taining this rare insight into the biogra-
phy of the Soviet foreign minister:

I was sick of the agents, they made all sorts of
demands and conditions and forced me
to work as an agent. If you refuse to work
for them, they will expose you as an agent
so you have to work for them, or danger
threatens. I worked in prison and in labor
colonies and helped them in undercover
work . . .

After being arrested on July 20, 1970, I
was transferred to the KPK (preliminary
findings room). In 24 hours I was trans-
ferred to the SIZO #1. I was placed in
Special Building #2, room #43.

Special Building #2, which is isolated from
all other sections of the prison, was
established in 1966 and was designated sole-
ly for undercover work. The old section was
re-equipped and 10 rooms were opened with
together all kinds of equipment for broadcasts
and recordings. In this building only agents or
objects who had been processed with the
help of agents were placed. The rooms were
not communal, they were for only 5-7 peo-
ple. No one else was placed in this
building . . .

In room #45 Aqghomelashvili (an agent)
beat Mikhailashvili (a Jew) on assignment
from Panfilov (chief of operations), in
room #44 agents . . . beat and cut with a
razor the object Datusani, in room #37
agent Usupyan on assignment from Pan-
filov and Svimonishvili beat the object
Valeri Kukhianidze, whose internal organs
got so beat up that he spit blood, after
which he died in the Central Prison
Hospital and was "written off."

The agents Gurami Gogua and Tedo
Dolizde were beating the object in room
#38, including Kobakhidze, who had his
legs strung up until they wrung a confes-
sion out of him. . . . In every room sat
agents who worked with an object on a cor-
responding assignment for which they gave
out narcotics, alcohol, allowed meetings
with and packages from relatives and even
visits with prostitutes—all of which was il-
legal in the special rooms and offices—they
promised freedom, etc.

They were often given the assignments to
beat objects such as for the purpose of ex-
tracting a confession, but also due to the
personal interest of the administra-
tors. . . . In a word, beating went on in all
the rooms, and the groaning and howling
of the objects was heard all over the
building. . . . In general, it was a slaughter-
house.

On orders of the procurator Lezhava and
his brother (head of SIZO #1) and on
assignment from E. Shevardnadze, I was
told, the object Roman Enukidze was sent
to me. He was in a group . . . of the Bureau
of Land for Gardening . . . Lezhava, Svim-
onishvili and others promised me that if I
handled this case they would free me, since
Shevardnadze himself had given his word.
I processed the object Enukidze, I put all
my energy into it. He had been under obser-
vation before. I put him in touch with his
home and convinced him of everything. I
made him confess, as I had made Doloyan
and Botadze, to the Minister of Internal Af-
fairs of the Georgian SSR.

Well, you get the idea. As the same-
dat editor concluded, "the widespread
use of torture . . . coincides with the

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**EUROPEAN DOCUMENT**

**AIDS: A BRITISH VIEW**

by Christopher Monckton

The responses of governments and
public agencies to the threat to
mankind from the rapid spread of
AIDS and its related diseases have
been dangerously and perhaps fatally inade-
quate. On the one hand, they want to
prevent the disease from becoming one
of the biggest killers man has known.
On the other, they are over-anxious to
avoid offending high-risk groups or
arousing unreasonable discrimination
against known carriers of the disease.
They are allowing an understandable
sensitivity to the rights and feelings of
minorities to outweigh their higher
duty to protect the lives of all their
citizens.

The authorities in some countries in
Africa (where the very high infection
rate leads many to believe the disease
may have originated) are now refusing
to report AIDS cases to the World
Health Organization, which now has a
small, under-funded but growing pro-
gram to combat the disease interna-
tionally. These irresponsible attempts
at concealment will obviously make the
task of worldwide eradication of the
virus even harder than it already is.

In the United States Dr. Everett
Koop, the Surgeon-General, has recent-
ly issued a 36-page report advocating
the stepping-up of public education on
the dangers of transmitting AIDS
through promiscuity (heterosexual as
well as homosexual) and through the
re-use by intravenous drug addicts of
possibly infected hypodermic needles.
Privately he admits that, if his cam-
paigns against smoking, drink, and
drugs have made little impact, a cam-
paign to change people's sexual
behavior will have still less chance of
success.

At the end of October a committee of
the National Academy of Sciences
produced a 390-page report entitled
Confronting AIDS,* describing federal
anti-AIDS funding as woefully inade-
quate and calling for a $2 billion an-
ual program of public education and
research on the disease in the hope of
finding a vaccine against it. Yet the
report concedes that there is little
chance of finding a cure in the short
term.

Both these reports continue a wel-

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*National Academy Press, $24.95.
must be presumed to be chronically infectious."

Yet both reports fail to draw the unwelcome but undeniable conclusion from the disquieting evidence which they present. For there is only one way to stop AIDS. That is to screen the entire population regularly and to quarantine all carriers of the disease for life to halt the transmission of the disease to those who are uninfected. Every member of the population should be screened every month to detect the presence of antibodies against the disease, and all those found to be infected with the virus, even if only as carriers, should be isolated compulsorily, immediately, and permanently.

Any program of action as radical, as costly, as universal, and as undesirably contrary to individual liberties as this appears to be unthinkable, which is why too few of the people who ought to have thought about it have done more than to dismiss it as impossible, unethical, unfair, discriminatory, or undemocratic. Yet there are occasions when it is imperative to think the unthinkable and then to do the undoable. The AIDS epidemic is one such occasion.

To justify a program of universal blood-testing and enforced isolation, it is first necessary to establish that there is no alternative. By now it is clear that the AIDS virus will not go away by itself. The great plagues of history were eventually extinguished partly because the victims were killed so quickly that the diseases could not transmit themselves to new hosts, and partly because immunities to them began to form. AIDS, however, lingers on as a carrier for years before killing its victims, allowing plenty of time for onward transmission, and it assails the very immune system (specifically the T-lymphocyte white cells) that might otherwise develop the power to destroy it. In these respects, AIDS is more threatening than any plague which has previously afflicted mankind.

There are only two ways of eradicating a disease like AIDS. One is to cure it: the other is to isolate it. What, then, is the prospect of a cure? All responsible medical authorities are agreed that the likelihood of early discovery of a cure is remote. Confronting AIDS says: "The Committee believes that a vaccine against HIV infection is not likely to be available for at least five years and probably longer." A palliative drug, azidothymidine (AZT), appears promising as a way of deferring the death of AIDS victims by slowing the progress of the disease in the body, but its side-effects have not yet been fully investigated and it will not, in any event, prevent the spread of the disease.

The problem with the AIDS virus is that, like the influenza virus, it changes its form so fast that the body's immune system cannot keep up. It will probably be harder to find a cure for AIDS than for the influenza virus, for which—despite decades of research—no satisfactory or general cure has been found. To take another example, the anti-viral agent against the Hepatitis B virus took seventeen years to develop, and is still not universally available.

Public health authorities would, therefore, be highly irresponsible if they based their policies for controlling the AIDS epidemic on the wishful assumption that a cure might shortly be found. Though the disease has been known only since 1981, and the virus itself was isolated as recently as 1983, early predictions of the current death-rate have proved to be underestimated, if anything, and present predictions that the annual death rate from AIDS in the United States alone will be 54,000 by 1991, and continuing to rise sharply every year thereafter unless a cure is discovered, tested, approved, and made generally available.

W ill the public health authorities' current response—a program of public education about the dangers of spreading the virus through homosexual or heterosexual promiscuity or re-use of infected needles—be enough to achieve a de facto isolation of carriers, and hence a decline in the rate at which the disease spreads, without the need for enforcement measures? Alarmingly, no. The homosexual community, for instance, is the group with the highest risk of contracting AIDS. About two-thirds of the AIDS cases in the United States are among homosexuals. The high risk arises both because homosexuals are, on average, extremely promiscuous and because the forms of sexual activity in which they indulge are particularly favorable to the physical contact between infected body-fluid and an uninfected bloodstream by which the disease is typically transmitted.

In many homosexual communities, the rate of promiscuity has dropped considerably in response to growing public awareness of the danger of contracting AIDS. Yet the rate of infection has not dropped, because increasing numbers of homosexuals are already infected and the higher percentage of existing infection tends to cancel out what would otherwise be the beneficial effect of the decline in promiscuity.

Unless promiscuity between infected and uninfected people drops to nil, the disease will continue to spread at approximately its present rate.

Hence, even where sexual behavior becomes less promiscuous, the advance of the disease appears inexorable. In any given population, the measured incidences of infection, of disease, and of death double approximately every ten months. Some slowing of this rate of increase can be hoped for once the disease has reached saturation among the high-risk groups (homosexuals, intravenous drug addicts, prostitutes and their clients, other heterosexually promiscuous people, hemophiliacs using infected clotting agents, transfusees receiving blood from infected donors, spouses of carriers and children of infected mothers). But unfortunately the disease is not confined solely to these high-risk groups.

As the incidence of AIDS increases, the likelihood of accidental infection of...
theoretically low-risk members of the population also increases. The reason is that, because AIDS is transmitted by contamination of the victim’s blood-stream through direct contact with body fluids from a carrier, infection can occur in many innocent and accidental ways: for instance, through even a very small cut in the skin, or (in one case on record in Germany) by an infected boy biting his previously uninfected twin brother.

It may well be that many people not in the high-risk groups have already become infected without knowing it. One of the reasons why universal testing is essential is that it is the only reliable way to detect such accidental infections. It would, in any event, be thought invidious and discriminatory to limit the testing only to high-risk groups; but, more to the point, it would also be a failure.

The truth, though the public health authorities are not quite admitting it yet, is that everybody, without exception, is potentially in danger of infection by the AIDS virus. Of course, homosexuals and intravenous drug users remain most acutely at risk, but in Africa it is already true that half of all AIDS cases are women (compared with under one-tenth in the United States), indicating that heterosexual transmission of the disease is now as significant as homosexual transmission. Although this figure may be explained in part by the frequent re-use of hypodermic needles in African medicine, or by the high prostitution rate in some countries, public health authorities in the developed world would be imprudent if they did not take stringent and immediate precautions against accidental infection of groups not now regarded as being at risk. The more widespread the disease, the greater the danger that members of low-risk groups may be accidentally infected by an existing carrier. Furthermore, it is obvious that the risk of infection by accident is higher still if the carrier himself does not know that he has the disease.

Would compulsory testing and enforced isolation work? If the vast majority of the population came to accept the need for it and were willing to cooperate, yes. The testing would have to be monthly because after the moment of infection there is a “window of apparent safety,” varying in length from two weeks to three months, during which the victim shows no antibodies. A single test might, therefore, turn out falsely negative and a carrier might subsequently spread the disease to others without knowing it.

Equally, a test might show falsely positive. Accordingly, everyone who showed positive on any monthly test should have the right to undergo immediate further tests to establish whether the initial reading was wrong. Fortunately, many different tests are available, so if one test proved positive others could at once be tried. During the few hours necessary for awaiting the results of the further tests, the testee would need to be isolated both from the infected and from the uninfected populations. Strict controls would be needed at all borders. Visitors would be required to take blood-tests at the port of entry and would be quarantined in the immigration building until the tests had proved negative. Already the first tentative steps are being taken in this direction: some countries now deny the right of entry to known carriers of AIDS. Many blood-tests for AIDS are now known, including enzyme-linked immuno-sorbent assays, immuno-fluorescent assays, and Western blot analysis. Most of these techniques are quick, painless, and inexpensive and all are accurate to a respectably high degree.

Universal testing, then, provided that it were regular, would successfully identify all—or nearly all—carriers. Some actual or potential carriers, particularly among the high-risk groups, might be...
would isolation be effective? Yes, and here is the one ray of light in an otherwise gloomy tale. Precisely because AIDS is not normally transmissible except by the direct mingling of a carrier's body fluids with the bloodstream of an uninfected person, isolation would immediately protect the uninfected population to an extent greater than with most other communicable diseases: and, even if uninfected people wished to visit or care for friends or relatives in the infected and accordingly isolated community, they could do so without risk provided that stringent precautions against accident were taken.

Isolation of AIDS carriers need not, therefore, be as terrible in practice as it sounds in theory, and it need not be as rigorous as the isolation which was once necessary for more readily communicable diseases such as smallpox or typhoid. Carriers need not be isolated from each other; the bulk of them, at any given time, would not be suffering from any symptoms of the disease; and carefully supervised visits from uninfected people would be possible.

In the United States, between 1.5 and 3 million people are already carriers of AIDS. Isolation of so large a number of people would be an enormous and daunting task, though not altogether impossible. However, it is unlikely that a society which has been habituated to freedom since its foundation would yet be willing to accept the alternative to widespread death which isolation would offer.

Mr. Lyndon LaRouche's Proposition 64, which advocated widespread screening and isolation of AIDS carriers, was heavily defeated on the California ballot, partly because the proposition was proposed by political extremists with a known propensity to cry wolf and supported by documentation that was unconvincing, poorly argued, and hysterical in tone, and partly because the public has not yet realized just how dangerous AIDS really is. Mentions of the disease still provoke more jokes and laughter than serious consideration of its ultimate effects on the human population.

In Britain, my own country, only 30,000 carriers are known. Isolation of this comparatively small number would not be insuperably difficult. But Britain will probably not take any radical action yet. Herein lies the real dilemma for public health authorities. While the disease is in the early stages of its penetration into the population, when stopping it would be easiest, few will appreciate its dangers and the public will have to take drastic measures will be absent. By the time the catastrophic consequences of the epidemic have become evident to all, and the will to eradicate the disease has grown strong enough to permit action, much of the fatal damage has been done and the numbers of carriers to be isolated will be very high.

In five years' time, public perceptions of the danger posed by AIDS will be transformed. By then, on the official figures, the cumulative total of AIDS cases will have risen to 270,000, of whom 179,000 will have died. New AIDS cases arising from heterosexual contact will have risen fivefold from their present levels and pediatric cases tenfold. And, though the vast majority of cases will still be coming from the high-risk groups, cases arising in low-risk groups from accidental infection will begin to become significant.

Although the idea of universal testing and isolation now sounds extravagant and preposterous, it will eventually happen. Unless governments act now, the people will begin to take matters into their own hands: uninfected communities, for instance, will set up their own testing stations and will try to keep carriers out of town. Already, AIDS carriers in schools and workplaces have begun to face discrimination. Universal testing would be antidiscriminatory and, above all, it would save the lives of those who are going to be needlessly killed because governments have not the courage to do now what they are, in the end, going to do anyway.

The founder and editor-in-chief of The American Spectator examines what he believes are the frequently incoherent, often infantile (and nearly always dangerous) ideas of the New Age Liberals in The Liberal Crack-Up.

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