# TRUTH STRANGER THAN FICTION: HIV IS *NOT* THE CAUSE OF AIDS[1]

Henry H. Bauer

Accumulated results of HIV tests in the United States show that the tests are not tracking an infection, let alone a sexually transmitted infection. Comparisons with AIDS data show that HIV and AIDS are not correlated over time, or geographically, or in how they affect men and women, or in how they affect members of different racial groups. HIV is not the cause of AIDS.

How could medical science have got it so wrong? To historians of science and medicine, there is nothing remarkable about that. Science has progressed for several centuries via smaller and bigger "scientific revolutions": overturning and proving wrong what the professional consensus had believed right up to the time of the revolution.

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My main intellectual interest for thirty years or more has been to understand how science works and what role unorthodox claims play. So I've read a lot of contrarian stuff. A couple of years ago I read a statement about HIV that just couldn't be true. That led me eventually to look at all available data from HIV tests in the USA. That brought me to realize that just about everything that you read and hear about HIV and about AIDS is at odds with the scientific literature.

I know that sounds incredible. I spent many months digging into that literature, and I couldn't quite believe it myself. I also couldn't believe that no one else had noticed what's so obvious when you put all the data together. I can only conclude that no one else had ever collated the results of HIV tests and looked for trends and correlations.

I don't have time to go over all those data here. I've published a book that cites all the official sources of the data, and I've posted 3 articles on-line that contain much of that information. I've put together a little "further reading" handout for those of you who want to do that. Today I'm going to concentrate on the two most essential points:

1. The accumulated results of HIV tests can answer *with certainty* the question, "Does HIV cause AIDS"?
   The answer is, "No, HIV does not cause AIDS".
2. That seems incredible. How could everyone have been so wrong for so long?
   The answer has two parts:
   a. *Everyone* hasn't been wrong; but the dissenting voices have been so ignored and so maligned that most people haven't paid attention to them even if they have heard of them.
   b. Science, of course including medical science, often--in fact *usually*--goes wrong before it goes right; and the mainstream always resists change, even in the face of what most disinterested outside observers would regard as disproof of the accepted theory.

Well: AIDS came to attention in the early 1980s when little clusters of people were coming down with Kaposi's sarcoma (KS), whose purple blotches on the skin became iconic of AIDS, and with *Pneumocystis carinii* pneumonia (PCP), thrush, and other opportunistic infections: things that are very common, most of us carry them around, but normally functioning immune systems and normally healthy intestinal flora keep them in check.

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[1] Seminar, Edward Via Virginia School of Osteopathic Medicine, 12 September 2007

AIDS diseases reported by CDC
(percentages)

| | 1982 | 1983 | 1984 | 1985 | 1986 |
|---|---|---|---|---|---|
| PCP | 59 | 58 | 61 | 63 | 64 |
| Other OIs | 10 | 16 | 17 | 18 | 22 |
| KS | 39 | 33 | 28 | 25 | 14 |

(Some totals > 100% because of multiple infections)

Those outbreaks of AIDS were chiefly in New York City, Los Angeles, and San Francisco. Over the next few years, AIDS was found in other places as well, but it remained primarily a big-city phenomenon--more than 70% of cases were in large metropolitan areas.

Geographic distribution of AIDS cases reported by CDC
(% of all reported cases)

| | 1982 | 1983 | 1984 | 1985 | through 1986 |
|---|---|---|---|---|---|
| New York | 48 | 42 | 36 | 32 | 29 |
| Newark | | 3 | 3 | 2 | 3 |
| | | | | | |
| SF | 10 | 12 | 12 | 11 | 10 |
| LA | 6 | 8 | 8 | 8 | 8 |
| | | | | | |
| Miami | 5 | 4 | 4 | 3 | 3 |
| Houston | | | | | 3 |
| Washington | | | | | 3 |
| | | | | | |
| | | | | | |
| In large cities | | | | | ≥70 |

About one third of AIDS cases were from New York and nearly 20% from California. In terms of rates, numbers divided by population, again New York was highest, next highest was California, and the next highest were less than half of that, the South-East States and Puerto Rico.

Now: the distribution of HIV is quite different. The rates in the South-East are higher than in California, and the rate in Puerto Rico is greater than that in the New York area; it is exceeded only by that in Washington (DC).

Geographic distribution of AIDS and HIV rates, 1982-86

| Region | relative AIDS rates | relative HIV rates |
|---|---|---|
| NY | 1.4 | 1.1 |
| CA | 0.6 | 0.6 |
| FL/GA/SC/AL | 0.25 | 0.8 |
| PR | 0.25 | 1.3 |

Comprehensive data about the geographic distribution of HIV-positive rates have been published for new mothers, army applicants, members of the Job Corps, blood donors, and tests performed at all public testing sites. In virtually every case, the prevalence of HIV is higher in the South-East than in California. That's so even for the groups who are at highest risk for AIDS, namely, drug abusers and gay men who attend clinics for sexually transmitted diseases.

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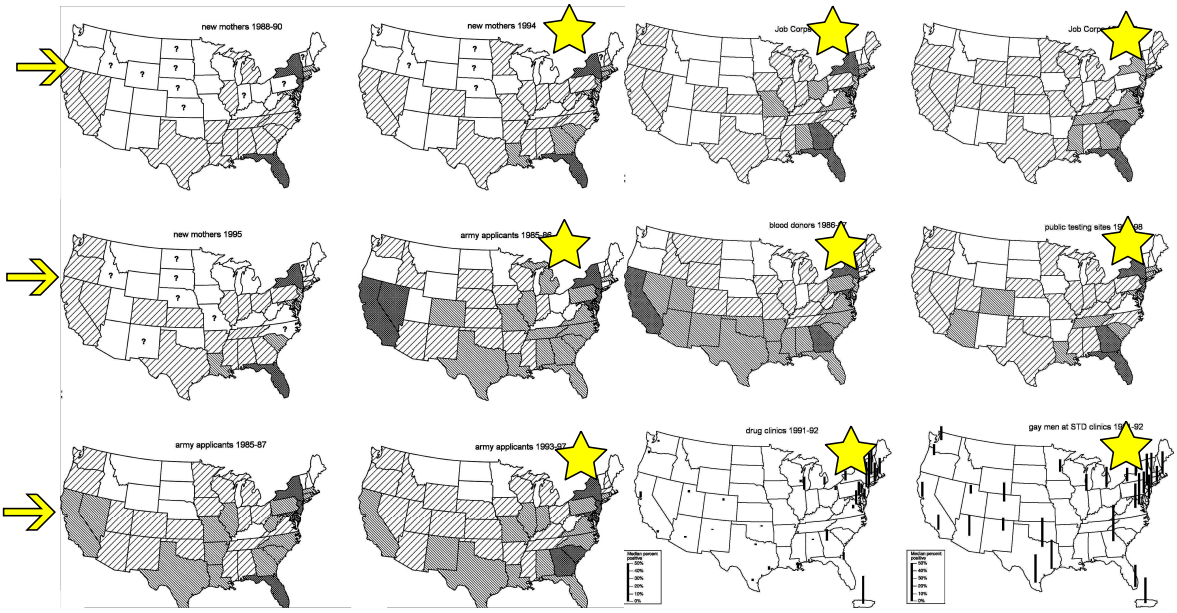


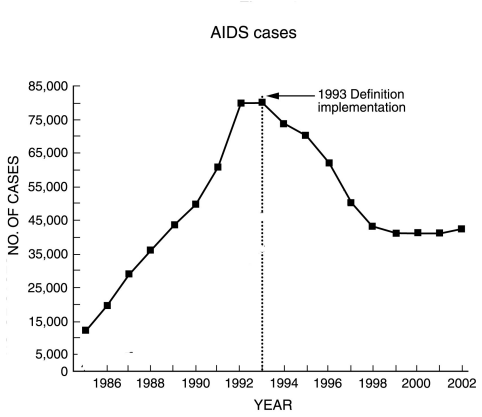

Furthermore, AIDS is supposed to have spread from NY, LA, and SF into the rest of the country. But HIV tests do not show an outward radiation from those cities. Rather, the geographic distribution of HIV infections shows no significant change during the more than a dozen years covered by the maps I've just shown; infectious agents that cause epidemics don't stay distributed in the same way in a variety of social groups for so many years.

***So: HIV and AIDS are not correlated geographically.***

What's more, not only has the distribution of HIV remained the same ever since testing started, so has the total number of HIV-positive Americans:

| Estimated number of infected Americans (millions) | Year | Published by |
|---|---|---|
| > 1 | 2005 | CDC |
| > 1 | 2003 | CDC, JAMA |
| > 1 | 1993 | Science |
| ~ 1 | 1989 | CDC |
| 1.5--2 | 1988 | NIAID & CA Health Dept. |
| 0.95--1.41 | 1987 | CDC |
| 1--1.5 | 1986 | CDC |

On the other hand and in stark contrast, the numbers for AIDS increased into the early 1990s and then decreased:



***So: HIV and AIDS are not correlated chronologically either***.

In my book, I describe several other ways in which HIV and AIDS are not correlated: their relative impact on men and on women, and their relative impact on black and on white Americans.

So: since HIV and AIDS are not correlated, one can't be the cause of the other.

This conclusion follows directly from the data given in official reports and peer-reviewed journals. But, you will naturally ask--or *should* ask: did I choose or select just those data that prove my point, and ignore other data? No. Here are the numbers of tests for which I gathered results:

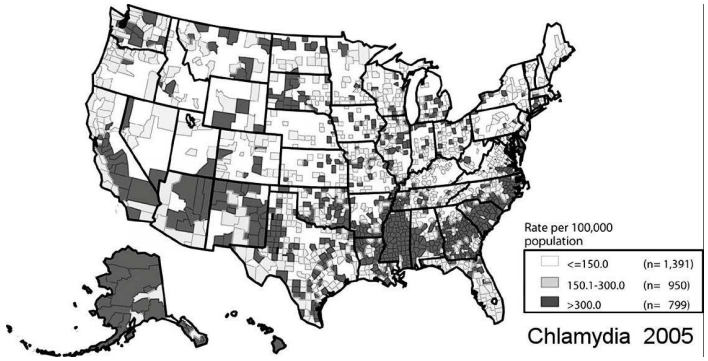
Data are from every published report on HIV/AIDS by CDC and the Army,
every relevant *Morbidity and Mortality Weekly Report*,
and several hundred articles in peer-reviewed journals

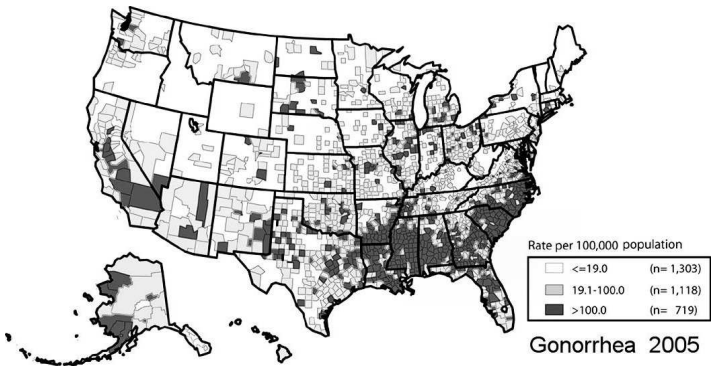
| *DESCRIPTION OF GROUP* | *DATES OF STUDY* | *NUMBERS OF TESTS* |
|---|---|---|
| | *LOW-RISK* | |
| *MILITARY* | | |
| Active-duty | 1985--2004 | 6,500,000 |
| Military applicants | 1985--2004 | 6,900,000 |
| ---teenage | 1985--89 | 1,100,000 |
| National Guard | 1985--2004 | 2,600,000 |
| Army Reserve | 1985--2004 | 1,600,000 |
| Navy & Marine Corps | 1986--88 | 1,100,000 |
| | | |
| *BLOOD DONORS* | 1985--2002 | ~11,000,000 |
| (first-time) | 1993--2001 | ~10,000.000 |
| | | |
| *JOB CORPS* | 1987--97 | ~500,000 |
| New mothers | 1994--95 | 4,600,000 |
| Family planning clinics | 1995--98 | 1,220,000 |
| Prenatal clinics | 1995--98 | 740,000 |
| Marriage-licensees | 1985--88 | >100,000 |
| University students | 1988--89 | 17,000 |
| | *INDETERMINATE RISK* | |
| Publicly funded sites | 1989--98 | 22,000,000 |
| ---including STD clinics | 1995--98 | 2,560,000 |
| --- ---Drug clinics | 1995--98 | 470,000 |
| --- ---Prisons | 1995--98 | 427,000 |
| --- ---TB clinics | 1995--98 | 89,000 |
| Teenagers at clinics | 1990--97 | 104,000 |
| STD clinic patients | 1991--96 | 180,000 |
| | *HIGH RISK* | |
| HIV counseling sites | 1995--98 | 2,590,000 |
| Young MSM | 1994--98 | 3,500 |
| MSM | 1998--2000 | 2,900 |
| MSM at STD clinics | 1993--97 | 200,000 |
| IDU in treatment | 1993--97 | 37,000 |

That's upwards of 60 million tests, and it represents anywhere between ¼ and ½ of the US population between teens and middle age. There cannot exist data sets lying undiscovered that could change the conclusions drawn from this array of evidence.

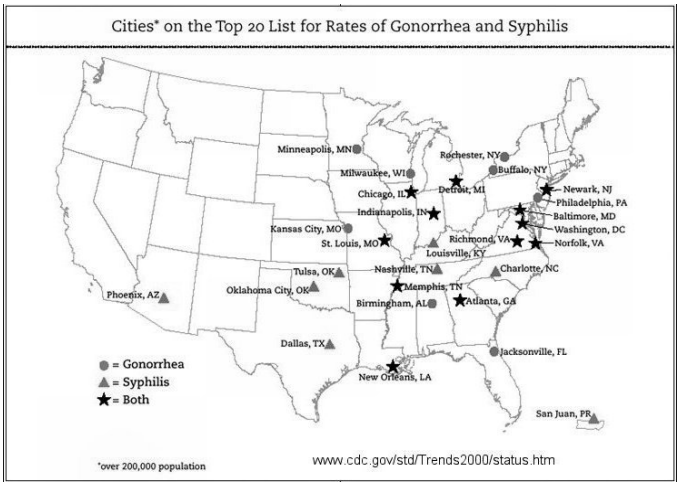
The fact that the level and geographic distribution of HIV have not changed for 20 years shows that it is not an infection that spread since the 1970s; yet orthodox theory requires HIV to be a sexually transmitted infection (STI or STD) that did spread beginning some time in the 1970s. The geographic distribution of an STD doesn't stay the same year after year, while that of HIV does. You don't find the geographic distribution of an STD to be the same among blood donors, new mothers, army applicants, and other groups, but the geographic distribution of HIV is essentially the same for all those groups. And STDs are not primarily big-city phenomena, whereas AIDS is.

It's often said that the risk of contracting HIV is greater for people already infected with an STD. But the data don't support that proposition either. Here are a few examples from real STDs. Neither chlamydia nor gonorrhea are concentrated regionally around New York as are AIDS and HIV:




Again, the cities where gonorrhea and syphilis are highest are not the ones where AIDS flourished.

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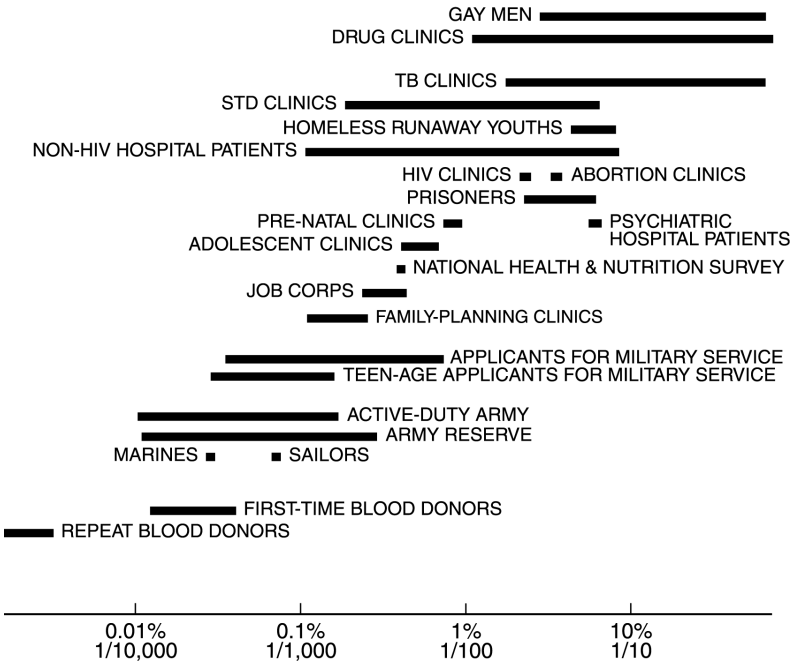
If HIV tests are not detecting a virus that caused AIDS, what are the tests detecting?

Clues to that lie in the way HIV varies between groups, and in the way it depends on age, sex, and race.

*F(HIV) = frequency of positive HIV tests*

Figure 22
F(HIV) reported in various groups



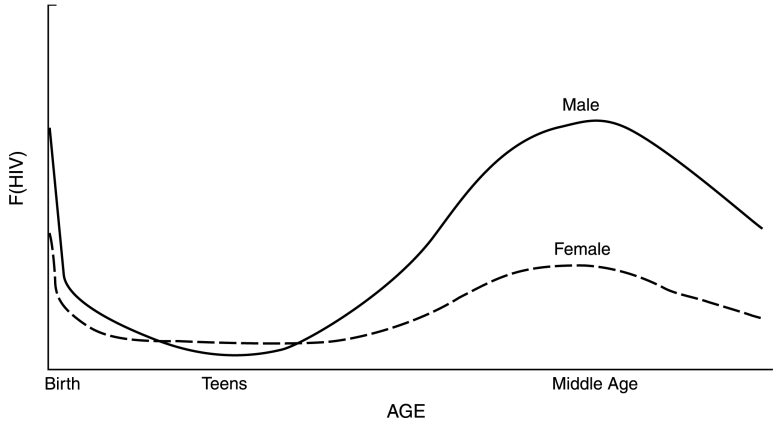

These data are again not compatible with an STD; if HIV were sexually transmitted, why would TB patients, women at abortion clinics, psychiatric patients, and prisoners, have higher or as high rates of infection as people attending specifically HIV clinics? But these data are exactly what you would expect if testing HIV-positive is an entirely ***non-specific*** sign of some sort of activation or stimulation of the immune system. Most highly screened against illnesses, even allergies, are blood donors; and among them, repeat donors are an even more highly selected group. Active military are on average healthier and fitter than those first applying to become recruits. People at drug clinics and TB clinics tend to be manifestly ill. So these variations are pretty much what you would expect of a non-specific indication of some sort of physiological stress. That is actually what a group of doctors and scientists in Perth, Australia, have been saying for a long time: that testing HIV-positive indicates oxidative stress. Another physician, Christian Fiala, who has worked with AIDS patients in Europe as well as in Africa, suggested to me that testing HIV-positive is analogous to running a fever: it may denote something trivial or something serious, it may reverse itself or it may not.

Some solid documentation supports this view. Many HIV-positive people have remained entirely healthy since the beginning of HIV-testing, without any medical treatment; but other HIV-positive people have become seriously ill. Many HIV-positive people remain positive; but very many HIV-positive people spontaneously revert to HIV-negative: drug addicts who kick the habit, and, most important, I think--among HIV-positive newborn children, about 90% typically become HIV-negative within a few years, about 75% in the first year.

***So: HIV-positive marks exposure and reaction to a NON-SPECIFIC challenge to health.***

Now for any given challenge to health, by allergens or pollutants or bacteria or viruses, a person's response is influenced by their genetic heredity and by their age and sex. The variations of HIV with age, sex, and race are exactly what you would expect of a physiological response to some health challenge. Every report I've seen that describes variations of HIV-positive with age fits this general scheme:

Figure 2
Variation of F(HIV) with age




Among newborns, males are 25% more likely than females to be HIV-positive. The changes from the teens to middle and later ages might reflect the increasing and then decreasing ability of the immune system's protective capacity. That in the early teens, females are more likely than males to test HIV-positive might reflect the greater physiological stress of the beginning of menstruation, compared to the milder physiological changes experienced by boys at puberty.

The racial differences in testing HIV-positive are quite startling. In every group for which HIV tests are reported with race as a variable, you find this sequence:

| Asian < | < white < | < Hispanic < | < black |
|---|---|---|---|
| ~0.65 | 1.00 (reference) | ~2.8 (~1.5--9) | ~5.5 (~3--14) |

Those racial disparities can be explained by race-correlated differences relating to immune function. I found quite quickly a number of relevant reports. Statins should be prescribed to Asians at half the dosage used with Caucasians, according to the manufacturers of Crestor. Blacks are more likely to reject kidney transplants, and their antibody response is stronger to the p24 antigen that is supposedly characteristic of HIV. Many articles describe correlations between immune-system genes and race. In any case, what other explanation could there be for the racial disparities? Surely not race-correlated differences in behavior!

I was astonished to find, though, that the CDC do say that the racial disparities in HIV are compatible with a behavioral explanation; presumably they mean that African Americans use drugs and behave promiscuously so much more than others because of long-standing discrimination. However: there's an objective way to decide between a behavioral and a physiological explanation: compare black Americans and Native Americans. American Indians have been treated as badly as African Americans have, and the rates of poverty, drug abuse, alcoholism, and violent crime are at least as high among Native Americans as among black Americans. So if the racial differences as to HIV result from behavior ingrained through long discrimination, Native Americans should test HIV-positive about as often as African Americans.

But if it's a matter of physiology influenced by genetic ancestry, then Native Americans should be similar to Hispanics, Caucasians, and Asians. And that's what the facts are:

| | civilian applicants to military | Job Corps | from public sites | young gay men | nationwide | ***Average*** |
|---|---|---|---|---|---|---|
| Sample size | 5,300,000 | 250,000 | 9,000,000 | 3,500 | 300,000,000 | |
| Asian | 0.59 | 0.4 | 0.63 | 0.9 | | **0.63** |
| White | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | **1.00** |
| **Native American** | **1.47** | **1.6** | **1.23** | **2.0** | **1.23** | **1.5** |
| Hispanic | 2.25 | 1.6 | 2.37 | 2.1 | 3.3 | **2.3** |
| Black | 6.25 | 6.4 | 2.76 | 4.3 | 8.5 | **5.65** |

Racial genetics also explains another peculiarity. In the United States, Hispanics on the West Coast test HIV-positive not much more often than whites, whereas on the East Coast they test positive much more often than whites and approaching the rate for blacks. Well: Hispanic isn't a racial category, it's an ethnic one. West-Coast Hispanics are chiefly of Mexican ancestry, whereas a large proportion of East-Coast Hispanics have Caribbean origins and therefore a high proportion of African ancestry.

Altogether, I have come to realize that every significant observation as to HIV can be explained on the basis of two propositions:

1. A positive HIV-test is a ***non-specific***, potentially reversible sign that the immune system is reacting to something.
2. For a given health challenge, the probability that an "HIV-positive" reaction will occur depends on the individual's physiology, and therefore depends on age, sex, and racial ancestry in a ***predictable*** way.

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Now to my second main point. It's not widely appreciated that progress in science and medicine almost always means discarding theories and beliefs that had been firmly regarded as true. Many people have heard of Thomas Kuhn's claim that science progresses through scientific revolutions; but people don't often realize that revolutions mean overturning what was previously believed.

What is even less appreciated is that the resistance to change has become much greater in the last few decades. Nowadays in several fields of science, the dominant theory is essentially a dogma and it is almost impossible to get grants or to get published if you are not on the bandwagon. That's so in cosmology with the Big-Bang hypothesis; it's so with continental drift in geology; it's so with global warming; it's so in theoretical physics with string theory. And it is certainly so with HIV/AIDS.

A well known aspect of resistance to change in science--well known to historians, philosophers, and sociologists, but not to practicing scientists--is that facts that appear to contradict the received view are either ignored or explained by introducing new hypotheses. There are several examples of this in the HIV/AIDS business.

***Idiopathic CD4-T-cell lymphopenia***:

By around 1990, there had been many reports of HIV-negative patients presenting with clinical symptoms of AIDS. In logic, that might be taken as a sign that HIV is not the cause of AIDS. Instead, HIV-negative AIDS was declared a separate and distinct condition, idiopathic CD4-T-cell lymphopenia (ICL): an immunedeficiency of unknown cause. But that's precisely the definition of AIDS before the claimed discovery of HIV.

***Immune restoration syndrome***:

Patients treated with antiretroviral drugs often fare worse than untreated patients. So a new phenomenon was named, "immune restoration syndrome" or "immune reconstitution syndrome": a presumed re-building of the immune system causes illness rather than recovery.

***Breast-feeding***:

HIV is supposed to be transmitted to babies via mothers' milk. However, the risk that babies become HIV-positive is greater when breastfeeding is supplemented with formula than with exclusive breastfeeding. More exposure means less infection??

***Kaposi's sarcoma (KS)***:

affected a sizable proportion of the early AIDS cases. But KS is now known to be caused by human herpes virus 8. Many KS patients are HIV-negative.

***Cervical cancer***:

You probably heard within the last year or so that cervical cancer is attributed to human papillomavirus (HPV) and preventable by vaccination. But in the early 1990s the CDC had added cervical cancer to the list of AIDS-defining diseases. Which is it? Does HIV cause it, or does HPV cause it?

So there you have it. On firm evidence, HIV doesn't cause AIDS. Why has the dogma persisted?

My explanation is not a conspiracy theory. I think science has become so highly organized as to be bureaucratic. Bureaucracies don't know how to change their stance, bureaucracies don't like to be contradicted, bureaucracies will never willingly admit that they have been wrong about anything. That's why you haven't been hearing all the reasons why HIV is not and cannot be responsible for AIDS.

I mention in my book several other big missteps in medical science even during the last century when many regard medicine as having become quite "scientific". But please recognize that I am not criticizing or placing blame on practicing physicians. It's the research establishment that has let the medical profession down very badly. My graduate-school mentor had a PhD from Bonn and an MD from Padua, and he carried out clinical research as well as chemical research. He used to say, "Doctors are not scientists". PhD's are trained to do research, which means *questioning* everything, trying to go beyond what we presently think we know, which means being prepared to prove some things wrong that we used to think were right. Doctors, by contrast, must be trained to use what we think we now know, and too much questioning of accepted doctrines would be debilitating. You couldn't help your patients if you were continually in doubt about what's wrong and about what might help. Researchers don't have to make decisions about actions that impact people's health and lives; physicians cannot avoid making those sorts of decisions, very often under conditions of some uncertainty. That crucial difference translates into different modes of assessing probabilities and different attitudes toward what is regarded as certain. The HIV/AIDS situation is a powerful illustration that medical science and clinical research have become more fallible than they need to be.

## REFERENCES AND FURTHER READING

### *HIV/AIDS*

Detailed discussion and documentation of many more points than I could cover in the seminar are in: *The Origin, Persistence and Failings of HIV/AIDS Theory*
reviews of the book and other information are at
<www.failingsofhivaidstheory.homestead.com>

Most of the analysis of HIV data, with source citations, is also in 3 articles, pdf's available at http://hivnotaids.homestead.com

Excellent concise summaries of the dissident case:

Rebecca Culshaw, *Science Sold Out: Does HIV Really Cause AIDS?* (100 pages)
Author is a mathematician whose graduate work was on modeling HIV mechanisms

Christine Maggiore, *What if everything you thought you knew about AIDS was wrong?* (126 pages)
Author was an HIV/AIDS counselor who changed her mind after testing positive, then negative, then positive… Now maintains self-help group in Los Angeles with many healthy HIV-positive members

Detailed discussion for a general readership:

John Lauritsen,
*The AIDS War: Propaganda, Profiteering and Genocide from the Medical-Industrial Complex*
Author is a gay man, a research analyst, journalist and writer who covered the AIDS story from the beginning and was right about it from the beginning

Several journalists who covered the AIDS story became convinced that HIV is not the cause:

Neville Hodgkinson (*Sunday Times* UK): *AIDS: The Failure of Contemporary Science*
especially informative about Africa and about censorship of dissidents

Joan Shenton (TV documentaries, UK): *Positively False : Exposing the Myths around HIV and AIDS*

Personal story of one of the first AIDS victims:

*Surviving AIDS* by Michael Callen
At a time when AIDS patients died within months, Callen survived by avoiding antiretroviral drugs, adopting a careful lifestyle, and having specific infections treated specifically by Dr. Josef Sonnabend. Callen co-authored the first manual of "safe sex" advice for gay men.

Detailed discussion of physiological and virological aspects:

Robert Root-Bernstein, *Rethinking AIDS: The Tragic Cost of Premature Consensus*
Author is physiologist and science philosopher, former MacArthur Fellow. Considers cause of AIDS to be multifactorial, with HIV possibly playing part of the role

Peter H. Duesberg, *Inventing the AIDS Virus*
Author is member of the National Academy of Science; recognized as foremost retrovirologist until he dissented over HIV/AIDS; discovered first oncogene, lately has concluded that cancer is not set off by oncogenes but by faulty chromosome reproduction. Explains why no retrovirus can do what HIV is alleged to do. AIDS is caused primarily by drugs, recreational (whether injected or not) and medical, especially antiretrovirals.

Delightful and sound essay warning against experts and computer models:

Michael Crichton, Aliens cause global warming. Caltech Michelin Lecture, January 17; www.michaelcrichton.com/speech-alienscauseglobalwarming.html
I also recommend Crichton's autobiography, *TRAVELS*. He understands what science is about.
He had earned an MD before becoming a writer.

New ideas are always resisted:

Bernard Barber, Resistance by scientists to scientific discovery, *Science*, 134 (1961) 596-602.

Gunther Stent, Prematurity and uniqueness in scientific discovery, *Scientific American*, December 1972, 84-93

Ernest B. Hook (ed), *Prematurity in Scientific Discovery: On Resistance and Neglect*. University of California Press, 2002.

Resistance to new ideas, and dogmatic defense of the prevailing paradigm, have become stronger

John Ziman, *Prometheus Bound*, Cambridge University Press, 1994

H. H. Bauer, Science in the 21st Century: Knowledge Monopolies and Research Cartels**,** *Journal of Scientific Exploration* 18 (2004) 643--660;
pdf available at www.henryhbauer.homestead.com/Science.html

Beware of statistics:

R. A. J. Matthews. 1998: Facts versus Factions: The use and abuse of subjectivity in scientific research. European Science and Environment Forum Working Paper; reprinted in *Rethinking Risk and the Precautionary Principle* (Ed: Morris, J.) (Oxford : Butterworth) 247-282 (2000)

Darrell Huff, *How to Lie with Statistics*, New York: W. W. Norton, 1954.

Science and scientific unorthodoxies:

H. H. Bauer, *Scientific Literacy and the Myth of the Scientific Method*. University of Illinois Press, 1992.

H. H. Bauer, *Fatal Attractions: The Troubles With Science*. Paraview Press, 2001.

H. H. Bauer, *Science or Pseudoscience: Magnetic Healing, Psychic Phenomena, and Other Heterodoxies*. University of Illinois Press, 2001.

Conflicts of interest and commercial distortions of science and medicine:

The following are all well documented, reliable, serious works. Abramson, Angell, Avorn, and Kassirer are MDs, and Angell and Kassirer are former editors of *New England Journal of Medicine*. Greenberg covered science and politics for many years and edited a highly regarded periodical.

Sheldon Krimsky, *Science in the Private Interest: Has the Lure of Profits Corrupted Biomedical Research?* Rowman & Littlefield, 2003.

John Abramson, *Overdosed America: The Broken Promise of American Medicine*. HarperCollins, 2004.

Marcia Angell, *The Truth About the Drug Companies: How They Deceive Us and What To Do About It*. Random House, 2004.

Jerry Avorn, *Powerful Medicines: The Benefits, Risks, and Costs of Prescription Drugs*. Knopf, 2004.

Merrill Goozner, *The $800 Million Pill: The Truth behind the Cost of New Drugs*. University of California Press, 2004.

Daniel S. Greenberg, *Science, Money and Politics: Political Triumph and Ethical Erosion*. University of Chicago Press, 2001.

Jerome Kassirer, *On The Take: How Medicine's Complicity with Big Business Can Endanger Your Health*. Oxford University Press, 2004.