Dr David Berger speaks with WSWS about stopping COVID in Australian hospitals

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Last month, Dr David Berger, a highly-experienced rural emergency doctor, issued an open letter to Australian health ministers demanding the mandating of masks in hospitals and all other health settings. This rudimentary measure has been abandoned by Australian governments, allowing the transmission of this deadly disease and the death of vulnerable patients.

As extensively reported by the WSWS, Dr Berger was censured and threatened with deregistration by the Australia Health Practitioners Regulation Agency for his determined fight for zero-COVID.

Dr Berger's open letter lists seven necessary procedures to stop COVID infections in hospitals and other clinical settings:

• Set and promote a target of ZERO HOSPITAL TRANSMISSION OF COVID AND OTHER RESPIRATORY INFECTIONS for the entire country, as our state and federal governments set and promote a target of ZERO ROAD DEATHS.

• Reinstate the mask mandate in clinical areas, at least, and for N95s, which science tells us are effective against airborne pathogens, as opposed to surgical masks, which are not.

• Establish—and publish the results of an audit program to monitor rates of hospital-acquired COVID and other airborne respiratory infections such as RSV and flu, because without such a program it is impossible to calibrate infection control measures. How else can we know if the measures we are taking are beneficial or detrimental? To quote Lord Kelvin: "If you cannot measure it, you cannot improve it."

• Monitor and publish the indoor air quality of healthcare facilities. This air is breathed by the public and its quality deserves to be known by the public. What have you got to hide?

• Apply mitigations where indoor air quality is found to be lacking, such as improving air change rates and/or HEPA filtration.

• Educate staff about the importance of respiratory hygiene with respect to airborne infection, in the same way as they are educated about hand hygiene. This is not presently happening.

• Audit and promote mask [N95] wearing in the same way as hand hygiene is promoted and audited. This is not presently happening.

We asked Dr Berger about these demands and why he decided to issue an open letter.

David Berger: Governments are basically going back to what was being said in 2019. Given what we've learnt in the past three years this is particularly absurd and dangerous: firstly, because COVID is the most infectious disease we've encountered in the past 60 years, and secondly all that we now know about this disease being airborne.

People might like to believe that we can all go back to 2019, and that nothing has changed, but this is not in accordance with reality and science.

The idea that we are not pulling out all the stops to ensure we're providing the safest healthcare to everyone is abhorrent because it discriminates against anyone with a disability and is a spectacular act of patient harm.

During the post-WWII period there was an aspiration to improve public health. We had the birth of antibiotics, effective hypertension drugs and a spate of childhood vaccinations during the 50s, 60s and 70s, and even in the 1980s and 90s. But what it was like in the 1930s in pre-antibiotic and pre-vaccine days is not in the living memory of many public health professionals working today.

When you and I were children there was an understanding among health practitioners what it was

like back in the 1930s. That institutional generational knowledge is gone. It's taken for granted that kids don't get sick, and people just live on into old age.

Hard fought gains are now being thrown away and responsibility for this rests with governments and senior health officials.

WSWS: Could you speak about the horrendous rise in hospital infections?

DB: We'd all like COVID to go away but it hasn't, and it won't, so unless the measures I propose are implemented, then more and more people are going to get infected in hospitals and die.

It's imperative that medical facilities and hospitals are safe for all people to access. If we fail on this, then we fail the first dictum of health care which is, "first do no harm."

The first thing we must do, in conjunction with ensuring adequate precautions are taken in hospitals, is to start measuring and publishing the rates of healthcare infections. We do it with road traffic deaths and have a manifest target of getting to zero road deaths, which will never happen, but at least there's an aspirational target.

Unless we have a target to measure our success with COVID then we can never improve. As Lord Kelvin said at the end of the 19th century, "If you cannot measure it, you cannot improve it."

And those measurements must be published, and healthcare facilities held accountable. This is our information, and it belongs to the people.

It's completely brain-dead to measure infection control by community prevalence. If it's low but you're still getting a lot of infections in hospitals, then it means you've got to do more to stop it.

Higher community prevalence is a factor, of course, and increases risk but what we have now is a rising sea level, with tidal variations, rather than intermittent tsunamis-like waves. In other words, the background level of infections is sufficiently high that there is no sense in calibrating infection control measures according to community prevalence.

You calibrate infection control measures according to whether they're successful or not. The only way you can tell if they're successful or not is by measuring outcome, which is hospital acquired infections.

This isn't new, complex or some amazing idea, it's simply basic project management. It's almost painful and wearying to have to explain this.

That government health officials can say we're not going to measure the outcome or show you the results, and be allowed by the media to get away with it, shows you the parlous state of the press today.