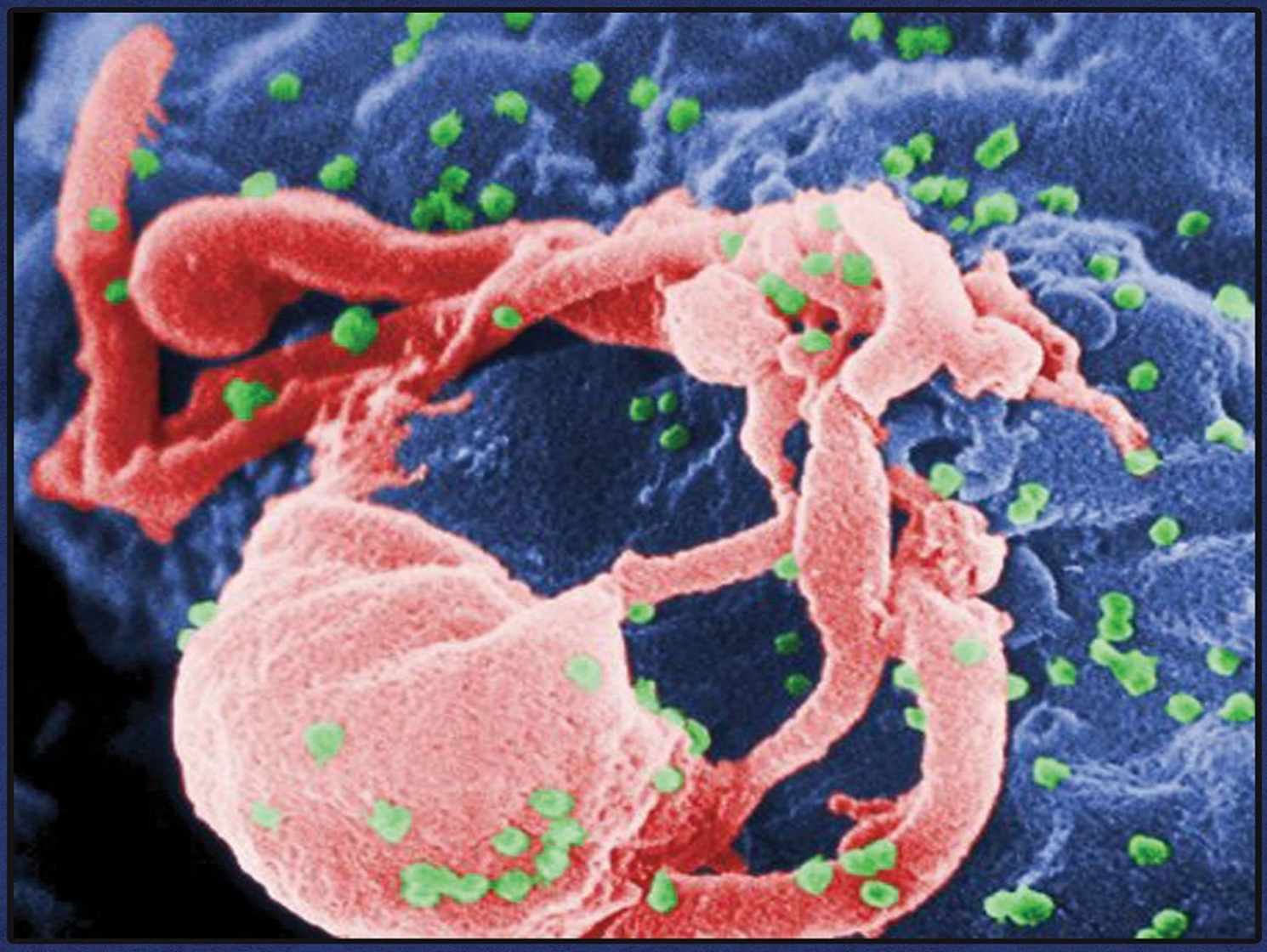
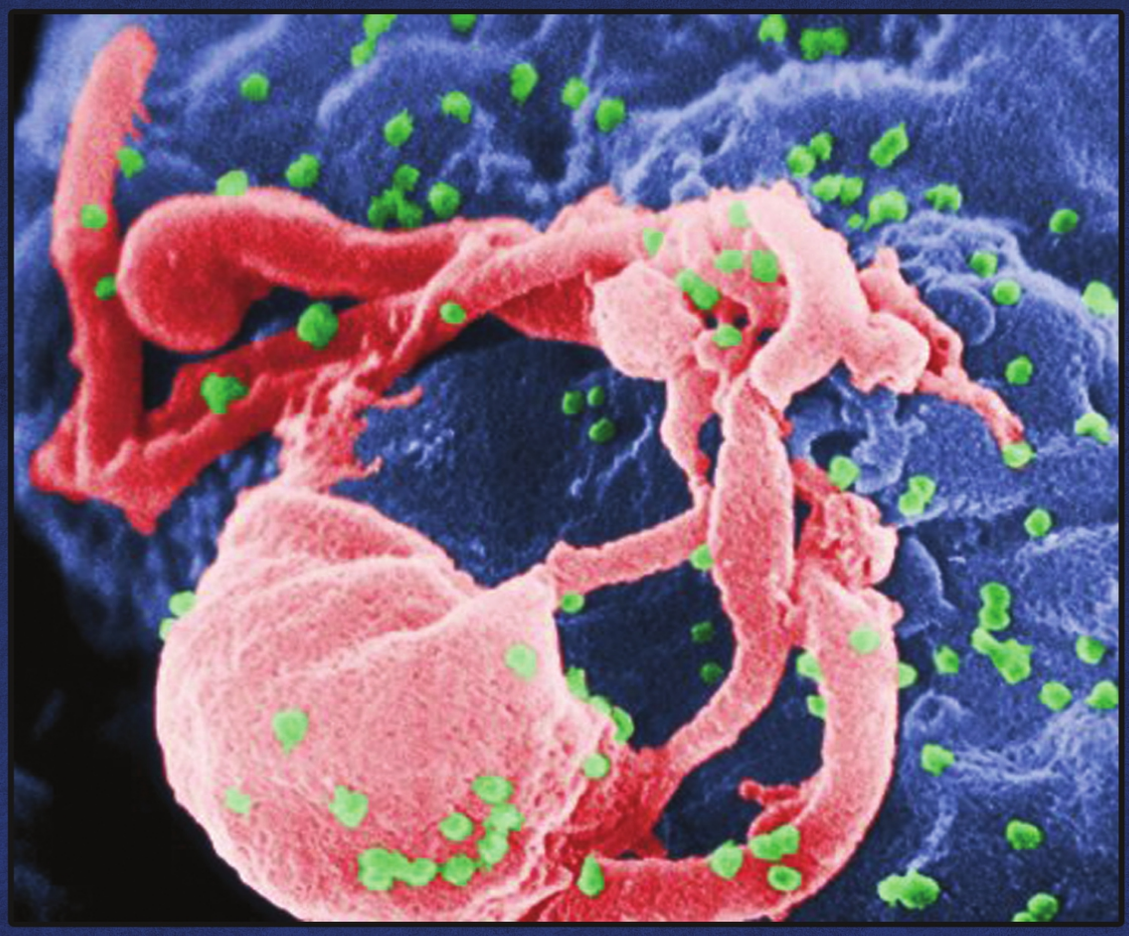
Second Thoughts About Viruses, Vaccines, and the HIVAIDS Hypothesis



Robert O. Young MSc, DSc, PhD



Published by Hikari Omni Media, LLC 16390 Dia del Sol Valley Center, California 92082

Dr Robert O. Young IS available for speaking engagements and full-body, non-invasive body

scans or tests. Please contact The pH Miracle Center at 760-484-1075 or email phmiraclelife@gmail.com
Hikari Omni Media, LLC 16390 Dia Del Sol Valley Center, CA 92082 www.HikariOmnimedia.com or www.phoreveryoung.com The publisher and author are not responsible for websites (or their content) that are not owned by the publisher or author.
Photography by Robert O. Young, MSc, DSc, PhD
ISBN: 1484972406 ISBN-13: 9781484972403
Printed in the United States of America

In the sciences, people quickly come to regard as their own personal property that which they have learned and had passed on to them at the universities and academies. If however, someone else now comes along with new ideas that contradict the Credo (that has been recited for years and passed on in turn to

***others) and in fact even threaten to overturn it, then all passions are raised against this threat and no method is left untried to suppress it. People resist it in every way possible: pretending not to have heard about it; speaking disparagingly of it, as if it were not even worth the effort of looking into the matter. And so a new truth can have a long wait before finally being accepted.* -Goethe**

Viruses
Introduction

The first isolation of a virus was achieved in 1892 by Russian bacteria hunter Dimitri-liquid through a filter fine enough to retain bacteria; yet to Iwanowski's surprise, the bacteria-free filtrate easily made healthy plants sick. In 1898 a Dutch botanist, Martinus Willem Beijerinck, repeating the experiment, also recognized that there was an invisible cause and named the infectious agent "tobacco mosaic virus." In the same year as Beijerinck's report, two German scientists purified a liquid containing filterable viruses that caused foot-and-mouth disease in cattle (viruses were at one time called "filterable viruses," but eventually the term "filterable" came to apply only to viruses, and was dropped). Walter Reed followed in 1901 with a filtrate

responsible for yellow fever, and soon dozens of other disease-causing viruses were found.

In 1935 another American, Wendell M. Stanley, went back to the beginning and created pure crystals of tobacco mosaic virus from a filtered liquid solution. He affirmed that these crystals could easily infect plants, and concluded that a virus was not a living organism, since it could be crystallized like salt and yet remain infectious. Subsequently, bacteriologists all over the world began filtering for viruses, and a new area of biology was born-virology.

Historically, medical science has vacillated on the question of whether a virus is alive. Originally it was described as nonliving, but is currently said to be an extremely complex molecule or an extremely simple microorganism, and is usually referred to as a parasite having a cycle of life. (The term "killed" is applied to certain viral vaccines, thus implying an official conviction that viruses live.) Commonly composed of either DNA or RNA cores with protein coverings, and having no inherent reproductive ability, viruses depend upon the host for replication. They must utilize the nucleic acids of living cells they infect to reproduce their proteins (i.e., trick the host into producing them), which are then assembled into new viruses like cars on an assembly line. Theoretically, this is their only means of surviving and infecting new cells or hosts.

Birth of Virology-a Miscarriage?

Underlying the birth of virology was the doctrine of monomorphism-that all microorganisms (herein called microforms) are fixed species, unchangeable; that each pathological type produces (usually) only one specific disease; that microforms never arise endogenously, i.e., have absolute origin within the host; and that blood and tissues are sterile under healthy conditions. This last point warrants immediate comment. Theoretically, under ideal health conditions the blood might be sterile, though it has the inherent potential to develop morbid microforms, as discussed in the main text of this book. Long and repeated observation of live blood in the phase-contrast, dark-field microscope, however, shows that the blood can contain various microforms in an otherwise asymptomatic host, or in a condition defined as normal or healthy in orthodox terms. The forms are easily visible before other physical

symptoms arise. (Since long and repeated observation has correlated their presence with other disease symptoms and their disappearance with the return of health, they serve as indicators of impending outward signs of disease.)

Monomorphism was the cornerstone of developments in 20th-century medical research and treatments. Refusal by the mainstream to examine fairly, much less accept, the demonstrated facts of pleomorphism-that viruses and bacteria (and also yeast and fungi) are evolutions from the microzyma; that microforms can rapidly change their form (evolve and "devolve") in vivo, one becoming another dependent upon conditions in the inner terrain (environment); that blood and tissues are not necessarily sterile; and that there are no specific diseases, but only specific disease conditions-was the foundation of a latter day "Galileo debate." It is so called because those who wore the "robes" of scientific authority, reprising the religious fanatics who punished the noted astronomer for his truths, would not be swayed from folly when presented with its contrary proofs. These proofs began in earnest with Antoine Bechamp in the last century (who also endured the indignation of a fanatical clergy).

In the early third of the 20th century, the heated debate took place over filterable bacteria versus non-filterable. This was a major battle concerning micromorphology (discussed briefly below). The orthodox view prevailed: bacterial forms were not small enough to pass, or did not have a smaller, earlier stage. What passed through "bacteria-proof filters was something else, i.e., viruses. Standard medical textbooks long made this fdtering distinction between bacteria and viruses. Subsequently, however, the cellular nature of many filterable forms originally thought to be viruses, such as some mycoplasmas, rickettsias, and various other groups, has been established. In this writer's opinion, with the victory of the monomorphic view, deeper understanding of infectious "disease" was lost, setting the stage for cancer, degenerative symptoms and AIDS.

What You See?

A typical bacterium is about 1 micron in size. Most filterable forms now called viruses range in size from .3 microns (300 millimicrons) to .01 micron (10 millimicrons)-partially in the colloidal range (.1 to .001 micron). Most of

the larger viruses are a third to a quarter the size of the average bacterium. Size is critical because .3 microns is the resolution limit of modern-day light microscopes (except for the claimed resolution of Canadian microscopist Gaston Naessens' Somatoscope, at .015 microns). Thus, as viruses were discovered (except for the very large ones, such as mumps), they required an electron microscope to be seen, especially given the fact that Royal Rife's microscope technology and career were destroyed by vested interests. Unfortunately, electron microscopes and the process of chemical staining disorganize all specimens, whereas Rife's technology allowed life to proceed and thus evolve under its lens. As viruses became visible to advancing technology, the ramification was that the technology revealed, to minds infected with monomorphism, protein structures deemed foreign to the body.

A New Theory

Formulated by Bechamp in the 19th century, microzymian principle is the basis of a new theory about "viruses." Briefly, this principle holds that in all living organisms are biologically indestructible anatomical elements, which he called microzymas. They are independently living organized ferments, capable of producing enzymes and capable of evolution into more complex microforms, such as bacteria. Bechamp's thesis is that disease is a condition of one's internal environment (terrain); that disease (and its symptoms) are "born of us and in us"; and that disease is not produced by an attack of microentities but calls forth their endogenous evolution. (The common biological basis for this is discussed below.)

My studies and research suggest that the complexes science calls viruses and retroviruses originate in the cell as microzymian principle suggests. However, they are created in response to an alarming situation (condition of disease) for the purpose of genetic repair. They are repair proteins evolved from anatomical elements (microzymas), not pathogenic organisms.

It is known that normal cell activity includes genetic repair. Both enzymes and proteins must be involved. What is the mechanism? Viruses are organized around DNA or RNA, not both. Thus, they are quite probably intended to repair genetic molecules or other structures, and show up with disease symptoms because the body needs them. Since viruses require a living cell/host for reproduction, how do we know that the scenario is not set

in motion for a purpose by the cell (i.e., its microzymas), rather than being the result of invasion? Because disease (disturbance of balance in the organism) is so prevalent, especially that which has not yet become indicated by common symptoms, repair proteins may be frequently or constantly present. A toxified cell may easily suffer localized damage to the genome. Since most observers are not even aware of microzymian principle, much less understand or even consider it, and since monomorphism stresses invasion, these protein complexes are regarded as foreign and disease is attributed to them.

Another note of interest is the size of viruses compared to the microzyma. Viruses are considered to be some of the smallest biological particles and are frequently of colloidal size: e.g., hepatitis A, 27 nanometers (.027 microns); hepatitis B (.042 microns); poliovirus (.03 microns); EBV (.042 microns); fflV (.080 to .12 microns), influenza (.08 to .12 microns); mumps (.15 to .30 microns); smallpox (.30 x .24 microns); and, according to Bechamp, the microzyma (.0005 microns). This coincides with what Gaston Naessens says about the size of his somatid, which ranges from "a few Angstroms to a tenth of a micron."[1]

In his book, ***The Blood and Its Third Anatomical Element***, Bechamp states: "The microzyma is at the beginning and at the end of all organization. It is the fundamental anatomical element whereby the cellules, the tissues, the organs, the whole of an organism are constituted living. … In a state of health the microzymas act harmoniously and our life is, in every meaning of the word, a regular fermentation. In the condition of disease, the microzymas do not act harmoniously, the fermentation is disturbed, the microzymas have either changed their function or are placed in an abnormal situation by some modification of the medium."[2] The virus is either a self-ordered microzymian polymerization, or (less likely) a structure made by microzymas. It is enveloped in protein which is also composed of microzymas, and could well be thought of as an autonomous molecular tool box.

Along with Drs. Glen Dettman and Archie Kalokerinos, I wonder, "whether Bechamp's writing anticipated, in some respects, the discovery of RNA and DNA?" Could the genetic structure be the construct, thus a tool, of the microzyma? They quote a personal communication (1974) from a Professor

Bayev of the USSR Academy of Sciences, who discusses his work showing that molecular self-restoration from its parts of pure transfer RNA from brewer's yeast is possible.[3]

In my own research I have found molecular restorations similar to that described by Bayev. In my experiment I used five-year-old coagulated capillary blood from a woman with cancer. With one drop of 0.9% of sodium chloride, the blood was restored to an appearance and level of activity characteristic of a freshly drawn sample. In other words, the anatomical microzymas of the dried blood were restored to activity. Even the white globules became active. One might eagerly ask for an explanation of the reversal of polymers made during clotting. It is unclear at this point how this reversal takes place, except to say that what can evolve apparently has the potential to devolve. It is observable, however. For example, I have seen, and recorded on video, rod microforms retrograding without any visible decomposition from 10 microns in length to the vicinity of .1 micron.

This research supports the very important postulate that the cell is not the smallest living biological unit, as promulgated by conventional medical science. In fact, a smaller biological unit is the imperishable microzyma, which is an organized, living being "of a special category without analogue," said Bechamp, who found them ready to become active in chalk deposits at least 11 million years old.[4]

The Pleomorphic Cycle

I suggest a developmental cycle in vivo consisting of three macrostages: (1) a primitive stage comprising the repair protein complexes; (2) an intermediate, or bacterial, stage including filterable forms such as the cell-wall deficient forms described by Lida Mattman, Ph.D. (in Cell Wall Deficient Forms, Stealth Pathogens); and (3) a culmination stage consisting of yeast and fungal phases, and then mold, the end phase. The usual course of development would be from microzyma to repair protein and then to bacterium, etc. However, under certain conditions, such as trauma for example, it is highly likely that the microzymas can skip the primitive stage and become bacteria directly. Although these transformations are as astounding as that of a larva to a butterfly, what is equally impressive under observation is the rapidity with which they can take place-in minutes, even

seconds, sometimes. By the same token, when provoked by conditions and the cycle proceeds to yeast, fungus and then mold, it may occur so rapidly that the bacterial stage, if it happens, has no time to be of any significance.

Thus, symptogenic microforms can originate within higher organisms without invasion, via a permutation of the endogenous microzymas when the situation calls for such change. The situation is an imbalance referred to by Bechamp as a "modification of the medium." Endogenous evolution is evident under the microscope when bacterial, yeast, and fungal forms are seen coming out of red blood cells which initially appear normal.

Biological Basis for the Pleomorphic Cycle

There is a common biological basis for the pleomorphic cycle and its increasing complexity of organization: More complex forms evolve inherently upon the death of an organism for the purpose of recycling its anatomical and chemical structures in the carbon cycle. The process of rapid evolution (which is reversible) is an essential life process which, beyond the repair stage, is necessary to return a dead organism to the earth. The second and third-stage microforms degenerate the body's vital substances and tissues via putrefaction (bacteria) and fermentation (yeast and fungus). Fermentation results in acid waste products, which further break down tissue. Disease symptoms, then, especially the degenerative type, are not produced by viruses, but manifest as chemical decomposition, or attempted recycling via fermentation and acid toxins, but with "host" survival processes still operable. Obviously, certain other factors may play important roles in producing symptoms, such as heavy metal toxicity, or state of mind, for example. Some of the body's survival methods also produce symptoms commonly called diseases. An example is eczema, an emergency expulsion of acid toxins via the skin.

The aforementioned causal (alarming) situation, or modification of the medium, is chronic acidification (pH imbalance) and oxygen deprivation in the blood and tissues due to acid-forming foods, adverse lifestyle, emotional stress, and environmental stress. This is not oversimplification. Acidification/hypoxia biochemically signals a dead host to the microzymas, while creating collapsed areas (dead zones) of the colloidal system in the

intercellular fluid , and it is the primary physiological disease condition out of which the symptoms commonly called specific diseases arise.

Thus, we distinguish between this disease condition and its consequent symptoms, which include both the morbidly evolved microzymas and the physiological signs commonly thought of as specific diseases. As they develop, microforms (bacteria, yeast, fungus and mold) are actually scavenging forms of the microzyma, developed when disease in the cell life requires tissue to be broken up. These upper development forms are the ones easily visible in the blood before physical symptoms arise. They disappear (devolve) when the recycling task is complete, once again becoming microzymas of the earth and/or air.

Virus or Toxin?

Regarding the early period of virus isolation, a question is whether the unseen entities isolated in filtered fluids were accompanied by the waste products (mycotoxins) of fermentation by yeast and fungus of cellular elements, such as DNA. If virus filtrates are injected into a host to prove virulence, it is almost certain that easily filterable molecular toxins will be introduced as well. Could Dr. Stanley's "pure crystals of tobacco mosaic virus" have been crystallized toxins? If so, they would certainly be highly symptogenic, as are exotoxins at the intermediate stage of the cycle, for example. However, it is not proof of anything that you can create illness by poison injection, except proof of that tautological fact.

In my research utilizing dark-field and phase-contrast microscopy, it is common to see crystallizations in the blood. It is normal for the body to use calcium or other mineral salts, and fats as well, to chelate the waste products from the morbid fermentation of body proteins, fats and sugars. Such crystal deposits are found in cancer tissue as well. A malignant tumor removed from the breast of one of my research clients was found to have numerous calcium deposits attached to it. It is an attempt to render inactive the substances that make our inner streams filthy, poison our cells, and coagulate colloidal systems in blood and intercellular fluid.

The term "virus" is the Latin word for poison, and gives us insight into the immediate cause of disease symptoms-poisons: mycotoxins, endotoxins,

exotoxins, and toxins from environmental sources (many of which are primary or secondary mycotoxins). Orthodox medicine is well aware that it is bacterial toxins more than the bacteria themselves (they feed in us), that cause the symptoms referred to as infectious disease. Little if any emphasis is placed on this fine but important distinction. Always, the germ is emphasized. There is little to no awareness (or acknowledgment), either, of the same role played by toxins of the culminate microforms of the pleomorphic cycle. Their action and the body's response to them are frequently ascribed to viruses, which do not produce toxins but are said to wreak havoc by a number of other means. However, if they participate in symptogenesis in a host it is because they are stimulated to evolve into more complex, toxigenic forms. Somewhat less likely is the possibility that they cause damage as a result of erroneous construction or function, for one reason or another-missing mineral nutrients leading to enzyme deficiencies, for example.

Misconception Breeds Contempt

In addition to chemical toxicity, however, what is the impact of the fear (emotional toxicity) that the word "virus" brings to mind and heart? It has been said that fear is the most deadly of disease conditions. If a "disease" kills one person, the fear of it may kill twenty. General prejudice concerning the danger of viruses is fundamental biological error based on Louis Pasteur's germ theory, and is itself a perpetrator of auto-suggested illness. For example, in Africa doctors attribute some AIDS sickness to "voodoo death" syndrome, the term for illnesses induced psychologically.

According to one nurse, "We had people who were symptomatically AIDS patients. They were dying of AIDS, but when they were tested and found out they were negative they suddenly rebounded and are now perfectly healthy."[5] Ironically, if the germ theory were founded on facts it would be correct to fear viruses, except there would be few, if any, humans living to discuss the issues. These socalled pathogenic entities are to researchers, medical practitioners and the press what criminals are to detectives-the focus and justification of their existence.

The Encyclopaedia Britannica has this to say about bacteria, which relates also to viruses:

The common idea of bacteria in the minds of most people is that of a hidden and sinister scourge lying in wait for mankind. This popular conception is born of the fact that attention was first focused upon bacteria through the discovery, some 70 years ago, of the relationship of bacteria to disease in man, and that in its infancy the study of bacteriology was a branch of medical science. Relatively few people assign to bacteria the important position in the world of living things that they rightly occupy, for it is only a few of the bacteria known today that have developed in such a way that they can live in the human body, and for every one of this kind, there are scores of others which are perfectly harmless and far from being regarded as the enemies of mankind, must be numbered among his best friends.

It is in fact no exaggeration to say that upon the activities of bacteria the very existence of man depends; indeed, without bacteria there could be no other living thing in the world; for every animal and plant owes its existence to the fertility of the soil, and this in turn depends upon the activity of the micro-organisms which inhabit the soil in almost inconceivable numbers. It is one of the main objects of this article to show how true is this statement; there will be found in it only passing reference to the organisms which produce disease in man and animals- for information on these see Pathology and Immunity. {Encyclopaedia Britannica, 14th ed., Vol. 2, p. 899)

The general message of the foregoing article applies even more aptly to viruses in the sense that much fear has been bred and cultivated around them, although they never produce disease symptoms, whereas some bacteria do. The writer of the above understands bacteria, with the exceptions that symptogenic bacteria found in man and animals do not produce disease (only secondary symptoms), that their precursors are endogenous to higher organisms, and they have not “developed in such a way that they can live in the human body.” If anything, the reverse is true. According to one theory of microbiology, microforms have colonized over eons to become higher organisms. In one sense, then, the human body has developed as a specialized environment for them.

An important dimension of the bacterial dependence of higher life forms is the floral population in the human digestive tract. Literally, these “foreign species” keep us alive.

Most bacteria have the same underlying function, whether found in soil, sewage, in the human digestive tract, or elsewhere in nature: they are an essential part of the life processes of higher organisms. They will not or cannot attack healthy cells or tissues, but certain ones will recycle sick or dead tissue in much the same way insect pests are drawn to weaker plants. As Bechamp said, "Nothing is the prey of death; all things are the prey of life."

Following in the wake of misconceptions arising from the fundamental biological error known as the germ theory of disease, defining the filtrates of diseased tissue as a newly discovered infectious microform was the birth of a major corollary error in bioscience.

Viral Behavior Reconsidered

Listed below are ways viruses are said to disrupt or destroy host cells according to orthodox medical science and the germ theory. Following each in italics is a different interpretation following from microzymian principle:

1. Viral proteins insert into the host cell's plasma membrane and directly damage its integrity to promote cell fusion (HIV, measles, and herpes viruses).

Proteins are attempting to repair membrane damage, or enter cells to make other repairs. There is the question as to whether viruses on cell walls are coming or going. In both cases it would be a matter of whether or not a cell has been disturbed by excess fermentation and acidity. But in the former case the cell would be dysfunctional before attachment occurs, thus requiring the repair complex. Another possibility, perhaps remote, is that dysfunctional receptors on cells are in need of repair, or they are covered by these complexes to inactivate malfunctioning cells. Positive electrical charges in a compromised terrain, primarily on acid molecules from fermentations, discharge cell membranes and act as mortar to stick cells together.

2. Viruses inhibit host cell DNA, RNA, or protein synthesis. For example, poliovirus inactivates cap-binding protein, which is essential for protein synthesis directed by capped host cell mRNAs, while allowing protein

synthesis from uncapped poliovirus
mRNAs.

Protein inactivation is probably being done by fermentation or by acidic toxins from fermentation, while "poliovirus" is produced in the cell to reverse the damage. 3. Viruses replicate efficiently and lyse host cells, e.g., liver cells by yellow fever, and neurons by poliovirus.

Highly unlikely. The lysing is more likely caused by acid mycotoxicosis, or by free radicals (ROTS) released in response to mycotoxic stress, or from other sources (ionizing radiation, for example). Repair particles are residual after cell wall disruption.

4. Slow-virus infections (e.g., subacute sclerosing panencephalitis, caused by the measles virus) culminate in severe progressive diseases after a long latency period.

How is this demonstrated? Perhaps "latency" is a period of successful or attempted repair that eventually falters. Symptomology naturally appears in the weakest parts of the body. Excess acidity is always a systemic problem that localizes, just as cancer is a systemic condition that localizes, even though its symptogenic influence may later spread.

5. Viral antigen proteins on the surface of the host cells are recognized by the immune system, and the host lymphocytes attack the virus-infected cells (e.g., liver cells infected with hepatitis B).

Liver cells are damaged beyond repair by mycotoxicosis, and the immune system, our elaborate janitorial service, is cleaning up the garbage. Perhaps the repair protein antigen is expressed to signal immune response (because the cell is beyond repair), which is one explanation for why there are antibodies to these proteins.

6. Viruses damage cells involved in host antimicrobial defense, leading to secondary infections.

The function of immune cells is damaged by fungal infestation and/or overwork by toxic overload, preventing proper cleanup and elimination of disharmonious, symptogenic elements.

7. Viral killing of one cell type causes the death of other cells that depend on them, e.g., degeneration of muscle cells enervated by the attack of poliovirus on motor neurons.

Once again, a misinterpretation and lack of understanding that it is not viral microforms that damage neurons. Toxins from bacteria, yeast, fungus and mold-as well as the fermentation of glucose, proteins, hormones and fats-produce, or influence the body to produce, disease symptoms. Not recognizing the "virus," for what it is, observers attribute disease to it.

8. Host cell responses to viruses include metabolic derangements and transformations resulting in neoplastic changes.

Metabolic derangement has occurred prior to the appearance of repair proteins, due to toxic overload in the cell. It is more likely that the proteins attempt to prevent cell transformation, and that cancerous development is cell conversion from primarily oxidative to wholly fermentative metabolism, mediated by fungus and mold.

Listed below are further orthodox views regarding virus replication, etc., with alternative interpretations in italics.

9. According to orthodox theory, viruses enter a host cell and replicate at the host's expense. Replication is accomplished using enzymes which are distinct for each virus family. For example, RNA polymerase is used by negative-stranded RNA viruses to generate positive-stranded mRNA, whereas reverse transcriptase is used byretroviruses to generate DNA from their RNA template and to integrate that DNA into the host genome.

It is normal for repair proteins to generate enzymes to do their work.

10. One reason suggested for viral tropism (the tendency to infect some cells but not others) is the presence or absence of host cell receptors that allow the virus to attach. It is said, for example, that HIV binds to the protein (CD4) involved with antigen presentation on helper T-lymphocytes, that Epstein-Barr virus binds to the complement receptor (CD2) on macrophages, that rabies virus binds to the acetylcholine receptor on neurons, and that rhinoviruses bind to the adhesion protein (ICAM-1) on mucosal cells.

See number 1 above.

Theoretically, once attached, the entire virion, or a portion containing the genome and essential polymerases, penetrates into the cell cytoplasm in one of three ways: (1) Translocation of the entire virus across the plasma membrane; (2) receptor-mediated endocytosis of the virus and fusion with endosomal membranes; or(3) fusion of the viral envelope with the cell membrane. Theory suggests that within the cell the virus uncoats, separating its genome from its structural components and losing its infectivity before replication. In either the nucleus or cytoplasm, newly synthesized viral genomes and capsid proteins are assembled into progeny virions, which may then bud through the plasma membrane. Unencapsulated viruses may be released also, directly through the membrane.

It is interesting, however, that viruses can somehow choose the "infection" to be abortive, latent or persistent, meaning respectively: (1) viral infections with incomplete replication cycles; (2) persisting in a cryptic state, like herpes zoster within a dorsal root ganglion, which suddenly becomes active to produce shingles;(3) continuously synthesized virions, with or without altered cell function (e.g., hepatitis B). These three ideas, especially latency, have arisen as feeble excuses for the untenable virus theory.

11. In order for viruses to reproduce, they must complete the following four steps:

a). Adsorption and penetration of a cell. The viral particle binds to the host cell membrane. This is usually a specific interaction in which a viral encoded protein on the capsid or a glycoprotein embedded in the virion envelope binds to a host cell membrane receptor and is then internalized. This internalization occurs by endocytosis or by fusion of the virion envelope with the host cell membrane.

This is the mechanism whereby the viral particle enters the cell for the purposes of carrying out repairs to the damaged DNA orRNA.
b). Uncoating of the virus, so that the nucleic acid can be released from the capsid into the nucleus or cytoplasm.

Repair work may require uncoating. An uncoated "virus" in the cytoplasm may have come from the nucleus and not yet have a coat, as in the case of hepatitis B according to medscience. A coat is then created to protect the nucleic acid, to make a communicative or responsive protein complex, or to allow exiting the cell for remote function or for neutralization and recycling by the immune system.

c) Synthesis and assembly of viral products as well as inhibition of the host cell's own DNA, RNA and protein synthesis.

Protein complexes produced in response to an alarming situation-fermentative and mycotoxic stress-are capable of self-ordered replication. As suggested by Bechamp, the microzyma is specific for each organ, therefore specific repair proteins will be needed for specific cells that make up specific organs that are being disturbed. There is the question of why the great numbers in some cases. One possibility is simply overreaction; for example, fever can be extreme.

d) And finally, release of virions from the host cell either by budding or lysis.

(1) Complexes leave the cell for remote function or to be neutralized; (2) Repairs have failed, and complexes are released prior to or during the breakdown of the cell by acid toxins or the immune system.

Further Considerations

Virologists refer to certain microforms as passenger viruses, which are present in asymptomatic situations, riding on their host's genetic molecule like a passenger. To the conventional mind searching for new diseases or for a viral cause of unexplained ones, they are most interesting, because the status of virologists in the scientific community depends upon the pathogenic potential of the viruses they study. Due to their location, passenger viruses are thought to have much disease potential, thus their true function goes unnoticed. These colloidal passengers are the silent majority of animal and human intranuclear proteins essential for genetic repair.

Kalokerinos and Dettman quote Dr. Fred Klenner regarding the changeability of viruses: “I am of the opinion that virus units have the potential of going from one type to another by altering their protein coat. We see chicken pox at Thanksgiving, mumps at Christmas, red measles in the spring, and polio and Coxsackie in the summer.”[6] Seasonal appearance of different forms may be mediated by variations of imbalance in the biological terrain or nutritive medium due to the fermentation of dietary excesses such as sugar and animal proteins that accompany holidays and seasons, calling for different repair proteins.

For example, outbreaks of polio have been associated with sugar consumption in summer. Various psycho-emotional stresses correspond to these seasons as well.

Supporting the general idea of dietary culpability is a statement published by the great English physician, Sir Robert McCarrison in 1936: “Obsessed with the invisible microbe, virus, protozoa as all important excitants of disease, subservient to laboratory methods of diagnosis, hidebound by our system of nomenclature, we often forget the most fundamental of all rules for the physician, that the right kind of food (nutrition) is the most important single factor in the promotion of health and the wrong kind of food the most important single factor in the promotion of disease.“7

Six years before Bechamp identified the microzyma as a ferment and, with his devoted associate, Professor Estor, began a 13-year odyssey of research into its nature, Florence Nightingale published a statement about the germ theory. In Notes on Nursing, 1st ed., 1860, she said of infection:

Diseases are not individuals arranged in classes, like cats and dogs, but conditions growing out of one another.

Is it not living in a continual mistake to look upon diseases, as we do now, as separate entities, which must exist, like cats and dogs, instead of looking upon them as conditions, like a dirty and a clean condition, and just as much under our own control; or rather, as the reactions of kindly Nature against the conditions in which we have placed ourselves?
I was brought up … distinctly to believe that smallpox, for instance, was a thing of which there was once a first specimen in the world, which went on

propagating itself in a perpetual chain of descent, just as much as that there was a first dog, (or a first pair of dogs), and that smallpox would not begin itself any more than a new dog would begin without there having been a parent dog.

Since then I have seen with my eyes and smelt with my nose smallpox growing up in first specimens, either in close rooms or in overcrowded wards, where it could not by any possibility have been "caught," but must have begun. Nay, more, I have seen diseases begin, grow up, and pass into one another. … I have seen, for instance, with a little overcrowding, continued fever grow up; and with a little more, typhoid fever; and with a little more, typhus, and all in the same ward or hut.

Would it not be far better, truer, and more practical, if we looked upon disease in this light? For diseases, as all experience shows, are adjectives, not noun-substantives.

That is, symptoms (called diseases) are describers of a situation.

I find legitimate Bechamp's conclusion that what are called germs of the air are fundamentally microzymas of beings which are being consumed by the recycling process, i.e., some kind of vegetative digestion-putrefaction or fermentation. In short, there are no pre-existing disease-germ species. The principles of microbian medicine constitute a fundamental biological error. As Bechamp said, "The microbian doctrine is the greatest scientific silliness of this age." This is not to say that there is no transmission, only that invasion is not necessary for symptogenesis, nor is it the primary mechanism for illness. It is to say that for transmission to take place, susceptibility in the form of a compromised terrain must pre-exist in the receiver, who is then likely to be ill anyway. With the exception of the immune component in the mucosal barrier, primary host "resistance" is a function of terrain condition rather than immunity per se.

Phantom Viruses Hepatitis

Hepatitis can be a painful symptom that has yielded profitable virus-hunting opportunities in recent years. Although there are several categories of this disorder, three main varieties of what is called "acute viral hepatitis" exist:

Type A (formerly “infectious hepatitis”), Type B (formerly “serum hepatitis”), and hepatitis C (formerly “non-A, non-B”). The corresponding viruses are HAV, HBV, and the non-A, non-B “group,” now called C. Type A is said to be caused by an RNA virus, spread primarily by fecal contamination of water and food, with blood and secretions also possibly being infectious (but it is due to the toxins associated with unsanitary conditions). Hepatitis B, discovered in the ’60s, is said to be caused by a DNA virus which replicates in the hepatocyte nucleus and receives its surface coat in the cytoplasm. It is said to be transmitted by transfused blood or blood products, or via common use of needles by intravenous drug users (but it is due primarily to over-acidification from the drugs, especially heroin. The exchange of body fluids into the blood, whether by unsterilized needles, abusive sexual activity, etc., can also play a role over time because of repeated immune stress caused by foreign proteins. See Section 1 for Bechamp’s view of the invasion of blood by injection of proteins). Third World babies with poor nutrition and unsanitary conditions around the time of birth are also susceptible.

The third type of hepatitis, discovered in the ’70s, is found among drug users and alcoholics, and accounts for 80 to 90% of hepatitis caused by blood transfusion. It is thus akin to B type and was at first thought by scientists to be hepatitis B until thorough testing of subjects revealed no virus B-nor A, for that matter. It was thus called “non-A, non-B” hepatitis and thought to be at least two viruses and perhaps more.
In 1987 scientists believed they found a single virus causing the third type, what is known today as the hepatitis C virus. However, what they identified was an antibody they associated with a virus. Now, just as with HIV, they could test patients for antibodies against an elusive or invisible virus. With this new observation, however, new paradoxes confronted the viral hypothesis. Huge numbers of people testing positive for the phantom C virus never developed any symptoms. Hepatitis is truly the result of over-acidification or toxification of the largest filter in the human body by such substances as lactic acid, acetic aldehyde and ethanol-not the disease of a pathological virus. It is interesting to note also that all these hepatitis viruses have incubation periods of 2 to 25 weeks, violating Farr’s Law (see below), yet are not classified as slow viruses. Also, the point at which a “natural invasion” takes place, as opposed to a highly artificial injective one, and

thus, how true incubation periods are determined, is another interesting question.

Hantavirus

A recent example of unwarranted panic in American biomedicine was the eminent hantavirus of 1994. Presumably it had jumped species, from mouse to man (the American Navaho Indians). However, after supposedly killing a number of people, this phantom virus apparently made peace with the Indians and retired to its mouse reservoir. The virus failed to materialize.[8] A front-page article in the San Francisco Chronicle reported that CDC "epidemiologists across the nation are carefully monitoring the deer mouse population and the level of virus within it." But all that was left to discover of the former "Navaho flu" by the CDC epidemiologists (shown in their space suits) were healthy mice in the mountains.[9] The Navaho flu is nothing new to the native Americans and is most likely tied to sanitation, nutrition and lifestyle.

Ebola

In May 1995 the CDC announced the new, threatening Ebola virus. The deadly killer virus was expected to leave its hidden reservoir in the rain forests of Africa to claim Europe and the United States. An article in Time magazine was peppered with men in space suits and colored electron micrographs of the virus (even though electron microscopes cannot take color pictures). A CDC virologist suggested the virus could leave the rain forest if "we get a virus that is both deadly to man and transmitted in the air." We are thus asked to fear the image of viruses somehow being launched into the air, perhaps by ejection from a host, and then floating on killer breezes to other lands. A more imaginable scenario was suggested by a European epidemiologist who heads the United Nations AIDS program. Echoing the CDC's alarm, he stated, "It's theoretically feasible that an infected person from Kuwait could go to Kinshasa, get on a plane to New York, fall ill, and present transmission risk there." But within a month the virus had disappeared in Africa, and not a single Ebola case was reported in the United States or Europe. [10]

The World Health Organization announced on December 19, 1995 that the Ebola virus epidemic that killed 245 people in West Africa was over. All tests on any remaining suspected cases were negative. A somewhat unsettling revelation was that every Ebola outbreak in Africa "is associated to have spread through public hospitals."[11] As it turned out, it was associated with re-used hypodermic needles in these hospitals. Just like hantavirus, Ebola vanished, never to be heard from again. Most interesting is that this epidemic, as epidemics will, stopped without vaccines or other drugs. But consider the impact such stories have made upon our minds and on the way we view and understand germs. What's next in virodrama, the Andromeda Strain?

There is one insidious possibility that must be mentioned in passing. Some mysterious outbreaks of the past have been shown years later to have been man-made. In some cases, government agency has used the public to test releases of organisms and weak biochemical toxins in order to verify, through medical reports, expectations of biowarfare activity. These incidents and the whole story of such behavior is well documented in the book, A Higher Form ofKillingby Robert Harris and Jeremy Paxman (Hill & Wang, 1982). In this scenario, the cause of such an incident would be constructed officially, or left as a mystery, in order to draw attention away from the truth.

Vaccines
Haphazard Beginnings

The greatest danger of the germ theory half-truth is its promulgation and acceptance as the whole truth, thus diverting attention from endogenous factors, primarily host ecology-resistance and susceptibility. Such factors are highly significant if Bechamp and his many followers, including me, are correct. Distraction from host factors has been quite thorough, with the exception of the false notion that the immune system is the "first line of defense" against infectious symptoms.

Louis Pasteur is credited with improving and successfully using the technique of vaccination, a practice blindly begun in 1796 by British physician Edward Jenner. Jenner happened to notice that dairy maids who had contracted the relatively mild disease cowpox did not later contract smallpox. On a hunch, he took pus from the running sores of sick cows and

injected it into the blood of an eight-year-old boy. As the story goes, the boy developed cowpox. Several weeks later Jenner inoculated the boy with smallpox, but the disease failed to develop. Upon this single anecdotal event was based the supposition that this practice was safe and effective. The process has changed little to this day except perhaps to have been worsened with additives. Its understanding is still clouded by Pasteur's theory, and it is as recklessly pursued as it was begun.

Theoretically, vaccination works by introducing a diluted and weakened (attenuated) or "killed" version of the pathogen into the body, causing the immune system's memory function to prepare for any subsequent contact, which is met with much greater response. It is commonly thought that infectiosity, or germ-virulence, tests are performed on laboratory animals and then vaccines are made which boost the immune system against germs. However, like Jenner's, the tests are primarily toxicity tests, and vaccines, especially viral ones, activate the immune system primarily in response to injected toxins. Whether the response is to toxins, microforms, or both, it is a misguided approach at best. Bypassing the mucosal barrier and thus the segment of the immune system which is the organism's interface with the environment, makes such experimentation, and vaccination itself, flawed, unscientific practice ipso facto.

A Toxin Pathway

Bacteria secrete a variety of enzymes (leukocidins, hemolysins, coagulases, hyaluronidases, fibrinolysins), any of which are disruptive in the body. For example, diphtheria toxin is composed of the enzymatic fragment A, which is at the amino end of the molecule, and fragment B at the carboxyl end, which allows entry into host cells. The two fragments are linked by a disulfide bond. Once bound diphtheria accesses the cell cytoplasm, the disulfide bond is broken, releasing fragment A. This enzyme catalyzes the covalent transfer of adenosine diphosphate ribose (ADPR) from nicotinamide adenine dinucleotide (NAD) to EF-2. The latter, a ribosomal elongation factor involved in protein synthesis, is thus inactivated. One molecule of diphtheria toxin can kill a cell by ADP-ribosylating more than a million EF-2 molecules. In diluted form this toxin, along with other toxic chemicals and fragments of bacteria, is what is introduced directly into the blood of infants under the guise of a health measure.

Diphtheria toxin creates a layer of dead cells in the throat, on which Corynebacterium diphtheriae outgrows competing bacteria (the diphtheria microform is an intermediate stage of a morbidly evolved microzyma, and competing bacteria also evolve out of sick cells). Subsequent wide dissemination of diphtheria toxin causes the characteristic neural and myocardial dysfunctions. Diphtheria toxin also causes disseminated intravascular coagulation, which activates the various alarm responses of the body. Thus, we know that toxins produce symptoms, but what is it that produces the condition which creates or supports the toxin producer?

Bordetella pertussis is a fascinating organism to study. A certain amount of empiricism, as opposed to logic, is required for success with pertussis. Diagnostic cultures are difficult and sometimes unreliable. Different lots of vaccine, made in the same way from the same strains, sometimes show different properties. Experimental work is not always reproducible from one laboratory to another, but this is common in biological research. The diagnostic culture problems and the unexpected variability in vaccines and in pertussis strains themselves are not easy to explain.

-Charlotte Parker Department of Microbiology, U. of Texas at Austin
Vaccine Recipes

To make a vaccine you need to acquire the disease germ-a toxic bacterium or a live virus. The mumps virus is a sterile, lyophilized preparation of the Jeryl Lynn (B level) strain of mumps virus. It is adapted to, and propagated in, cell cultures of chick embryo, free and stabilized with sorbitol and hydrolyzed gelatin. The rubella virus (Wistar RA 27/3 strain) is grown in human diploid cell cultures. Measles (from Eners' attenuated Edmonston strain) is grown in cell cultures of chick embryo.[12] The various so-called virus strains are stored by pharmaceutical companies for later culture. Where these stockpiles come from and the specific methods used seem to be guarded secrets, but as Bechamp emphasized, they must originally be obtained from diseased higher organisms, for they are found nowhere else in nature. If protein complexes exist in the viral stores, their replication in culture is simply the behavior pattern of the repair proteins they are. It is highly likely that toxins accompany these strains as a means of stressing the culture cells.

To make a live vaccine, the microform must be attenuated, or weakened. This is accomplished by serial passage-passing the microform/toxin many times through animal tissues, e.g., monkey kidneys, human diploid cells (the dissected organs of an aborted fetus), chick embryos and calfs.[13] Killed vaccines are prepared with heat or radiation, or else chemically, usually by using the mycotoxin formaldehyde.[14]

The weakened microform must be mixed with antibody-boosting and immune-activating adjuncts such as the antibiotics neomycin and streptomycin, as well as stabilizers such as sodium chloride, sodium hydroxide, aluminum hydroxide, aluminum hydrochloride, sorbitol, hydrolyzed gelatin, formaldehyde, and thimerosal (a mercury-based antiseptic).

For example, diphtheria, pertussis and tetanus (DPT) vaccine consists of a combination of tetanus and diphtheria exotoxins with pertussis microforms. Diphtheria toxin is produced by growing Corynebacterium diphtheriae in a medium composed of pig pancreatic hydrolysate of casein. Tetanus toxin is produced by growing Clostridium tetani in a medium composed of pig tryptic digest of casein. Both toxins are combined with formaldehyde, ammonium sulfate (a mycotoxin), and diluted with saline containing thimerosal. They are then adsorbed on aluminum phosphate and combined with a suspension of Bordetella pertussis organisms.[15]

The first pertussis (whooping cough) vaccine was created in 1912 by two French bacteriologists, Jules Bordet and Octave Gengou, who wanted to use it on the children of Tunisia. After growing the pertussis bacteria in large pots, they killed them with heat, preserved the mixture with formaldehyde, and injected it into the children.

One change made in the original Bordet/Gengou recipe was to add an “adjuvant.” This material, usually a metal salt, somehow heightens the capacity of the pertussis vaccine to produce antibodies in the host. In 1943 a pioneer American pertussis vaccine researcher, Pearl Kendrick, reported that alum had this adjuvant effect. The vaccine was said to be more protective, and fewer pertussis bacteria had to be included. After her report, alum or alum-based substances were added to the vaccine. Kendrick was also

instrumental in having pertussis combined with diphtheria and tetanus vaccines already in use in the 1940s.

The vaccine is made in essentially the same way today as in the time of Bordet and Gengou, although each manufacturer prepares it differently, and the exact processes and formulas are considered trade secrets. Pertussis bacteria are usually grown on a casein hydrolysate medium with yeast dialysate, supplemented with agar and charcoal. The mixture is prepared in vats, then washed, and the bacteria killed with heat and formaldehyde The resulting toxoid is preserved with thimerosal. Other possible ingredients are hydrochloric acid, the adjuvant (usually an aluminum compound), sodium hydroxide, and salt.

In the past, human blood was often added. This is now prohibited by federal law, but manufacturers are still permitted to add blood from "lower animals other than the horse." The microzymas of horse blood destroy human blood.

The vaccine is stored for a while at near-freezing temperatures, then combined with the diphtheria and tetanus exotoxins and poured into vials for distribution. Ultimately it is shipped to pharmacies, private physicians, and public health clinics, whence it is injected into the blood of infants.

Calf Serum

The precedent of cruelty to animals, promoted, if not set, by Louis Pasteur, is apparently a hallmark of germ theory. It is not better demonstrated than by the following description of the preparation of so-called calf serum dreamt up in the early days of vaccine manufacture, and continuing, as far as I can tell, into the late 1980s, if not to this day:

A calf is strapped down to an operating table. A space on the abdomen of about 12-15 inches is shaved with a razor, then about 100 slashes are cut into the flesh. The seed virus, consisting of a culture of smallpox passed through a solution of glycerine, is rubbed into the wounds.

Made to stand in a headstock so it cannot lick its belly, the calf grows very sick and the wounds become swollen and inflamed. In a few days, as the body reacts to the poison, small blisters appear, scabs form over the wounds

and fill with pus. In five to seven days, the wounds are ulcerated, issuing pus and morbid cells. The calf is again strapped to the operating table, and the infested area is washed with warm water. Each scab is scraped off and its contents are pressed out of the sores into a container. An equal amount of glycerine is added to the pus, and the whole is stirred. Once thoroughly mixed, the concoction is passed through a sieve to remove solids such as pieces of flesh, scabs and hair. After being stirred once again, the mixture is put into vials, sealed, and distributed as "pure calf lymph," commonly known as smallpox vaccine.[16]

These aforementioned concoctions are obviously poisonous products of disease. By injecting these products into the blood of school children, physicians, via legal manipulation of health boards and school boards, potentiate illness and ensure that medical products and services will continue to be in high demand. It is interesting to note that the vaccine given to those considered to be at high risk for hepatitis A (such as highly overactive homosexual males, users of illicit injectable drugs, residents of a community experiencing hepatitis A, hemophiliacs and other recipients of therapeutic blood products), or those testing positive for hepatitis A, is made of immune serum globulin obtained by ethanol fractionation of plasma pooled from hundreds of donors. Considering that microzymas and morbidly evolved microzymas are being transferred from one individual to another, one might conclude that this could have disastrous consequences. (The fact that animal blood and fluids are transferred to humans by vaccination bears no further comment, except to say that Frankenstein would be proud.)

It is also very interesting that the vaccine given to those testing positive for hepatitis B is created by cloning the antigen HBsAg in a bed of yeast {Saccharomyces cerevi's Jae, the culminate stage of the morbidly evolved microzyma) and formulated as a suspension of the antigen adsorbed on aluminum hydroxide. [17] Such morbid, poisonous vaccines are given to infants at 2, 4, and 15 months of age. The vaccine is enough to disturb the central balance of the biological terrain and cause an array of symptomologies in anyone, especially an infant. That more people are not quickly poisoned to death by this practice is testimony to the astounding resilience of human physiology.

Vaccination Results

Does the vaccinal approach produce wellness or any health benefit? Kalokerinos and Dettman point out that statistics in England and Wales, presented at the Presidential Address of the British Association for the Advancement of Sciences (Porter, 1971), show that deaths of children under 15 years of age attributed to scarlet fever, diphtheria, whooping cough and measles saw a 90% decline from 1850 to 1940. Yet, antibiotics and compulsory (i.e., widespread) vaccination against diphtheria were not introduced until 1940. The death rate due to these illnesses dropped from over 6,000 per million children in 1850 to under 1,000 per million children in 1940, a period marked by vastly improved public health, sanitation and nutrition.[18]

Along the same lines, an English doctor, D. Powles, observed: "The major contributing factor toward improved health over the past 200 years has been improved nutrition. Nearly 90% of the total decline in the death rate in children between 1860 and 1965 due to whooping cough, scarlet fever, diphtheria and measles occurred before the introduction of antibiotics and widespread immunization against diphtheria."[19] Also, it has not been well publicized by authorities that infectious epidemics are naturally cyclic in populations. The procedure has generally been to introduce vaccines as the downcurve begins, giving the impression of effectiveness. In addition, there are numerous instances in history of violent outbreaks of illness following near-total immunizations of population groups.

Once I looked into this subject and its history, microzymian principle brought it into focus for me. Since germs evolve out of, or take advantage of, the susceptible state, and are symptoms themselves, drugging or vaccinating susceptible individuals cannot render them immune, and may have the reverse effect. When and if a vaccine works as intended, the result is only to suppress the appearance of a specific set of symptoms, not to prevent disease. Therefore, it is not conferring wellness, nor reducing susceptibility, but simply creating an effect in a highly artificial and dangerous manner, while allowing the disease condition to worsen. Is there a price to pay for this invasive and unscientific approach? In this writer's view, it is what we've got-pandemic degenerative disease, cancer and AIDS, because we are not dealing with the foundational disease, which may then get worse and re-expresses itself in more intense ways.

Contaminants

The November/December 1995 issue of The Vaccine Reaction, Volume 1, No. 5, issued by the National Vaccine Information Center, reveals that Swiss scientists have reported finding the enzyme reverse transcriptase (RT) in the live measles/mumps/rubella (MMR) vaccine. This has been traced to the chicken embryos whose cells are used to create the vaccines. It has reportedly been detected in yellow fever and some influenza vaccines, also prepared in chicken embryo cells. No disease has been attributed to RT in the MMR vaccine, but it is a factor in retroviral disease theory and its presence in this case is a mystery. RT, which is officially said to be produced by many "tumor-producing" viruses, supposedly the retroviruses, catalyzes the transformation of RNA into DNA. However, there is no proof of viral production of tumors-only theory.

I suggest the following process to explain how it gets into the vaccine, based on microzymian principle: Disruption of the embryo cells, by toxins or other means, probably damages their DNA. The response is endogenous microzymian production of repair protein complexes ("retroviruses"), which in turn produce RT in order to effect repairs. As the toxification process continues, central balance in the embryo cells is disturbed sufficiently and the ensuing endogenous pleomorphic development of upper development forms results in excess fermentations, with corresponding increase in the level of toxins. In order not to "spoil the broth," however, preservatives are added at a certain point to arrest development.

Experiments with fertile eggs, which I later discovered were described by Bechamp, provide evidence of endogenous microzymian development. I have observed that the hypodermically extracted serum of a fresh egg looks normal under a high powered light microscope. However, when the central balance is disturbed by shaking the egg, which is then allowed to sit for a period of time, extracted serum shows the presence of bacteria, yeasts, and their associated toxins, i.e., acetic, sulfuric and butyric acids. An equally elegant, but even simpler, demonstration is bruising an apple without breaking the skin. Soon the area begins to turn brown and rot from the inside. This is a life process mediated by endogenously developed microforms.

The enzyme that orthodox researchers associate with retroviruses is being found in live vaccines such as MMR and polio. But RT does not cause disease. It is toxins which taint the vaccine, whether produced in culture or introduced as ingredients, that have the potential to interact with each individual's immune system and DNA and disrupt the body such that various symptoms are produced. This practice of introducing foreign (genetic/viral) proteins directly into the blood may result in morbid pleomorphosis with further potential for toxification. Of course, that is precisely what has been occurring for many years, with the blessing of the allopathic medical system, whose financial health depends on disease.

Another example of unwanted or unpredictable vaccine contaminants: polio vaccines grown on monkey kidney have been identified as a source of simian viral (SV40) and spherical retroviral structures.[20] Such stray protein structures and fragments in vaccines can be regarded as a large, uncontrolled, cross-species genetic experiment in which a gene from one species might be spliced as a repair protein into another.

Reactions

Though secondary to the failure to address disease, vaccine reaction has become the more common issue because of its immediacy. It results from the aggressive willingness of medical authorities to play Russian roulette with people's lives. When asked about potential, dangerous reactions, officials reply, "The benefits outweigh the risks." The simple fact is, there are no benefits, even before we get to the fact that this assertion is based upon statistical information that seems far from complete. According to the U.S. National Vaccine Information Center, more than 54,000 adverse events following vaccination, including convulsions, encephalitis and deaths, were reported to the FDA during a three-year period ending October 1993. However, since the FDA estimates that only 10 percent of doctors report adverse events, the real number could have been extremely high, more than half a million, including 50 or 60,000 serious injuries and 10-11,000 deaths. Connaught Laboratories, a vaccine manufacturer, estimates a 50-fold under-reporting of adverse events.

I can find no accurate statistical estimate for how many deaths and serious injuries are caused by vaccinations each year in the United States. It appears

as though the government would rather not release such information, although a federal fund has been set up to cover the millions of dollars in lawsuits that are always pending. Thus, the law has been constructed so that perpetrators of this damaging practice cannot be sued, but continue to profit, while the government shields them with the people's money.

Perhaps the government feels that with no way to enforce accurate reporting from doctors, it is futile to indulge in a guessing game. From the doctors' perspective, there is little to gain from reporting, except an inexorable and embarrassing statistical slide toward collision with the truth. Consider these words from Kalokerinos and Dettman 20 years ago: "Moreover, it is disappointing to observe the futility and ineffectiveness of many 'flu' vaccines that have been accepted by an unwary public."[21] In this writer's opinion, the statement applies to all vaccines.

Taken in the Rear

Montague R. Leverson, M.D., Ph.D., M.A., an American physician, happening to come across some of Professor Bechamp's writings in New York, became fascinated with his views. Realizing that the dated works anticipated Pasteurian "revelations" in certain important points, he decided to go to France to meet Professor Bechamp, where he heard the story of Pasteur's plagiarism of the professor's work directly. In a lecture entitled "Pasteur, the Plagiarist," delivered at Claridge's Hotel, London, on May 25, 1911, he outlined briefly Bechamp's claim to be the first to produce a ferment in a medium containing no albuminoid matter, something thought impossible up to that time. (Ethel Douglas Hume's book about Bechamp was based on work begun by Leverson, who is also the translator of Bechamp's masterwork, The Blood.)

Understanding microzymian principle, he had this to say about inoculation:

When a drug is administered by the mouth, as was beautifully pointed out by Dr. J. Garth Wilkinson, in proceeding along the alimentary canal it encounters along its whole line a series of chemical laboratories, wherein it is analyzed, synthesized, and deleterious matter is prepared for excretion,

and finally excreted, or it may be ejected from the stomach, or overcome by an antidote.

But when nature's coat of mail, the skin, is violated, and the drug inserted beneath the skin, nature's line of defense is taken in the rear, and rarely can anything be done to hinder or prevent the action of the drug, no matter how injurious, even fatal it may be. All the physicians of the world are incompetent either to foresee its action or to hinder it. Even pure water has been known to act as a violent… poison when injected into the bloodstream. How much more dangerous is it, then, to inject poisons known to be such, whether modified in the fanciful manner at present fashionable among vivisectionists or in any other manner… . Inoculation should be regarded as malpractice to be tolerated only in case of extreme danger where the educated physician sees no other chance of saving life.

Now the forcing of these inoculations upon individuals by law is one of the worst of tyrannies imaginable, and should be resisted, even to the death of the official who is enforcing it….
… The entire fabric of the germ theory of disease rests upon assumptions which not only have not been proved, but which are incapable of proof, and many of them can be proved to be the reverse of truth. The basic one of these unproven assumptions, the credit for which in its present form is wholly due to Pasteur, is the hypothesis that all the so-called infectious and contagious disorders are caused by germs, each disease having its own specific germ, which germs have existed in the air from the beginning of things, and that though the body is closed to these pathogenic germs when in good health, when the vitality is lowered the body becomes susceptible to their inroads.

Dr. Leverson goes on to describe disease as nature's attempt to eliminate waste, and diseased tissues as being due to improper living. He suggests plenty of fresh air, the best sanitation, scanty clothes, and a scientific study of diet. He saw overeating as the precursor to "an enormous number of diseased conditions."[22]

Vaccine Causes Polio Symptoms

Although Leverson is correct in his criticism of inoculation, even the body's amazing "coat of mail" sometimes fails to be enough, as oral vaccine also poses danger. In a report on the Internet by Nando.net/Associated Press, we have a statement by Dr. Rebecca Prevots of the Center for Disease Control in Atlanta (Jan. 30, 1977) that almost every case of polio in the United States between 1980 and 1994 was caused by, or related to, the oral vaccine itself, "which consists of a live but weakened virus," the CDC said. But, they hasten to add, there is a new, safer plan. "This emphasizes the timeliness of the change in policy," said Prevots. Time is said to pass in a different manner for different personalities, but it still seems a bit of a stretch to apply "timeliness" to a period of 14 years with 133 impacted lives involved.

The new policy is "expected" not to eliminate risk but to cut it in half. In the official oddsmanship game of risk versus benefit, this is tendered as comfort to those yet to be afflicted. It consists of two preliminary killed-virus injections given to infants in the first four months "… to build up their immunity to polio. Then they are given two oral doses of 'weakened-virus' vaccine between ages 1 and 6." One can only hope that these microbists desist from this folly because, in addition to their misplaced belief in germ theory, they do not yet understand that the extent of vaccine risk goes beyond reaction.

Compulsory Vaccination

As Leverson emphasized, people are forced to this abomination by law in many cases, especially schoolchildren. Overcoming this assault on human rights usually requires extreme persistence, courage and a knowledgeable approach. (I don't recommend his approach, but it is self-defense!) The argument is literally that those at risk for damage must be sacrificed to save millions of others (i.e., "the benefits outweigh the risks"). But there is no science or even logic to this. If one is vaccinated, theoretically one is safe. If one chooses not to be vaccinated, then s/he does not threaten vaccinated people, but only those who have chosen that risk. Yet, the responsibility for the decision has been stolen from families under the guise of government responsibility to protect children from parents.

The unvaccinated, threatened by medical authority with the risk of developing a serious "disease," are not told that said risk is greatly increased

by germ theory mentality itself. It's the medical equivalent of a mob protection racket, and the law has been manipulated to maintain the profitability of ill health produced by this practice. Holistic means of preventing or dealing with these symptoms are not even in the equation.

To summarize, if we consider Bechamp's thesis that bacteria are evolved forms of anatomical elements called microzymas, that there are specific disease conditions rather than specific diseases, and that the microform is not the antecedent of disease, but arises in it; and if we add to this my thesis that the primitive stage of evolution, viruses, are apathological and created as response to structural breakdown, and that yeast, fungus, mold and their symptogenic poisons produce the symptoms attributed to viruses, is it possible that medical science is misdirected, if not malfeasant, in its intense pursuit of vaccinal answers? Was Bechamp on the right track? Are his many followers, including myself, correct as well? Is this why we cannot make a successful vaccine, and have, in fact, made dangerous and deadly ones?

On a final note of sanity, Edgar Cayce, the renowned psychic who could diagnose illnesses and treatments while in trance, was asked and answered the following question during a diagnostic session:

Q. Can immunization against contagious diseases be set up in any other manner than by inoculations?

A. If an alkalinity is maintained in the system-especially with lettuce, carrots and celery, these in the blood supply will maintain such a condition as to immunize a person. In an alkaline system there is less effect of cold and congestion.[23]

HIV/AIDS and the Monomorphic Disease Model

In 1960 a veteran retrovirologist urged his peers to "raise questions whether the known facts about viruses suffice to account for it." The subject was cancer, the veteran was Peyton Rous, and the quote is from a paper in Cancer Research. Mindful of that example, in 1987 I asked a similar question in a paper likewise published in Cancer Research: whether the known facts about two human retroviruses suffice to account for leukemia and AIDS.

Clearly, following Rous's example did not make me very popular with the multinational club of retrovirologists. My article was officially ignored and not "dignified" with a response because the AIDS virus establishment was "too busy … saving lives" and testing for antibodies to HIV. I was often shunned like an AIDS patient by my former fellow retrovirologists. My views were unwelcome for several reasons: after a frustrating, twenty-year-long search for a human cancer virus, the retrovirologists were craving for clinical relevance and hence happily adopted HIV-"the AIDS virus"-as the cause of AIDS. The discovery of HIV was announced in the U.S. at a press conference and the virus-AIDS hypothesis became instant national dogma. On this basis, the retrovirologists convinced their governments to spend billions of dollars to stop the predicted viral epidemic, already being labelled "the epidemic of the 20th century." The virus was also the immediate darling of the biotechnology companies. Due to its very low complexity, it can be readily cloned for diagnostic test kits and vaccines. In turn, the virus was a hit with the press because it mobilized in readers the instinctive fears of a contagious disease, and appealed to the public prejudice that all evil comes from without.

-Peter H. Duesberg, Ph.D.

What Proof?

Perhaps the foremost thing that should be said about HIV is that it has never been proven to be the cause of AIDS, or any human illness for that matter. Not one scientific paper exists that demonstrates it. Based on activity in contrived situations in test tubes, among other illogical things, its culpability was a pronouncement handed down by an authority figure at the National Institute of Health. It is the same authority (Dr. Robert Gallo, head of NTH cancer labs) behind the expenditure of around a trillion dollars in cancer research which has produced nothing but an epidemic that is virtually out of control. (One wonders what it will take before people finally get the idea and stop creating walks, rides, telethons and cake sales to contribute money to the bottomless pit of biased, misdirected, wasteful and cruel orthodox medical research in cancer and degenerative disease.) And it is the same authority who has taken out two patents whose value depends upon HIV being accepted as the cause or a co-factor. One patent is for the technique of testing for HIV, and the other for a method of laboratory cultivation. No one

in a position to do anything about it questions this obvious conflict of interest.

Kary Mullis, microbiologist inventor of the Polymerase Chain Reaction, says, “I can’t find a single virologist who will give me references which show that HIV is the probable cause of AIDS …. If you ask a virologist for that information, you don’t get an answer, you get fury.”[24] Mullis has continued his outspoken criticisms of the AIDS establishment: “Where is the research that says HIV is the cause of AIDS? We know everything in the world about HIV now. There are 10,000 people in the world now who specialize in HIV.

None have any interest in the possibility HIV doesn’t cause AIDS, because if it doesn’t, their expertise is useless.”[25] Their embarrassment would also be considerable.

AIDS exists on paper. It is just a new label applied to a defined combination of immune-deficiency symptoms, which are not new, and a group of existing “diseases.” Intense public attention has been focused on the combination using statistical manipulation and fear that is bred in a general lack of understanding about health and disease. The question is whether all the destruction of AIDS can be laid at the feet of a nearly undetectable virus that defies every rule of medical microbiology. For example, HIV is said to cause AIDS after the appearance of antiviral immunity. Furthermore, the establishment has shown irresponsibility in referring to this syndrome as a disease. And the fact that it has been given the handy four-letter word encourages others to do likewise. This reinforces programmed notions, especially the idea of a single evil entity causing the whole thing. To emphasize these important points, AIDS will be here designated as “AIDSyndrome” in many instances.

A Medical Establishment on the Elastic Band Wagon

The HIV/AIDS theory is so elastic it stretches to embrace all reasonable criticism. Typical of this elasticity is the so-called latent period of the virus, which has gone from about one year to twelve, and shows potential of going to twenty. The elasticity is equaled only by the degree of credulousness required to accept HIV dogma. For example, it is said that in spite of the

extremely low incidence of HIV in the body, it (mysteriously) tricks the immune system into attacking itself! I use the term HIV/Elastic Theory, or HIV/ET.

Another major factor is oppressive socio-economic and political conditions. Such conditions exist in the Third World particularly, but in their own way in sections of the United States. This aspect will not be detailed here, but includes such phenomena as corporate dumping of banned drugs on unregulated Third World markets, pesticide manufacture and use with frightening disregard for safety, squalid living conditions, and rainforest destruction. These, not HIV, are among the primary causes of what is labeled AIDSyndrome in the Third World. Pharmaceutical companies are heavily involved in the pesticide market. The corporate-interest connection with these abominations goes: pharmaceuticals, pesticides, agriculture, petroleum, international banking. Therefore, since the HIV/ET hoax has to cover a lot of financial territory, it must have considerable stretchability.

AIDSyndrome Scenarios

1. The first recorded AIDSyndrome case in history, one of five reported by the CDC in June 1981, was a 33-year-old Los Angeles male. He was engaged in a lifestyle which we now consider high risk; but there are reasons for risk other than those defined by AIDSyndrome "viromania" (a word coined by microbiologist Peter Duesberg). For one thing, he admitted using "poppers," the aphrodisiac amyl nitrite (a poisonous secondary mycotoxin), then popular in homosexual bathhouses and discos. We are familiar with nitrites, used in tiny amounts as a preservative in meat. Sodium nitrite, a relatively weak member of the family, has been regulated for years as a potential carcinogen. It is well known that once in the body it is converted into carcinogenic nitrosamines (via its reaction with mycotoxins-not so well known).

Few mycotoxins, however, are more toxic than the organic nitrites (poppers), which react violently with almost anything. In water, they form the unstable nitrous acid, which destroys any biological molecule within reach. Nitrites and their breakdown products have long been known to scientists for their ability to mutate DNA, a point recently verified by direct experiment.[26]

During the 1960s and ’70s, poppers and other drugs were heavily abused, especially by sections of the male gay community. As a result, in 1969 prescription laws were tightened, and as usual, contaminated illegal products appeared on the streets adding insult to injury. In addition, impure products were marketed as “room odorizers.” According to a former nitrite researcher with the CDC, doses from inhalation are likely to exceed those from eating preserved meats by a million times.[27] Yet this massive insult to the body, and the drug abuse factor in general, including filthy street injectables, OTC drugs, and especially prescription drugs such as antibiotics, antifungals and other immunosuppressive chemicals, are not considered causative, in favor of a scarce, barely detectable, inactive, difficult-to-transmit retrovirus. However, HIV/ET would respond by saying that, if anything, the drug factor increased susceptibility to a virus that invaded him and destroyed his immune system.

Popper use has been associated with one “AIDS indicator”- Pneumocystis carinii pneumonia (PCP)[28] - officially said to be caused by a protozoa. But the corresponding organism is not a protozoa; studies show the DNA sequencing of PCP to be identical to that of the Saccharomyces cerevisiae yeast.[29] PCP is responsible for 62% of all AIDSyndrome mortality in America and Europe, candidiasis is responsible for 23%, and Cryptococcus neoformans is responsible for 12%. This means that yeast and fungus-the culminate microform symptoms of disease-contribute 97% of all AIDS-related mortality in those continents.

Thus, in the first recorded AIDSyndrome patient, a yeast infestation of the lung instigated pneumonia (symptom of over-acidification from fermentation processes), and oral thrush, a thick overgrowth of Candida albicans, choked him to death. He died, not from the ravages of a scapegoat retrovirus, but from an overdose of mycotoxins-nitrites-and the mycotoxins of yeast and fungal infestation-acetyl aldehyde, alcohol, and uric acid.

In Kenya, Africa, a 39-year-old woman from Zaire entered the hospital for treatment of her lung condition, which had begun with a relatively innocent cough and an unexpected drop in weight. Soon her coughs began to bring up blood, and tuberculosis was the diagnosis. But the patient had a strong allergic reaction to prescribed drugs, and her condition progressed from bad to worse, producing diarrhea, uncontrollable fever, swollen lymph nodes,

and anemic blood disorders (all symptoms of a compromised biological terrain, as described in the main text). The woman was then diagnosed with AIDSyndrome (but not I-AIDS-Iatrogenic-AIDS).

The woman's husband, whom doctors assumed must have transmitted AIDSyndrome to his wife, was suffering entirely different symptoms. He had pneumonia, a Candida infestation in his mouth, and lesions of Kaposi's sarcoma on his now irregularly pigmented skin. He lost weight to a relentless diarrhea and was constantly fighting off episodes of gonorrhea. Their children had no symptoms.[30]

We are asked by national public health officials to believe that the Los Angeles case and the two Zaireans all suffered the same affliction from the same cause. The irony is that in terms of germ theory this is highly questionable, but when considered in the light of microzymian principle, it is highly plausible. With one instance of overlap, each person was affected with radically different symptoms-a Pneumocystis pneumonia (as noted, yeast in the lungs); a tuberculosis (symptom of exotoxin from an intermediate pleomorphic stage); and a Kaposi's sarcoma, or papular tumors of the skin and mucous membranes (caused by mycotoxins). Before AIDSyndrome, these conditions never would have been connected by clinical doctors. Now they are struggling to believe that the common factor is the presence of nearly undetectable antibodies against HIV, and they could not be at a much worse disadvantage.

African AIDS

The World Health Organization's definition for African AIDSyndrome includes some opportunistic infections, like tuberculosis; also, the African version of wasting called "slim disease," a composite of weight loss, diarrhea, and fever; plus such conditions as persistent cough, skin problems and swollen lymph nodes. These signs comprise old, indigenous African health problems. But here is another example of HIV/ET. Compromised immunity makes "diseases" worse, so whatever "diseases" are already common become the indicators. All we have to do is plug HIV into the equation and we have AIDS. This makes sense to most people.

On the other side of the coin, malaria, for example, the leading killer in the Third World, produces fever and other symptoms frequently misdiagnosed as AIDS.[31] Tuberculosis, also a common killer and part of the defined African syndrome, presents a challenging situation there, as described by a Nigerian medical professor: “The serologic demonstration of HIV infection in patients with tuberculosis in Africa is very important because it aids the separation of seropositive from the seronegative patients, since such a separation may be impossible in all cases on clinical grounds.”[32]

According to a Ugandan doctor treating AIDS cases, “A patient who has TB and is HIV-positive would appear exactly the same as a patient who has TB and is HIV-negative. Clinically, both patients would present with prolonged fever; both patients would present with loss of weight-massive loss of weight, actually; both patients would present with prolonged cough, and in both cases the cough would equally be productive. Now, therefore, clinically I cannot differentiate the two.”[33] What can be the difference? Of course, a major one is that the AIDS case may be given expensive poison drugs which are nearly certain to end the patient rather than the illness, while filling pharmaceutical coffers.

Doctor Konotey-Ahulu has illustrated the confusion created by the HIV/ET: “Immunosuppressive diseases, of course, there always have been in Africa and elsewhere before antiquity was born. … I have clinical photographs from 1965 of a Ghanaian man who looked like some of the AIDS patients I saw in Africa recently. The man, who was like a skeleton, had severe nonbloody diarrhea (more than twenty bowel actions a day); he had what looked like fungus in the mouth [candidiasis], skin changes, periodic fever and cough-all the classical features of African AIDS… . The patient (according to relatives) had literally consumed on average one and a half bottles of whisky [a mycotoxin] every single day for the previous eighteen months before admission. We found it difficult to believe the story, but there are photographs today showing a complete reversal in 1966 of physical signs and symptoms, including the diabetes, when hospitalization cut short his alcohol supply and active treatment was administered, with gradual protein calorie buildup and pancreatin supplements.”[34]
Ongoing HIV testing since 1985 has revealed that eight times more Africans than Americans are infected (6 to 8 million)[35], yet the continent has produced fewer AIDS cases: 129,000 by 1992 and 345,639 as of December

1994.[36] By contrast, several large studies recently published findings that among thousands of randomly selected Africans with standard AIDS diseases, fewer than half were HIV-positive.[37] What does this say about a supposedly raging epidemic?

A completely separate epidemic seems to affect rural Africans, this one having no identified risk group. Some reports suggest a correlation between AIDS there and the symptoms of malnutrition. Doctors observe that AIDS patients who eat least often, or whose diets are skewed by food availability, suffer the most rapid decline in health. This should surprise no one. In rural Africa, the most important aspects to be considered, as in the entire history of epidemics, are: sanitation, which rarely exists; clean water supplies, also rare or nonexistent; and decent nutrition. It would seem that HIV/AIDS has created no new epidemic in Africa. But since HIV/ET is such a well-received hoax, it jumps in and "takes credit," while obfuscating relevant issues.[38]

In 1985, 250 patients from a local hospital in a remote area of Zaire, none of whom had clinical AIDS, were tested for HIV. Twelve percent clearly showed positive, while another 12 percent were borderline; but there was no correlation with any health complaints. The researcher concluded, "Thus, if antibodies indicate prior exposure to [the AIDS virus], this population must have had and survived [AIDS-virus] infection without lasting health problems."[39] In a similar situation in Venezuela, Indians who live cut off from the rest of the country's people were found with from 3.3 to 13.3 percent infection, with no symptoms.40 Being so isolated, they are highly unlikely to have been infected within the latent period. In both these cases, investigators concluded that people could have been living with the virus for a generation or more.

One might be challenged, as the Ugandan doctor was, to distinguish between an AIDS/tuberculosis and a traditional one. Since the clinical symptoms are identical, the CDC has stipulated in its current definition that tuberculosis must be renamed AIDS if HIV antibodies are also found. In the absence of HIV antibodies, the disease is classified under its old name, tuberculosis, and treated accordingly. Therefore, simply by definition/elasticity, HIV antibodies can never be found apart from AIDS, and vice versa; and any symptomology has the potential to become an AIDS indicator with HIV

around. In general, if doctors can tell the difference between AIDS on the one hand, and non-AIDS presence of its indicator diseases on the other, only by testing for antibodies to HIV, which sometimes don't even have to be present (discussed below), it would seem we have a syndrome of contrived or arbitrary origin, circularly defined.

HIV/AIDS and Koch's Postulates

Koch's postulates is a set of conditions long accepted as the requirements for establishing a fixed microorganism as the cause of a specific disease. The case for HIV as the AIDS virus, as with the identification of any causative infectious agent, should depend upon meeting these parameters, of which there are four. (Keep in mind that researchers disagree about what constitutes proof that any germ causes a disease.)

1. The germ must be found in all cases of the disease. Tissues said to be affected by HIV include primarily the white blood cells of the immune system, particularly the T-cells, the brain neurons in dementia, skin cells in lesions of Kaposi's sarcoma, as well as, theoretically, any cell in the body expressing the CD4 surface receptor said to be the key to HIV cell entry. But no trace of the virus can be found in either the Kaposi's sarcoma or the neurons of the central nervous system. HIV/ET has now moved from involving only immune cells to other types of cells in order to explain certain AIDS-defining symptoms which are not immune deficiencies anyway, including the cancers, dementia and wasting diseases, and which have not been, or cannot be, explained in terms of a germ-theory virus model that involves destruction of the immune system.

And if HIV were actively infecting T-cells or other members of the body's immune system, extracellular virions should easily be found circulating in the blood. But in most individuals suffering from AIDSyndrome, no particles can be found anywhere in the body.

Another aspect of HIV/ET is that now several HIV "reservoirs" have been suggested. One encyclopedia, which will go unnamed, says: "Researchers have also been able to show direct infection of bone-marrow cells-the precursors of circulating blood cells-and the proliferation of the virus within these cells. Thus bone marrow may represent an important reservoir of HIV

in an infected person and provide a potential mechanism for dissemination of the virus through the body." This is misinformation, pure speculation, a conclusion based on laboratory pyrotechnics, or scientific fraud. It is also said that macrophages can support HIV replication while harboring the virus from immune surveillance. Circulating macrophages are said to play an important role in the distribution of HIV throughout the body, including the brain. The question is, wouldn't there be significant amounts of virus in a reservoir? The fact remains: it is nearly impossible to recover HIV from its "victims." (See below under "Autoimmune Theory.") One paper published in March 1993 reported two individuals with about 100,000 particles per milliliter of blood, among dozens of patients with little or no detectable extracellular particles.[41]

The abundance of uninfected T-cells (about one in 500) in all AIDSyndrome patients is the definitive argument against the false claims for high cell-wall particle "loads," or "burdens," in AIDS patients. The absence of active, infectious virus automatically disqualifies HIV as a player in the AIDSyndrome.

2. The germ must be isolated from the host and grown in pure culture. Even for the most experienced virus hunters, a virus that is so extremely scarce is difficult to find. Only with rare luck and extreme persistence has HIV been extracted from an antibody-positive person. This amounts to finding the proverbial needle of HIV in a haystack of human DNA. This difficulty speaks to HIV's lack of potential in disease.

3. The purified germ must cause the disease again in another host. There is no animal or human model for HIV and AIDS, and where there is no animal or human model, you cannot establish Koch's postulates. (It is more than disconcerting to think of the number of primates that have been injected to this day in an attempt to produce AIDS.) HIV/ET jumps in and says that HIV should receive special dispensation from Koch's postulates. A major stumbling block is the latency which is claimed, but whose modus is not explained by authorities. In 1989 the official latent period between HIV infection and the onset of AIDS was one year. This period of "incubation" has since been stretched to 1012 years. For each year that passes without the predicted explosion in AIDS cases, approximately one year is added to this period. Even this is insufficient; with only 5 percent of infected Americans

developing AIDS each year, the average latent period would have to be revised to more than 20 years for 100 percent to become sick.

HIV should cause AIDS within two weeks of infection at most, but it does not, and with the complete lack of a demonstrated process by which HIV diminishes immune function, belief in a decade or more of unexplained latency requires a level of "faith" beyond this writer's capacity. Another major stumbling block is that even once the latent period is apparently over, there is still precious little development of the virus.

4. The germ must then be isolable from the newly infected host. We are now back to the problem of meeting requirement number 2.

The Antibody That Isn't

According to germ theory, an antibody is a certain antidote to a pathogen. According to HIV/ET, however, the more antibodies you have to HIV, the sicker you are said to be. AIDSyndrome is the only "disease" in the allopathic file cabinet in which antibodies to the causative agent mean you're in trouble; and it defies just about every known law, rule, guideline, fact, and behavior in the germ theory book. This includes, as we have seen, Koch's postulates, and, as we will see below, Farr's Law. Furthermore, vaccine research proceeds on the basis of producing antibodies to HIV in the patient. Apparently, these "synthetic" antibodies will signal recovery, while one's own signal death.

The Autoimmune Theory

One explanation put forth for the deadliness of such a scarce pathogen is that it somehow induces a self-destructive immune response (the system attacks itself). Evidence for this is said to be low white cell counts in people with AIDSyndrome; however, there is nothing to support the hypothesis, i.e., no plausible process by which this occurs has been suggested (see "What's Overlooked" below).

For the sake of discussion, let us allow germ-theory interpretation of immune function and autoimmunity. With only one in 500 immune cells said to be infected in HIV positives, it would seem to require a virus of extraordinary cunning to get uninfected cells to attack each other and not

infected ones, which would be self-defeating for the virus. Or in the latter event, such cunning could be matched only by the adroitness required to move quickly from one host cell to another just before destruction. Or, if macrophages are involved, the process should lead either to increasing titers of virions in the blood, lymph, etc., as infected cells are lysed, or to increasing concentrations in macrophages if they are ingesting T-cells. This supports the reservoir notion (if there were any viruses to be found in them). It is thus easy to expand HIV/ET.

HIV/AIDS and Farr's Law

Established in the early 1900s, Farr's Law, which is fundamental to virology, states that viral disease develops exponentially, and dictates that illness will strike soon after infection. The rate-determining factor of the exponential growth of viruses is viral generation time, which is between 8 and 48 hours. Since laws are made to be broken or excepted, viruses with incubation periods longer than allowed by Farr's Law are called "slow viruses." And since HIV joins an exonerated class of viruses by not multiplying according to this law of virology, virologists stretch HIV/ET to accommodate it. The question arises, though, of how anyone can determine or demonstrate when a "natural" HIV infection takes place, and thus determine latency, since no one is being tested daily or weekly, etc., and there is no animal model. Within the slow-virus concept, adopted as an exception to Farr's Law, retrovirologists can find refuge, hold on to their theory, hibernate in their labs, and hope the long winter of HIV latency is over before they expire.

According to expert retrovirologist Dr. Peter Duesberg, "The slow virus concept has never been reconciled with the short generation time of viruses and the immune system. Once the virus lies totally dormant, an intact immune system will never allow any virus to be reactivated to multiply into numbers that would threaten the host. For a virus to be reactivated, the immune system first must be destroyed by something else-the real cause of a disease. A reactivated virus would just contribute an opportunistic infection. Thus, there are no slow viruses, only slow virologists."42 Also, says Duesberg, "Retroviruses are all very similar. I mean, there are differences, but as far as pathology is concerned, you don't see a marker in one which is going to explain why it supposedly wakes up from sleep and becomes active."[43]

The Chemotherapy Drug Azidothymidine (AZT)

HIV-antibody-positive individuals suffer major health risks from AIDS medications routinely administered by physicians uncritical of drug-company propaganda. AZT, an isolate from herring sperm, was first synthesized in 1964 by Jerome Horwitz, heading a lab at Detroit Cancer Foundation and financed by an NIH grant. Designed to kill cancer cells, Horwitz's creation is a chemically modified form of a DNA building block. When a cell divides, it must copy its complete genetic code, which is stored in long chromosome chains. The DNA components (nucleotides) are linked to one another in a sequence. But Horwitz's altered DNA building block enters the growing DNA chain while a cell is preparing to divide and acts as a premature terminator, blocking addition of DNA components. Being unable to copy its DNA sequence, the cell dies.

AZT was the perfect killer of dividing cancer cells. When the compound was tested on cancer-ridden mice, however, it failed to perform as expected and instead revealed its extraordinarily deadly nature. The experimental drug was withdrawn from testing and never approved for human use-until AIDSyndrome. Side effects of AZT include ulcerations and hemorrhaging; damage to hair follicles and skin; destruction of mitochondria, the energy dynamos of cells; wasting of muscles; and the destruction of the immune system and other blood cells. Children are affected more severely, because many more of their cells are dividing than in adults.

Amid scandal-(l) the single, human trial that was ruined, yet was claimed to have proven effectiveness; (2) free corporate (Burroughs Wellcome) acquisition of large amounts of National Cancer Institute (taxpayer) raw material and technology; and (3) government stonewalling of other, potentially less expensive antivirals-AZT was first approved for treatment of AIDS in 1987.44 The cost was $250 a shot, or about $18,000 per year, per case. In 1990 it was approved for AIDS prevention, and has currently reached an average cost of $6,000 per year.

I have worked with many HIV-antibody-positive individuals who have for years remained completely free of any AIDS-indicator symptoms or any other significant ones. When treated with medications like AZT, however, people are observed to sicken and die from "wasting disease" in a short

period of time. I, as well as other molecular cell biologists, know of no one who has been treated with AZT and lived for more than around one year. Fortunately, it has begun to fall out of favor as the drug of choice.

Use of AZT is a good example of two other medical phenomena: (1) the odds game called the therapeutic index, or the relationship between a drug's effectiveness and its toxicity; and (2) the dependence upon destruction that informs "scientific medicine." The acceptable toxicity of a drug is directly proportional to, and established by, the deemed deadliness of the disease. However, to this date the Physicians' Desk Reference quotes the low toxicity of AZT reported by Broder, Barry, Bolognesi, and colleagues in 1986. According to at least four independent studies published since, however, the toxicity of the drug is a thousand times higher.[45]

Broder, Barry, Bolognesi, and colleagues overlooked or disregarded two basic factors in their lab experiments: (1) In the test tube in which they tested AZT, there was a high concentration of "infected" cells. But, as noted earlier, in a person with HIV, titers are very low, and the ratio of infected to healthy cells is very low (only 1 in about 500 T-cells in HIV antibody-positive persons is ever "infected"); (2) Like all other chemotherapy drugs, AZT is unable to distinguish between target cells and healthy cells. The disastrous consequence is that AZT must poison 499 good T-cells in order to poison one inhabited by the AIDS "virus."

Real Fallout

Various individuals diagnosed with AIDS who were paraded in the media, trapped into following the AIDS "company line," later died of AIDS-related symptoms. Many were treated with AZT from the very beginning, even though they showed no signs, or few signs, of ill-health at the start of the program. Two examples are Kimberly Bergalis (featured in the October 22, 1990 issue of People magazine) who supposedly "caught" HIV from her Florida dentist, and Arthur Ashe, the heterosexual tennis professional. (Kimberly had only a minor yeast infection at the start of her AZT program.) In typical fashion, the news media focused upon, and widely broadcast, the details of their gradual degeneration and painful deaths, which exhibited all the classic symptoms of AZT poisoning. "AIDS" death and AZT death are outwardly indistinguishable. Here is a perfect combination: an illness

incorrectly billed as universally fatal, treated by a useless, frequently fatal drug.

What's Overlooked

Shades of doubt concerning HIV/ET validity in terms of germ theory have arisen since three-quarters of the 20,000 hemophiliacs in the United States were infected by HIV through the blood supply a little more than a decade ago. During that period, clotting factor VIII doubled life expectancies, while relatively few developed AIDSyndrome. HIV has made no measurable impact on the well-being of hemophiliacs, except for devastation of those who are treated with AZT.[46] No evidence has shown that death rates from blood transfusions ever increased from HIV transmission, nor has anyone demonstrated that death rates declined once the virus was screened out of the blood supply.

Even if AIDSyndrome does exist as a new phenomenon, perhaps insufficient scrutiny has been paid to the idea that it is not virus-based, but related to an inverted way of living and eating. For these reasons, and the sociopolitical ones mentioned earlier, illness is simply on the rise in general, and individual cases are often more intense and intractable. Cancer is now epidemic, for example. "Flesh-eating" bacteria have made an appearance. Disease intensity and statistics must also be considered in terms of the ineffectiveness and iatrogenic influence of the orthodox approach to illness-the equivalent of trying to remove a screw with a hammer. HIV/ET attempts to divert responsibility for health disaster from an inept, sometimes malfeasant, pharmaceutically controlled medical tradition. A century of medical practice and health concepts based on the scientifically erroneous germ theory is as much the cause of AIDS as any single factor-probably more. AIDS could easily have been predicted epidemiologically as an aspect of the burgeoning crisis in health. It had to be blamed on a virus on order to distract attention from the real problems.

Speaking of prediction: Several doctors and writers have made a strong connection between AIDSyndrome and syphilis. The consequences of misdiagnosed or improperly treated (including penicillin) syphilis may be misinterpreted as AIDS indicators. According to one researcher, almost every AIDSyndrome indicator has been seen in syphilis.[47] An interesting

corollary here is the Tuskegee Alabama Syphilis Study, in which 400 Alabama sharecroppers were allowed to suffer and die with untreated syphilis (which they were not told they had) for 40 years until the study was exposed in 1972. Did a medical establishment (CDC, Public Health Service, NIH) capable of such behavior learn anything about syphilis which might have helped predict, and formulate a description of, the "new" AIDSyndrome epidemic?

With the primary U.S. AIDS groups, or with any group for that matter, if you understand microzymian principle and consider the blood as a flowing tissue, it will be seen in general that body fluids which find their way from one individual directly into the blood of another are a stress factor on the body. This is by virtue of the introduction of foreign tissue and possibly morbidly evolved microzymas. Total impact depends on the degree to which the terrain is already compromised. In fact, a major danger is blood transfusion itself, essentially a "tissue transplant," which is a threat or irritant to immune function. There is no reason to believe that such repeated stress will not, by itself, overwork and weaken immune function and drain overall energy reserves.

Current medical science gives credence to the so-called autoimmune response, where white cells said to be deranged indiscriminately destroy and/or clear out healthy and unhealthy cells. This misconception arises as a consequence of germ theory mentality, which misunderstands the central function of the immune system. It is essentially a sophisticated janitorial service. It operates to keep the place clean and to recycle usable material. Should "self cells or tissue become useless or even dangerous to the body, the immune system will clean them out. Thus, it is not deranged, but is doing its job correctly. The host is somehow not doing its job, however, to maintain a balanced internal environment, which is the first line of defense, not immunity, against tissue destruction and infection. This is because infection can come from within. And it bears repeating that the fundamental misconception of the germ theory is that infection must be invasion, rather than an endogenous morbid change in chemistry or micromorphology.

Compromised or weakened by fungal infestation (evidence for which is obvious and strong) or by drugs and chemicals such as mycotoxins, the immune system may weaken and fail to be efficient, but it will not attack

healthy cells. There is a situation where this may appear to be so-when free radicals produced by the immune system in response to mycotoxins and morbidly evolved microforms damage local cells and tissue by the “shotgun” effect - but it is not a direct attack on “self,” and is frequently an overreaction to the alarming situation.

What Constitutes AIDS in 1998?

HIV/ET responds to the question of why the syndrome hasn’t spread into the general population with the reply that it just needs a little more time. To accomplish this, however, the situation requires a little massage as well. On occasion, the definition of AIDS has been expanded (along with the latency period), with more indicator diseases being added to the list. In 1987, purportedly for surveillance purposes, a major change was made to the definition, which not only added diseases to the list, but removed, in the presence of a positive HIV test, exclusions for other known causes of immune suppression. The rationale was to provide consistent statistical data for public health purposes. Thus, a person could now be diagnosed with a surveillance case of AIDS.

In the CDC guideline, the caveat was given that clinicians would not rely on this definition alone to diagnose serious disease caused by HIV. Good medical practice, which was apparently expected to be employed later, could be expected to catch cases that somehow slip through the vast surveillance net because they have either a negative H1V-antibody test or, in the presence of HIV antibody, an opportunistic disease not listed in the definition. With the new rules, in the case of diagnosis of any one of several indicator diseases by a “definitive method,” AIDS had to be diagnosed even if the patient were HIV negative.

One question would seem to be: Why not employ good medical practice at the outset? Also, with the vast range of conditions listed, one is hard pressed to imagine what might not be included, except perhaps the common cold. But the overall effect of this change was to boost statistics and bring more people into the web of fear surrounding the syndrome. In 1992 another statistic-bumping revision was handed down.

Today the AIDS-indicator list includes, but is not limited to, Pneumocystis pneumonia, Kaposi's sarcoma, non-Hodgkin's lymphoma, candidiasis, cryptococcosis, tuberculosis, herpes simplex, cryptosporidiosis, coccidioidomycosis, toxoplasmosis, wasting disease and dementia. And symptomologies such as syphilis, chronic fatigue, anemia, arthritis, nephritis, pneumonitis, diarrhea, cervical cancer, and a T-cell count of less than 200 cells per microliter, or less than 14% of the expected level, have been added to the diagnostic list. It appears that when a higher rate of new AIDS cases is needed "for public health data," the CDC expands the definition. With the stroke of a pen an illusion of the spread of AIDS is created. To include the major symptoms of malnutrition (wasting) as an AIDSyndrome indicator, especially in Africa and the Third World, is to ensure a burgeoning statistical picture.

Nor is this the first time such statistical manipulation has occurred in medical history, polio being an excellent example. According to Dr. Herbert Ratner, former public health officer for Oak Park, Illinois, prior to vaccine introduction, doctors were being paid $25 apiece by the National Foundation for Infantile Paralysis for polio case reports. Also, Ratner indicated, it was known that paralytic polio went away in 50 percent of cases within 60 days. After the arrival of the Salk vaccine, the case definition for polio was changed to require symptoms for 60 days before a diagnosis could be reported. Thus, if someone had it and it went away within that time, it was never counted, making the vaccine look better.48 After vaccine introduction, cases previously reported as poliomyelitis were differentiated as aseptic meningitis. Despite this subterfuge, case incidence increased dramatically after vaccine introduction (80 percent from 1958 to 1959) but the Public Health Service manipulated statistics and made statements to give the opposite impression.[49]

Should anyone question the idea that the CDC at any time "needed" a higher case rate, consider the following: In the early years of AIDSyndrome, while this supposed epidemic was developing, the CDC stood back and did nothing to identify and help the sexual contacts of AIDSyndrome patients. It was a departmental "do-nothing" policy. This has been documented and published by a former Public Health Adviser and AIDS researcher who worked at the CDC at the time.[50]

A Final Thought

To prove that HIV is the cause of AIDS and make HIV/ET more than a speculative hypothesis, it would be necessary to show the presence of HIV among patients with AIDS diseases whose personal history did not include: (1) chronic, abusive, male homosexual activity with associated chronic drug abuse and antibiotic dependency; (2) massive ingestion or injections of recreational drugs; and (3) use of toxic prescription medications, including AZT and antifungals. Likewise, one would have to show HIV absent among groups of healthy, asymptomatic individuals. In spite of the millions which have been spent on AIDS research, such a study has never been undertaken, although we have seen instances of long-term HIV presence with no correlated illness.

In my research, I can see only minor differences among dried blood samples of people with cancer, dementia, MS, and diabetes on the one hand, and the person with AIDS on the other. They all show excess fermentation processes and disseminated intravascular coagulation. They are all rotting from the inside out. There seems to be one model that makes sense and consistently validates clinical observation and research: There is only one physiological disease-terrain imbalance seen as acidification, due primarily to an inverted way of eating and living. Acidification leads to the one sickness, or primary symptom of disease-morbid microzymian response, or the overgrowth of microforms whose poisons result in secondary symptoms (commonly called “diseases”), these being produced in or by the body in keeping with the uniqueness of each individual. Forms of toxicity such as environmental chemicals and heavy metals also play a role, but in most cases will also disturb the central balance of the microzymas, thus complicating the situation with morbid microzymian evolution.

There are no “diseases” created by “microbes” invading from without. Viruses are not even symptogens. HIV has no causative connection with disease, and no new epidemic exists.

References

[1] L’Orthobiologie Somatidienne. Video by Gaston Naessens, 1991.
[2] Bechamp, Pierre Jacques Antoine. The Blood and Its Third Anatomical Element, (Montague R. Leverson, translator). London: John Ouseley Ltd., 1912, pp. 205 and 229. [3] Kalokerinos, A. and Dettman, G. Second Thoughts About Disease: A Controversy and Bechamp Revisited. Warburton, Victoria, Australia: Biological Research Institute, p. 9 [booklet published from an article in Journal of the International Academy olPreventive Medicine, July 1977; 4(1)].

[4] Hume, E. Douglas. Bechamp or Pasteur? Ashingdon, Rochford, Essex, England: The C.W. Daniel Co. Ltd., 1923, p. 109.
[5] Farber, C. Out of Africa, Part I. Spin Magazine, March 1993: 61-63, 86-87. [6] Kalokerinos and Dettman, op. cit., p. 12.
[7] Ibid.
[8] Denetclaw, T.H. and Denetclaw, W.F.J. Is "Southwest U.S. mystery disease" caused by hantavirus? Lancet, 1994; 343: 53-54.
[9] Russel, S. On the Trail of Hantavirus. San Francisco Chronicle, July 4,1995: AI, AI2. [10] Russel, S. Signs that Ebola Virus Is Fading Away. San Francisco Chronicle, May 24,1995: A6.
[11] Kaiser, R. Africa State Hospitals Make Viruses, Not Patients, Feel at Home. Washington Post, June 4,1995: A6.
[12] Physicians' Desk Reference (PDR), 1997, p. 1730.
[13] Beale, A.J. Vaccines and Antiviral Drugs. In: Topley and Wilson, Principles of Bacteriology, Virology and Immunity, (Publisher, Year?), p. 149.
[14] Jegede, V.A. et al. Vaccine Technology. In: Encyclopedia of Chemical Technology, (Publisher, Year?), p. 629.
[15] PDR, op. cit., p. 2650.
[16] Rappaport, John. Touching All Bases-Exploring Alternative Theories of AIDS. The Reader (Los Angeles Free Weekly), August 7, 1987; Vol. 9, No. 42: 10. [Note: Reference pertains to evidence that calves were recently, or are still, cruelly used for this purpose. Minor details of the process differ from those described in the article.]
[17] PDR, op. cit., p. 2656.
[18] Kalokerinos and Dettman, op. cit. (Ref. 3), p. 13.
[19] Ibid., p. 12.
[20] Goldberg, B. Origin of AIDS. Lancet, 1992; 339: 1548.
[21] Kalokerinos and Dettman, op. cit.
[22] Pearson, R.B. The Dream and Lie of Louis Pasteur. Collingwood, Australia: Sumeria Press, 1994, pp. 32-35.
[23] Cayce Reading #480-19. The Cayce readings are on fde at the Association for Research and Enlightenment, Virginia Beach, VA.
[24] Hodgkinson, N. Experts Mount Startling Challenge to AIDS Orthodoxy. Sunday Times (London), April 26,1992; I: 12-13.
[25] Carroll, John. The Weird Way to Win a Nobel Prize. San Francisco Chronicle, October 21,1993: E9.
[26] Mirvish, S.S., Williamson, J., Badcook, D., Sheng-Chong, C. Mutagenicity of Iso-butyl nitrite vapor in the Ames test and some relevant chemical properties, including the reaction of iso-butyl nitrite with phosphate. Environmental. Molecular Mutagen, 1993; 21: 247-252. [27] Rappaport, John. AIDS Inc. Scandal of the Century., San Mateo, Cal.: Human Energy Press, 1988, p. 38.
[28] Ibid., p. 40.
[29] Fungalbionics Convention: The Fungal/Mycotoxin Etiology of Chronic and Degenerative Disease. Metro Toronto Convention Centre, September 30,1994. [30] Konotey-Ahulu, F.I.D. What is AIDS? Watford England: Tetteh-A'Domeno Co., 1989, p. 109. [31] Rappaport, op. cit. (Ref. 27), p. 73.
[32] Williams, A.O. AIDS: An African Perspective. Boca Raton, Fla.: CRC Press, 1992, p. 238. [33] Duesberg, Peter H. Inventing the AIDS t7ras,(**Publisher, YEAR?), p. 293. [34] Konotey-Ahulu, op. cit., pp. 56-57.
[35] World Health Organization, The Current Global Situation of the HIV/AIDS Pandemic, 1995. [36] Duesberg, Peter H. AIDS acquired by drug consumption and other noncontagious risk factors. Pharmacology and Therapeutics, 1992; 55: 258.

[37] Ibid., p. 240.
[38] Rappaport, op. cit. (Ref. 27), pp. 71-82.
[39] Biggar, R.J. et al. Seroepidemiology of HTLV-III antibodies in a remote population of Eastern Zaire. British Medical Journal, 1985; 290: 808-10 (cited in Coulter, Harris L. AIDS and Syphilis, The Hidden Link. Berkeley, Cal.: North Atlantic Books; and Washington: Wehawken Books, 1987; p. 61).
[40] Duesberg, Peter H. Retroviruses as carcinogens and pathogens: Expectations and reality. Cancer Research, 1987; 47: 1199-1220 (cited in Coulter, Harris L., op. cit. [Ref. 38], p. 61).
[41] Lemonick, M.D. Return to the Hot Zone. Time International, May 22,1995; 145: 56-57. [42] Duesberg, Peter H. AIDS acquired by drug consumption … (Ref. 36), pp. 237-38, 241, 247.
[43] Rappaport, op. cit., p. 130.
[44] Committee on Government Operations. AIDS Drugs: Where Are They? 73rd Report. U.S. Government Printing Office; October 3, 1988. (Cited in Culbert, Michael L., D.Sc. AIDS: Hope Hoax and Hoopla. Chula Vista, Cal.: The Bradford Foundation, 1898, pp. 10-11). [45] Chiu, D. and Duesberg, P.H. The toxicity of Azidothymidine (AZT) on human and animal cells in culture at concentrations used for antiviral therapy. Genetica 95, 1995: 103-109. Duesberg, Peter H. AIDS acquired by drug consumption … (Ref. 36), pp. 201-77. [46] Yarchoan, R, Pluda, J.M., Perno, C.-F., Mitsuya, H., Broder, S. Anti-retroviral therapy of human immunodeficiency virus infection: Current strategies and challenges for the future. Blood, 1991; 78: 859-84. McLeod, G.X., Hammer, S.M. Zidovudine: Five years later. Annals of Internal Medicine, 1992; 117: 487-501.
[47] Duesberg, Peter H. Is HIV the cause of AIDS? Lancet, 1995; 346: 1371-72. [48] Coulter, Harris L. AIDS and Syphilis, The Hidden Link. Berkeley, Cal.: North Atlantic Books; and Washington: Wehawken Books, 1987, p. 37.
[49] Rappaport, op. cit. (Ref. 27), pp. 152-53.
[50] Hearings before the House Committee on Interstate and Foreign Commerce. House of Representatives, 87th Congress, 2nd Session, H.R. 10541, May 1962, pp. 94, 96, 112 (cited in: James, Walene. Immunization: The Reality Behind the Myth, 2nd edition. Westport, CT: Bergin & Garvey (Greenwood Publishing Group, Inc.), 1995, pp. 35-36).
[51] Sermos, Gus G. Doctors of Deceit and the AIDS Epidemic-A View From the Inside. McComb, Miss.: GGS Publishing, 1988, p. 3.