

Henry H. Bauer.
The Origin, Persistence and Failings of HIV/AIDS Theory

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This is an important book. In 250 fact-filled, closely reasoned pages of text, Henry Bauer, professor emeritus of chemistry and science studies, and dean emeritus of Arts and Sciences at Virginia Tech, systematically demolishes the theory—more correctly the hypothesis or conjecture—that human immunodeficiency virus (HIV) *causes* acquired immune deficiency syndrome (AIDS). According to conventional wisdom, that disease, which first presented in the early 1980s among the gay communities of San Francisco, New York and a few other large US cities, has, via bisexual switch-hitting, exchanges of dirty needles among intravenous drug users, and transfusions of HIV-polluted blood, become a full-blown epidemic endangering everyone, be they gay, straight, or somewhere in between. HIV/AIDS now is a global public-health crisis of alarming dimensions, ravaging Sub-Saharan Africa and threatening to decimate much of the developing world, or so the usual story goes.

Skillfully collating, summarizing and analyzing an extensive literature, including hundreds of scientific studies, published and unpublished, reports produced by government agencies and non-government organizations, and statements issued by public-health experts, Bauer methodically undermines every argument and stylized fact ostensibly linking AIDS to HIV. The epidemiological data presented in the more than 60 tables and figures scattered throughout *The Origin, Persistence and Failings of HIV/AIDS Theory* powerfully support the author's rejection of mainstream thinking. Among the many provocative conclusions Bauer draws are that HIV/AIDS has never reached epidemic proportions in the United States (or if there was an "epidemic", it peaked in 1993); HIV is not an infection and is not transmitted from person to person sexually, by the sharing of infected needles, or by contact with contaminated bodily fluids; everyone is not at risk, even if they fail to practice "safe sex" (pp. 44–47, 197–199); HIV has never been isolated in human tissues, and so what it is that HIV tests detect remains a mystery (p. 94); antiretroviral drugs may actually elevate mortality rates among non-symptomatic HIV-positive patients (p. 130); and, perhaps what is most important, "no proof that HIV causes AIDS has ever been published" (p. 104).

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Careful sifting of the existing body of research allows Bauer to propose alternative hypotheses about the origins and subsequent trajectories of HIV and AIDS. It is incontrovertible that “AIDS first infected gay men; about 90 percent of AIDS victims were male throughout the 1980s” (p. 13). Its signature diseases were Kaposi’s sarcoma, a virulent type of pneumonia (*Pneumocystis carinii* pneumonia, or PCP), and several varieties of fungal infection (p. 12). But significant confounding factors apparently were overlooked.

Noting that at the beginning only a small minority of male homosexuals actually presented the signature diseases, Bauer suggests that the evidence supplies “good grounds for thinking that most or nearly all of the gay men first identified as AIDS victims were drug users” (p. 119). And the drugs they used were not necessarily taken intravenously; “an extraordinary variety of ‘recreational drugs,’” such as amphetamines and “poppers” (Nitrite inhalants), were consumed by partakers in the “fast-lane,” sexually promiscuous gay lifestyle, who were disproportionately represented among the original AIDS patients (p. 19). Moreover, many of the early victims of AIDS were not “otherwise healthy,” as the doctors treating them often assumed. Eighty-six percent of the gay men comprising the first 50 AIDS cases in the United States previously had contracted gonorrhea; the patients’ medical histories also showed prior diagnoses of syphilis (68%), mononucleosis (14%), hepatitis B (14%), non-B hepatitis (48%), or parasitic diarrhea (32%). Significant numbers of them (44%) had taken drugs prescribed for enteric parasites; another 10% had been treated with systemic steroids (p. 188). Repeatedly vulnerable to sexually transmitted diseases and other serious infections, large numbers of fast-lane gay men also took antibiotics indiscriminately (p. 120).

Bauer concludes that AIDS was most likely to strike gay men initially, not because they were gay and not because AIDS is sexually transmitted, but rather because, among the fast-lane minority, immune systems had been compromised by a lethal combination of drug use, sexual promiscuity, and repeated bouts of infectious disease. Indeed, adopting the hypotheses that (1) HIV has a hereditary component (p. 54) and (2) testing HIV-positive “in some way reflects a general, *non-specific* challenge to health” (p. 80; emphasis in original), helps explain other regularities in the epidemiological data that are inconsistent with the mainstream HIV/AIDS “theory.” The likelihood of testing HIV-positive varies predictably by sex, age, race and geographic location. What Bauer calls F(HIV), the frequency of HIV-positive tests in any given sample, is higher among men than women, peaks in middle age, is higher among African-Americans than whites or Hispanics, and is highest in the Atlantic and Southeast regions of the United States.

Such regularities “make clear that the presumption of sexual transmission [is] mistaken” (p. 80); “HIV is not a venereal disease” (p. 24). The observed geographical concentration of, and racial differences in, F(HIV) provide an alternative explanation for why black Americans of African heritage are more likely to test HIV-positive than whites. (Accepting the HIV orthodoxy also requires accepting the racist view that blacks are more sexually promiscuous than whites.) African-Americans simply may be uniquely susceptible to HIV, as they are, for example, to sickle-cell anemia. The hypothesis that testing “HIV-positive indicates nothing more than a non-specific reaction by the immune system” (p. 90) helps explain why F(HIV) tends to be higher among hemophiliacs, tuberculosis and pneumonia patients, drug users, prisoners, people admitted to hospitals, and people living in big cities. It also helps explain why HIV/AIDS never swept the gay community (p. 87) and why, among truly “otherwise healthy” people, such as newborn infants and blood donors, spontaneous reversion from HIV-positive to HIV-negative frequently is observed. The fact that in every year since 1986, public-health authorities estimate that one million Americans are HIV-positive is yet another indication that F(HIV) is background noise, “a marker of prior infection” with unknown provenance (p. 27).

The higher frequency of HIV-positives among males is still a puzzle. Why the male-female AIDS ratio has fallen continuously since 1984 is not. After Margaret Heckler, President Reagan's first Secretary of Health and Human Services, announced the discovery of the AIDS virus by Robert Gallo of the National Cancer Institute at a press conference on April 23rd of that year (p. 196), and HIV officially was accepted as the cause of AIDS, the statistics of HIV/AIDS changed dramatically—and not for the better. Beforehand, AIDS was diagnosed when patients presented the signature diseases. From then on, any person testing HIV-positive was classified as “living with AIDS,” even if non-symptomatic or suffering from a non-AIDS-defining disease. Prior to 1984, a woman diagnosed with cervical cancer had, well, cervical cancer. After 1984, a woman with cervical cancer who tested HIV-positive was classified as having AIDS. And so, “the male-to-female ratio for AIDS has decreased steadily because other diseases than the originally AIDS-defining ones are now included” (p. 21). The same is true for tuberculosis, pneumonia, and other sicknesses: “People who are ill with a number of perfectly common ailments but who test HIV-positive are now counted as AIDS patients” (p. 20). As a result of this new definition, the number of AIDS cases in the United States has continued to rise while the number of people testing-HIV positive has remained constant and, with a growing population, $F(\text{HIV})$ has declined.

The epidemiology of AIDS in Africa is different. Its signature diseases there are “not the same as the characteristic AIDS diseases in Europe and North America.” As a matter of fact, because diagnosing AIDS in Africa does not require a positive HIV test, “deaths from causes that have beset Africans for a long time” may simply have been reclassified as AIDS-related. Nevertheless, mortality rates from all causes have not risen sharply in Africa (p. 134). Fear-mongering about an AIDS “epidemic” in Africa plausibly reflects naked self-interest: “the world has been generous with help against AIDS while not generous with help against ordinary poverty and malnutrition” (p. 136). Bono, call your office.

In addition to exploding the myths of mainstream HIV/AIDS thinking, in Part II of *The Origin, Persistence and Failings of HIV/AIDS Theory* Bauer asks why, in the face of evidence to the contrary, the scientific establishment continues to assert that HIV causes AIDS. Here, he draws analogies to other areas of medicine, such as gastroenterology and cardiology, where theories lacking solid empirical support held sway for decades. Ulcers are caused by a bacterium, not stress (pp. 144–146); there is no evidence that high cholesterol causes arteriosclerosis or heart attacks; statin drugs may be beneficial not because they reduce cholesterol counts, but because they have anti-inflammatory effects (p. 149). In another of Part II's chapters (12) and most of Part III, Bauer summarizes popular views about how science progresses and contrasts them with harsh reality. His analysis of the persistence of HIV/AIDS orthodoxy has much in common with Lee Smolin's (2006) account of how advances in scientific understanding of the quantum world have been hobbled by string theory, which, like the game-theoretic models of economics, is plagued by too many equilibriums.

The readers of this journal will find Bauer's discussion of the reasons underlying the hegemony of HIV/AIDS theory especially congenial. He credits a constellation of special interests, including those of gay activists, drug companies, advisory panels of the federal Food and Drug Administration, academic researchers and the governmental and non-governmental agencies that sponsor them, with erecting and maintaining a HIV/AIDS “knowledge monopoly.” By quashing dissent and promoting the search for a “magic bullet,” the monopolists have blocked inquiry into the potential efficacies of existing drugs and alternative therapies. Under the Ryan White Care Act, \$20 billion was spent between 1991 and 2006, mostly on non-research-related aspects of HIV/AIDS (p. 213). In 2006, the National Institutes of Health spent \$2.9 billion on AIDS, more than was spent on any other disease, including cardiovascular diseases and diabetes. AIDS ranked in second place in spending

per patient (\$3,084) and spending per death (\$162,790) in 2006, exceeded only by West Nile virus (2004 figures) at \$19,292 per diagnosed patient and \$339,622 per death (p. 214). More than 20 years on, we still do not know what causes AIDS or what being HIV-positive means.

Bauer ends by calling for antitrust action against these knowledge monopolists and research cartels. Public choice scholars have learned, however, that antitrust law enforcement also is shaped by special interests (e.g., Shughart 1990; McChesney and Shughart 1995). If government cannot be trusted with science policy, as Bauer charges, it cannot be trusted with competition policy, either. That caveat aside, *The Origin, Persistence and Failings of HIV/AIDS Theory* is a masterful attack on scientific orthodoxy. It is eye-opening and worthy of the attention of a broader audience than, I fear, it will reach.

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