Cromer blames the "anti-intellectualism of Christianity" for destroying "virtually all traces of Greek rationality in Europe for 1,000 years" (103); but mainstream history of science recognizes the Church as having provided many of the crucial players in early modern science.

Even on the subject matter of science itself, there are such unaccountable errors as describing hydrogen and other elements in Group I of the Periodic Table as "alkali halides" (8); or ascribing the discovery of isotopes to the late 1930s (9) or "just sixty years ago" (10) though Soddy had received a Nobel Prize for that in 1921.

In Chapter 2 and throughout, Cromer relies on Piaget's ideas as unquestionably true, which just may not be the case. And chapter 4 is exegetical of the Bible and Homer without benefit of scholarly citations.

Cromer would have served himself better by publishing only an expanded Chapter 10. I was surprised that so uneven a work was published under so distinguished an imprint.

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**The AIDS War: Propaganda, Profiteering and Genocide from the Medical-Industrial Complex** by John Lauritsen. New York: ASKLEPIOS, 1993, 480 pp. $20 ISBN 0-943742-08-0 [Pagan Press/Asklepios, Box 1902, Provincetown, MA 02657-0245].

**Poison by Prescription: The AZT Story** by John Lauritsen. New York, NY: ASKLEPIOS/Pagan Press, 1990 (4th printing 1992), 192 pp. $12 (p). ISBN 0-943742-06-4.

**The Myth of Heterosexual AIDS** by Michael Fumento. New York, NY: Basic Books, 1990,432 pp. $22.95.

**Rethinking AIDS: The Tragic Cost of Premature Consensus** by Robert S. Root-Bernstein, New York, NY: Free Press, 1993, xvii + 512 pp., $35.

**Why We Will Never Win the War on AIDS** by Bryan J. Ellison & Peter H. Duesberg, Inside Story Communications (190 El Cerrito Plaza, Suite 201, El Cerrito, CA 94530), 1994, x + 292 pp. ISBN 0-9646475-0-8 [available from Inside Story Communications, 1512 E. Noble, #102, Visalia, CA 93292, at $19.95 (p) plus $3 s&h].

Only dead fish swim with the stream (*AIDS* War, 263). That defense of unorthodox venturing is but one of several points of interest for anomalists in

these books' by people whose opinions about AIDS differ from Established views.

Anomalists (and administrators [2]) are vouchsafed the uncommon insight that "what everyone knows" may be quite wrong. Often that may not matter very much; but then again it may. Where medical practice is concerned, it can matter very much indeed to those directly concerned as patients or as those treating them. If, for example, the Establishment position that HIV causes AIDS is wrong and it is instead drugs and multiple infections resulting from promiscuity, then the Establishment position *may in fact be inducing people to get* AIDS. Is it really needle-sharing or the drugs themselves that are dangerous? *Who says IV-drug-abusers typically share needles? (AIDS War,* 185-6). "Clean needles" campaigning among drug-users amounts to saying that using drugs is not a risk to health! "In the last couple of years, gay men in San Francisco and New York City, two epicenters of the 'AIDS epidemic' have gone back to the levels of drug abuse and promiscuity that obtained in the 70s and early 80s" *(AIDS War,* 424-5).

What everyone knows about AIDS includes:

1. It first surfaced as an epidemic in the US among the gay communities in San Francisco and New York.
2. It is caused by a retrovirus, HIV (Human Immunodeficiency Virus).
3. It is an STD (sexually transmitted disease) like syphilis and it can also be transferred via blood transfusions, by sharing of needles among intravenous drug abusers, or through inadvertent contact with infected blood.
4. Everyone is at risk. Athletes must be careful not to be exposed to one another's blood (so players are removed from the basketball court as soon as they suffer a cut). One can even get it from the dentist, as a famous case in Florida demonstrated.
5. Because AIDS first appeared among gays, the gay community will largely disappear under this scourge.
6. However, because many gays are not exclusively gay, HIV will inevitably spread into the general population. There will come an epidemic of unimaginable proportions, unprecedented since the centuries when the bubonic plague killed millions at a time.
7. It is invariably fatal. Once infected by HIV, it is only a matter of time before one succumbs.
8. While no cure has yet been found, some anti-viral drugs can prolong life in those infected with HIV.

On all these points, according to these books, the conventional (media) wisdom is wrong. Together they make a very substantial case, whose force is all the stronger because the various authors do not agree with one another in each particular; yet the reader will find that they strengthen one another's argument, sometimes despite themselves. Thus Fumento accepts that HIV causes AIDS, yet his demonstration that the disease is *not* spreading into the general popula-

tion speaks against that. Ellison regards HIV as totally innocuous whereas Root-Bernstein gives it a possible role as one of a number of opportunistic infections that can be the last straw for the immune system; yet both agree that more research on the detailed cause of AIDS is called for and both recognize AZT as deadly.

Among aspects of this controversy that will seem familiar or particularly germane to anomalists are:

- There has never been a substantive reply from the Establishment to Peter Duesberg's comprehensive, professional argument that HIV is not the cause of AIDS (AIDS *War,* 68, 131, 135, 136; Ellison 132).
- Hysteria that HIV causes AIDS and inevitably a gruesome death may in itself be deadly to one who tests positive for HIV antibodies: people who are convinced that they will soon die, often do. Contagious hysteria has affected people even recently in Britain (AIDS *War,* 266 ff., 461).
- Much bad data do not amount to a little good data: "vast numbers of flying saucers or 'unidentified flying objects' (UFOs)... were observed in the '60s. None of the observations were very well documented, but there were so many of them! How could it be that they were all wrong!? I take no position... [on UFOs] but merely point out that such visitations remain to be demonstrated. Likewise with the benefits of AZT" *(Poison,* 111).
- The media's inevitable role in making it appear that something is widespread when it is not, or in failing to inform about the occurrence of something that may be quite widespread. Fumento illustrates the media's talent for creating "experts" who really aren't: on epidemiology, "an obscure virologist and a heretofore-unknown army infectious disease specialist" because the *real* epidemiologists were not saying sufficiently alarmist ( = "news-worthy") things (256). Media-generated crises of brief duration are common enough: regarding the danger of pitbulls, for example (270) or the prevalence of missing children (271) — "some estimates of lost children [per year] run as high as 2 million.... More than 100,000 children are abducted each year."

On this score one should study Ron Westrum's work on "hidden events"' which offers highly pertinent clues to some of the enigmas and points of dispute about AIDS: How the revised definition excludes knowledge of illnesses and deaths from immunodeficiency *that would have been classified as* AIDS *up to* 1984, for instance; or how fallible are assumptions about what the prevalence of HIV might have been in Africa and elsewhere before tests for it were available.

If you're going to read only one book about AIDS, it should be *The* AIDS *War.* John Lauritsen "began researching 'AIDS' in early 1983. Initially I was shocked by the incompetence with which the Centers for Disease Control (CDC) conducted survey research, my own profession since 1966. Later I

would be shocked by the dishonesty, venality, and ruthlessness of the AIDS Establishment" (10).

Strong stuff. But Lauritsen, himself gay (and in the minority within the gay community in his views about AIDS), provides chapter and verse. Anomalists, who have also needed the Freedom of Information Act to shake lose vital documents, may find less surprising than the general public the attempted secret hoarding by the Establishment of documents that reveal its public stance to be mistaken or dishonest. Lauritsen's main points are:

- HIV is *not* the cause of AIDS
- Drug abuse is likely a primary cause.
- AZT treatment is iatrogenic homicide (treated at greater length in *Poison by Prescription).*

Michael Fumento — with 50 pages of notes accompanying the 350 pages of text and a 10-page index — documents the catastrophic predictions, made since the mid-1980s, that AIDS would bring disaster to the general population, and the fact that these predictions were wrong — as honest interpretation of the data would also have shown at the time the predictions were made. Fumento's book focuses as much on social as on biological and statistical matters. Hysterical publicity in 1986-87 featured predominantly white, middle-class heterosexuals describing the risk everyone was running, even as the data then showed that less than 0.5% of AIDS cases could have been occasioned through sexual transmission among white, middle-class heterosexuals (130-31). Quotes from the media coverage reveal slanted metaphors, fake stories, sound-bite slogans and other insidious devices — for instance that every act of heterosexual intercourse is actually somehow intercourse with all the partners that one's actual partner had in the last 10 years.

Fumento points out that the only rational way to discuss risks is by *comparing* them, quantitatively wherever possible. He gives this analogy: breast cancer afflicts primarily women, yet men do contract it too. So breast cancer could — like "everybody-at-risk-for-AIDS" — be trumpeted as "no one is safe" and "it's everybody's disease"; white men could be featured in ads urging frequent testing; and so forth. Yet that would be misleading when 130,000 women and only 900 men are so diagnosed annually (151,337). Still, to put it in perspective, "more native-born American males are diagnosed with... [breast cancer] *each year* than the total number who have contracted AIDS through heterosexual intercourse since the AIDS epidemic began" (151).

In "Lies, Damned Lies, and Statistics" (chapter 17), Fumento discusses some of the pitfalls of "statistical data" for the unwary, in particular the (ab)use of pie-charts. Consider country A of 50,000,000 with only 10 AIDS cases of which 1 is homosexual; and country B, also with 50,000,000 people, that has 1,000,000 with AIDS, 90% of them homosexuals. The alarmists can "truthfully" cry about country A, "90% of AIDS cases are heterosexual!", even though the incidence of heterosexual AIDS there is only about 1 in

2,500,000; whereas in country B, though only 10% of heterosexuals are infected, the incidence of heterosexual AIDS is 100,000 times greater, about 1 in 25! So in actual fact in Japan, for example, most of the AIDS cases were hemophiliacs, but that does not mean that hemophiliacs in Japan were at greater risk than hemophiliacs in the United States, even though their portion of the pie-chart in Japan was so much greater (246). In another sleight of statistics, the incidence of AIDS in babies in New York City was used as a projection for what awaited the whole United States — "By 1991, 1 in 10 Babies May Be AIDS Victims" (USA *Today,* 20 July 1988) — even though New York City then had about 1/3 of all the pediatric cases in the country (249).

Also excellent is Fumento's description of how "heterosexual AIDS" was co-opted by various groups making their own political hay: Birth control advocates seized on it to promote the use of condoms (164); conservatives to discourage heterosexuals from engaging in illicit relations (187); many homosexuals promoted the thesis as a strategy to get more resources devoted to AIDS research and treatment (198).

Lauritsen and Fumento write for a general audience. Root-Bernstein's book, by contrast, is a heavy scholarly tome: 373 pages of text are supported by 102 pages of notes and references, a 6-page glossary and 25 pages of index, and names, addresses and telephone numbers of 6 organizations that seek a re-examination of the HIV-only hypothesis. Chapters 10 and 11 should be read even by those who skip much of the detailed material in the middle chapters of this book. Chapter 10 is a careful comparison of several hypotheses of AIDS-causation in the light of the amassed evidence. Clearly the best explanation is Root-Bernstein's view that AIDS is a multi-factorial, synergistic syndrome to which HIV contributes, but contributes in all probability no more than do several other viruses and non-infectious insults to the immune system.

Chapter 11 addresses the conundrum, "How could so many scientists be so wrong?", and the crucial questions, "What can be done to prevent the spread of AIDS that is not being done now? What can be done for people with AIDS that has not yet been tried?" To the first question, which again is of particular interest to anomalists, there are "several answers, each of which sheds light on a different aspect of how science is performed." First, all data have more than one possible explanation. Second, the one-cause, HIV-only theory is the simplest and thus indicated to those who rely on Occam's Razor. Third, there is over-specialization: AIDS calls on immunology, virology, biochemistry, pharmacology, epidemiology and other fields whose practitioners are not used to working together. All have different criteria of plausibility, different criteria for judging which data should be heeded and which set aside. None — no field of science — pays special attention to anomalies (until they have become unbearably numerous and weighty). Fourth, gullibility or wishfulness and the weight allowed to authority are as much in evidence within science as elsewhere. Fifth, "Priority, patent rights for AIDS tests, national honor, and polit-

ical and social exigencies all played their role" (353); after 1984, all American funding agencies affirmed and promoted the HIV-only hypothesis.

Not only is Root-Bernstein enlightening about the main issue. He also reveals little-known facts about the limited efficacy of such standard, vaunted high-tech medicine as kidney transplants, blood transfusions and the like. Thus the probability of death within 3 years after kidney transplant is 20% in absence of complications and 40% with complications (60). Hemophiliacs had, in 1970, a life expectancy of only 33 years (247). Improved treatments since then have raised that to 55 years — which still falls some 20-25 years short of the general population, indicating that hemophiliacs still suffer a diminished efficacy of the immune system. In one study, recipients of blood transfusions had a mortality rate of *about 50% in the year following transfusion,* whether or not they became infected with HIV. In another study of people who received on the average a 70% smaller amount of blood, the death rate was still 21% in the first year and 30% by the end of 3 years (242-3). One wonders whether those numbers were included on the informed-consent statements those patients or their relatives had doubtless been required to sign.

Ellison's book makes an unfavorable initial impression on several scores, among them its unbridled tone and its ambivalence as to authorship[4]. But one can gain useful information from Ellison, especially that non-infectious ailments *can simulate outbreaks of infectious disease* (chapter 1): For 15 years, Japanese medical science chased a phantom virus presumed responsible for epidemic outbreaks of SMON (Subacute Myelo-Optic Neuropathy), whose real cause turned out to be the drug clioquinol (Enterovioform). Success against microbes (with antibiotics) and viruses (through vaccination) led medical science to invoke them routinely as causes of disease, yet history reveals other cases besides SMON where a high incidence of disease in certain localities was *wrongly* taken as evidence of an infectious agent at work: scurvy, for instance (22 ff.), or beriberi (25 ff.) or pellagra (17, 27-33). I recall some years ago the discovery that local incidences of a particular cancer in some parts of China were traced to nitrites in the water. Here are some of the counters to the 8 mentioned points on which the conventional wisdom is supposedly wrong:

1. AIDS-type illness and death can be traced back more than a century (Root-Bernstein, chapter 1). A crucial point (see below) is how AIDS is defined.

2. HIV is currently implicated in AIDS *by definition. When encountered in the presence of HIV antibodies,* any of 29 disparate diseases — bacterial, fungal, viral, and even of unknown etiology — is now defined to constitute "AIDS"; yet those same 29 diseases also occur in absence of HIV — "we have already uncovered in the scientific literature some 4,621 confirmed cases of HIV-free people dying of AIDS diseases" (Ellison, 125).

In 1982, the CDC's definition of AIDS was opportunistic infection by any of 14 diseases *in absence of other* "identified cause of immune suppression" (Root-Bernstein, 59), a most necessary caveat since those diseases were a

known danger to transplant patients, to people who had had cancer chemotherapy or chronic treatment with corticosteroids, or to those born with defective immune systems. But since 1984, when Gallo's discovery of HIV was announced, the presence of HIV or antibodies to it has been part of the definition of AIDS, *so that other people who die of those opportunistic infections nowadays are not considered part of the AIDS problem even though they were so considered up to 1984.* There have been numerous patients with typical symptoms of AIDS from whom no HIV could be isolated *and* who even show no sign of exposure to it (*i.e.* who lack antibodies) (Root-Bernstein, chapter 1). One Swedish study showed only 22 of 270 HIV-positive IV-drug abusers dying within 5 years — none of them from AIDS (Fumento, 134).

Moreover, an outbreak of AIDS into the general population was predicted on the Establishment presumption that it is caused by a readily and sexually transmitted virus, namely HIV. That the prediction was wrong surely counts against the truth of the underlying assumption.

A powerful analogy to which Root-Bernstein periodically returns is that of a drowned man. There is too much $CO_2$ in his blood, yet it would be perverse to call that the cause of death — it is "an epiphenomenon, a secondary or additional symptom" (65). The real cause of death was inability to breathe, a lack of available oxygen just as much as the excess of $CO_2$. The cause of that cause in turn might have been inability to swim, or a cramp while swimming, or a heart attack, or an accidental or deliberate blow on the head, or any one of many other possible events. HIV is like the CO, in that analogy. "The existence of the full range of AIDS symptoms and opportunistic infections in both HIV-free and HIV-infected transplant and cancer patients" should warn us that HIV could be epiphenomenal.

Root-Bernstein's favored hypothesis is that AIDS is a multi-factorial, synergistic disease: the immune system eventually succumbs to otherwise innocuous infections after a long succession of stresses. (Already in 1985, *AIDS War,* chapter *l,* Lauritsen had shown how the CDC's manner of presenting the data misrepresented the place of drugs among risk factors and had suggested that AIDS stems from multiple insults to the immune system.) Root-Bernstein has proposed a similar cause for auto-immune disease, and this is consistent with the auto-immune symptoms often seen in the later stages of AIDS. Among many eye-openers in *Rethinking AIDS* is its enumeration of the sundry ways by which immune systems may be stressed. Premature infants and elderly people "incur demonstrable immune deficiencies associated almost complete with their age" (146). Between 1930 and 1960, "the vast majority of *Pneumocystis* cases in children... [were those who] had been severely malnourished in the early years of life" (136). In 1947 came one of the earliest reports of an adult with *Pneumocystis* and disseminated cytomegalovirus infection, two opportunistic infections very commonly founds in AIDS suffers — the patient was found to have severe vitamin-A-deficiency. "The limited information that does exist suggests that all addictive drugs probably have significant effects on

the immune system" (121). A wide variety of pharmacological agents including anesthetics, steroids, aspirin (!!), cancer chemotherapeutics and more, are immunosuppressive (129 ff.). So is the trauma associated with surgery. Exposure to the cells of other human beings produces an immune response, which is why blood donors are "matched" as closely as possible to recipients, and why organ transplants require the recipients to be given immunosuppressive drugs. Yet despite "matching" of blood, "blood transfusions directly suppress T cell-mediated immunity in both animals and humans is a dose-dependent fashion resulting in inverted T4/T8 ratios similar to those seen during the early stages of AIDS" (143); "hemophiliacs, like people with sickle cell disease and people who receive massive transfusions, are often immunologically deficient in the total absence of HIV infections."

As with components of blood so with semen, which is "One of the oldest identified alloantigens known to cause immune suppression... if it obtains access to the bloodstream or lymph" (1 15) — as is likely through receptive anal intercourse, "the most hazardous sex practice associated with the development of AIDS for both men and women" (115-6).

Support for the multi-factorial hypothesis of AIDS genesis comes copiously from the medical literature. Synergy is often observed: simultaneous infection with *several individually innocuous viruses* can have disastrous consequences for the immune system. "People with AIDS and most of those at risk for the syndrome have multiple concurrent infections and many non-infectious causes of immune suppression" (184). Striking are bar graphs (figures 3-7, pp 165-9) showing the prevalence of active infection and of serum antibodies to various infectious agents in various groups of people. European and North American hemophiliacs show high frequencies of antibodies to eight common opportunistic infections and appreciable frequencies of active infection by five of those. Intravenous drug users show even higher frequencies, 11 for both. *Equally high frequencies are found in* HIV-seronegative *North American and European homosexual men;* and the profile of people with AIDS is very similar to the latter, the chief difference being the additional presence of HIV antibodies and HIV infection in the latter group. By start contrast, European and North American heterosexuals show very low frequencies of any active infections and marked frequencies of antibodies to only 6 or 7 of those diseases.

The clearest apparent support for the HIV-only theory of AIDS causation is the fate of people infected by HIV through blood transfusion. Root-Bernstein points outs, however, that these people had already suffered multiple immunosuppressive stresses *from whatever led to the need for transfusion* (238 ff.). Moreover, the rate at which HIV-infected hemophiliacs develop to AIDS is much slower than the HIV-only possibility would predict (221, 244 ff.).[5] The multiple-factors theory, on the other hand, explains the finding of immunosuppression in *the majority of HIV-negative* hemophiliacs and homosexual men (chapter 7). Root-Bernstein also offers plausible reasons why multi-fac-

torially induced AIDS might have become so prevalent when it did (chapter 8); and he notes the vast difference between African and Euro-American conditions in terms of AIDS-risk factors (chapter 9): the frequencies of antibodies and of active infections in African heterosexuals (302) rather exceeds that in European and American intravenous drug users! That AIDS is a heterosexual disease in Africa, then, would not be a basis for predicting a similar outbreak in Europe or America if the multi-factorial explanation is correct.

Anomalists know that argument from authority is dubious; and skeptics know that argument from maverick authorities is more often misguided than trustworthy. Nevertheless it is worth pondering that the competent people who do not accept that HIV is the sole cause of AIDS include such distinguished molecular biologists, immunologists, clinical researchers as Peter Duesberg, Luc Montagnier (the actual discovered of HIV), Robert Root-Bernstein, Harry Rubin, Albert Sabin, Joseph Sonnabend, and Nobelists Manfred Eigen, Walter Gilbert and Kary Mullis.

3. For an STD, what would be the population most at risk? Prostitutes, one might think. So what should one conclude from the fact that the US Public Health Service never put female prostitutes into the "at risk" or "high risk" categories for AIDS (Fumento, 98; Root-Bernstein, 40)?! "Prostitutes who do not abuse intravenous drugs almost never become infected with HIV", whereas they typically do become infected with syphilis, gonorrhea, herpes (Root-Bernstein, 40, 42).

Health workers have become infected in only a few dozen cases despite many thousands of instances of accidental exposure to HIV-carrying blood. A surgeon runs a 1-in-4 risk of infection by hepatitis B after accidental skin puncture but only a I-in-1000 risk with HIV. "HIV is extremely difficult to transmit to a healthy individual" (Root-Bernstein, 44-5).

4. "Less than 15 percent of women infected with HIV transmit their infection to their infants in Western nations... women who have been artificially inseminated with sperm from donors who were subsequently identified as being infected with HIV almost never become infected" (Root-Bernstein, 35-6).

Of 8871 health-care workers who developed AIDS by September 1992, only 7 did not have such risks as IV-drug use, hemophilia, transfusion, homosexuality, etc. Occupational exposure to HIV is not very risky at all!

5. Though 2/3 of all AIDS cases may be gays, it is only a small percentage of gays who have AIDS (AIDS War, 188-9). It is only "the commercial gay milieu", the "fast-lane" homosexual scene, that has the deadly combination of "recreational" drugs, much venereal disease and over-use of antibiotics, and unrealistic or unhealthy attitudes. Lauritsen has made this point directly to "hundreds of *PWAs* (People With AIDS)" without rebuttal (AIDS War, 191).

Root-Bernstein is a pains in several places to point out that homosexuals who avoid risky sex practices and eschew other immunosuppressive factors are at little risk for AIDS *even should they contract HIV* (though becoming so

infected tends to indicate that co-infections and other risk factors are likely to be present as well).

6. Lauritsen challenged the dire official predictions of an exploding epidemic already in 1987 (AIDS *War,* 119).

HIV infections in the general population in America, Britain and Canada "are no more common in 1992 than... in 1985" (Root-Bernstein, 43).

It is clear even from the CDC's own data that the epidemic has passed its peak, which was reached between 1990 and 1993 *under the original definition of* AIDS, early in 1993 under the 1987 definition, and then or even earlier under the 1993 definition.[6]

7. Lauritsen reminds us that the induction of antibodies used to be called "vaccination" and served as induced immunity against the disease (AIDS *War,* 50). It is an oddity of the manner in which AIDS is now officially defined that no cure is possible: once having tested positive for *antibodies* against HIV, people living in apparent good health a dozen years later remain classified as sufferers doomed to develop AIDS. In all other diseases such long survival is taken as evidence of immunity or cure (Root-Bernstein, 67-8).

"The notion, of antibodies as a prognosis of death, defies all classical experience with viruses and bacteria; virtually every microbe causes disease only in a minority of infected individuals, since the majority are usually healthy enough to mount a rapid immune response. Certainly no fatal viral disease is known to cause death in nearly all infected people — except the paradoxical 'AIDS "virus"' (Ellison, 126).

8. The evidence is quite clear, from the FDA's own Establishment Inspection Report, that the AZT trials that led to its approval as a treatment for AIDS were invalid (AIDS *War,* chapter XXIX & pp. 452-3; *Poison,* chapters I and II). No one has lived more than three years on AZT treatment (AIDS *War,* 263, 302).

The case against AZT, one might think would need no more making than a reminder that "AZT was designed over twenty years ago for the treatment of leukemia... by termination of DNA synthesis. However, since AZT failed to prolong the lives of leukemic animals, it was not accepted for cancer chemotherapy. "The rationale of AZT therapy... [is that] the retrovirus HIV depends on DNA synthesis for multiplication, and AZT terminates DNA synthesis.... Yet... many studies show that no more than one in 1,000 lymphocytes are ever infected with HIV — even in people dying from AIDS. Since AZT cannot distinguish between an infected and an uninfected cell, 999 uninfected cells must be killed to kill just one HIV-infected cell. ... AZT... has a very high toxicity index... there is no rational explanation of how AZT could be beneficial to AIDS patients, even if HIV were proven to cause AIDS" *(Poison,* 7; Ellison, chapter 9). AZT kills bone marrow, which is why it causes anemia; and it produces cancer in animals *(Poison,* 95, 104).

Among the important things I hadn't known and that I learned from Lauritsen is that the United States, unlike most industrialized countries, has no sys-

tem to ensure that adverse drug effects are reported. Once the FDA has approved a drug, "it's clear sailing... In theory, physicians are supposed to report adverse effects to manufacturers, who are supposed to relay the information to the FDA. But... with no incentives for compliance, no punishments for non-compliance, and with no federal data gathering system, the post-marketing surveillance is haphazard at best" (Poison, 93). And so people with AIDS discover only by talking with each other what the debilitating consequences of taking AZT are. "AZT... was rushed through the approval process faster than any drug in the FDA's history... the officially recognized toxicities of AZT are far from complete... (and) the 'non-official' toxicities..., well known through the formidable PWA grapevine, are not being systematically recorded" (Poison, 95).

So the Establishment position of AIDS is clearly inadequate. But as with all anomalist demonstrations that the mainstream doesn't have the final answer, this in itself brings us no closer to understanding what's really going on. There remain such puzzling questions as:

- Does HIV play, if not the crucial role then an important subsidiary role, perhaps as the final clincher for an otherwise-weakened immune system?
- Where and when did HIV originate? What is its prevalence in general populations?
- What exactly is going on in those other countries where one reads that HIV/AIDS is beginning to spread? In Thailand, where vaccines are to be tested? In Africa, where huge numbers of people are said to be infected and dying?
- What answers might Ellison, Fumento, Lauritsen, or Root-Bernstein have to the steady stream of news items that implicitly accept the HIV-only notion: the recent British hemophiliac study (5); that different HIV-1 strains are responsible for the epidemics in Africa and South-East Asia than in Europe and America (7); that NIH issued in 1995 a 61-page pamphlet summarizing the case that HIV causes AIDS (8); that a genetic defect in the HIV genome might be the reason for certain long-time HIV-infected survivors (9).

A brief look at the Internet turned up http://www.aidsauthority.org/ which has recent information about such things, entry to a Rethinking AIDS discussion list, and archives.

A final point of special anomalist interest is, how did a mistaken view so capture Establishment support that it has even led to routine administration, to apparently healthy people, of such highly toxic substances as AZT, just because they have HIV antibodies? The answer lies in such features of human science and society as wishful thinking, scientific ignorance, self-interested researchers, Establishment-gulled media, cure-demanding activists, and so on.

It is another example of the banality of evil; incompetents seeking advancement, honest scientists keeping quiet, bureaucrats covering up, misunderstanding of what medicine and science are capable of, Establishment-cowed media — all those common human and social characteristics seem to be responsible here that so often tritely conspire to produce evil; as Lauritsen points out, "It is a comment on our age: *Nobody is responsible for anything" (The AIDS War,* 435).

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## Notes

1. Longer reviews of these books by the same writer, focusing not on their interest for anomalists but on the relationship with political correctness, can be found in *Virginia Scholar,* #7 (January 1996) & #8 (April 1996).
2. 'Josef Martin,' *To Rise Above Principle: The Memoirs of an Unreconstructed Dean,* Urbana: University of Illinois Press, 1988, p. 46.
3. Ron Westrum, "Social Intelligence about Hidden Events," *Knowledge: Creation, Diffusion, Utilization,* 3 (#3, March 1982) 381-400 and other pieces cited therein.
4. An explanation of that in terms of difficulties among publishers and authors is given in *The Skeptic,* 3 (1995 #2) 42-58 [P. O. Box 338, Altadena, CA 91001; skepticmag@aol.com]. Duesberg's version of the book, *Inventing the AIDS Virus,* is to be published by Regnery in February 1996.
5. A recently published study of essentially all hemophiliacs in Britain concluded that HIV is responsible for a considerably increased death-rate within a few years of infection — Darby *et al., Nature,* 377 (7 September 1995): 79-82. But since no data were given on co-infections or treatments, it cannot be gainsaid that Root-Bernstein could accommodate these data too to the multi-factorial hypothesis.
6. HIV/AIDS Surveillance Report, 5 #4 (through December 1993), p. 29 (from the Division of HIV/AIDS, National Center for Infectious Diseases, Centers for Disease Control & Prevention, Public Health Service, U. S. Department of Health & Human Services).
7. Jon Cohen, "Differences in HIV strains may underlie disease patterns," *Science,* 270 (10 November 1995) 919.
8. Constance Holden, RANDOM SAMPLES — All about AIDS," *Science,* 270 (10 November 1995) 919.

9. Jon Cohen, "New clues found to how some people live with HIV," *Science,* 270 (10 November 1995) 917-8.