John was told the PCP was back. They did an X-ray and PCP doesn't look like anything else – does it? So, the same antibiotics with no steroids, no oxygen, were administered and, after 11 days at home, I had to wheel John into hospital. He was very ill and, on top of his illness, he had a dreadful reaction to the drugs. Once again, he was admitted with a PCP diagnosis. He was put straight onto Pentamidine to which, after a week, he had still not responded and the doctors told me that he might die.

It was then that they decided to do a bronchoscopy and lo, "abnormal amounts" of CMV were reported, and very abnormal amounts of Ganciclovir were administered, and once where natural blood was flowing there were now outrageous amounts of toxic drugs. John was told by one of the most eminent consultants that they never found PCP but they treated for it anyway. John thanked them for their kind consideration.

Whilst feeling understandably at a very low ebb John contracted pseudomonas from the hospital and was moved to his own room. It was a pleasant room with a sunny disposition and a wonderful view over south London. His neighbour was a lovely girl who spent most of her time in bed. "You look awful," I remember thinking as I passed her room, and she would look out with an expression in her eyes of, "O my god! What is wrong with me? Why can't they find out what is wrong with me?" There were times when she obviously felt better because I would see her struggling down the ward with her drip as a walking stick, stopping to cough every now and again. Little did I know that she was coughing and spluttering MDR-TB all over me, John and the whole ward.

After a four week stay at St Tommy's, John went to stay at the London Lighthouse for respite care. He was doing amazingly well and the doctors were astonished that he had bounced back. I was relieved and everything was on the up. We spent Christmas together up north and travelled back a week after New Year. By this time, John's hair was falling out and he had a red rash all over his face. He wasn't feeling too well either, so he revisited St Tommy's. When he came back home that evening, he was crying and he told me that the doctors said that the PCP had come back. I was shocked, scared and desperate and, at the same time, trying to reassure him. I remember wondering if it was going to be like this forever, and how John and I were possibly going to manage.

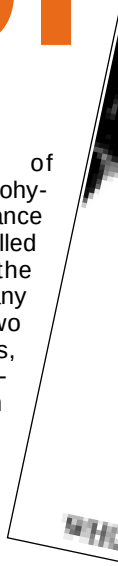
For the next ten weeks John's condition slowly deteriorated. The doctors didn't seem to know what was wrong with him, his treatment seemed very hit and miss and non-specific. On reflection, I think it was a complete mess. He was at home for the ten weeks with me. I looked after him as best I could but he was very ill. His temperature often went up to forty degrees centigrade. He was dizzy, had no appetite and we were on a desperate and futile course of popping pills that did nothing, trying to stay positive in the face of extreme circumstances. The period culminated in yet another admission to St Thomas' where John's treatment was for Mycobacterium avium intracellulare (MAI). It was after 3 weeks of John being in isolation that the microbiologist came up with MDR-TB – the strain matched his neighbour's at St Tommy's from the previous November – and John was moved to Kings College where they had proper isolation rooms.

At this stage John looked like he was on death's door – he was chronically malnourished according to the Kings College consultant, jaundiced as a result of one of the drugs, with chronic diarrhoea and liver failure. He died three weeks later. There were no drugs that could treat the MDR-TB and he was made comfortable. This story covers a period from August 95 to April 96. John had been antibody diagnosed in November 93.

I'm disgusted at John's treatment, tired and weary after having fought a long and losing battle, not to mention the loss of my partner – and so unnecessarily too. And I know that if the specialists didn't constantly jump to conclusions, refuse to listen and insist on their "we know best" attitude, then I wouldn't be writing this and you wouldn't be reading it.

Mary Poppins might have recommended it with your medicine, and "HIV" dietitians generally advocate it to combat wasting, but if you want to live healthily, your body doesn't need refined sugars. The energy buzz it gives is far outweighed by mood swings, problems absorbing essential nutrients and other detrimental effects

A Spoonful of



Fluctuating blood sugar levels are depressing whether you are HIV antibody positive or not. For many people the daily mood swings from manic, in-your-face energy to depression and wanting to go to bed in the afternoon is a shocking reality. Not only that but any symptom you have from any other imbalances in your body will be exacerbated when your blood sugar is low.

Blood is one of the most sociable, uncomplicated components of your body. It flows around veins and arteries with a welcome push from the heart every second or more delivering oxygen, nutrients and protection and taking away the nasty, mucky toxins which we all produce at an astonishing rate. Everything in your body is geared towards keeping all biochemical levels in your blood constant, a process called homeostasis.

If you have too much calcium floating around in your blood, your body says hey, too much, and it finds a weak place to deposit the calcium. If it gets dumped in your kidneys you will get kidney stones. If it was your gall bladder you would be down the doctors with gall stones, joints and it would be arthritis, arteries and a heart attack or stroke will be almost visible on the horizon.

It is a similar story with sugar, in that a whole host of problems can arise when we let too much sugar into our bloodstreams and place strains on the controlling mechanisms. Everyone has their own individual level of sugar in their blood which your body goes to great lengths (using hormones) to maintain at a constant level. This amount is usually between 70 and 100 grams of glucose in every 100 ml of blood. It is an amount known as the resting level.

Deviations (especially a drop) from normal blood sugar levels can have major effects on how you feel. It can govern our moods, energy, feelings of health and can be a dominating part of your life. Sounds a bit like HIV to me. Low blood sugar can spoil your life and can make you irritable and aggressive. The results are immediate. Other effects can be headaches, migraines if someone is prone to them, fatigue, anxiety and depression.

Low blood sugar is very common and the complete list of symptoms is huge. Doctors who regularly use glucose tolerance tests as a diagnostic tool have offered figures ranging from 10 to 50% of the population for the incidence of hypoglycaemia. Hypo meaning deficiency, glyc denoting sugar and aemia meaning a specified condition of the blood. Hypoglycaemia means a deficiency of glucose in the blood and is the opposite of hyperglycaemia which means there is an excess.

The fix is great for a short while when you are on a sugar high

Carbohydrates are the foods that give us energy and they come in the forms of starches and sugars. Starch is lots of sugar units all linked together in long chains, courtesy of the plants which stored them that way. When you eat carbohydrates these long chains of sugars get slowly broken down releasing bits of energy during a period of digestion which usually takes about three hours. Digestion of carbohydrates starts in the mouth with your saliva, which highlights the importance of chewing your food, so that the carbohydrates and saliva have a decent chance of meeting each other. An enzyme called amylase, found in saliva, breaks the polysaccharides (long chains with many sugars) down into disaccharides (two sugars joined together). Like plants, we have a way of storing unused sugars. We turn them into glycogen with the help of the pancreas and store them in the liver and muscles as energy reserves. The liver and muscles can store about 100g each. If the energy does not get used up straight away and there is no room in your liver or muscles for more glycogen then the leftovers get turned into fat.

Glycogen stores can last for about 12 hours and after three days of not eating you start to draw on fat reserves from the body.

This slow break down of carbohydrates is really important because it implies that there is an opposite, and there is: eating sugar. Your body does not have to do any work in breaking it down, because sugar in single units provides an instant fix. The fix is great for the short while afterwards while you are on a sugar high but after that when your blood sugar drops you might as well have suffered a triple bereavement and a relationship breakdown for the amount of pleasure it will bring you!

If you eat refined sugar you will soon find that your energy levels go up and down and that you don't feel too good a lot of the time. It is much better to eat some starchy carbohydrates instead. You find them in rice, millet, buckwheat, potatoes, quinoa, wheat and all the other grains. It is best to use the whole grain, so use brown rice instead of white rice etc. at least a few times a week. The whole grain contains fibre which is good for your intestines and the husk contains the vitamins and miner-

als that you need to properly utilise the energy from the carbohydrates.

The amount that you eat should depend upon the amount of work that you do. If you are exercising a lot or running around after young children all day then it is important to include lots of carbohydrate in every meal. If you eat more carbohydrate than your cells can use your body will thank you for the extra and store it as glycogen or fat in case you need it at some time in the future.

PHOTO: KALLO

If you find your energy levels are dropping in the day have a snack of carbohydrates, such as rice cakes. This will give your body some energy which it finds easy to use. You can buy these in health food shops and supermarkets.

When sugar, from starches or simple sugars, reaches your bloodstream it gets monitored by your pancreas, specifically a glandular area known as the Islets of Langerhans which produces insulin. High circulating blood sugar stimulates the production of insulin which increases the rate of oxidation of glucose in cells and the rate at which glycogen is deposited in the liver and in the muscles. It decreases the rate at which glycogen gets broken down, stimulates the production of fat from glucose and also reduces the rate of gluconeogenesis – a process in which protein is broken down to produce glucose. What this means is that all sugar storage methods are activated and production of sugar from other substances is slowed down.

Sugar dependency is really common nowadays. Since the industrial revolution when some bright spark decided that sugar was a great source of energy, as well as profit, we have mainly been encouraged to eat more sugar. Between 1835 and 1961 there was a six-fold increase in the consumption of sugar per head. By 1961 sugar represented 18% of the total calories consumed (40% was fat). Saturation point reached about 60kg per person each year which is 5.75 heaped tablespoons daily. Many people's jobs now depend on sugar, and the sugar manufacturers spend lot of money on advertising to convince us that tooth decay isn't really caused by sugar as well as investing heavily in trying to find a vaccine for tooth decay. Sound familiar?

All this sugar consumption puts a big demand on the pancreas by getting it to produce insulin at higher levels than it was ever designed for. The ultimate outcome of treating the pancreas in this way is diabetes, a condition in which the pancreas has become exhausted and can no longer produce insulin.

The following mineral deficiencies adversely affect the Islets of Langerhans: zinc, manganese, chromium, potassium and magnesium, all of these deficiencies are fairly common in this junk-food, McSnack world.

Low blood sugar is an emergency situation in the body. The cells in the brain can only use glucose as an energy source so when supplies run low in the blood drastic action needs to be taken. If your brain is about to conk out (coma) through lack of available energy, then adrenaline is released by the adrenal glands which increases the levels of sugar circulating in the blood. If this becomes a daily routine you will ruin not only your pancreas but your adrenals too, which will be less able to respond in real emergency situations. Your adrenal glands also get stimulated by coffee, cigarettes, drugs and stress so if you are trying to sort out your blood sugar then think seriously about giving these up. Hard as it is, you will not get very far down the path to good health and stable sugar levels if you don't.

Sugar never used to be a contentious issue for people interested in health work. Sugar was bad, end of story. Things are different now, thanks to that lone trader HIV which has turned around perceptions on sugar and just about everything else. "You need more calories. You'll be wasting away soon, you need to add calories to everything you can from every source available," is now a familiar cry from HIV dietitians up and down the land. This is a crazy situation to be in because it does not address the issue of what is causing the wasting, all it does is to make you fat right here and now which isn't easy in this body-conscious, washboard stomach era. Sugar is a bulky substance with no merit other than providing energy. It's called refined sugar, which sounds like refined petrol – everything has been taken out except the substance itself. It is just sugar. Unlike petrol it is not a good fuel, for humans anyway – there is talk of sugar-powered cars but I think we are a bit more advanced than even the most advanced engineering.

If you consume sugar in its natural state it comes with all the necessary nutrients that you need to use it effectively but sugar courtesy of Mr Tate and Mr Lyle comes with no further support. So not only does it give you no nutrients, but it inhibits the absorption of certain minerals (especially magnesium) and fills up loads of space inside you which prevents you from eating other, more nutritious foods. So far, so bad.

To sort out your blood sugar levels it is important that you look after your fundamental macromineral levels. This can be done with the help of a nutritionist and a whole food diet. Your trace mineral levels also have to be pretty good too, with zinc, manganese and chromium being of particular importance. There is a supplement made by several companies called Chromium GTF which stands for Glucose Tolerance Factor and it helps you do just that. It is worth popping into the Nutri Centre or phoning them up if you live far away (remember to use your discount voucher from this magazine) and asking about their different formulas.

Your diet must have no sugar. Absolutely none. So think carefully about that drinking chocolate powder (73.8%), chocolate biscuits (up to 38.2%), tomato ketchup (22.9%) and all the others. No sugar. This also includes limiting the amount of fruit that you eat to one piece a day, possibly two, but no more. Snack on celery or rice cakes instead. Eat small meals often, instead of aiming for three big ones throughout the day. Four or five small meals with a bit of brown rice, millet, potato or whatever is a much better idea because it will give you a steady stream of energy. Protein helps to maintain blood sugar levels too, so make sure that you are eating high quality protein – it's quality not quantity that counts so go for the easy-to-digest pulses variety wherever possible.

Sorting out your blood sugar levels can be quite hard work, but as your energy swings become less dramatic along with your moods you will notice the benefits. All chronic diseases have underlying imbalances of which blood sugar levels are one of the most common. As you begin to respect your body and provide nutrients in the amounts that nature intended you will reap the benefits on all levels.

BOO ARMSTRONG

In the palm house at Kew Garden. Ascending the intricately-patterned white wrought-iron staircase, the atmosphere was getting increasingly hot and sticky. Sex was in the air.

Safe sex seeking a ne

by Tom Wright

I'd met Meg about three months earlier. We'd both reached turning points in our lives in the previous year and, sensitive to our newfound selves, were enjoying a sweetly-chaste old-fashioned courtship. Now it felt ripe for something more.

At the top of the staircase, surveying what felt like our own garden of Eden, I stood behind her, wrapping her in my arms. I planted a kiss on the top of her shoulder and felt my cock begin to grow between us. For a moment it was all hot sticky sexiness. And then it was gone. "Let's take a walk outside now," she said. The sudden change of atmosphere began to worry me.

As we neared the herbaceous garden, came the ominous, "I've got something to tell you". Now I knew something was very wrong, but my imagination couldn't prepare me for what came next. "I'm HIV positive." I slumped to the ground. I cried, she cried, we cried together.

Until then it seemed to have the potential of a marriage made in heaven. My grander fantasies ran to ripe old age and grandchildren. My more immediate fantasies were of sex. Melting, succulent, oozing, running in and out of each other's bodies sex. At that moment it seemed that fantasises were all they could be.

I was well informed. I had a friend who was involved with ACT-UP. I knew the formula. HIV=AIDS=DEATH. There were huge amounts of money being invested in drugs to counter the virus. There had been some success in by-passing the red tape to get those drugs out to the people in need. New, better drugs were being developed all the time. There was the promise in time, just in time perhaps, of a vaccination, of a cure. There were long-term survivors, self-help groups, alternative therapies too. In the face of certain death, there was hope. There's always hope, thankfully, where humans are involved. Hope enough for me not to turn away from what at that time was one of the most positive aspects of my life.

It was hard to believe she would get ill and die. She looked so well. The initial shock subsided. We talked a lot. In time we got back to sex. I still wanted it , she wanted it. But I was terrified of catching "it", and she was terrified of passing "it" on to me. In fact, I was terrified of kissing her, of having kissed her, of having shared a bed with her, however chastely, of having shared cups and cutlery with her. It felt weird to hold her in my arms, so close to all that lethally-infectious blood pumping around only a skin's depth away. Fearful. And rightly so. I'd seen the ads, and read the papers. I was well informed.

Enter the health advisor. First she warned me of the folly of starting a relationship with someone who would die in five to ten years and of the risk I would run. But there was always hope. Then I was initiated into the "at risk" rules of safer sex. They were at one-and-the-same-time crushingly clear and full of questionable anomalies. No fucking without a condom, no sex during a period, no biting or scratching or anything that might draw blood, no oral sex either way around if there were any lesions or ulcers in the mouth, and no kissing or oral sex for 20 minutes after brushing your teeth if there were bleeding gums. More generally: beware of accidental blood spillages, mop with bleach; beware of passing on any infectious diseases to my partner; don't hold out any hope of a cure, that was years away; and, of course, don't dream of having any children.

There was more. Had I had a test? Had I done anything risky in the past? Maybe I should get tested regularly to make sure I was clear. But then that could only clear me for the time up to three months before the test, so as long as I continued having sex with Meg a negative result would never be definitive.

The effect of all this was to push my emotions in many different directions at once. I was reassured that what little we'd done till then was "absolutely safe", I felt confident to kiss and cuddle again. I was overjoyed that at least oral sex was "safe". I was gutted that I'd never know skin-to-skin penetrative sex with Meg, and envious as hell of the men who had known it with her in the past. I was sad we couldn't fuck on her period (I'd always loved that messy time of sex). I felt a void where my fantasy of a child had been.

And I was confused about the finer points of all this. There seemed to be so many grey areas and I wondered why the lines had been drawn where they were. Why was transmission possible through the soft delicate skin of the vagina and penis, but not through the mouth? Wasn't the skin lining the rectum much more delicate still? Well, the skin of the vagina can suffer microlesions during intercourse apparently. OK, but what of mouth ulcers, cracked lips and bleeding gums? Why not microlesions in the mouth too, they're full of teeth after all? Why could my mouth go where my cock couldn't? And if a large amount of virus was needed for infection then why were microlesions so important? If they were, then why couldn't mosquitoes transmit the virus? Wouldn't soft, slow thrusting be safer than hard, fast thrusting? Couldn't I just put myself there very gently to feel that skin-to-skin touch? Just once?

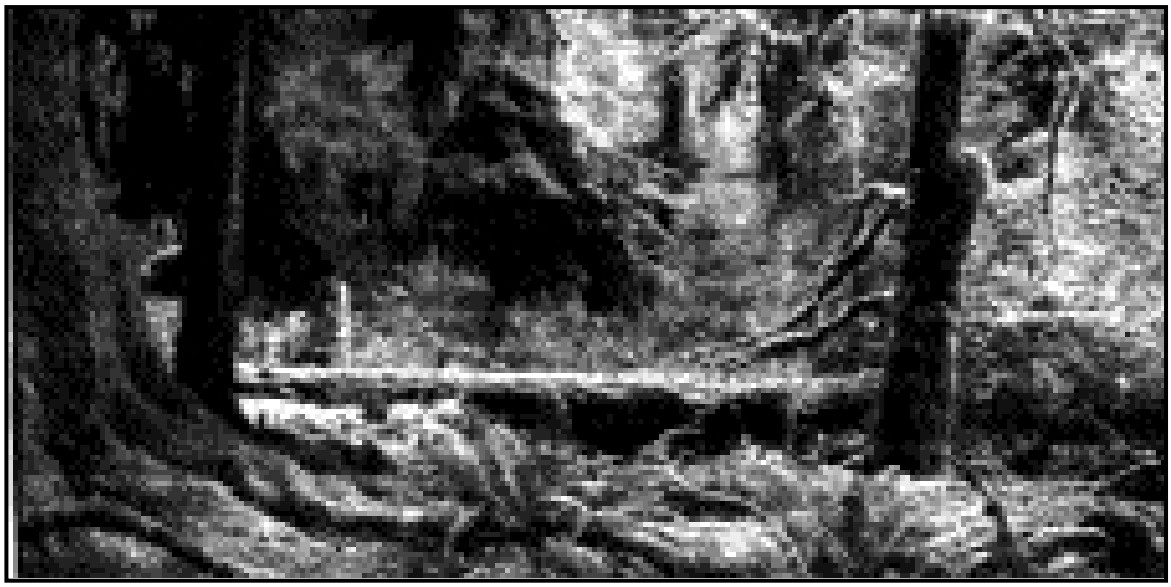
But that would have to wait. I felt lucky that I could have sex at all. Albeit with the off-putting smell of warm rubber and noxious spermicides, the feeling of missing out on something, and, always hovering in the background, fear. Big fear. Despite having weighed up the risks and found them minimal. Fear of a grizzly death.

Over the course of the following year

and a half I had cause to fear for my life on many occasions. It felt like Russian Roulette. My gums used to bleed sometimes when I brushed my teeth before bed. Bed, bedtime, feeling horny, shall I kiss now or wait five minutes, or 10 or 20? Even after 20 minutes could I really risk running my mouth over those soft, mushy nether lips, oozing body-fluids? Yes, no, yes, no, ohh yes , yes, YES! I'd bit my lip earlier in the day, should I or shouldn't I? No, yes, shit no, I can't. Or noticing a subtle new flavour, her period's started, run to wash my mouth out over and over, shit, what have I done, will I get "it" now. Or noticing blood on the condom, on me, on my skin, running to the shower holding the condom in place to wash away the blood before I can let my cock free. Moments of terror punctuating pleasure.

I tested a couple of times, always negative, but terrifying. A slow building fear that became a cold-sweaty panic just before hearing the result. And yet never relief. There'd always be some incident in

w definition



Surveying what felt like our own Garden of Eden

the previous three months not covered with certainty by the test.

While all this was going on we were delving deeper into the subject of HIV and AIDS. Cracks in the HIV=AIDS=DEATH monolith were beginning to appear, and in the cracks new hopes took root and began to grow.

Some were saying that HIV was only a cofactor for AIDS, some that HIV wasn't necessary at all and was merely a marker; there was the possibility of seroreversion with Chinese herbs and Qi Gong; negative babies born to positive mothers, and curiouser still, positive babies spontaneously seroreverting a year or two after birth; there were long term survivors who'd survived as long as AIDS had been named; one fifth of AIDS cases in US hospitals until 1984 were in people who were HIV negative, and then the way the data was collected was changed to hide this fact; the commonsense idea that antibodies are good and usually mean that an infection had been successfully fought off; doubts about transmission, HIV being said to be necessary in large quantities to cause infection, quantities not found in sperm or vaginal fluids, or presumably from the microscopic amount of blood from microlesions, and HIV being very unstable; and finally the assertion that female to male transmission was very difficult and rare, 4000 acts of intercourse to achieve infection.

I met a woman at a support group whose husband was in the last terminal stages of AIDS. He'd been a closet gay and positive for seven years before he came down with AIDS and couldn't hide it any more. She'd taken a test, sure it would be positive, but it wasn't. In the cracks hope began to grow.

Sometime in all of this Meg and I both began new careers in areas related to the body encompassing Chinese medicine, bodymind disciplines and nutrition. We got healthier, clearer, and stronger. And more questioning, more sceptical and more cynical. Voicing doubts about the validity of HIV=AIDS=DEATH out in the media-informed world became charged. If it was touched upon at a dinner party or whatever, it would inevitably monopolise the evening. Our position grew from fear to greater and greater hope. It was hard for people with no personal experience to hear what we had to say. Harder even for those with experience, who maybe had lost someone to AIDS, but had never asked questions of the orthodox view. But those open enough would usually end up conceding at least that the matter was not as cut and dried as they had thought.

But it was one matter to get people to question the common assumptions about HIV and AIDS, quite another to take it that step further into the implications of it all. In fact in all the "dissident " material I've read none has touched the last big taboo.

The first time Meg and I had sex without a condom was on a secluded beach while we were on holiday. We were both very nervous. The joy of it all soon took over. It was such a relief. It was so, well, natural. The smell of the sea, the feel of the air on our bodies and ohh those sweet body fluids mixing and mingling. Tasting those smells in the back of our thoughts. True intimacy in a loving relationship at last. After nearly two years of fear-induced separateness. Yes, yes, yes. If ever two people deserved that pleasure after all we'd suffered in the name of what I now believe was at best a flawed hypothesis, then we did.

But that is jumping ahead some. At this point we still believed that HIV could in the presence of cofactors cause AIDS. We did what we did then in the belief that the risk of transmission to me was minimal. It was still shrouded by fear. We did it softly, to avoid those microscopic lesions, and afterwards I would wash thoroughly. Sometimes we would use condoms, sometimes not. At times I doubted the wisdom of it. I took special care to eat well, took loads of supplements and didn't have condomless sex if I felt at all under the weather or stressed or overtired – conditions which might compromise my immunity. We avoided sex on her periods and remained vigilant for small cuts.

Over the next couple of years we learned more of the intricacies of the whole HIV=AIDS=DEATH industry: that the existence of the virus itself had never been established; that the formula HIV=AIDS=DEATH was never more than an unproven hypothesis, announced at a US government-sponsored press conference, by a man with a history of scientific malpractice, and never subject to the normal peer review process; that AZT was a highly toxic drug developed in the '60s to kill cancer cells but put on the shelf because it killed the test animals, and was now being given to asymptomatic HIV

positives, even babies, and probably killing them too – AIDS by prescription; that the test did not in fact detect antibodies but only groups of molecular proteins, that are nonspecific to HIV and highly cross-reactive; that the two different types of test often gave contradictory results, even that the same result could be interpreted differently by different labs, and most astonishingly that different countries set different criteria for interpreting the results; that there was virtually no money going into researching other possible causes of AIDS; that there were eminent scientists who questioned the HIV hypothesis but who were being frozen out of the "debate"; and that the whole AIDS industry was so hopelessly riddled with vested interests, financial and political, that any hope of objective truth reported objectively, let alone critically, had long since evaporated.

I grew to enjoy carefree condomless sex with Meg as over time my doubts about safety faded. The fact that she was HIV positive was no longer an issue. In fact I'd now regard this as safe sex. The only pain and suffering we endured was that caused by the myth of HIV and its associated fear and stigma.

For her it all began with a positive test result some time after a disease-ridden trip to India. She tested positive for Hep B at the same time and these antibodies are notoriously crossreactive to the HIV tests. I believe now that this was probably the source of her positivity.

I acknowledge that people die from the diseases grouped together as AIDS, but I don't believe that HIV is the cause, in fact these days I have an open mind on whether HIV itself exists – I've yet to see the proof. HIV might have been a good idea at the time, but one that should have been dropped long ago. It seems to me it has been clung onto only for reasons of political and financial expediency, and that makes me angry. Angry for many reasons: not least for the impact it had on Meg and my lives, specifically for the impact it had on our sex lives for such a long time.

Writing this I'm aware of how shocking to most the idea that I had unprotected sex with an HIV positive woman will be. But the strength of our position is that we arrived at it after 3-4 years of dedicated researching and soul searching. Certainly not lightly. Faced with a fearful unknown we sought to understand it to come to terms with it, but in asking the questions we did we found AIDS to be a very different animal to the one we were facing all those years ago. The weakness of the AIDS orthodoxy is that from the onset, the potent mixture of sex, a deadly virus and death created a moral imperative to silence debate. A dangerous state of affairs.

So am I encouraging the abandonment of condoms and a return to promiscuity? Well, no I'm not. I'm sad especially for the generation which has reached sexual maturity during the course of the "epidemic" for the climate of fear with which they've had to cope. Though judging by the rise in STDs over the last decade they haven't been so taken with safer sex as their elders would like to think – more evidence for the impotency of HIV – but the fear has still been there.

Having "HIV" in my life has forced me to question deeply what sex is and what it means and could mean to me. I've come to the conclusion that there is safe sex and unsafe sex, but that those categories are not dependent on whether a condom is used or not, and even that the idea that using a condom can make sex safe in itself a very dangerous idea.

Somewhere in this story I began to study Shiatsu massage and a dance form called Contact Improvisation. In both disciplines touch is the major ingredient and in both there is time before and after the event to relax and lie still and feel the changes in one's body. And they can be dramatic. Mostly a sense of calmness and wholeness, of having done something that has had a positive effect on body and mind. After an unskillful massage or dance the effects can be quite the opposite, though thankfully those experiences are rare. Whatever, the question arose in me, if these are the effects on on my sense of well-being of a massage or a dance, then

The only pain and suffering was caused by the myth of HIV itself

what of the effects of sex? It is after all more charged and intimate. My conclusion: there is nothing casual about sex, about any sexual encounter.

Long before "HIV" entered my life, I had cause to question the efficacy of the modern Western model of medicine. What I have learned through the whole HIV experience has only served to increase those doubts and strengthen my belief in the value of the Eastern approaches to health and medicine. There is much written elsewhere on the contrasting paradigms of Western and Eastern approaches to health. Suffice to say that while I acknowledge Western medicine has much to offer in some fields, I find the Eastern approach much more convincing in its modelling of health and disease.

Simply summed up, a person in balance is a healthy person, able to meet life's demands and ward off disease-causing agents, a person out of balance is a weakened person and liable to disease. Person in this case includes body and mind (and spirit) and is in Western terms best summed up by attitude, which unites frame of mind with posture, how one is in one's body. Balance is a function of how one leads one's life. This encompasses everything, from the environments in which we live our lives to the quality of relationships we have with other people, from the food we put into our bodies to the exercise we choose to take, from the way we spend our leisure time to the way we work.

In fact Eastern views on health are part and parcel of the art of living. And an important part of the art of living is the art of loving. I'll offer a more detailed view of this in a further issue, but for now it is sufficient to say that the ancient wisdom, as I thought, is that sex is a very powerful life experience, anything but casual in its effects.

So with this holistic view of life, of health and disease, in mind, I offer this conundrum. Which of the two situations would be more likely to leave you out of balance and open to sickness.

1. A loving, tender, sometimes slow, sometimes fast, mingling, oozing, condomless fuck with someone in good health that you know very well, at the end of a relaxed evening or in a secluded spot after a long walk in the country, who happens to have tested HIV positive shortly after a Hep B shot or having recovered from some exotic disease on a trip to some far-off place. Or something similar.

or 2. A quick adrenaline-fired condomed fuck in an alley at the back of a nightclub at three or four in the morning with someone of unknown HIV status, of dubious health that you met a couple of hours before while both of you are coming down off a combination of legal and illegal drugs. Or something similar.

(Please excuse the clichés but clichés have a funny knack of carrying more than a grain of truth in them – in fact I've experienced both variations in my life and I know which I felt safer with.)

Sadly, Meg and I split up recently. A personal tragedy for us both which the relationship couldn't sustain, no more or less dramatic than any "normal" couple's story. We're still talking. Such is life.

So I'm left wondering how I'm going to explain this all to my next lover and what their response will be. The obvious choice is to take another test. A test I don't believe in to satisfy someone I haven't even met yet, for it certainly won't satisfy me. I'd expect it to come back negative, though I'd be careful to make sure I didn't take it if I had flu or a heavy hangover, though I don't really have them anymore. And if by some chance it were to come back positive then I certainly wouldn't be worried about an early death. I certainly would, in the current climate, be worried about the prospects for my sex life though.

I do have to admit to some small lingering doubt. When I began having condomless sex with Meg I was 98% sure I wouldn't get infected by a virus I 100% believed existed but 80% believed was harmless by itself. Now I'm 99.9% sure I'm free of a virus I 15% believe exists but, if it does, 100% believe is harmless in itself.

Having admitted to my small doubt, as I believe is reasonable for any human being to have, doubt being as intrinsically human as hope, I only wish someone in the orthodoxy would admit to theirs. It might at least improve my chances for a new sex life, if not make for less heated dinner parties.

It's hard being a small fish swimming against the tide.

AUSTRALIAN PRAISE

Please accept my congratulations on the last issue of Continuum, and indeed on all the others you have edited since the departure of Jody. I have been the eager recipient of all the Continuums since the very first edition and had the pleasure of speaking to Jody on a couple of occasions. You are indeed carrying on his tradition of challenging and truthful journalism and expanding everyone's minds in the best possible way.

For your interest (and sympathy) I have enclosed an example of the awful turgid shit which passes for AIDS journalism here in Australia, the stuff which, when I read it, makes me feel like jumping on the first British Airways flight to Heathrow. Really, when will we ever get rid of this ego-driven AIDS bureaucracy, I don't know? In the meantime it is interesting to see just what they come up with next in the eternal quest to save us all from this 'killer' virus'!

As you would know by now, we lost Stuart Bennett from HEAL very recently and I fear that many from AIDS Inc. were secretly delighted. [It was Stuart's wish to record that he believed his death was iatrogenically caused. HC]

I could not let Michael Urs Baumgartner's excellent article go by unacknowledged. It is so good, punchy and accurate I find it hard to believe the maturity from such a young pen. More power to him. Thank you for publishing it. I look forward to your next edition.

Paul, Australia

HIV EXHIBITIONISM

Tony Kaye's 'AIDS-art' exhibition "Don't Be Scared", held in Jibby Beane's car-park-gallery, exemplified the modern-day mythology that 'HIV' has become. Test tubes of so-called 'HIV'-infected blood were displayed along with 'live' exhibited models branded 'HIV'.

On my first visit to the show the test tubes of blood were available for the public to 'touch'. On my second visit the test tubes of blood were suddenly exhibited under a glass fish-tank case. Islington Council threatened the show with closure if the blood samples were not caged up. The irony was, there was no 'HIV' blood in sight! Such an entity is a non-entity.

I spoke to one of the 'live' naked exhibits, named Gretchen Adams, who introduced herself by saying: "Hi, I'm an HIV Model". I told her that the model of 'HIV' was a synthetic construct of cell culture technology. She replied by stating: "That may be your opinion, but I know I'm HIV". I told her that she did not exist.

Montgomery Schaffer
London

SURPRISED, BRISTOL

Just a quick note to say that I really enjoyed the meeting on Tuesday. It was great to meet some of the 'real people' involved in this issue instead of just names in the books I've been reading.

I've had an interest in the AIDS/HIV controversy for the past couple of years since reading an article in The Guardian about Peter Duesberg's theories. During this time I feel I've gained an increasing awareness of the gross misdirection of the medical/pharmaceutical industry and in the course of my research I've come across numerous examples of fraud and corruption. As a result I thought that nothing could surprise me but reading Robert Willner's book Deadly Deception really opened my eyes and I began to glimpse the sheer enormity of this situation.

I sometimes feel 'underqualified' to have an opinion on this issue as I've neither tested 'HIV positive' myself or, until this week, knew anyone who had. But I realise that if I had experienced a 'positive' diagnosis I would be very grateful that there are people who have chosen not to accept mainstream opinions and have persevered in getting their ideas heard.

Lynne Sheppard
Bristol

WHITEWASH?

I was appalled by the racist article on AIDS in Jamaica written by Matthew Probert, (Vol. 3, No. 6). The catalogue of negative stereotypes was offensive and created an impression of Jamaica as a lawless, culture-less, unhealthy and polluted society.

When assessing the issues in other countries, the researcher should go in with an open mind and be receptive to the positive aspects of other people's way of life. Clearly, this researcher was focused on a purely white eurocentric view of the world as reflected in his damning judgements of a whole nation. If you only look for negatives, you'll only find negatives.

I am sorry that the editor did not see fit to demand a complete rewriting of the article prior to publication. Perhaps another example of white racism? Our subscription to your publication will be cancelled if it occurs again.

Shirley Mallon
HIV Co-ordinator
Birmingham City Council

The researcher's wife is Jamaican, and the editor has worked there. It is a beautiful island where most people endure profound economic oppression. The issues were of health and stress: an article about Bosnia could focus on the positive, but that would not illuminate the urgent social problems there – would it be called racist, though?
HC

LIGHT YEARS AHEAD

I don't know whether or not "HIV" does or does not cause "AIDS". It seems to me that the arguments put by both schools of thought contain flaws and contradictions.

What I do know however is that in terms of being informative, articulate, intellectually stimulating (I'm thinking of the AIDS Kitsch article here) and thought-provoking, Continuum magazine is light years ahead of any other "HIV" publication.

Here's to many more issues of challenging reading.

Alastair Paterson
London

LIVE, LIVE, LIVE!

Even though I've been ill with what the doctors thought to be TB, not once did I give into them or all of the antibiotics. Granted I took them but I knew soon I would be taken off them. I, as you see, have a guardian angel watching over me.

Meanwhile it's been a rough month and here I sit in the Royal Bournemouth Hospital where there are wonderful doctors and nurses.

But the best part of this story is I don't have TB. They don't know what I have but it's not TB or PCP. It's just a bad infection. So I'm going to be kept here until it is gone, which I hope is soon as I do want to be able to get a sun tan.

I will leave you with a quote that one nurse said to me before I went to sleep: "I smoke, I drink and I party, party, party and in November I'm going to Italy."

Well, have a sunny month!

Later:

I'm home, thank God. Hospital life isn't for me. But since I've been home, I've gone to my first acupuncture session and was told there's a lot to do but I will be better without all the tablets they want to give me.

Yes, your GP will be upset but whose body is it anyway? Friday 19th July I went back for a follow-up x-ray and the doctor was as pleased as punch. The cavity is one half in size and getting smaller, so I must be doing something right! I suppose I must say, listen to your heart and live. Don't give in to the medical profession.

See you next month (when I'll have more news).

With love,

Michael G

ENQUIREWITHIN

HOME TESTING KITS

Q. Do antibody tests give different results in different groups?
A. Smith, Manchester

A. The FDA recently approved the sale of antibody test kits for home use to pick up people at risk for AIDS who refuse to get tested in a clinic but would do so at home. Thousands, perhaps millions, not at risk are inevitably going to use the kit too.

People not at risk have something to worry about: Baye's Law – a principle of statistical analysis that states: When you use a test in a population with a very low incidence of the disease you are testing for, you will get huge numbers of false-positives on ANY test for ANY disease.

Every scientist researching HIV testing knows this including the American Medical Association, which on June 27th approved a recommendation for mandatory testing of all pregnant women. In low-risk populations, Xin M. Tu of Harvard School of Public Health estimated that 90% of positive tests are false.

Baye's Law depends on what degree of infection actually exists in the population being tested. The lower the level of infection, the higher the false-positive rate even if the specificity of the test remains constant. (The specificity of a test indicates how often uninfected people will test positive – a false-positive). A test with eg. 99.9% specificity will perform worse as the prevalence of infection in the tested population gets lower.

The 1993 estimated prevalence of HIV infection in the general population is about 1 in 17,000, from a recent CDC publication indicating an infection rate of .006 percent among 1993 blood donors. So, out of 100,000 people, there would be six who were infected. The remainder – 99,994 – are not infected and should test negative.

The home HIV test (called "Confide") claims a specificity of 99.95%, correctly identifying uninfected people 99.95% of the time. The rest of the time (0.05%) it will test false-positive. Out of every 100,000 tests performed on those not at risk, 50 people (99,994 x 0.0005) would test false-positive for every six who were actually infected! And if the specificity of the test slips even slightly, only down to 99.90 percent there would be 100 false-positives for every six true-positives.

Isn't the whole testing process perfectly accurate when you add the Western blot to the algorithm? In fact, what matters in this mathematical analysis is not whether you "confirm" a test with the Western blot, but what the specificity of the full testing sequence is (think of it as the combined specificity of two ELISAs plus a Western blot). The CDC has estimated the specificity of the testing sequence as 99 to 99.8%. Giving them the benefit of the doubt between the two numbers, what will happen in a 0.006% prevalence population if tested with three sequential tests yielding a combined specificity of 99.8%? THERE WILL BE 200 FALSE-POSITIVES FOR EVERY SIX TRUE-POSITIVES.

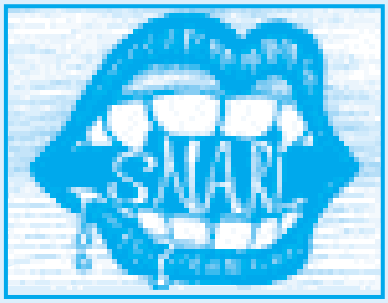
The idea that it is possible to perform widespread testing in low-prevalence populations and obtain any degree of accuracy is currently based mostly on a study performed by Donald Burke for the US military in 1988. Burke himself testified before a House of Representatives subcommittee that many public laboratories performed too inaccurately to be considered for the military contract to analyse blood samples. He used a multi-step testing sequence and obtained a specificity of 99.999 percent. Without getting into weightier issues such as whether any HIV antibody test has ever been properly authenticated by a proper virus isolation gold standard, let us for now accept Burke's findings at face value.

Burke's testing sequence would still produce one false-positive for every six true-positives in the general population ie. a 14 percent chance of getting a false-positive.

ANY testing scheme, whether mandatory or voluntary, that involves large numbers of people from low-prevalence populations is a disaster in the making.

Christine Johnson is an alternative AIDS activist and lay researcher with HEAL, LA. This answer is edited from a larger response prepared for Zenger's, California ©1996.

HOSPITALS CAN BE BAD FOR YOUR HEALTH



by ***MAVIS CRUET***
a (Welsh) Fairy

Worrying reports, both anecdotal and in the tabloids in recent years indicate that far from being the safe, hygienic environments we all assume them to be, most hospitals are in fact places where you are more likely to contract a serious illness. Notwithstanding the infamous "flesh-eating bug" scare, several nasty infections are endemic in most hospitals in the UK.

According to the *Handbook on Nursing Practice*:

"opportunistic organisms such as *Pseudomonas aeruginosa* and other gram-negative bacilli rarely cause infection in environments other than those found in a hospital. These particular organisms are often resistant to many antibiotics and are able to flourish under conditions in which most pathogenic organisms cannot multiply. Patients who are particularly susceptible, as a result of receiving immunosuppressive drugs or because of certain diseases, are affected by a number of normally non-pathogenic fungi and viruses which cause severe and sometimes fatal infections. A number of factors adversely affecting patients' general resistance include diseases such as uncontrolled diabetes, leukemia, trauma such as severe burns, and poor nutrition...the unavoidable (*sic*) use of immunosuppressive drugs and steroids...places a significant number of patients at risk."

In many parts of the world – not least within our cash-strapped National Health Service – the epidemic methicillin-resistant *Staphylococcus aureus* (MRSA) is causing severe problems:

"This microbe is characterised by the ease with which it spreads – mainly via hands and even by airborne skin particles. Outbreaks of MRSA have not always been associated with significant clinical infection (*sic*) but immunocompromised, debilitated patients...are at particular risk from infection and deaths do occur." (*Phillips, 1991*)

Results from the 1980 prevalence survey showed that 9.2% of patients studied were suffering from hospital acquired infections. Of those persons so infected, 20% had chest infections caught in hospital, and 30% suffered urinary tract infections which they would otherwise not have experienced, largely as a side-effect of catheterisation leading to *Septicaemia*:

"It is estimated that two in every hundred patients catheterised in the UK die as a result of hospital acquired urinary tract infections." (*Meers and Stronge, 1980*)

Many Health Authorities woke up to the chilling facts surrounding hospital-acquired infection in the early 1980s by appointing teams of Infection Control Nurses and Communicable Diseases Consultants, but deaths are still occurring:

– The recent outbreaks of drug-resistant TB in London hospitals was the cause of illness and death of at least one person diagnosed HIV+. [*see HospitalWatch*]

– In regional Health Authorities such as Gwent, where a project aimed at *"the reduction in the incidence of MRSA and improved communication of patients requiring barrier nursing"* was instigated in 1992, there are still reports of individuals who have been admitted to hospital by their kindly GP with a minor complaint ("AIDS-related", of course), whose condition has deteriorated beyond control, and have died.

One wonders how many so-called "AIDS-related" deaths could have been prevented by resisting the urges of medical personnel to put one's health at risk by going into hospital?

Personal Contacts

GAY SOUL, 50, Perceiving togetherness, connecting the mind, experience, strength and hope, sharing knowledge, journey of ecstasy, happiness and serenity. No angel but grateful HIV+. Box 1001.

37 FIT BLOND (M), Seeks masculine guy to share nice lifestyle in country. Lots of love and support for right guy. Let's prove them wrong together. Write now. Box 1002.

YOU could meet someone by placing an advert here for as little as £10.
Go on, why not give it a go?

REPLYING TO A PERSONAL AD

1. Place your reply in a plain envelope with the box number clearly marked in the top right hand corner.
2. Place this, together with a loose first-class stamp for each reply, into a larger envelope and post to:

Continuum Classifieds,
172 Foundling Court, Brunswick Centre, London, WC1N 1QE.

Therapists, etc.

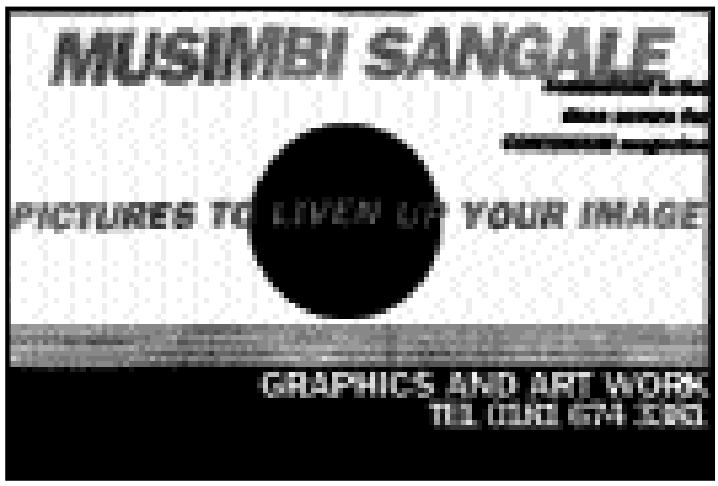
EXCELLENT MASSEUR
(MTI, IPTI registered)
gives deep tissue massage
Comfortable, safe environment
Refreshments & shower available
Ring Tom on 0171 262 0237

The Ingleby Trust

providing respite/holiday accommodation for 52 weeks/year, for persons who are affected by a "life-threatening illness (specialists in HIV/AIDS)"

For details contact Linda
Tel/fax: 01492 876756 or write to:
P.O.Box 8, Llandudno, N.Wales, LL30 2ZL

HOLISTIC THERAPIES
If this is what you do, why not let our readers know?
Reach more clients with this space



WHALE BOOKS

AIDS: The Good News is HIV Doesn't cause it. The Bad News Is "Recreational Drugs" and Medical Treatments Like AZT Do. (£14.95) - Peter Duesberg &
John Yiamouyiannis Ph.D

AIDS: The Failure of Contemporary Science (£17.99)
- Neville Hodgkinson

Vitamin C, Nature's Miraculous Healing Missile (£17.95)
- A. Kalokerinos, MD.

Queer Blood: The Secret AIDS Genoide Plot (£10.95)
- Alan Cantwell, MD.

The Medical Mafia (£11.95) - Guylaine Lanctot, MD.

The Cure For All Diseases (£16.95) - Hulda Clark

Oxygen Therapy (£11.95) - Ed McCabe

REAPPRAISING AIDS

is a monthly publication available by subscription from:

7514 Girard Ave., #1-331,
La Jolla, CA 92037, USA

Tel: (810) 772-9926,Fax: (619) 272-1621

email: philpott@wwnet.com

$25 p.a. USA, $35 p.a. elsewhere

If you would like your organisation or publication mentioned here, please contact Tony on 0171 713 7071 to discuss your requirements

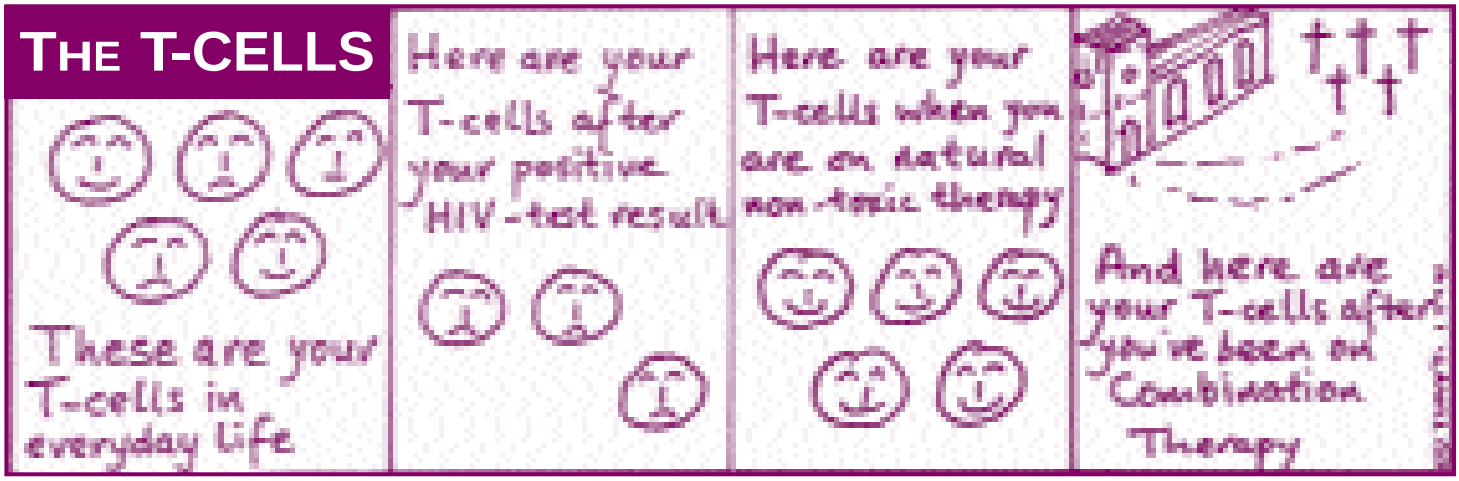
Advertising rates:

BOX: £10 per column centimetre (min £20)
LINEAGE: 75p per word (min £10)
PERSONAL ADS: Up to 25 words - £10
(additional words 40p each)

DISCOUNTS: **3 consecutive insertions – 5%**
6 consecutive insertions – 10%

All adverts must be prepaid with order. Cheques & Postal orders accepted payable to Continuum.

All enquiries to Tony on **0171 713 7071**



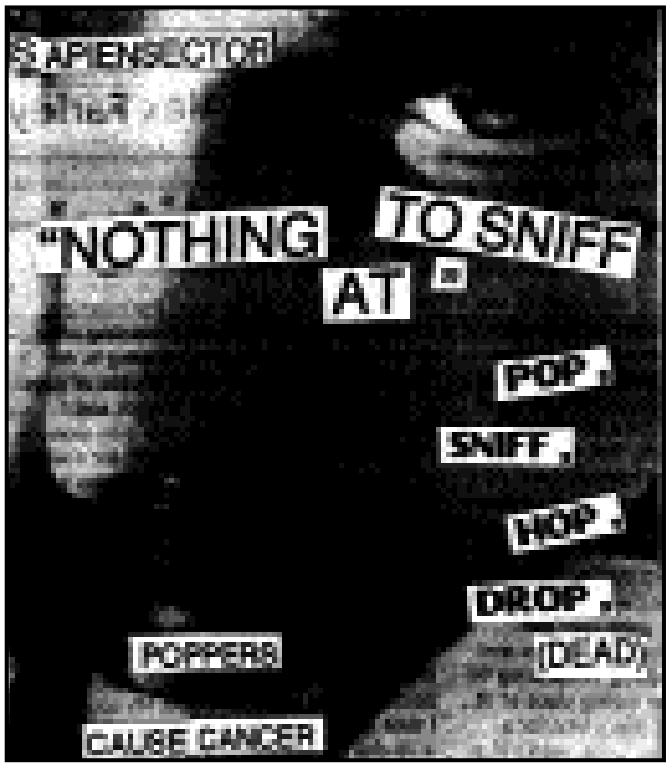
Lust for Life

Patrick is an artist and student living in London. He tells how he came to disregard his diagnosis and get on with life.

About twenty-five years ago my tiny face popped into the grey daylight of a small Northern town. My mum and dad were delighted, my older sister less so. She demonstrated this one summer afternoon by slamming her young brother's penis in the door. Our relationship has never been the same since, and all through Catholic high school I was unsure who to trust less on the subject of what to do with my private parts – the nuns or my sister.

My intense hatred of school meant that with no qualifications to speak of the prospects on the career front looked limited. I went to work as a cook in a local hospital, which I enjoyed at the time. The novelty of getting up at five o'clock to prepare porridge for eight hundred soon began to look less than exciting though; I began to have serious doubts whether a lifetime of preparing NHS food was something to get worked up about. One evening after preparing diabetic bananas and custard I decided to get myself over to Manchester for a night out. It was on one such night that I met my first boyfriend, David; it was only a matter of time before I was waiting on the platform for the train to Manchester, with a toothbrush and some essential items in a bag; this small town boy was getting out. Looking back, I was probably about as green as they come. In Manchester I moved in with David, and somehow ended up working in another hospital. Life carried on.

It was Christmas 1990, and we were sitting tucked up in bed with a box of Kleenex and some nibbles watching The Six Wives of Henry the Eighth on tv. Earlier that day David's cold had got so bad that I had insisted he go to the doctor's; not being exactly intimate with the inside of a doctor's surgery, I had had to drag him down



the drive to get him on the bus. By this time David was gasping for breath; the doctor decided that an x-ray was necessary, and somehow we managed to walk to the hospital with David gasping for breath every step of the way. We got a taxi home, and settled down later to watch the film. The doorbell rang. It was the doctor. "I think you've got AIDS. You should go to the hospital." This wasn't quite the script I'd had in mind when I left home for Manchester. Love Story was turning into Nightmare on Elm Street, and I wanted to wake up. As for treatment, we were both delighted by the prospect of him living longer, and so I was as encouraging as possible about him taking AZT. Nobody ever bothered to mention that the chronic anaemia might just have something to do with taking a toxic chemotherapy drug.

David died one year later, after being visited by the usual menagerie of AIDS-related bacteria, viruses and fungi. It hardly seems possible that AZT did anything other than speed up the process. I decided to put my mind at rest with an HIV test. It was negative. Whether God was getting me back for not listening to the nuns at Catholic School I don't know, but by a monstrous coincidence my best friend was killed in a car crash not long after David's funeral. Life seemed shit. But at least I was negative.

About a year later I met someone else. I moved again, this time to London, to be with him. If I looked a bit green in Manchester, in London I was positively cabbage-coloured. It wasn't long before my boyfriend gave me NSU as a token of his affection, so off I went to the clinic. They looked me up and down and suggested I get tested for 'everything'. The NSU cleared up, but I went back anyway to get my results. "I'm afraid," said the doctor," that you're HIV positive." I stood up. Sat down. "You must be mistaken." There was no mistake. Fate can be very strange; on the same day that I received my result I visited a homoeopath with my boyfriend. He noticed that I was upset, and I told him about the test. "Don't panic", he said, "It's nothing to worry about. You should go and see a friend of mine, Jody Wells." Another loony on a mission, I thought, but nevertheless went a few days later. Jody was kind and concerned, and sat talking to me for hours about AIDS.

It took a while to sink in, and I did lots of research and reading of my own. I became disaffected with the medical profession, except in as much as they were useful for getting me subsidised to the tune of Sickness Benefit, Disability Living Allowance, and an all-zone Travelcard (what a shame you can't use it on the night bus at five in the morning).

I'm still in London, having shacked up now with this dodgy geezer from Essex. I do the odd bit of poster art to get my message across. Act stupid and take the benefits, act smart and don't take the drugs. Don't be a gay lifestyle victim. AIDS is just another consumer category – don't buy it. I'm very well, thank you.

Could your *Lust For Life* be an inspiration to others? Phone 0171 713 7071