

“Death is being ‘normalised’ because the priority is keeping the economy open”

# Australian respiratory scientist speaks to the Global Workers’ Inquest

**Our reporters**  
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The *World Socialist Web Site* recently spoke to David, a respiratory scientist who heads a respiratory laboratory in New South Wales (NSW). His testimony to the Global Workers’ Inquest into the COVID-19 pandemic sheds further light on the impact of the World Health Organisation’s refusal, in the early stages of the pandemic, to acknowledge that the virus is airborne.

David commented on the dangerous transformation of public health measures in Australia, which had previously reduced the number of coronavirus infections to almost zero using mitigation measures.

In December 2021, Australian governments, state and federal, used false claims that the Omicron variant was mild to remove virtually all safety measures. This allowed the virus to rip through the country.

Infections have risen tenfold since the beginning of the year and the number of deaths over the past three months are nearly double the fatalities over the previous two years combined.

## **Tell us about your workplace and what you do?**

I’m the head scientist of a clinical service in a major hospital that specialises in lung function measurement, which is crucial to being able to diagnose and manage a variety of different lung diseases.

We see, treat, and monitor common chronic diseases, such as asthma and smoking-related lung diseases. There is also occupational lung disease, that is, people who have either been directly or indirectly exposed to agents that have impacted on their lung health. For example, people who worked in coal mines or have been exposed to silica dust or asbestos in their working environment.

## **What is the impact of these diseases on patient’s lives?**

Ultimately life expectancy is reduced. A good proportion of the work we do is monitoring lung disease, which is vital. Asthma, for example, is very common. We often see patients later in life who have never had their lung function measured. If they had, we could have intervened earlier and prevented their disease from being so chronic. These patients are now in their 50s, 60s, and 70s and it is clear the disease has caused irreversible lung tissue damage. We are dealing with a chronic disease that in many cases was preventable or with intervention, could have been less severe.

## **How has your work changed as a result of COVID-19?**

Because COVID is an airborne virus and we work in a respiratory lab, it was clear that it could be a source of infection, or spreading of infection, particularly to staff, but also other vulnerable patients. Even before COVID, we had viral filter technology that protects patients from our equipment and protects our equipment from our patients.

When the pandemic hit, there was a desire to write guidelines on how to operate a laboratory in this environment, but this had to be done by the scientists themselves. There were no clear instructions from within the

healthcare system.

I guess we felt that if there were not going to be any instructions from management then the scientists would need to get together to work out a way forward.

In early 2020, a group of scientists in the state got together on a Zoom call. I took part in this. We wanted to know what other people were doing and learn from each other about our experiences.

## **Was there much discussion about how COVID was transmitted at that time?**

It was quite a popular conception among us that it was predominately airborne. If it spread through droplets, it would be a finite particle that may or may not have been respirable and could rain out in the air, and therefore it may not be as infectious as COVID actually is.

I suggested at the outset that we needed HEPA (high-efficiency particulate air) filters. There was a hesitancy to recommend people get them because of claims that the evidence didn’t exist or that they were expensive. The importance of the filters has now been validated by some of the work that has gone into exposure risk and papers that have been published in these areas.

HEPA filtration is also used in surgical theatres so it made sense that they be used in a high-risk setting such as a respiratory laboratory where patients can cough from the tests that we perform.

## **What went through your mind, as a scientist, when the World Health Organisation (WHO) kept insisting it was not an airborne disease?**

While there may not have been direct evidence at that time, there would have been a considerable amount of indirect evidence suggesting that the virus was airborne. I thought that due to the ability of this virus to spread so rapidly it must be airborne.

WHO’s insistence that it was droplet transmission contributed to the real lack of initial preparation, which was haphazard and poorly thought through. In relation to PPE, it was extremely difficult getting suitable N95 masks because they were in short supply. Only surgical masks were available, but they are very ineffective.

Our solution was to shutdown services, which was one way to protect ourselves, but it wasn’t helping patients with lung disease who needed these tests.

The shutdown caused significant challenges. Initially there was major anxiety among staff about the risks that needed to be addressed and managed. Only urgent patients were seen during this period.

Some of these patients are now presenting with diseases that have advanced because there wasn’t an ability to address them. Our waiting lists are now exploding to three to four months, but our accreditation says

it must not be more than four weeks. Some of these patients have had COVID and now have ongoing breathlessness adding to the workload.

I had to reorganise the service, so it is vacant one day a week for all the urgent patients. Some patients urgently need tests, so it is becoming more challenging to juggle.

I'm a scientist but I'm now doing a lot of administration and booking work to make sure patients are seen. I often have to work on the weekends in order to manage the service. Most days I don't have lunch because there are constant pressures on the service. This was always there before COVID, but it's ever present now.

You're also thinking about so many people; your staff, your patients, who are in the high-risk category, and then there is my family. You worry about bringing the virus back home, so this is always in the back of your mind.

The NSW government claimed that hospitals could cope with the rise in cases but what a lie that was. In truth, the hospitals are at a point of collapse.

Since the NSW state government removed all the protections that were in place to minimise the spread of the virus, I now have staff that have been infected. Every one of them, however, caught the infection from their children. Their children were exposed because of the reopening of schools. It is quite clear my staff didn't get it in the workplace.

**Would you say that it's less risky for you and your staff at the respiratory lab than at home or in the community?**

Yes, that's exactly right. For me now the safest place is work due to the evidence-based safeguards we have put in place. My perspective has changed dramatically on that very question over the last four months. I feel that my laboratory space, which was previously a high-risk environment for staff and patients, is much safer now.

It is paramount for my family that COVID not come into the household because my son is immunocompromised. Typically, we are the only people wearing masks when we leave the house. My son got teased by some kids at school because he was still wearing a mask. He was one of the only children in the class doing so. There's tremendous pressure to fall in line with the government's reopening agenda.

**What did you think about the federal and state governments removing the COVID mitigation measures and telling people that they have to "learn to live with the virus?"**

This was completely against their duty to oversee public health and make sure that the environment we live in is the safest it can possibly be. They have now exposed society to a tremendous health threat.

The *British Medical Journal* and the *Lancet* description of the British government's "let it rip" policies were very accurate. They didn't mince their words but described it as a criminal activity and "social murder." How can it be anything else?

In some respects, I wasn't surprised. It was a continuation of what is happening in the US and Europe. Human and public health measures have no degree of importance to governments. Paramount to them is the opening of the economy, with profits put before human need. That's the reason we are now exposed daily to this pandemic and why it has been able to spread globally in the manner that it has.

In Australia, the governments have profoundly relaxed everything, from using the check-in apps, tracing, and even accessibility of test centres. These are criminal actions. There were protections in place, but they have been removed and society is now exposed to a significant and preventable disease that needs to and can be eliminated.

You must have a multifaceted approach to deal with a virus of this nature. It can spread from human to human and is different to other diseases that might be chronic because of occupational exposure or genetics. You cannot just rely on vaccinations. That conception is not grounded in any sort of scientific rigor.

The vaccines have some positive impact, but they are not stopping

mortality. There are people who have been vaccinated and are still dying or suffering from Long COVID and other complications.

**One aspect of the "live with the virus" policy is the normalisation of death. What do you think about the way governments claim that many of those that died had comorbidities?**

Many of these patients who have had comorbidities could have lived many, many years longer. From my perspective the attitude of the government is inhumane and completely unacceptable.

Working in a chronic healthcare environment, I deal with comorbidities every day. It's not an excuse to just allow people to die early because they have an illness. We have a medical system that is designed to keep these patients alive and active. This is the product also of scientific research.

I have patients that have chronic lung disease, who live for quite some time and live good lives while we manage their care. We don't look at someone and say, "You don't deserve to be around much longer because of the severity of your disease."

This normalisation of death is occurring because the priority is to keep the economy open. It's a strategy to make the consequences of reopening more palatable.

I knew a relatively healthy man in his 80s who was fully vaccinated and died very quickly from COVID. Even though he had these comorbidities, this didn't mean he would have died suddenly like that. He had a good quality of life and was completely independent. His family were completely unprepared for his death. They didn't see it as inevitable.

**What is now being discussed in the hospitals about the Omicron wave and the latest variant?**

I get little to nothing from within the hospital itself. Most information I get externally from reputable sources. I fear the next variant is going to increase the risks at work even though we have protective measures in place.

It's surprising but there's no strategy for dealing with the increase in patients. We've learned much about waves of the increasing prevalence of the virus from other countries, but I don't see any strategies here to prepare for this.

**It is important that scientists have independently organised and figured out what to do to combat the pandemic in their workplaces. This points to the need for independent action?**

Yes, it was a natural thing to do among those who needed answers to important questions. We've never had to deal with such safety issues in our services, but we were not getting information from management. Our collective knowledge and experience are what helped us most. It was very effective.

**What will be the impact if COVID continues to spread across the country?**

We will see an upturn in patients, who were otherwise healthy, now suffering from Long COVID. Many of these patients end up with a degree of complex breathlessness which can be very difficult to identify the source of and to manage. I know of some hospitals that are now establishing specialist Long COVID clinics.

We will also see waning immunity. Elderly patients who were protected to a point with the vaccine will become unprotected. We're going to see premature mortality with patients who would have lived if they hadn't got the infection.

**Have you seen patients with Long COVID?**

I've seen patients who have long-term breathlessness and the reasons for that are difficult to determine. In some patients it's clear that their lungs have not been affected but they are still breathless.

Breathlessness doesn't always have to come from the lungs, it can come from other sources, such as cardiac breathlessness. We will have to become competent in trying to work out what the origins of these symptoms are.

One thing I've learnt in respiratory medicine is that you don't want to

have limited lung function the last few years of your life. It has a direct impact on a patient's quality of life, to the point where they can't work, and every breath is a struggle. We see this on a regular basis. We should be doing everything in our power to prevent patients from having the last years' of their lives to be of such poor quality.

**This week NSW nurses are striking for a second time over wages and the unbearable conditions at work. What do you think of this action?**

Strike action by nurses is brave and instructive to others who have difficulty in their workplaces. The pressures at work are just increasing. Complaining to management yields little to nothing as seen in the minimal support we have received during the pandemic. It's getting harder, not easier.

Nurses are such a crucial part of the workforce, and not just in hospitals but their service to the community is vital. They should not only be supported by other nurses; they should be supported by everyone. Workers from other areas of health care, and beyond, need to come to their assistance.



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