"Never in modern history have we just rolled over and said, 'Yes, we must totally submit to infectious diseases.' It's a bizarre and unprecedented situation."

Video interview with Zero-COVID activist Dr David Berger, republished with transcription

Richard Phillips, Cheryl Crisp
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In April this year, the *World Socialist Web Site* conducted a video interview with Dr David Berger, a highly experienced remote area emergency doctor.

Berger, is a well-known and dedicated fighter for a scientific approach to COVID-19, writing thousands of tweets refuting pandemic misinformation and issuing timely warnings about what must be done to combat the deadly disease.

As well as social media work, Berger has written valuable articles exposing grossly inadequate responses to COVID-19 that have been published in the *Age*, the *Sydney Morning Herald*, the *Guardian*, *BMJ* (formerly, the British Medical Journal) and the *Medical Journal of Australia*.

Last month, the Australia Health Practitioners Regulation Agency (AHPRA) falsely accused Berger of "impolite" and "unprofessional" behaviour on social media and threatened to deregister him if he did not undertake a so-called "education" course.

This anti-democratic attack has been denounced by doctors, health workers, teachers and workers across a range of industries on the *World Socialist Web Site* and in a recent Open Letter and petition published by senior Australian doctors and medical scientists. Almost 1,700 people have signed the petition.

We are republishing the April video interview with Dr Berger, along with an edited text transcript, to assist those fighting AHPRA's blatant attempt to gag this principled fighter for Zero-COVID and consistent opponent of the Australian governments' homicidal "let it rip" policies.

Richard Phillips: Before we begin Dr. Berger, could you tell us something about your medical background?

David Berger: I qualified in medicine in London in 1991. I think that's kind of relevant because I came from a medical tradition. That sort of post-war British medical tradition, which as I look back on it now, was extremely idealistic.

I had very idealistic teachers in medical school with a feeling of a very direct connection to the sort of crusading doctors of the late 19th, early 20th century. I then trained in general internal medicine and just decided that I wanted the breadth, more than the depth, so I went into GP training.

During that time, I worked in various places in the UK, in the Solomon Islands and in Switzerland, and I was a rural GP in England with my wife. We left the UK in 2012, went to Northern India for a year, where we lived in the Himalayas. We both volunteered—our children were at school—in a small community hospital and then came to Australia.

Since then I've been working pretty much entirely in remote emergency medicine, mostly in Western Australia, but also across Northern Australia, in Queensland and New South Wales.

RP: And you're a member of the OzSAGE working group?

DB: Yeah, I guess peripherally. I contributed to their paper on remote health with reference to COVID. Otherwise, I'm not an active member of the group, but I did contribute to that.

RP: What were the general recommendations that you made, why were they necessary and what was the government response?

DB: Well, there's not really any response. I mean, there's never a response. I also wrote, I was the first author on a letter that we wrote in February 2021, a letter, which was signed by about 500 prominent academics and clinicians in Australia and overseas, calling for recognition of the airborne nature of transmission and the consequences of that in terms of suppressing transmission.

That letter received a response from the government, but it was barely worth the name. You don't tend to get a response, but these things always get looked at. That paper was just arguing for a recognition of needs of rural populations, in particular, Aboriginal populations with respect to things like the ability to isolate, which as we're finding now in Northern Australia is extremely difficult for a lot of Aboriginal people, just simply logistically.

It also dealt with the need to combat a lot of the anti-vaccine propaganda that's been going around. That's been extremely prominent, extremely pernicious, some of it propagated by fundamentalist churches. The needs of rural communities are somewhat special in terms of transport, particularly here in Australia, transport accessibility to health care. But in the end, we're all in the same boat wherever we live.

Cheryl Crisp: We have just posted an interview with a respiratory scientist who works in a major hospital in New South Wales. He raised that he and others got virtually no information when COVID first developed. They

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received virtually no information from the hospital and none from the government.

Are doctors surprised that they have had to undertake their own collaborations for information rather than getting it from hospitals, governments?

DB: Yeah, definitely. I mean, this whole thing has been a surprise. We've all learned a lot in the last two years, all of us in different ways. I'm a non-specialist public health physician and not a specialist infectious disease physician, but it was very obvious what was happening when you looked at the *Diamond Princess* and the *Ruby Princess* cruise ships, and then the case report that came out very early in March, 2020 of the infection of the choir in Skagit, Washington state.

They had a choir of about 110 people, I think. Two infected individuals during a two-hour choir practice managed to infect over 50 members of the choir. It was very obvious from all of those things and from the experience with SARS one, which had already been established to be an aerosol-borne infection, that this was an airborne infection.

To see the downgrading of PPE in the UK and Australia in February, March and April, 2020, and the downgrading to droplet protection surgical masks, which are not really PPE anyway, was a huge surprise. I jointly wrote with Andrew Miller a 5,000-word paper on the need to protect healthcare workers. It was submitted to various state health authorities, ministries in Australia, and the federal government, but it received next to no response.

Subsequently, you're now seeing in Australia that we have largely accepted the need for airborne protection for health care workers, but this was a huge struggle, a huge, bad-tempered struggle. In January 2021, I wrote an extremely bad-tempered editorial piece in the British Medical Journal [BMJ] called "Up the Line to Death," about how governments were betraying healthcare workers.

I have to say though that doctors, as a profession, are not coming out of this as the good guys. There has been extreme resistance to the notion that this is an airborne disease and the need for protection of healthcare workers, patients, and the general population.

This has come from entrenched interests within the medical profession. If you were going to say to me that there was this conspiracy theory that doctors are going to care if the disease is transmitted by droplets or aerosols, I would have said three years ago, "You are completely insane. Who's got a vested interest in that?" It turns out, we're kind of fighting "big hand-washing" and it's the weirdest thing I've ever seen.

It's been a huge struggle, but the second wave of infections in Melbourne—August through October 2020—saw 4,000 healthcare workers infected. That was a big wake-up call for Australia.

I got in big trouble at the time for being so outspoken. The surprise is that it had to take so many of us arguing so strongly for the most basic protections. And that's in the healthcare realm, but then you need to look more broadly in society as a whole.

It isn't rocket science to suppress transmission. Battle lines have been drawn between the let it rippers and we must accept a toll of death, short- and long-term disease and disruption to go back to "normal," as if we can go back to a 2019 "normal," and on the other side, people who believe in the fundamental principles of public health, that we must suppress transmission of disease.

This goes back to John Snow and the Broad Street pump in the 1850s. Snow was the man who first demonstrated the cholera was a transmissible disease. It was a huge struggle then, and it took decades for this to be accepted.

Over the next 50 years, 70 years, a hundred years, this became accepted. We started to clean the water that we drink. We had indoor sanitation, in Western countries at least, and a recognition that drinking dirty water was a root cause of transmissible disease. And now it feels like deja vu.

It feels like we're going through the same thing. That overcrowded, underventilated spaces are the causes of transmission of the disease. We've accepted for years that in winter, when you're crammed into stuffy rooms, everybody gets a cold. Well now it isn't just a cold, but COVID, and that's no longer acceptable. It shouldn't be, but I think we've all been sleepwalking.

RP: You have described the struggle as an information war. We've been told vaccines were going to be the silver bullet, that Omicron is mild, children don't get infected, and now, in the last three months, we've seen the reopening of the schools and infection levels and deaths on a scale way beyond what had happened in the previous two years.

DB: That's right.

RP: What are the conversations you're having with other doctors about this? There must be incredible concern and anger about the political forces you're fighting here.

DB: Yeah, there is. I speak to a lot of different doctors. Doctors are just citizens and yes, they have some special insights, but they also have their own political views and tend to be conservative.

They also have their own interests, financial interests, where essentially many of us are sort of small business franchise owners, and they're in there being as parochial as any other group of citizens. So, I think many doctors will accept the line that they're fed.

Others look at the discrepancy between what they're supposed to be being led to believe and the reality that they see on the ground. I do think there are many fine doctors but, as I've said before, as a profession we've not covered ourselves in glory on this. And we need to really wake up to some of the ideals of the 19th and early and mid-20th century in terms of combatting disease.

What's happening now is unprecedented. We have never, in modern history, rolled over and said, yes, we submit to this infectious disease. It's all too hard, wearing masks, cleaning the air, suppressing transmission. It's a big hassle. We're not going to do it.

Polio only had serious consequences in less than one in 200 children. The vast majority, 75 percent of people who got polio were asymptomatic. If there was a polio epidemic going around, it was much less visible than a COVID epidemic. And yet we've essentially eliminated polio from most of the world and it's not far off eradication, which means it's not present at all. The same goes with measles.

Same goes with so many things. Cholera has essentially been eliminated from most of the world, not because of cholera vaccines, but because of better hygiene measures, handwashing, better water, high quality water.

What's happening now is unprecedented when you look at the known risks in terms of death, acute disease and longer-term disease and the unknown longer-term risks of an illness that replicates in pretty much all of the body tissues. If you keep grounding yourself in that reality, you just have to pinch yourself, because what's happening is crazy.

I often use the example of chicken pox and shingles.

The relationship between those two conditions was not established until the 1950s, when they had electron microscopes and could see the virus. If

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you said here's a childhood rash, a virus that causes a bit of a febrile illness, kids get a bit niggly for a week or two but are mostly fine, or very few get really sick.

But then you explained that this virus then retreats to live in the anterior horn cells of the spinal cord and can re-emerge six, seven, eight, nine decades later to cause a completely different illness called shingles with extremely severe and debilitating neurological and ophthalmological effects, you would say that's crazy. And yet that's something that we accept as reality.

But now, with COVID, we are infecting ourselves and more critically our children, repeatedly, with this virus, that is rapidly mutating and changing its form, with no firm knowledge of the long-term consequences.

And if you look simply at it from a risk management framework, it's insane. The risks that we're exposing ourselves to are insane and we were doing it to the children. So, we'd better watch out because it's the children of today who write the history books of tomorrow and they might be pretty pissed off with us. They'll be choosing our nursing homes, so we'd better stay on their sweet side.

I personally feel really at sea. I've always been fairly circumspect and a bit cynical, maybe, but realistic, but now it seems that anything's possible, and that we can convince ourselves of the craziest things, that humans should be farmed, like factory chickens.

Rather than that we should, as doctors, take account of the humanity of all of us. Anybody with a clinical vulnerability, anybody with diabetes, who's immunosuppressed, on monoclonal antibodies, has treatments for rheumatoid arthritis or who's on steroids, or who has any other intercurrent morbidity, any other underlying illness is endangered.

What we're effectively saying is, "Well, we've done our bit. We protected you for two years, but it's just too much hassle now. We'll get on with it. The young and the fit, the vaccinated young and fit will probably be okay. Losses in that group, injury in that group will be acceptable. Rest of you, do what you like, survive if you can."

That's a pretty harsh position that we've adopted, really without a thought and that everybody's taken on. It's old style, early 20th century eugenics, it's "ableism" and it says to the more frail people, the more vulnerable, the people who do not fit to a certain ideal of physical perfection, tough luck.

CC: The *World Socialist Web Site* right from the beginning analysed that the underlying reason for these measures—sharply seen with Johnson in Britain, Sweden, and now, really every government--is that no government places the priority of health over production.

DB: Correct.

CC: Dominic Perrottet, the New South Wales premier, said it outright. "We have to open the schools on day one and not close them again because that's what the economy needs."

DB: Yes.

CC: Driving of children back into schools means that they are no longer educational institutions but just infection hubs.

DB: Correct.

CC: Many of those getting COVID are being inected from their children who are at school, and nobody knows what the effect of Long COVID will be. All this is bound up with the prioritisation of profit, production over health.

To a large degree that has been accepted, but, certainly in Australia and New Zealand, people did follow the lockdowns and the restrictions. Likewise in China, where the population agrees with Zero-COVID. But even with China, there are now demands, particularly through the *Financial Times* and the major international corporations, for them to discard this policy.

DB: Yes. It's a weird situation on the face of it and it's not something I would ever have predicted. When you look at it in historical context, it becomes much more obvious why this has happened. We have this increasingly individualistic society and we're now conflating the economy as society.

What is the economy? It's made up of individual people carrying out activities. But the economy is now the aim, the be-all and end-all, serving individuals to promote the short-term activity of the economy at the expense of their own health.

But it doesn't serve them, it serves the people with the levers of power and the financial leaders. It's very bizarre because I don't have a history as a kind of socialist activist, but if you look at what's happening now it's like the 1880s, the 1860s and the kind of struggle out of which Marx and Engels wrote *Das Capital*.

It almost feels like we're back at the tail-end of the English industrial revolution in the way that ordinary people are being exploited to deliver profits for Qantas or whomsoever.

CC: The billionaires have doubled their wealth.

DB: Yes, they're very happy for everybody to get back to work. They shelter in their villas, and don't have to go into the office or stand on a crowded train or bus. It's a really scary situation and I have to say I've been incredibly disillusioned to see scientists and medical professionals helping conflate these political decisions, helping to promote them as scientific ones.

This whole thing about children's mental health, and "Oh they've got to get back in school, et cetera." The evidence is very clear, and I'm not arguing against school per se, education per se is a good thing, but I wish it would teach people to discern fact from fiction a bit better.

Actually, children's mental health has not suffered during protections, lockdowns and the evidence says that self-harm rates have gone down and suicide rates, et cetera. There's evidence from all over about that.

The crocodile tears about the poor kiddywinks, get the children back into school, I don't buy that for one second. And how you can worry about children's mental health from being out of school, but not worry about children's mental health from contracting an infection, which infects their vulnerable parent or grandparents, with serious consequences. I don't know how you can do that and sleep at night, but people do.

The schools and the children have been weaponised to get people back into work. You don't need a huge imagination in my opinion to see this agenda at work. As a rather idealistic doctor who thought that we were there to promote health in individuals and health in society, it's been a pretty dispiriting two years.

RP: What sort of pressures have you come under to shut up? There's a campaign to marginalise scientists and doctors who have spoken out. Guy Marks, Brendan Crabb and Raina MacIntyre wrote an article in January, "How to eliminate COVID." Nobody reported on it, basically. We published it in the WSWS, but nothing in the mainstream media.

DB: I know. There's no interest. We don't have to go into the ins and outs of concentrating media ownership in a few right-wing moguls with very clear agendas, but we're seeing the consequences of that very, very clearly. We see supposedly independent media outlets, quasi-independent such as the ABC [Australian Broadcasting Corporation], which face so

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much funding pressure that they cannot escape being essentially a client media, not completely, but largely a client media that is promoting a government line.

The window of discourse in the media is extremely narrow and has become extremely polarised. I've been called a Zero-COVID zealot, a Zero-COVID extremist. It's just bizarre, absolutely bizarre and yet that stuff sticks. All I'm arguing for is disease suppression, and ultimately elimination, as we've done with every other infectious disease, or at least every other infectious disease that's affected white people, malaria and other things less so.

But promoting individual health, resisting the notion that people should embrace illness in this kind of cultish way, is now presented as an extremist position.

After a false start by the WHO and criticism of its failure to call COVID airborne, Dr Tedros, Dr Ryan and Dr Van Kerkhove are saying that you cannot pretend COVID is over, that there's no herd immunity and we have to take rational disease-control measures and suppression measures. Yet this is presented as an extremist position.

If we circle back, yes, this is an information war and the battle lines have been very clearly drawn. An awful lot of it essentially comes down to money behind promoting the idea that the herd needs to get back to work and it must accept a certain degree of attrition.

That's the message. So that, as I said before, it's all pretty dispiriting but it must be fought against.

CC: Have you dealt with many people with long COVID?

DB: No, I haven't. I had a very good pandemic and been lucky enough to be in Australia, and then for the last year or so have been in Western Australia. My experience of seeing patients with COVID is relatively recent and I haven't seen many.

We were incredibly fortunate here in Australia until COVID was more or less deliberately let in. I'm extremely suspicious of Gladys Berejiklian and Brad Hazzard and the way in which they failed to eliminate mid- to late-June last year.

CC: I noticed that Vicki O'Donnell, from the Kimberley Aboriginal Medical Service, has spoken about the situation in Western Australia, particularly amongst Aboriginal communities.

[Western Australian Premier] Mark McGowan has declared that the pandemic has peaked but she has said it hasn't peaked and there're absolutely no options for people in the Kimberley, particularly Aboriginal communities, to deal with COVID. Have you had to deal with those sorts of communities with COVID?

DB: Yes. Logistically and culturally Aboriginal people tend to live together and in a much more communal lifestyle than Western people. The nuclear family is a concept unknown, with child-rearing shared, and all kinds of relationships, close relationships of cousins/sisters, and such like, that aren't recognised in Western cultures.

So being able to isolate brings huge logistical challenges. I think it's fair to say that none of what's happening now is a surprise. There has been a gross failure to provide suitable accommodation to help at least even slow transmission amongst Aboriginal groups.

Let's take a 30,000-foot-high view of this. The thing that has most worried me since the beginning of all this is if Jacinda [Ardern] hadn't closed the New Zealand borders, I don't think we would have.

But we eliminated. We eliminated in April 2020, pretty much by accident. I don't think anybody expected that we would, but we did because, as you said, people were extremely compliant. There was a great community spirit, et cetera. Ever since, here and in New Zealand and in other countries as well, like Korea, there has been a failure to put in place any other measures.

We've had this razor-thin defence at the border, and the failure to understand that this virus spreads through the airborne route has meant that we have failed to harden our infrastructure and change our behaviours to accommodate that.

If we had recognised that early in 2020, as we could have, because it was known and we should have worked to educate people about how COVID is transmitted.

If we had made available N95 masks, free for the entire community; educated people knew about how to keep well. If we had instituted ventilation improvements in indoor buildings; HEPA filtering, where that was not possible; and done everything to secure our society against this pandemic, and potentially future pandemics, which will either come out of this pandemic or may arise de novo.

If we had done this then, we wouldn't have a precipice where we opened the border and then all of a sudden there's a huge deluge of cases. We would have fortified our defenses. But we did nothing, nothing at all. Even to get HEPA filters into hospitals and universal masking with COVID patients has been a huge struggle.

This kind of intransigence, this resistance to innovation, this unwillingness to accept that the world has changed has really been catastrophic. And I think in the case of Australia and New Zealand it has meant that we squandered a significant amount of our first, early advantage. It's not to say there was no advantage. We saved a lot of lives, but we squandered a lot of that advantage.

If you look at it in military terms, we had good tactics, but there was no strategy. A lot of hope was put in the vaccines, which I had too, a sterilising vaccine that would significantly reduce transmission, but it has not transpired.

If we'd had a sterilising vaccine, like a measles vaccine or something like that, we'd be in a much better situation. We wouldn't be having this interview now probably. But we don't have that. And yet when that became apparent, that the vaccines would help drastically reduce serious illness, potentially reduce Long COVID, but not eliminate either, would not significantly suppress transmission; when that was realised in early 2021, there was no consequence shift in strategy.

It was like, well, we'll just press on any way, get everybody vaccinated and then people will just go on and we'll just accept the toll. If one's looking for the roots of where we are now, it is a lack of strategic vision, even in countries that did well.

RP: Well, you also see that reflected in the budget. There is nothing. In the lead up to the budget, there's no plan B. There is no forward planning about what to do. No expansion in personnel, in facilities, it's an outrage.

DB: No, there's nothing. And you know, it gets up some people's noses when you talk about this pandemic in military terms but it's quite a useful framing. Generals have to think in terms of tactics and strategy, shorter term tactics to gain control of the situation, and then longer-term strategy to maximise the advantage.

We're not doing that. There's no vision and every time there's a new wave it's like, oh my golly, gosh, there's new wave, what a surprise. We simply are unable to encompass the fact that there will probably be another one, which is inevitable. We're breeding ever more resistant variants and there's no selection pressure in that breeding for reduced virulence.

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We're rolling the dice every day in allowing unsuppressed transmission and we may rue that one day because we may get something that's really transmissible and really lethal. There's no reason why that can't happen. There's no magic law that says this is a film with a happy ending.

CC: And quite impervious to the vaccines.

DB: Yes. Inevitable. We have out of control replication of the virus in an environment of partial immunity which selects for variants that will escape immunity. That's what we see with Omicon already. At the same time, there's a kind of semi-religious belief that somehow it's going to become less virulent, less severe.

There is no biological rule that says that must be the case. There is no selection pressure on the virus to become less virulent. It infects people before symptoms and during symptoms. It infects before symptoms and as long as that occurs, it doesn't matter if it kills the host. We're rolling the dice.

Now with the antivirals, the antivirals are great, but they have problems. They mutate DNA, potentially human DNA, certainly mutate RNA, which is how they kill the virus. So that's a great thing.

We have, for instance, Molnupiravir, which is an oral antiviral which is effective by about 30 percent at reducing hospitalisations. But it's a mutagen and causes lethal mutation in the virus to kill it. The person who's taking it is still shedding mutated virus for about three days and of course in India, this stuff's available over the counter for 20 rupees a tablet, I think. There's going to be an awful lot of people walking around who've had subpar courses of this stuff, shedding huge amounts of virus that's mutated.

It's not just that we're not doing anything to secure our long-term future but we're actively shooting ourselves in the foot.

RP: Have you had a look at the material we've published on the Global Inquest and now plan to take forward a program of education and mobilisation?

DB: I haven't actually. It sounds great. I'm sold.

RP: We've been interviewing many scientists, also health workers. As you say, it's a war. We have to begin a mobilisation from below, in alliance with scientists, doctors, et cetera. It's a political struggle.

DB: Yeah. It is a political struggle. It's nothing to do with science. It's a political struggle. It's an information war. It's about combating misinformation and slants, which minimise the problem. You can't mobilise and fight a war if most of the population doesn't believe that there is a problem.

RP: That's true. But as we were discussing before, the population when given a lead will respond. And you saw this over the Christmas period, the politicians were declaring Omicron's mild and people should go out and shop but they didn't.

DB: Oh yeah. I have to say, Australians are really civic minded, they do think about the community, much more, I think, than in Britain. Aussies love to do stuff for each other, and they love the Bunnings' sausage sizzle, and cake bakes for the RFDS [Royal Flying Doctor Service] and all that stuff. People love it.

This notion that we've suddenly been indoctrinated to be selfish people not caring for those around us, not caring for people who are vulnerable. It shows the power of propaganda.

CC: Just before Christmas, when Omicron emerged the chief medical officer, Paul Kelly declared that Omicron was his best Christmas present.

DB: I know and on the basis of zero good information. The GP, I think is president of South African Medical Association, Angelique Coetzee. She said, within three or four days, that all the patients she'd seen with Omicron showed it was really mild. And that was it, it became a meme, "Omicron is mild" and went totally crazy….

People were desperate for it and the politicians milked it for their own ends, but there wasn't any meaningful truth to it. It's milder because we are all vaccinated but it's much more transmissible.

If you look at the global death curve, there are basically two curves that are the most important. The only ones you really need to look at, because this is one world. Global new cases, global daily new cases, and global daily deaths.

If you look at the Omicron global daily new cases, it's huge. It's massive. Way higher than Delta and way more transmissible. But if you look at global daily new deaths, that's also higher than Delta. It's only a bit higher than Delta, but it's higher than Delta. And so, a small percentage of a massive number is still a very large number. This is basic math. But you can fool people into not believing this with propaganda, unfortunately. And that's where we are.

RP: One of the purposes of the Global Inquest is to hold particular individuals accountable. The British Journal of Medicine *[BMJ]* described the responses of governments around the world as social murder.

DB: Yes, written by Kamran Abbasi. It is social murder.

RP: And individuals, people have to be held accountable for what they said and did.

DB: Yes. You can say to people, well, it's all personal responsibility and you've got to protect yourself. But if you're a minimum wage shelf packer, or you're a bus driver and you've got a family to feed, and hardly any sick pay, you don't have the option to isolate in your second home and work via the internet Once you get into that kind of inequity in terms of disease, then yes, of course, it's social murder.

I have to say, I think you guys have done a great job with your coverage. I think you're really one of the best media outlets and which has done a good journalistic job and actually delved into the ins and outs, not simply regurgitated press releases. So well done.

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