Interview with the Honourable Jon Gerrard*

BRYAN P. SCHWARTZ, DARCY L. MACPHERSON

I. PART I

Bryan P. Schwartz (BPS): You're a longstanding parliamentarian. You were elected at the federal level, served as Secretary of State for Science and Technology and were the longstanding leader of the Manitoba Liberal Party; you often had to do a lot of heavy lifting in the legislature, especially during COVID.

The Emergencies Act[1] at the federal level has a lot of language about ensuring constant legislative oversight. In contrast, in Manitoba,[2] a public

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* Interview of Jon Gerrard, conducted by Dr. Bryan Schwartz, Professor Darcy MacPherson and Lily Deardorff on January 29, 2025.

The Honourable Dr. Jon Gerrard is a Manitoba politician who served as a Member of Parliament (MP) from 1993 to 1997 and Secretary of State for Science and Technology in the government led by the Right Honourable Prime Minister Jean Chrétien. During this time, he was also Secretary of State for Western Economic Diversification (1996-1997). He also served as the leader of the Manitoba Liberal Party from 1998 to 2013 and a member of the Manitoba Legislative Assembly (MLA) for the riding of River Heights from 1999 to 2023.

Prior to starting a career as a politician, he obtained a Bachelor of Arts in economics from the University of Saskatchewan (1967) and a medical degree (MD) from McGill University (1971). After that, he specialized in pediatrics and oncology, earned a Doctor of Philosophy from the University of Minnesota (1976), and he worked as a pediatrician primarily at the University of Minnesota in Minneapolis.

He started working at Cancer Care Manitoba in 1980, caring for children with blood problems and cancer. He served as the head of Pediatric Hematology-Oncology at the University of Manitoba from 1985 to 1992.

1 *Emergencies Act*, RSC 1985, c 22 (4th Supp).

2 *The Emergency Measures Act*, CCSM c E80.

health officer makes a recommendation to a minister; it doesn't have a framework for legislative deliberation.

What is your sense of whether there was an adequate role for elected legislators during the COVID period in Manitoba?

The Honourable Dr. Jon Gerrard (JMG): Let me just add a couple of things to what you listed. I was elected federally as an MP from '93 to '97. For that whole period, I was the Secretary of State for Science Research and Development, which was a junior ministerial position for which I was in the Cabinet. Interestingly enough, they had us in the Cabinet [meetings] for one time in four. Nevertheless, they treated us with Cabinet status.

Jean Chrétien's[3] idea was that we would travel across the country and be links between what was happening in Ottawa and what was happening on the ground. So, I did a lot of travelling across the country. Halfway through, I was also given the responsibility for Western economic diversification, and that was also interesting in terms of learning about business and industry, as well as science and research and development.

So then, I became a member of the legislature in 1999 and served until 2023. I was elected the leader of the Manitoba Liberal Party from 1998 through 2013. As the leader, I had to have a wide scope of activity and particularly so since, some of the time I was the only Liberal MLA, and some of the time I was with Kevin Lamoureux.[4] Then, after I had stepped

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3 The Right Honourable Jean Chrétien PC OM CC KC AdE is a Liberal politician and was the 20th Prime Minister of Canada from 1993 to 2003.

4 The Honourable Kevin Lamoureux is a Liberal politician from Manitoba. He has been a member of the House of Commons for the Winnipeg North constituency (2010-present). He also served as a Manitoba MLA (1988-1999 and 2003-2010).

down as leader, I was an MLA with Dougald Lamont,[5] Cindy Lamoureux[6] and Judy Klassen[7] for a while.

Okay, so, let me set the framework. By the end of February 2020, it was very apparent that we were into a major pandemic. It was known by the end of January that this was highly communicable from human to human, and that a significant proportion of people who were transmitting it were asymptomatic. The Chinese higher-ups told the higher-ups in the United States that about 50% were asymptomatic, which is a high proportion. And the Chinese told the leaders in the United States at that point that this was very dangerous in part because it was highly transmissible and in part because a lot of the transmission was asymptomatic.

Now, there have been various studies since then in terms of the proportion which is asymptomatic, and it may not be as high as 50%. The possible exception is in senior homes, where the evidence does suggest that it was probably about 50% asymptomatic transmission.

On March 2nd, [2020], the Manitoba Liberal Party had their first press release on this, and we emphasized the importance of having a provincial plan which addressed protecting people living in personal-care homes, because, at that point, the need was already very clear. Even though there had not been any personal-care home deaths in Canada, there had been personal-care home deaths in other jurisdictions, including the United States.

It was important that the plan include individuals on low incomes, being prepared to crack down on price gouging, and ensuring the work of government continues, setting up a central command center to coordinate activities, including things related to food and deliveries. There was also a mention of Northern communities and Indigenous communities, where a

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5 Dougald Lamont is a Liberal politician from Manitoba. He served as a member of the Legislative Assembly of Manitoba for St. Boniface from July 2018 to October 2023. He was the leader of the Manitoba Liberal Party from 2017 to 2023.

More information about Dougald Lamont can be found in in the interview with Mr. Lamont in this issue of the Manitoba Law Journal (see page ■).

6 Cindy Lamoureux is a Liberal politician from Manitoba who has served as MLA for Tyndall Park since 2016. She is also the interim leader of the Manitoba Liberal Party (as of October 2023). She was the only Liberal to hold her seat in the 2023 Manitoba general election.

7 Judy Klassen is a Liberal politician from Manitoba. She served as MLA for the riding of Keewatinook from 2016 to 2019. She also served as the interim leader of the Manitoba Liberal Party from October 2016 to June 2017.

lot of people are living in fairly close quarters in many of the First Nations communities.

The Legislature reconvened at the beginning of March, and anyone who reads the transcript of that period realizes right away that the Manitoba Legislature was completely dysfunctional for much of the first half of March. And what essentially had happened was that the NDP decided that they didn't like some of the things that the Conservatives were putting forward, completely unrelated to the COVID pandemic, and so that they filibustered, they brought in matter of privilege after matter of privilege. They prevented the ministers' statements. They prevented the question period. When we, as Liberals, asked for a matter of urgent importance to debate the COVID pandemic, that too, was prevented. And this had serious consequences.

Basically, the NDP[8] and the PCs[9] got tied up in other things than the COVID pandemic and forgot that they really should be focusing on the COVID pandemic and figuring out a way to get people in the Legislature working together on what was a provincial and global crisis.

Subsequently, the Conservatives, instead of continuing on with the session or even pausing it and then coming back to it within a week or two, for April, May and June, there were only five sitting days of the Manitoba Legislature. In my experience, being in the Legislature and dealing with crises like major floods[10] and dealing with the situation in 9-11.[11] I found that, in governance, it helps to have the Legislature functioning. When you

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8 The New Democratic Party of Manitoba was the main opposition party in provincial politics at the time of the COVID-19 pandemic.

9 The Progressive Conservative Party of Manitoba (known informally as either the "PCs" or the "Tories") was the governing party in provincial politics at the time of the COVID-19 pandemic.

10 Flooding is a reality in Manitoba. After a disastrous flood in 1950, the Red River Floodway was built to divert potential flood water away from the City of Winnipeg. While the Floodway protects the Province's largest city, areas outside Winnipeg can still be seriously impacted by flooding. The flood of 1997 was particularly difficult for residents outside of the city.

11 "9-11", in this context, is a reference to the attacks that befell New York City, Virginia and Pennsylvania on September 11, 2001. The fallout of these attacks did not just affect the U.S., though clearly, the most direct (and gut-wrenching) effects were felt there. It affected the world as a whole. Air travel to the U.S. was suspended. Provinces bordering the U.S. (such as Manitoba) had legitimate concerns about what could be coming next. In that sense, in the days following September 11, 2001, many jurisdictions had to treat the situation as a potentially continuing crisis.

have the Legislature functioning, you can get all 57 MLAs to contribute to improving the nature of the response to the crisis. And even if the members of the Liberal Party and the NDP party, in this case, are in opposition, we're not running things. The fact that you can bring things up and bring things to the attention of the government meant that the government had to report on a daily basis. When there was a flood crisis, the government had to provide a report on what was happening and what they were doing in Manitoba.

BPS: So, Jon, the model we have in Manitoba is essentially technocratic in dealing with public health. The locus is the public health officer. What access did you have to the bureaucracy to give them information, and to get information? Our model basically transfers a lot of the decision-making to the technocracy. What's the flow of information and thinking between you and the public health office?

JMG: Okay, let me go back to the September 11th crisis. An all-party committee was immediately set up to deal with security issues around the Legislature and around the Province, and that generated dialogue in a committee sense. I don't think it was actually a publicly-reported committee, but it was an informal exchange of information, which was very helpful both because it offered the government the opportunity to listen to the other parties, and to make adjustments in terms of plans.

Now, if we fast-forward to the situation with the COVID crisis, I recall in particular that we had one session, possibly two sessions, as a caucus with the Chief Public Health Officer, Brent Roussin,[12] fairly early on. The session was designed primarily as a one-way session, and it was not on the record. When you've got things happening within the Legislature, they are on record, and this is an important difference.

We were working less in session [at the Legislature], in the early phase of the COVID pandemic but one positive thing that happened was that the Ministers indicated that they would respond to emails from other MLAs instead of letters, which meant there was a greater ability to get information to the Ministers quickly. Basically, it wasn't used for policy *per se*; it was used

[12] Dr. Brent Roussin is a physician and a specialist in public health and preventative medicine. He has served as the Chief Provincial Public Health Officer of Manitoba since June 3, 2019.

for helping an individual person or an individual situation, which was good.

I mean, if I've got somebody who's dying, who's had a cardiac arrest, and they're just about to collapse, and they're having trouble getting into the hospital, you could send a note to the Minister if somebody was in dire need of attention. It didn't need to be health; it could be other things.

It was useful, but it did not address the issues of public policy. There was not a useful vehicle for getting information, whether to Brent Roussin or the Minister of Health.[13]

I was a Minister in Ottawa. I think it is important to recognize that you have ministerial responsibility and, in this case, senior bureaucratic or technocratic responsibilities. So, it's really important that you have a dialogue — an effective dialogue — between the Minister and the senior bureaucrats if you're going to get action, whether it's legislative or otherwise. And if it's one-sided, it is not effective. My experience in Ottawa was that one-sided dialogue was not nearly as useful as when you had the Minister with some knowledge of the area and some outside sources of information to feed into discussions with senior bureaucrats including the Chief Public Health Officer While the Chief Public Health Officer appeared to be acting along, he was, or should have been, in regular daily, or sometimes hourly, discussions with the Minister so that together they could finalize decisions.

BPS: I've never been inside as an elected politician or anything. But it seems to me, as an outsider, that the perspective you can bring as an elected person is unique and adds a lot of value.

Let's focus on education for a moment. I think a lot of places overdid the lockdowns of schools during the COVID-19 crisis, which is my own view, but I want to get a perspective on the effectiveness of lockdowns and their consequences. For example, online education sounds good, but a lot of people don't have computers, or there are three kids and only one computer. That kind of real-world practical insight is something that maybe an elected person gets and they get more unfiltered feedback from the population than you get through the technocrats.

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[13] Manitoba had three Ministers of Health during the COVID-19 pandemic. These were: Cameron Friesen (2018-January 2021), Heather Stefanson (January 2021-August 2021) and Audrey Gordon (August 2021-October 2023).

So, my sense of the ongoing value of elected folks is that they hear from people in a direct and more informal, maybe not always pleasant but less unfiltered way and can convey information about how the real world works, which might be quite different from how it looks on a flow chart. That's my thought; the government would have benefited a lot from getting your input as elected MLAs in terms of hearing directly from constituents. Is that actually true? What's actually going on the battlefront?

JMG: Yes. In my view, it could have made a huge difference. We'll be talking about that a little bit more as we go along. One of the things that was interesting was that the government wasn't always very responsive. You talked about access to computers for kids in schools and so on, and what I found was that I wasn't getting much response.

So, I started working with a woman, Angela Taylor,[14] who has been working with Inspire Communications[15] and with others, and we developed an approach that would feed computers which were being repurposed into her organization, which would then get these out to kids in the inner city. Sometimes as an MLA, partly from your position, you can get things done right without you having to wait for or be dependent on the government. And I mean, this is the sort of thing which was happening. In time, more and more school boards responded by providing tablets or other laptops for students, realizing that there was an issue and a problem. So, we'll talk a little bit more about education later on, but that is what was happening. If there had been better information sharing with the government, this may not have been necessary, but we had to go around the government to get things done, at least I did, as an MLA.

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[14] Angela Taylor is now the Chief Executive Office, and Founder of Supporting Community Together, an organization that provides training, consulting and support with respect to issues around neurodivergent populations both in education and other domains. She has a Bachelor of Arts degree, her Post Baccalaureate in Education, focusing on inclusion and counselling, and a Masters in Disability Studies. She currently is completing her PhD in Education at the University of Manitoba, focusing on effective care as defined by the neurodivergent. Angela has over 25 years of extensive experience with youth with various neurological differences, including trauma and autism.

[15] Inspire Community Outreach Inc. is an incorporated non-profit social services agency providing evidence and culturally informed, family-centered education and programming, designed to meet the needs of those living with mental health issues and neurological/cognitive differences.

Darcy L. MacPherson (DLM): When you mention sessions of the Legislature, I assume you mean daily sessions of the Legislature?[16]

JMG: Yes, that's right. I'm talking about daily sittings of the Legislature. Daily sittings were basically abandoned, and I think it was because of the nature of the dysfunction of the Legislature in early March. It was the Conservative government wanting to control everything instead of being more open in terms of sharing, listening and wanting the opposition members to be raising questions every day, which we should have been doing.

DLM: Right. But it sounds like there was also some political opportunism by some of the opposition parties in an attempt to force the government to talk about things other than the pandemic, for example.

JMG: Yes, that was in the first, roughly in the first half of March. At the end of the first half of March, that matter was settled and there was no reason that the Conservatives couldn't have had a sitting, if not every day, at least several days a week in one fashion or another, often remotely.

BPS: Jon, did you have a sense of who was actually making the decisions? I'm watching TV, and all I see across Canada is public health officers, Ministers, and Premiers saying, "I just do what my public health officer tells me to do." I think the concept was, "I don't dare do anything different because then I'm in big trouble if something goes wrong." Did you have a sense of who was actually making the hard choices, was it the premier's office? Was it the minister's office senior bureaucracy, the public health officer? I don't know the answer to these questions. As an outsider, the optic to me was elected officials at the highest level telling me "We just do what the public health officer tells us to do."

JMG: Yeah, I think there was a political advantage that the Ministers and Premiers saw in delegating the fallout to public health officers. Now, there

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16 In the context of a legislative assembly in Canada (whether the federal Parliament, the National Assembly of Quebec or other provincial legislatures), "session" usually refers to the period where the legislative assembly where the assembly meets until the assembly is declared to be out of session

were clearly instances where decisions were being made at the Ministerial and the Premier's level. For example, I believe there was a Premier's decision level with personal-care homes. There was a decision made to build these meeting spaces or spaces adjacent to or associated with personal-care homes where visitors could meet with residents of the personal-care home. This involved using containers that you use for transporting goods; they were put up, made kind of fancy inside, so that they worked. I think that this was a decision which was largely made by Premier Pallister[17] with consulting with his other ministers. He was keen on having businesses occupied and doing things. And I think he saw this as part of it. It had mixed reviews; in some places it worked well, and in other places it was essentially not used and not effective at all. That's one example. but clearly the Premier and the Minister of Health control the budget and they were involved in some of the major decisions as we went along.

BPS: After the pandemic started, I started teaching a course on the law in emergencies.[18] A lot of the lessons in our history are to avoid groupthink, that when you're faced with a crisis, a small group of people just talking to each other, adopt certain assumptions and certain views of the world, and don't ask questions that need to be asked.

The biggest question that went largely unasked is: What are the social costs of mitigation? Yes, COVID is really bad for you, but what are the

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[17] The Honourable Brian Pallister is a Manitoba politician. He was a member of the Legislative Assembly of Manitoba from September 1992 to April 1997, under the banner of the Progressive Conservative Party of Manitoba, during the government of The Honourable Premier Gary Filmon. He served as the provincial Minister of Government Services from May 1995 to January 1997.

He served as a Member of Parliament from November 2000 to October 2008 in the electoral district of Portage-Lisgar, originally under the banner of Canadian Alliance, and later, under the banner of the merged Conservative Party of Canada.

Pallister was also the leader of the Manitoba Progressive Conservative Party from July 2012 to September 2021. He served as the 22nd Premier of Manitoba from May 2016 to September 2021. .

[18] For many years, Dr. Schwartz taught a course called the "Israel International Law program", through Hebrew University of Jerusalem. Prior to the pandemic, Canadian law students (including many from the Faculty of Law of the University of Manitoba) would travel to Israel and receive lectures on a variety of topics. Unsurprisingly, during the COVID-19 pandemic, the in-person component could not be offered. Therefore, the course was offered online. The course focussed on the concept of responses by the legal system in times of crisis. This included leadership during the pandemic itself.

health consequences, educational consequences, and so on, of lockdowns? There are some risks of not locking down, and there are risks of collateral damage caused by lockdowns. Schools, for example, if a kid can't go to school, they maybe can't be able to reintegrate back into school and are at much higher risk later in life of depression, anxiety, unemployment, alcoholism, all kinds of stuff. I didn't see a whole lot of public officials thinking about that during the debate in Canada. The debate shifted pretty quickly. It wasn't really a debate to flatten the curve and that seemed to be pretty much one-track thinking at the policy level. Anyway, that's my perspective on it. What do you think about the overall approach to policy?

JMG: Let me give you some examples of where I think that an effective feed-in from members of the legislature could have had an impact if there'd been a government ready to listen and if we'd been in session.

There was a delay in recognizing that there was asymptomatic transfer of the virus from asymptomatic carriers but the information from China was not necessarily accepted. But by the end of March, there was evidence from the *Diamond Princess*[19] that there were asymptomatic carriers and that they were transmitting the virus. Now, they came up with a number like 18%. Whether it's 18% or 50%, it's significant. There was a study[20] in the small community of Vo'[21] in Italy, and again they showed that there was asymptomatic transmission. This becomes very important in decision-making.

In April, we were arguing and putting forward the concept that if you had one case in a personal-care home, then you should test everybody, including residents and staff. Maybe after a year or two, we may have gotten a little closer to that, but other jurisdictions were using that approach very effectively. Part of the reason this was important is that the evidence suggests that the transmission, in many cases, was coming from staff who

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19 The *Diamond Princess* cruise ship, operated by Princess Cruises, was sailing in February 2020 when cases of COVID-19 were detected on board. The ship was quarantined for two weeks following which the remaining passengers and crew were evacuated. There were 3,711 people aboard the cruise, 712 of whom were infected with the virus. There were a total of 14 reported deaths on board.

20 Enrico Lavezzo *et al*, "Suppression of a SARS-CoV-2 outbreak in the Italian municipality of Vo'" (2020) 584 Nature 425.

21 Vo is a municipality in the Italian province of Padua. Vo' is located about 50 km west of Venice.

are moving around in the community, who sometimes had other jobs. Although there was a move to limit the movement of nurses working in multiple personal care homes, here was a loophole in Manitoba that applied to the private-sector nurses.

Personal-care homes would call for help, and they would call for help for private-sector nurses, and I remember this one instance pretty clearly where one private-sector nurse who'd worked in one facility where there was COVID and then worked in another facility, and all of a sudden you had COVID in the other facility. So, the ability or the need to test everybody, residents and staff, when you have one case is really important in terms of controlling an outbreak. And this was what other places realized much quicker and were doing a more effective job of controlling outbreaks in personal-care homes or nursing homes.

BPS: So that's an example of something that wouldn't be obvious and might not occur to you if you were a centralized planner but you would know from talking to people in the community. So, that's an example of how the lack of wider input might have skewed the prudence of decision-making.

JMG: Yes, absolutely. I'm a physician and although I was a pediatrician and not an infectious-disease physician, I've been doing a lot of reading about epidemics because once I became an elected politician, I started broadening my field of reading and of keeping up to date, particularly on public-health issues.

I'll give you a second example. By April, we'd been calling for testing of everybody in a personal-care home once one case happened. I'm not actually sure if it ever routinely happened in Manitoba, although we were getting closer to it about a year and a half or two years into the pandemic after we'd had some crises. In May, we'd called for an assembly of rapid response teams because it was clear from what was happening in personal-care homes in BC and in Ontario, where people were getting a viral infection and the people who were contacts of somebody in a personal-care home who had COVID all of a sudden had to quarantine and were no longer working. So, you end up with a situation where COVID gets into a personal-care home and all of a sudden, you may have to have up to half the staff quarantined. So, you're then facing a crisis with half the staff.

BPS: Demand is way higher and supply to meet it is way lower.

JMG: Yeah, but it's way lower because you've got people having to quarantine who'd normally be working there.

BPS: And if you're working in multiple facilities, like your loophole, then the supply problem will be amplified. Right? If one facility has a problem, and somebody is doing jobs at five of them, then you've affected the available labour at five facilities, not one.

JMG: Yeah. So, where you had a COVID outbreak in a personal-care home, you needed to have the province ready with a rapid response team that could go in there, fill in the gaps and have the expertise so that they knew exactly what had to be done in a personal-care home to shut down the outbreak.

And that is what we suggested in May. We said that the province needs to have enough people in the rapid response team so the province could handle outbreaks in up to three facilities at a time.

BPS: This is just a technical question. The rapid response team might be at many different facilities, so how do you protect them so that they don't become transmitters?

JMG: This is where the training comes in. If you train people in a rapid response team to manage the situation, in teams, and using personal protective gear, and they are people who know how to be careful, so that they don't get infected. This is why we needed to have a rapid response team and needed to train people so that they could handle the outbreak. You may have a situation where you've got people in the rapid response team being tested daily to make sure that they're not infected. We did this with hockey teams; we tested people daily.

BPS: So, when you have these kinds of ideas, but you can't stand up in the Legislative Assembly because it's not meeting, so you can't just bring it up during the question period. And there is not a "Kitchen Cabinet" kind of thing where the Premier is informally meeting with people to get the feedback. You mentioned that you could send emails and you might get a

response, but was there any way you could get your ideas over to the decision makers?

JMG: Well, for example, we put out a press release. We made a public statement and called for this publicly and got some public attention to it. But there was no adequate way of bringing this up through an email, there wasn't an all-party committee of MLAs, and there wasn't dialogue you would have had if the Legislature was sitting so there was no question period or opportunity to talk about these things face-to-face with members of the government.

BPS: So, one of the factors you mentioned was this background toxicity, an antipathy between the government and the NDP that went beyond the ordinary political competitiveness. Are there reasons why the decision-makers didn't want to get the input? Were they too busy? Whether they didn't want dialogue because they didn't want to give out any information that might alarm people or make them look bad?

You'd think if I had that kind of responsibility, I would want to hear from as many people as I could, but that didn't happen. So, you've given us one reason, and that's consistent with what we've heard from people in different parties. What else is going on in terms of people not actively seeking the information? In fact, you're finding the channels to get information are few and are calcified. Why is that?

JMG: Okay, so let's talk about setting up the rapid response teams. I think in this instance there was a dynamic between the Chief Public Health Officer and the members of the Cabinet and the Premier. The Public Health Officer saw the importance of emphasizing people staying at home, wearing masks, later on, vaccines, etc. But setting up a rapid response team was probably a decision which would need to be done from a political lead or from a dialogue between the Chief Public Health Officer and the politicians.

We're seeing in Ontario that they're bringing in military personnel, essentially to do this, to act like a rapid response team. So maybe there was a feeling that, "Oh, we can rely on the military coming in."

I'll give you another example. We've talked about education. When you get into a war, the Second World War or other wars, one of the first things you do is set up training schools. You set up a training facility so that people

are trained for the jobs that need to be done. During the pandemic, the focus early on was to keep people home, and the role of education was sadly drastically under-considered. There were instances where, over time, there was some training of people, but far less than should have happened. When we talked about the rapid response team, we talked specifically about having the training of people so that they're able to do the job. If you train people well, you can probably have people with varied backgrounds being part of that response team. If you don't go out and do the training, you're probably relying on having physicians and nurses who've got some experience working in this environment. Now, today we are seeing the importance of the education system in a crisis response.

I regard it as a major problem that they didn't start thinking about training people right away. Now, if it was very short-term, you may not necessarily have much time for training. But this went on for three years. We should have been doing a lot more training early on. We're seeing tremendous shortfalls in staffing right now, and if we'd been training right from the start, we would have recognized how important it was. I don't think we'd be in as much of a mess as we are right now in terms of nursing care and medical care. We burnt out a lot of people.

DLM: I was just going to talk about your background as an MD. Even though epidemiology was not your specialty, I would have thought that if I had a medical doctor in the Legislature during a medical crisis, my thought would have been to talk to you anyway because access to a doctor who is also an MLA would be important, especially to liaise with Brent Roussin, especially as you are someone with both the political side and the medical side at their fingertips.

What I'm hearing from you is that didn't happen even though you were trying at that time to do the reading necessary to allow you to fully understand the statistical realities that accompanied this disease. Do I have that right?

JMG: Yes. In this circumstance, it was up to the government to reach out and choose who they were going to talk to and invite in. If the Minister of Health is going to invite me to a meeting, they are probably going to need to invite a representative of the NDP. So, it's probably best to have it work as an all-party effort, and we've done that in the past when dealing with

issues such as agricultural problems, crime problems, *et cetera*. So, there was a model here that could have been used. I think that it doesn't work to have a member of the opposition, who is an MLA, talk directly to the Public Health Officer, who's a bureaucrat because the bureaucrat needs to have clear signals from the government. The bureaucrat is following the lead of the government. The bureaucrat can't follow the lead of an opposition MLA.

DLM: So that political reality was one of the impediments along the way, regardless of the personalities involved.

JMG: Yeah. This is sort of a long-established tradition. I realized this when I was exposed to this first in Ottawa if you've got administrative responsibilities, you can't expect the people who are working as bureaucrats to be responding to the minister and as well to other elected officials —they can't. In terms of policy decisions, you can't have other Members of Parliament or the Legislature giving directives to people who are under another Minister.

BPS: Yeah, it's a paradox the way we're set up here because the legislation contemplates the primary decision-makers, the Chief Public Health Officer, and all you need is one Minister to sign off. I guess the practical reality is the Chief Public Health Officer is, at the very least, getting strong directors from the Premier, so the theoretical flowchart is somewhat different than the practical flowchart. No bureaucrat wants to be seen as conflicting with the political leadership, undermining the political leadership, or sharing information that the leadership doesn't have. So, what you're saying is that it's not only that the elected person is getting information and insights from direct contact with their constituents, but the flow of communication has to be politician to politician, and then the governing politician can talk to the bureaucrat. There was no way to short-circuit that.

Watching TV, all the provinces looked pretty much the same. All the provinces and the federal level were the same. Day after day of panic, looking at elected officials looking like they were deferring to their public health officer. Were there any jurisdictions that got it seriously right in Canada and the United States in terms of setting up cooperation among the different political parties and coordinating with the bureaucracy? Were there provinces that we could learn from that did better in terms of that?

JMG: I think that there were some public health officers who did a better job than others in communicating, although the general message was probably similar. I think the public health officer in British Columbia,[22] for example, stood out. She was one of the first to have to deal with it. And then her lead was sort of followed by many others.

Another area which I think is important to talk about that started to come up in emails to me and other MLAs was the role of relative humidity in the pandemic. Information came out around that time that the transmission of the COVID virus is often as aerosols and these aerosols have a lifespan in the air, which is dependent on the relative humidity, as the aerosols last a lot longer when the air is dry. So, when you've got a relative humidity of, say, between 40 and 60 per cent, the lifespan is considerably shorter. This idea, at that point, was innovative. The MLAs looked at it and the evidence at that point wasn't as clear as it is now. But one of the things that was noticeable is that when we had waves of high levels of high increases of people with COVID in Manitoba, it tended to be at times when there was low relative humidity. It was dry in the fall, for example, not just outside, but particularly indoors, and we measured the relative humidity in our home, and it was coming in about 20, so we put in a humidifier and we raised it to 40. Just a small change, but one that quickly should have been the subject of some fairly rigorous research to determine more about what was happening. We were seeing a lot of transmission when there was low relative humidity indoors in Manitoba, and I suspect that was a contributor to transmission just because the aerosols containing the COVID-19 particles lingered longer. There is more information out there now, but I'm not sure there was a plan in terms of moving forward. As far as I am aware, it wasn't mentioned in the Alberta report,[23] which was recently put out, but I think that ventilation is something that needs to be

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22 Dr. Bonnie Henry is a Canadian epidemiologist and physician. She has been the Provincial Health Officer of British Columbia since 2014.

23 Government of Alberta, *Alberta's COVID-19 pandemic response: Alberta COVID-19 Pandemic Data Review Task Force: final report*, (Edmonton: King's Printer of Alberta, 2025). This is available online: < https://open.alberta.ca/dataset/88bbf80e-f8c8-4355-b751-c2086e204b34/resource/73efb35c-41d9-4264-881d-15a1f76861d3/download/hlth-albertas-covid-19-pandemic-response-2025-01-revised-biographies.pdf>.

looked at in a broader sense. We know that the risk of transmission is much lower outdoors than it is indoors. We knew that improving ventilation was one of the factors which can slow down transmission. We had argued fairly early on that the government should use the summer for a major overhaul or at least have a look at the ventilation in all schools, for example, to decrease transmission. Some schools used ventilation systems, and there were recommendations in terms of keeping windows open, but there wasn't a strong provincial policy and provincial leadership on this, and funding would also be needed, of course.

BPS: That's a kind of "out of the box" idea. If I'm looking at organizational structures, it's not like you have an in-built role for this. I don't know where in the technocracy somebody's in charge of thinking about humidifiers to lower disease transmission. I didn't know about this until you told us, and it would seem like the cost-benefit ratio would have been great if you were trying to slow the curve. Humidifiers cost some money, but they sound relatively cheap compared to some other mitigation measures, like lockdowns and so on. It sounds like a classic example of an idea that is not going to penetrate thinking just through the ordinary channels.

DLM: I had never heard of that, either. But I would have thought that that would be the obligation of the Chief Public Health Officer to keep up to date on the studies that were being done, including international studies, because there were studies all around the world at that point. I don't know if they were about the humidity transmission rates, but I think U of M[24] did some COVID-19 studies. But I'd never heard about those studies you are talking about.

Some of the solutions they used struck me as somewhat anti-intellectual. They wanted to do some very basic things, like needing people to stay home, which I don't think is a bad idea, but it's very cut and dry. "If you don't let people in, you won't get sick." That is just basic biology; if you've done grade 10 biology, you figure that out pretty quickly. So, I wonder whether the fact that those other measures that we might have taken were not at least publicly debated was to a degree to prevent confusion. You know, "This is what we're doing. We don't want to confuse people with the facts. We don't want to change course very often because if

[24] The University of Manitoba

we just stay on one course it's much easier to enforce. If that's the only option you give people, it's much easier to explain why you're ticketing people who aren't staying home."

JMG: It's one of the things that is needed. We can again talk about the crisis or crisis changing environmental circumstances, which is fairly dramatic, but the Conservative government was looking at ways that could save money, even as it was battling the COVID crisis. And too often, the government is in that sort of position. They will cut back on research, even though it is important. We had some significant contributions from Ryan Zarychanski[25] about treatment in Intensive Care Units. But the problem is that when we are doing research, it tends to be in hospitals because that's where researchers doing clinical research are working, but we need more research about what is happening out in the community with factors such as humidity and ventilation and outdoor and indoor circumstances. In a sense, we can rely on research which is going on around the world, but at the same time, we need to have research focused on critical questions related to critical areas of public health, which are important for decision-making. Interestingly, the research funding and support of research is not under the purview of the Chief Public Health Officer. The Chief Public Health Officer can monitor cases and do a variety of things, but more in an observational capacity, and not to fund or implement research projects.

At one point, we were putting forward a Bill as a Liberal caucus, and I had written into the bill that some changes needed to be made to the *Public Health Act*[26] by including the importance of the Chief Public Health Officer in providing a plan for the year ahead. I was then told by the lawyers at the Legislature that there was no provision in the *Public Health Act*[27] for the Chief Public Health Officer to do this type of advance planning. So, the Chief Public Health Officer has a lot of responsibilities, but when you break it down, there are pieces which are important to the crisis, like the support of science and research, which are really flowing through other

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25 Dr Ryan Zarychanski a hematologist, critical care physician and clinical scientist, is a professor of internal medicine at the Max Rady College of Medicine. He served as the chair for two international adaptive platform trials evaluating anticoagulation strategies in COVID-19.

26 *The Public Health Act*, CCSM c P210.

27 *Ibid.*

departments, whether they're it be Health or whether it be Science or the Innovation departments.

So, again, you're facing the situation where you've got the Public Health Officer, who is, in a sense, seen as the czar running the whole show, but in fact, there are lots of pieces that are not necessarily under the direct purview and decision-making by the Chief Public Health Officer.

BPS: In my view, the legislation is just hopelessly antiquated. It's based on a model where the Public Health Officer has a mandate, which is to slow the rate or eliminate the rate of transmission, but the Public Health Officer doesn't have a mandate to spend money or commission research. You need an all-of-government approach. There are people who know about education, people who know about all kinds of things that are part of the overall policy picture, part of the overall factual picture, but localizing it to one issue with one official and one minister doesn't make sense. The decision-making model should be all of government with input from the Legislature. And if you actually look at our legislative model, that's not how it's set up. So, you tell the Public Health Officer, here's your mandate, but it doesn't include funding or anything. It's like they didn't want the Public Health Officer to have a mandate to do a lot of other things like spending money, training, and so on, and shouldn't involve other ministries and other folks.

But before we go a little further, Jon, we're doing kind of a debrief here. You mentioned the Alberta study.[28] There was a judicial inquiry mandated at the federal level by the use of the *Emergencies Act*, but that's just about the use of the *Emergencies Act*'s special powers. I don't know why but as far as I know, the Governments in Canada have not done any kind of systematic review. Things always go wrong, but you have to challenge your disaster; you have to do an inquiry to figure out how to do better. I don't know if the governments were so fatigued after COVID that there's no political advantage, but there are lessons to be learnt from things that go wrong. It is not to punish or shame people, but to just figure out how to do it better next time. But we don't seem to be doing that. What are your thoughts about why that didn't happen or whether it should happen?

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28 *Supra* note 23.

JMG: Well, let me talk about the situation in Manitoba. In the last election, Wab Kinew[29] talked about having a public inquiry in terms of what happened and opening things up for comment. It's my understanding that he's since the election talked about basically having an internal review, I haven't seen any results from that at this point, so I don't know exactly what's happening. But I think it's really critically important that we have a thorough review and that we look at all the things that we can do better and change.

We've talked about outdoors and indoors. My father was born in Northern Rhodesia, which is now Zambia.[30] He lived there for the first few years of his life. His parents were there essentially as medical missionaries. He went back to England for schooling, and then when he was 16, which would have been in about 1932, he went back to Zambia and visited, talked with and met with people. And one of the things that he was told about when he went back was the flu pandemic of 1918.[31] It had swept through there and had devastated communities in Zambia, but there was one community which had escaped where there were virtually no problems. So, he went and saw and met with the Chief, and he asked him, "What did you do? How come you escaped? What did you do differently?" And it turns out that the Chief had mandated that during the day, everybody had to be outside. They could not be inside from sunrise to sunset. So, they were outdoors during the day, where there was less chance of spreading, and I'm presuming this difference between indoors and outdoors was a major reason why this community escaped. And it's paradoxical in the sense that he succeeded by ordering people to be outside, and our approach was to order people to be inside. And I think as things progressed and people realized that you were pretty safe outside, there was more emphasis on

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29 Wabanakwut "Wab" Kinew is a Manitoba politician. He has been a Member of the Legislative Assembly of Manitoba since 2016. He became the leader of the New Democratic Party of Manitoba in September 2017. He became the Premier of Manitoba in October 2023.

30 The Republic of Zambia (formerly Northern Rhodesia) is a landlocked country in southern central Africa.

31 Spanish Flu, also known as the 1918 pandemic, was caused by a global outbreak of an H1N1 virus that started in 1918, near the end of World War I and lasted till 1920. The estimated deaths range from 17 million to 50 million people. During the COVID-19, this was the previous pandemic most often used as a comparator for the current situation.

people getting outside and getting some exercise and not congregating but at least getting outside significantly more.

One of the things that happened in Manitoba was that the First Nations communities tended to be much more severely affected than other communities. We don't really have a good explanation for why, and it's something that should be looked at. My hunch is that you've got a lot of homes in First Nations communities where you've got six to ten people often living in close quarters, and if you order everybody to be inside, you are setting up circumstances where you're more likely to get transmission inside. And I think that we have to be careful about and need to consider this if there's another pandemic. If there is another pandemic, we need to know if there is a dramatically lower risk of transmission outside compared with inside, so we can advise people. There was some of this during the COVID pandemic, where people were able to gather outside a little bit more freely to get exercise outside, and so on. But I think that most people were still cooped up and were not able to get much exercise and that there may be things we can do that will be healthier and won't have as much of a long-term impact. I think that is pretty important.

BPS: So, there are a couple of points emerging from what you just said for me, Jon. The first thing is that, yes, research is good because what we think is obvious is sometimes not true. You gave the stark example where your instinct might be it's just common sense, you're sick, stay indoors. And it turns out that with Spanish flu,[32] that was not necessarily the case. Humidifiers are another example where common sense doesn't say that relative humidity is going to be a factor. You actually need research to do that. So, you need this type of scientific thinking going on.

Secondly, you need uninhibited scientific debate. So, I side to some extent with the people who think that there was too much government attempt to interfere with free scientific inquiry during the pandemic. Mark Zuckerberg[33] just went on record about how you get screamed at by federal officials threatening Facebook if they were to allow people to spread so-called disinformation.

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32 *Ibid.*

33 Mark Zuckerberg is an American businessman who co-founded the social media platform Facebook in 2004 and its parent company, Meta Platforms.

You mentioned that we should have invested more in research. Did we have an atmosphere for free debate during COVID in Manitoba? Or were frontline doctors inhibited about saying things because the government was too concerned about staying on message? What happened here in Manitoba?

JMG: So, there are a couple of things. First, let me talk about masks. I've got a friend who for reasons of his illness and mental health, he can't wear a mask. He found that during the pandemic, he was really stigmatized because he wasn't wearing a mask. He found it very difficult. In fact, the Chief Public Health Officer said, "There are some people who can't wear a mask, and we need to be aware of that." But we need to have better ways of people self-identifying or identifying in some way, so that this tolerance for people who are different is a little greater. I think there's no question that from the scientific evidence, masks were beneficial and decreased transmission. There's some argument about what the degree of effectiveness was, but I think, in general, that there was really good evidence. In part, we know this because there were many physicians and nurses who were very careful about their masks and other protective gear who didn't get infected. And so, I think that there's an important role for the Chief Public Health Officer to ensure that the message is out there that masks make a difference. I think we're going to see a continued debate about to what extent and who should be mandated. I think, in particular, some people who were in a health system lost their jobs for not wearing a mask, that we should have figured out somewhere where their expertise could be used, where they didn't have to wear a mask.

The other area, which was sort of tackled in the Alberta report,[34] is that physicians were being prevented from prescribing drugs like ivermectin[35] which is used to treat a parasite. Some early studies suggested that ivermectin could be effective. A substantial number of clinical trials were done, but the results from the randomized control trials did not show that ivermectin was effective. Interestingly enough, there was some suggestion that there may be some evidence that using ivermectin in areas where this parasite was prevalent might make a difference. And I don't know that I've

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34 *Supra* note 23.

35 Ivermectin is an anthelmintic used to treat river blindness, intestinal infection from threadworms, and other worm infections.

ever seen a full answer, but Canada is not an area where this parasite is prevalent. There was a careful look that I and others saw that ivermectin was not going to be effective in Canada. This point obviously has been argued and debated, and some physicians in Alberta, for example, wanted the ability to prescribe ivermectin. If you're going to use a drug like ivermectin, it should probably be used as part of a clinical trial, and the Alberta report says that more research and clinical trials should be funded. I think that's where you've got something for which there is no good evidence of effectiveness, having it available through a clinical trial, which is done properly and can give us answers is sometimes a useful approach.

BPS: Did you sense any heavy-handed tactics in Manitoba to suppress dissidents, like if you were a doctor who believed that medical-grade masks worn properly might work, but non-medical-grade masks worn improperly, as most of us did, might not work? I'm not subscribing to the view or disagreeing with it; I just think it's at least a viewpoint that you should be able to express even in the middle of a pandemic. Did we have that kind of atmosphere for free discussion, or do you have the sense that there was any kind of suppression of free debate?

JMG: Well, there was clearly a lot of discussion, clearly about masks. Where there is conflicting evidence from other places, there is sometimes a role for community-based research, in Manitoba in this case, to try and make some sort of sense out of what's happening here. I think that there are some people who felt that their ability to live was affected. I think that one of the sorriest things in the COVID pandemic was talking to people who were working in the intensive care unit. I was told again and again that people who came into the intensive care unit—were sick—were people who hadn't gotten the vaccine. Of course, this was after the vaccine was available. And a number of them said, "I wish I'd gotten the vaccine, but it was too late at that point." I think somehow that should have been made clearer, whether through individual stories or otherwise. I suppose being a physician and a scientist, I understood what they meant when it's 50% or 70% or 90% or 95% effective, but I think there were sometimes that I thought that the communication could have been organized so it was clearer in terms of what things meant. And certainly, with the stories from the Intensive Care Unit where practically everybody who got really severely sick and died was

somebody who was not vaccinated. And I think that we somehow should have been able to get that message out a little clearer than we did.

BPS: I'll just give you my views. Yours might be different, Jon, but I'm just giving you something to bounce off.

During the COVID debate, there were different views. Just to simplify it, let's call it the "anti-disinformation" view and the "libertarian" view. So, the anti-disinformation view was, "If you have wrong views, shut up because people will act on your junk science, and that will cause harm." The libertarian view was, "If you have a free debate, sure, there'll be a lot of idiocy. But there will be some good ideas that you wouldn't hear otherwise. Plus, if you suppress ideas, you erode trust. So, you have the open debate." Ultimately, you make a decision. People have to abide by the law, but they can still keep talking. Now, I'm on the libertarian side.

For a while, it looked like the anti-disinformation side was all the rage, but I think that movement crested. Is that a fair characterization of the different views on free expression and dissidence during a crisis?

JMG: I think there are a few perspectives when we consider what disinformation is. Science is important, but part of science is continually testing what we know and doing the research and the work to confirm or not confirm our beliefs. And clearly, the COVID pandemic is in a sense a unique opportunity because getting COVID was so common and there were large numbers of people getting sick and so testing for ivermectin now would not have been nearly as useful as testing it during a pandemic. So, we have to use the pandemic as an opportunity to test things carefully and to check if the assumptions we are making are actually accurate using good scientific research. And from a human side, people like the chief public health officers have a clear mandate to do what can be done to decrease transmission, to save lives, but also to ensure that not so many people are getting sick. Otherwise, it would overwhelm the health care system, and that was certainly a consideration during the pandemic.

I think there's interesting aspects of our experience during the COVID pandemic. The government of the day helped a lot of people and helped a lot of businesses that would have been in big trouble without major help, but what tends to be remembered are not those parts, but the parts that were controversial, like the use of masks and drugs and so on. And this is another reason why it is useful to have a summary after the fact. I think the

Alberta report[36] wasn't necessarily a good example of that, because it didn't reach into a lot of areas where it should have gone, and tended to emphasize, you know, doctors being able to prescribe whatever they want. I think what we have, in some cases, are limits on the use of drugs which are not effective, or where the evidence is not strong enough that they are effective. And sometimes, we have those tools because we want to make sure we're using drugs which are effective, but we're also considering the costs of options in a public health care system, and so I think if you are going to use something of unknown effectiveness, it should be part of a clinical trial. This is where we really can make advances.

BPS: We started at the beginning, and then I kind of leapt to the end about after-action reports. I think medicine is pretty good at after-action reports; you have things such as review committees looking at what happened and just trying to figure things out, not just punishing people. It's the same thing in the airline industry; if you have a near miss, there is a systematic debrief. We don't seem to be doing that. What happened in between? Did the government get better at the whole democracy and input thing as the epidemic went along in Manitoba? It started off badly, from what you've said, and we've heard this from other sources, about the toxicity between the two parties[37] really getting in the way early in the pandemic. We don't seem to be doing much in the way of after-action retrospectives, but in between, did the government get better at listening? Did the government get better at commissioning research, or were we just constantly in a crisis mode and didn't learn much as we went along? What happened along the way?

JMG: Well, I think it is important to note that the Chief Public Health Officer in Manitoba (and this was happening in other places) had a learning curve. It was not immediate advice to use masks, but after a number of weeks or months, we were mandated to wear masks. There were also other learning curves. I mentioned Ryan Zarychanski, who did a really nice study in the intensive care unit, finding which medications were helpful and effective in improving the outcomes for people who are sick with COVID-

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36 *Supra* note 23.

37 This is a reference to the two political parties with the most seats in the provincial Legislature the PCs and NDP.

19 and in intensive care units. We should have had more than that, but if you look globally, there was a large amount of research going on. I've already said this, but in my view, there wasn't adequate acknowledgement early on in terms of asymptomatic carrier transmission. But when we got into a year or a year and a half in, there was certainly a greater acknowledgement and understanding of the asymptomatic transmission. There was a constant learning curve. Did it always get us learning in some areas where we should have been learning more? Yes, it didn't cover the waterfront, but over time, it certainly improved the ability to handle the COVID-19 pandemic. Then we also have the vaccines, the evidence that I've seen suggests that there were millions of lives saved through the use of the vaccines. What was remarkable was how quickly the vaccines that were being used were developed using methodologies which were relatively new. And that's an example of learning in a crisis situation. We still have some lingering questions about the RNA vaccine,[38] but in general, they've been shown to work and to be pretty effective. But I think that we can't necessarily stop there;- we always need to look at impacts as well.

BPS: I know early in the epidemic that there weren't channels of communication that were adequately set up. Did the government get better as it went on? I'll give you one example, maybe to make it concrete. The government had to make a very difficult decision about reopening schools, and they did. But did they reach out and say, "What do you think, Jon, about opening up the schools?" Or was it more behind-closed-door decision-making? I don't know who actually made that decision, and I'm not saying it's the wrong decision – I think it was probably the right decision. But I always wondered who made that decision. I mean, technically, it comes from the Chief Public Health Officer and the minister. But when that decision was made, were you consulted with other parties, and who actually is making the decisions there?

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[38] RNA (ribonucleic acid) vaccines help to prevent infection in the body to fight foreign invaders such as viruses and bacteria by introducing a messenger RNA (mRNA) molecule, which can then be used for protein production. The mRNA used in these vaccines usually corresponds to a protein found on the outer membrane of the virus. By using the mRNA for a protein found on the virus, when the body produces the protein corresponding to the mRNA, the immune system recognizes it as foreign and produces antibodies against it. This helps with immune response when the real virus enters the body, as the immune system can quickly identify and fight the foreign virus.

JMG: I don't remember being consulted specifically on that. It's interesting that the closing down of public schools was done as a result of modelling, which probably originated in part from George W. Bush[39] realizing in the early 2000s that a pandemic was a potential problem and organizing a group of people to start thinking about a plan. I think in time, that group of people was disbanded, but some of the efforts for a plan started there. There is a book about the results of their modelling.[40] But essentially, the modelling showed that schools were a major source of transmission of viruses like the COVID virus and that one of the ways of decreasing transmission was to shut down schools. I think we need to assess now that it has been tested. The evidence that I've seen suggests that it was an effective measure, but it's interesting that there were somewhat different approaches in different places. We should be comparing and contrasting those.

I'll give you one example: I remember seeing a study done in school or schools in one part of the United States where they decided to open up much more quickly with sports activities outside. The approach they took was a little bit like what was done with hockey teams — when we got hockey back, people were tested before every game, and if they had COVID, they were not playing. So, they were using significant amounts of testing of kids in schools but allowing them to play outside and to compete in sports seemed to be actually quite effective when done in this way. From my experience with my granddaughters and talking to many others who have kids, it seems like kids, particularly those between 10 and 16 years of age, seem to be hit pretty hard by having to stay home during the COVID pandemic and not being able to do outdoor activities in the way that they had been. I think we need to look at how we manage another epidemic so we don't have a cohort of kids who are adversely impacted.

BPS: Yeah, and there are public-health risks to staying home and being sedentary. Causation is hard to prove, but there are risks of staying home, and there are risks of not going out. Being inactive is a health risk. Not exercising is a health risk. Social isolation is a health risk. Trying to weigh

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39 George Walker Bush is an American politician for the Republican Party. He served as the 43rd President of the United States of America from 2001 to 2009. He was also the Governor of Texas from 1995 to 2000.

40 Michael Lewis, *The Premonition: A pandemic Story* (New York: W.W. Norton, 2021).

and balance those things is difficult. Some things are obvious, and people will immediately say, "Well, we've got to slow the rate of transmission."

Some things are less obvious like it's not healthy to be stuck indoors. I'd like a government where they're thinking about all these things, and they're getting input from this from as many folks as possible. Frankly, with the current legislative setup in Manitoba and the fact that we haven't done a systematic debrief, I don't know if we would handle the next epidemic any better. We don't know what the next epidemic is, but we know that there will be one. We'll have another epidemic of something, and it's just inevitable, like floods in Manitoba, right? Sooner or later. Are we really better equipped to deal with it in public policy next time than we were this time?

JMG: I think the answer in some ways is yes, and in some ways is no. There are some areas in which there was learning, but in other areas, we really need to have that review and report to better understand. For example, the role of ventilation and humidity and what should be done in terms of recommendations for ventilation systems and adjusting relative humidity indoors. We need to get to work and find out more about what we should be doing here and have a plan.

BPS: More largely in Manitoba, we had the immediate COVID epidemic, but we have some really serious public health problems that we don't seem to be able to get on top of. Diabetes, for example, is just devastating to people who are suffering from it. It has led to many people suffering from amputations and premature death as a result. Fetal alcohol syndrome is another major issue. We have some serious public-health problems in this province that are hard to deal with from a political point of view. These have been some long-standing problems, and there is no solution in sight. There's not that same urgency as you would have with dealing with an epidemic.

You've been watching his stuff as a practitioner of medicine and a public policy official for an adult lifetime. Robert F. Kennedy[41] has had some crazy thoughts, and he's had some good thoughts. He is talking about all this stuff sort of like the systemic problems with American public health,

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41 Robert F. Kennedy Jr. (RFK Jr.) is an American politician and lawyer. He is the 26th United States Secretary of Health and Human Services.

the obesity epidemic? So many kids now have chronic diseases, allergies and so on. I don't know what the answers are, but we're not getting on top of it in this province and probably not in this country. Do you have any thoughts about different approaches or why we're not getting on top of this stuff.

JMG: Sure. Well, let me start with diabetes. I think that there's a fundamental problem in terms of the overall prevention of conditions like diabetes. We have a history of diabetes here in Manitoba. In 1996, diabetes, particularly type 2 diabetes, was provincially called an epidemic. A fairly extensive study was conducted, and there were recommendations. That was a fairly good step at the time. By 2001, we had excellent studies showing that for people with prediabetes, you could prevent 60% of them from getting diabetes with primarily physical exercise and diet. We have never taken that evidence from what to do with individuals to show that we can do it in a community. The closest thing was a study[42] by Heather Dean[43] that involved kids with type 2 diabetes. She took them to summer camp, where the diet and exercise were optimized for helping kids with diabetes. In two weeks, their blood sugar was normalized.

BPS: Wow. Two weeks. Wow, that is amazing.

JMG: So, taking that the next step, and looking at doing this in a whole community in a way that you can really find out what's effective and what isn't. Basically, that was not done. And in fact, I've raised many, many times in the legislature the need to prevent diabetes. We wrote a report in 2013. Can send you a link to it.[44] It talked about some of the needs in terms of prevention, and it's not just about sugar; there are a lot of other variables that come into this in terms of diet. The interesting thing here is that in 1996, we had between 40,000 and 50,000 people with diabetes, almost all type 2 diabetes in Manitoba, and currently, we have approximately 150,000.

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42 Heather J Dean, "Dancing with many different ghosts: treatment of youth with type 2 diabetes" (2002) 25:1 Diabetes Care 237.

43 Dr. Heather Dean is a professor emeritus of pediatrics and child health and the University of Manitoba Max Rady College of Medicine.

44 Jon Gerrard, *The Diabetes Epidemic in Manitoba*, Manitoba Liberal Caucus Report (2014). This is available online: <https://www.jongerrard.ca/wcm-docs/news/thediabetesepidemicinmanitoba_20231218155639.pdf > [perma.cc/9C7E-UZW6].

So, it's a huge increase. I've done the analysis — if we had prevented diabetes, not completely, but if we had kept the numbers of people with diabetes between 40,000 and 50,000 instead of rising to 150,000 — cumulatively, from 1996 to the present, we would have saved between five and six billion dollars in health care costs. It's huge. And it's not just about costs. The best evidence, and not from Manitoba but from Toronto, is that about 30% of people in hospitals have diabetes, which is way above the level of diabetes in the population, which is closer to 10%. So, one can do the calculations again. And if we had kept the level of diabetes in Manitoba at 40,000 to 50,000 people, we would have about 20% fewer people in hospital today. Think about what a difference that would have made in terms of the healthcare system, right?

BPS: Yeah, absolutely.

JMG: And the same thing applies to the emergency room because people with diabetes are disproportionately using emergency rooms. Again, we don't know from Manitoba, but it looks like it's probably a similar sort of number from data elsewhere. So, about 30% of people coming in may have diabetes. It may not be quite as much as in hospitals, but overall, it has a huge impact on the healthcare system. Both the NDP and the PCs, over the time that they've been in power since 1996, have neglected to have an effective approach to reducing the incidence of diabetes in Manitoba. There may be a little bit of an effect to have the incidence of diabetes not increasing as much as it was, but it's small so far.

We failed people, right? We fail people who've got diabetes and who get sick, and you have all the complications that you've already talked about. We fail the health care system, because it has had a huge impact on its cost and function. And there are many other areas besides diabetes where we can be more effective in prevention

BPS: This is not original insight coming from me, but our system is primarily therapeutic, not preventative. And it doesn't matter who's in power. There's a challenge to get people to think about measures that may not manifest in anything for 10 to 20 years. You have to deal with what's immediately a crisis. I think it's hard for any government to think longer-term, but it's so important. We have a huge problem. It doesn't matter who's in power. It's still a problem. But if you thought big picture and long term,

as you say, we'd have fewer people in emergency rooms if we would address the public health issue, and that would, in turn, have a cascading effect on a much better ability to deal with the people who need immediate therapy. But the party doesn't seem to matter. I think it's a larger problem of public choice that, of course, as a politician, you have to deal with what the immediate problem is. And it's hard as a governing party, always having to deal with immediate problems, and they never stop. And it's hard to think long-term, and it's hard to think in terms of planning. It's not very glamorous, and you're not going to get a lot of immediate credit for it. It's kind of interesting. As I said, Robert F. Kennedy Jr, I think he's made some pretty over-the-top statements that I pretty strongly disagree with, but maybe he's refocusing the American debate a bit on preventative and public health problems rather than therapeutic ones. I guess we'll have to see. I don't see that debate happening in Canada yet. Well, you tell us you did a lot of good work there.

JMG: I have raised this multiple, multiple times in the legislature.

BPS: Yeah.

JMG: It's my view that if we had a Liberal government, we could have done this very differently. And I think that Manitoba and the people of Manitoba have suffered.

BPS: Yeah. And by the way, was type 2 diabetes a major risk factor for COVID morbidity?

JMG: Yeah. It was a risk factor. It may have been one of the reasons why people in the First Nation Indigenous communities had more severe COVID and more deaths.