We’re all hoping for this pandemic to be over. But hope alone won’t solve it.

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EDITORIAL

This deeply reported piece, written by Stephen Maher and edited by Sarmishta Subramanian, is the most comprehensive accounting yet of what went wrong, and right, in our nation’s handling of the pandemic.

The story challenges ideas and actions, untethering them from political party affiliation. It illuminates moments of heroism and exceptional leadership; shines a light on policy failures and planning; exposes shortcomings and uncovers the thinking that made a difference.

It brooks no excuses.

In publishing this piece, *Maclean’s* rejects the argument, prevalent in this country, that good enough is good enough. Hindsight is 20/20, the argument goes. We’ve done better than Italy and France; not as well as Australia and Japan. We’re middle of the pack. What’s to complain about? Pandemics are hard.

We reply: More than 21,000 Canadians are dead. More die every day.

To mark this extraordinary and tragic moment, we are giving our entire magazine over to a single piece—invoking, with humility, the *New Yorker’s* spirit in doing so with its 1946 Hiroshima issue.

There are lessons to be learned. Let’s learn them.
A traffic message board above an empty highway in Halifax on April 21, 2020
Playgrounds sat idle during the height of the lockdowns; in this Toronto park on March 26, 2020, fun was off limits.
A new style of portrait emerged: through a window, at a safe distance.
CHAPTER ONE

A danger dawns

By Stephen Maher

‘Everybody knows that pestilences have a way of recurring in the world; yet somehow we find it hard to believe in ones that crash down on our heads from a blue sky. There have been as many plagues as wars in history; yet always plagues and wars take people equally by surprise.’ —Albert Camus, The Plague

In the last hours of 2019, Dominic Cardy and Julie Smith checked into the Arenal Observatory Lodge & Spa, a hot spring resort in La Fortuna de San Carlos, Costa Rica, with a view of the spectacular Arenal volcano, which rises out of a rainforest full of waterfalls, howler monkeys and exotic birds. Their room wasn’t ready when they arrived, so they took the hotel clerk’s suggestion and had a drink in the bar. “And it flashed up on the screen that there had been the first suspected transmission,” Smith recalled later.

Smith heads a literacy organization in New Brunswick, but for 10 years she worked for the federal government, mostly in Ontario, doing policy work in areas including counter-terrorism. Her boyfriend, Cardy, has been the New Brunswick education minister in the Progressive Conservative government of Blaine Higgs since 2018, but for many years he worked in the developing world for the National Democratic Institute. Self-described policy wonks, they like to unwind by talking about news and ideas, even when they are policy wonks, they like to unwind by talking about news and ideas, even when they are policy work in areas including counter-terrorism. Her boyfriend, Cardy, has been the New Brunswick education minister in the Progressive Conservative government of Blaine Higgs since 2018, but for many years he worked in the developing world for the National Democratic Institute. Self-described policy wonks, they like to unwind by talking about news and ideas, even when they are policy work in areas including counter-terrorism. Her boyfriend, Cardy, has been the New Brunswick education minister in the Progressive Conservative government of Blaine Higgs since 2018, but for many years he worked in the developing world

Costa Rica would have been among the first international media reports on the virus, the result of a bulletin issued the day before by ProMED, a volunteer-run information service alerting scientists and doctors of infectious disease outbreaks.

On the evening of [30 Dec., 2019], an “urgent notice on the treatment of pneumonia of unknown cause” was issued, which was widely distributed on the Internet by the red-headed document of the Medical Administration and Medical Administration of Wuhan Municipal Health Committee.

On the morning of [31 Dec., 2019], China Business News reporter called the official hotline of Wuhan Municipal Health and Health Committee 12320 and learned that the content of the document is true.

The report was based on a Google translation, which explains why a red notice was called a “red-headed document.” It described four patients with fever, in acute respiratory distress that failed to respond to antibiotic treatment. Dr. Li Wenliang, a 33-year-old ophthalmologist at Wuhan Central Hospital, had sent messages to a private WeChat group warning medical school classmates: “There are seven confirmed cases of SARS at Huanan Seafood Market. The latest news is, it has been confirmed that they are coronavirus infections, but the exact virus strain is being subtyped. Protect yourselves from infection and inform your family members to be on the alert.”

When someone posted Li’s message on a bulletin board, Western virus watchers were alerted, and so were Chinese police. They detained Li and seven other medical staff for violating a Chinese law against spreading rumours. They forced Li to issue a statement retracting his warning. He was allowed to return to his hospital, where he contracted the disease, which killed him on Feb. 7. He is now celebrated as a hero in China and around the world.

Early on Dec. 31, the Reuters news agency in Beijing reported that the Wuhan Municipal Health Commission was investigating 27 cases of viral pneumonia. Chinese officials reported the outbreak to the World Health Organization (WHO), and global media organizations started to take notice. The same day, authorities closed the market in the heart of Wuhan (population 11 million) that had been identified as the locus of the outbreak.

On the other side of the world in Costa Rica, Cardy and Smith read everything they could find about the mysterious virus. “I remember raising it with her, [saying] ‘This doesn’t look good,’” said Cardy. “All those things you look for that usually make the initial scare around a disease somewhat less scary once there’s more science and data—in this case, every single day, every single new piece of information made COVID seem like it was going to be much more viral.”

Smith was living in Ghana when Ebola broke out in neighbouring countries, when Ghanaians were petrified it was going to spread to their country. She and Cardy were both aware that security experts believed the world was at risk from a new global pandemic—something they had learned at conferences and in their readings—as they continued their Costa Rica vacation, they talked about the policy implications.

“I think we were unpacking that expectation that we were going to have the 100-year sort of...
respiratory disease at PHAC’s Centre for Infectious Disease Control and Prevention, and working for the agency in 2003, when a Toronto woman contracted SARS on a trip to Hong Kong and brought it back to Canada. It quickly spread through an ill-equipped Ontario health system.

Tam also literally wrote the book on how Canada should manage a pandemic. In 2006, she co-authored “The Canadian Pandemic Influenza Plan for the Health Sector,” a complex, detailed 550-page road map for Canada facing a viral invasion. Tam consulted dozens of doctors, academics, public health officials and other stakeholders, and warned of the risk Canada faced.

With that experience, her 55 peer-reviewed papers and years of high-level experience as an expert with the WHO, Tam would have been among the people in the world best-placed to understand the threat from the mysterious viral pneumonia spreading in Wuhan.

In early 2020, Tam did not yet see evidence that the new coronavirus that was panicking officials in China was going to reach Canada. On Jan. 7, PHAC issued a mild travel warning, merely asking Canadians visiting Wuhan to “avoid high-risk areas such as farms, live animal markets, and areas where animals may be slaughtered.” It’s not that Canada wasn’t paying attention. “Right now we are monitoring the situation very carefully,” said Tam. “There has been no evidence to date that this illness, whatever it’s caused by, is spread easily from person to person; no health-care workers caring for the patients have become ill, a positive sign.”

On Jan. 21, while Trudeau was in Winnipeg for a caucus meeting, he made headlines, not over the coronavirus, but for buying boxes of fancy doughnuts at a local shop rather than at a chain. Tam had reassured Canadians the previous day: “It is important to take this seriously and be vigilant and be prepared, but I don’t think there’s any reason for us to panic or be overly concerned.” The country was much better prepared since SARS, she suggested. “From my perspective a lot has changed from 2003, and we are in a better position to respond to a variety of emerging infections.”

In China, the virus was spreading. By then, there were 278 cases of mysterious pneumonia, the vast majority in Wuhan. There were four
cases outside China, in Thailand, Japan and South Korea. The day before, senior Chinese leaders, alarmed by the spread of the illness, had ordered Wuhan locked down. Worryingly, the Wuhan Municipal Health Commission had reported that 15 health-care workers in the city had been diagnosed with the illness, a clear sign it was spreading between people. In nearby Taiwan, officials intensified the airport screening they had already implemented weeks earlier.

But in Canada and elsewhere, the virus continued to be a remote concern. On Jan. 23, Tam was among the dozen expert advisers who helped WHO director general Dr. Tedros Adhanom Ghebreyesus decide it was not yet time to declare the coronavirus “a global health emergency.”

That evening, the novel coronavirus made its debut in Canada. A 56-year-old man who had recently travelled to Wuhan was admitted to Sunnybrook Health Sciences Centre in Toronto. He had a temperature of 38.6°C, a low-grade fever, and was congested. Dr. Jerome Leis, medical director of infection prevention and control, was watching for patients who fit the risk profile. He had an X-ray of the patient’s lungs sent to his home. One look told him what he was dealing with.

“There were diffuse opacities throughout both lungs in different regions of a patient who really only had a few days of symptoms,” he said. “So I thought that was quite striking. Usually, if you hear about someone who’s got a bit of a cold, we don’t expect to see those types of lower lung abnormalities so quickly.”

The hospital sent a blood sample in a taxi to Public Health Ontario’s laboratory, where technicians had been frantically working with information from China to develop a test for the virus. Once Sunnybrook got the result, Dr. Lynfa Stroud, division head of general internal medicine at Sunnybrook, and Leis went to the ward to let staff know they were looking after Canada’s first novel coronavirus patient.

It was a dramatic moment for nurse Kathryn Rego. “They came up to the nursing station and we went into this tiny little room and squished all of ourselves in, and that’s also not a common thing, that every single person on a unit stops,” she said. “The cleaners, our support staff, everyone stopped what they were doing, just squished into this room to hear that this guy was positive.”

The news that they were caring for a coronavirus patient was startling, but not unexpected. Sunnybrook had prepared for the possibility. When Clarice Shen, a nurse in her third month on the job, showed up at work that day she discovered she had been assigned to a “closed” room in the general internal medicine ward, with no patient. Confused, she asked a supervisor about it, and was told the room was reserved in case a patient came in with the novel coronavirus. It was a negative pressure room, one of eight the hospital had set up after SARS, where a patient could be kept in isolation, following protocols for any novel pathogen. A few hours later, she had a patient: the man who had travelled to Wuhan. Shen volunteered to work more shifts so she could care for him, because they could both speak Mandarin. The man had a mild case. He spent a week in hospital, and was discharged.

For Canada, the story was just beginning. There were four confirmed cases by the end of that month; 20 by the end of February; and 8,589 by the end of March. A year after that first patient checked into Sunnybrook, there would be 747,110 confirmed cases in Canada and 19,009 deaths. But already, by that January evening, the microbe known as SARS-CoV-2 had begun its remorseless spread, following its viral logic. Viruses want only to replicate, to find new hosts and fresh lung tissue to infect. To stop them, to curb transmission, societies must follow a narrow path. A few countries succeeded in doing this in that vital first month. Canada did not. It was the first failure of many, setting the country up for a year of challenges we would struggle to meet.

In New Brunswick, Dominic Cardy and Julie Smith were worried. Since returning from Costa Rica, they had been tracking news about the coronavirus, texting each other links to stories. On Jan. 23, the same day the patient arrived at Sunnybrook, Cardy texted Smith to avoid touching her face. He sent a link to a cellphone video taken in a Wuhan hospital showing patients suffering on gurneys in hallways. “The stuff coming out of China is worrying,” he wrote. “Have you seen the videos? People collapsed in the streets etc.”

“I basically tried not to touch anything at
The great grocer

Kallisha Hoyes found her job transformed into a suddenly essential, risky role. ‘Without us, no one’s eating.’

KALLISHA HOYES GETS up early. Really early. On a good day, the drive from her home in Shelburne, Ont., to Marc’s No Frills in Mississauga, Ont., takes an hour. And Hoyes, a front-end manager, likes to arrive before the grocery store opens at 8 a.m.

Wearing a mask she will keep on all day, she signs in to a system that now requires employees to log symptoms. While the aisles are quiet, she replenishes hand sanitizer and spray bottles full of disinfectant. She starts gathering items for customers’ online grocery orders. When the doors open, she supports customers and cashiers, sometimes running two lines at a time, using gloves to handle change.

When the gloves are off, Hoyes sanitizes her hands after touching just about anything. Door handles. Coffee cups. “My hands are cracking because I sanitize so often,” she says. “Everything I do, I’m overthinking it.”

The No Frills used to be quiet during weekdays, with so many customers chained to their desks. Not anymore. Now, the store is busy all the time. People seem to treat errands as an escape, a change of scenery. Hoyes gets it. While on maternity leave through the first couple of months of the pandemic, she’d often find an excuse to hit the grocery store after her husband got home. “I wanted to get out of the house.”

Hoyes prioritizes mental health, and is open about recovering from a period of depression. Still, the workplace is a stressful, risky environment from which she almost never takes a day off. Many colleagues quit, fearing the virus. The $2-an-hour “hero pay” top-up employees of Loblaw Companies (which owns No Frills) received during the first wave is a distant memory. There’s no word on vaccines. And Hoyes feels for non-unionized workers, whose jobs are even more precarious.

“Literally, we’ve been thrown into frontline work,” she says. “I don’t think it’s being acknowledged fully by the community, or even appreciated. Without us, no one’s eating, you know what I mean?”

Some customers won’t wear masks for medical reasons. Others, especially folks from a retirement residence next door, don’t wear them properly. Though Hoyes will occasionally get a heartfelt “thank you” as shoppers pass by, she and her co-workers more often bear the brunt of pandemic anxieties. A customer recently accused a cashier of racism for enforcing a limit on the amount of toilet paper they could buy. (The cashier was a person of colour.)

After her commute, Hoyes returns to her 19-month-old and 10-year-old sons exhausted. When she spoke to Maclean’s after getting home one day, she checked: “I’m at 17,000 steps.”

She showers right away and throws her clothes in the wash. When she has the energy, she takes the kids outside, has a glass of wine with her husband, sews masks for her side business or tries culinary trends from TikTok (she highly recommends the feta pasta recipe that recently went viral). But sometimes she just sleeps—“I’m telling myself it’s okay”—and rests up for the next early morning. MARIE-DANIELLE SMITH
Chief Public Health Officer Dr. Theresa Tam in Ottawa on March 23, 2020; early messaging prioritized hand sanitizing, not masks.
the airport and have used Purell three times this morning already,” Smith replied.

By then, 655 cases had been confirmed around the world, and 95 people were severely ill. There were now cases in Hong Kong, Macau, Taiwan and the United States. The virus was spreading in Guangdong province among people who had not travelled to Wuhan. A WHO situation report on Jan. 23 contained a sense of growing urgency. “WHO assesses the risk of this event to be very high in China, high at the regional level and moderate at the global level,” it said; the global risk level was corrected afterward to high.

In the U.S., President Donald Trump was briefed, and on Jan. 24, Congress had its first coronavirus meeting. U.S. classified intelligence briefings, which would presumably have been shared with Canada’s leaders, were warning of a possible global pandemic. The medical community, too, was publicly sharing dire warnings. On Jan. 27, Dr. Gabriel Leung, dean of the University of Hong Kong medical school and a graduate of the University of Western Ontario, made headlines around the world when he revealed modelling showing the virus was much more widespread than China had acknowledged. He followed it up with a Lancet article a few days later telling the world to get ready for COVID-19: "Independent self-sustaining outbreaks in major cities globally could become inevitable because of substantial exportation of presymptomatic cases and in the absence of large-scale public health interventions. Preparedness plans and mitigation interventions should be readied for quick deployment globally.”

On Jan. 30, the WHO finally declared “a public health emergency of international concern,” which didn’t stop China from pressuring other countries to keep their borders open.

Cardy and Smith followed these developments with concern. On Feb. 2, Cardy got the opportunity to do something about it. Louis Léger, the chief of staff to Premier Blaine Higgs, had invited Cardy to his place in Fredericton to watch the San Francisco 49ers and the Kansas City Chiefs in the Super Bowl. Cardy, who doesn’t care for football, jumped at the chance, because he wanted to use it to convince Léger that New Brunswick had to start getting ready for the virus.

Cardy went to Léger’s home, where they watched the game with Léger’s daughter. Eventually, talk turned to politics. “He started off by asking, ‘What’s worrying you?’” said Cardy. Léger admits he was expecting a normal discussion about politics. “At that time we were in a minority situation, with all the complication of a minority, the house coming back with a budget,” Léger recalls. Instead, Cardy launched into a discussion of COVID-19. “He was genuinely very preoccupied by it,” Léger recalls. “He was reading, reading, reading, and I think he saw it coming.”

Persuaded by the urgency of Cardy’s observations, Léger asked him to write a report for the premier. Cardy and Smith set to work on it together, in their Fredericton condo.
Brent Robson’s computer screen last spring was a constantly messy patchwork of maps. Maps showing international airport statuses. Maps showing cruise ships, floating red dots on the oceans. Maps showing dozens of countries, overlaid with temporary populations of Canadians stranded and trying to get home.

As emergency response director for Global Affairs Canada, Robson typically does low-key work, running an Ottawa response centre that helps people abroad with lost passports or other problems. Crises arise one foreign country at a time, with Canadians getting caught up in, say, a localized natural disaster or a terrorist attack. But last March, he became commander of a sprawling effort unfolding simultaneously across more than 100 countries, his attention endlessly redirected from one logistical complication to the next. The pandemic all but shut down an entire planet’s civilian travel system. Robson had to help get more than 57,500 people home.

He’d spent most of his federal career doing consular affairs work in Africa, Asia and in the United States—fortunate, because the pandemic rescue mission effectively converted the entire Global Affairs department into a harried consular affairs operation. His tiny team grew to 1,000 people, many in a round-the-clock call centre fielding hundreds of anxious inquiries a day. Others coordinated with on-the-ground diplomatic teams and airlines that dispatched hundreds of charter flights to bring home tourists, international students and workers stuck abroad.

It went far beyond the work Robson’s team did in January and February 2020 in repatriating a few hundred Canadians affected by the outbreaks in Wuhan and on a couple of cruise ships. They had to expand the effort to pretty much everywhere on Earth that Canadians were—which was pretty much everywhere. And it started on March 16 with one “big bang”: Prime Minister Justin Trudeau warning all Canadians to hurry home, before they’d be unable to. “I’d say within a week we had the flight model up and working, we were engaging our missions to come up with creative solutions to a whole series of lockdown challenges,” Robson recalls, “and we were full into repatriation mode.”

To handle his team’s mushrooming size—and to cope with the then-new dictates of physical distancing—his team took over much of the Lester B. Pearson Building, Global Affairs’ headquarters in Ottawa. He describes it as “organized chaos”: so much happening all at once, but everyone knowing their role. François-Philippe Champagne, then the minister, even joined in as a virtual travel agent, negotiating Canadian airplane landing times in some locked-down countries.

On July 17, the final flight returned 165 people from Trinidad and Tobago. The leadership challenge of Robson’s career had wound down, after four exhausting months. “I’m just waiting for some of these restrictions to lift,” he says now. “Maybe get back on the ski hill, get my adrenalin rush that way. Something a little more controlled.”

Operation repatriation

When civilian travel ground to a halt, Brent Robson led efforts to bring Canadians home from the far reaches of the planet.
They enlisted the help of Cardy’s sister, Vanessa Cardy, a family doctor who practises in Wakefield, Que., near Ottawa, and in the Cree community of Chisasibi, on James Bay.

Smith was sure the federal government was failing to act quickly enough, imposing travel guidelines after the virus had already moved and constantly struggling to catch up. It was a pattern that would continue. “If you actually read the news, Italy has collapsed because of this. But people can still come from Italy,” she said. “And then we finally deal with Italy, but it’s in the States. It always felt like the response was behind.”

Cardy wanted to make sure that New Brunswick didn’t end up like many other places in the world, where officials learned with horror that their hospital ICUs were suddenly full.

The virus had spread to 32 countries and there were soon worrying indications that officials in Iran and China were hiding the extent of transmission. At a caucus meeting on Feb. 24, Cardy delivered a grim 4,000-word report explaining the risk he saw. He described the impact of “super-spreaders,” like the South Korean woman who had infected dozens by attending a church service while symptomatic—a phenomenon that would, months later, become the focus of intense study. He outlined the threat and laid out steps New Brunswick could take using emergency legislation to contain the virus.

“The COVID-19 virus will arrive in New Brunswick,” his paper argued, “and may be already present, given the unreliability of tests, the weakness of Canada’s public health response to date and the nature of our open society. This is not a question of if, but when. COVID-19 will kill some New Brunswickers, infect many others and disrupt the operation of government, the economy and the lives of all citizens. The extent of the damage and disruption cannot yet be predicted, but it will occur. Government will be judged on their handling of this crisis.”

Cardy had convinced the premier. But some public health people were reluctant, he said. “I still remember one of them saying … one of the sections in my paper was how to manage a pandemic. And he’s like, well, the first thing politicians need to know is that they shouldn’t manage pandemics. That’s our job.”

Cardy, who was right when a lot of other people were wrong, thinks it was difficult for politicians and health officials—in Fredericton, Ottawa and across the country—to accept the urgency of the situation. “There was a tendency from elements of the bureaucracy that have high levels of trust but had very little experience dealing with anything similar in recent decades, coupled with a political class that’s feeling pretty beleaguered and disconnected and being knocked back and forth by populist movements from left and right. When you combine all those things, it led to a pretty slow and piecemeal and not very well-targeted response, because in Canada, we were weeks and weeks after everyone else was talking about asymptomatic spread.”

Cardy was determined to keep the virus out of global air travel,” she wrote. “A pandemic wave will sweep across Canada in 1-2 months affecting multiple locations simultaneously. This is based on analysis of the spread of past pandemics including the 1918 pandemic.”

Tam knew what to look for, but in January 2020, she was either not seeing it coming, or not making her fears public. She had had experience dealing with SARS, which killed 44 Canadians before it was wrestled under control. In 2005, Tam and five colleagues published a research paper on screening measures—questionnaires and thermal scans—used in Canadian airports during that outbreak with a goal of preventing passengers with SARS from introducing it to Canada. Tam and her colleagues found that although the Canadian government spent $7.6 million on the effort, it did not detect a single case.

Tam knew what worked and what didn’t, knew what resources Canada had, knew the players here and around the world, and knew how a pandemic would behave. She has been a reassuring TV presence throughout the pandemic, delivering succinct public health messages in her mid-Pacific accent, which sounds as if it was picked up at health conferences. She’s not a dynamic speaker, but she is approachable. She told children in a CBC Kids interview that her song of choice for handwashing is “We will, we will, wash you,” to the tune of the Queen classic.

Tam comes across as calm and determined, unfappable, trustworthy, the right person for the job. But she seems to have been wrong about a number of things when it would have been good to be right. In early 2020, her agency repeatedly said the risk of an outbreak in Canada was low. On Jan. 6, a spokesman for PHAC told the Ottawa Citizen that Tam was monitoring the issue, but Canada was well-prepared, in part because of public health systems that would “identify, prevent and control the spread of serious infectious diseases into and within Canada.” Health Minister Patty Hajdu, too, made similar reassuring statements.

Early interventions were modest. On Jan. 22, the government moved to screen passengers from Wuhan at three Canadian airports. When Liberal MP Marcus Powlowski, a Thunder Bay ER doctor, asked Tam in a health committee meeting if it might make sense to ask travelers returning from China to isolate for two weeks, given the virus had moved beyond
MADELEINE PEET DID not set out to become a COVID tester. She’s neither a doctor nor a nurse, or even studying for a career in healthcare. Before she began working at COVID-19 testing sites, she toiled part-time at a restaurant in Halifax while on a break from studying sociology at Ryerson University in Toronto. Now she travels around Nova Scotia, administering tests at pop-up sites. She wields nasopharyngeal swabs, and speaks confidently about epithelial cells. It’s a big shift for someone who was initially squeamish about the process. “I wanted nothing to do with it,” she recalls. “It freaked me out a little bit.”

Peet started small as a volunteer at testing sites in November, helping to register patients before she warmed to the idea of administering tests herself. After a few weeks as a volunteer, she was tapped to become a trainer and now coaches other civilians through the testing process, which she says only takes about 45 minutes to learn. It involves a long swab, which travels up the nostril (Peet lets the patient choose which side) until it connects with the throat. “You can always feel when you meet that resistance. I leave it there for about five to 10 seconds, and I twist it before I pull it out.”

Peet estimates she performs about 50 swabs a day, but she’s careful to remember that many who come to see her are as apprehensive as she once was. She tries to help them relax, and finds many can laugh once they get over their initial jitters. “It’s nice to chat with people who haven’t had a lot of human interaction in quite a bit. While you’re giving them that swab, it feels good to check in on people.” Occasionally, a patient who is extra nervous will need time to calm down before they fully consent to the test. Months ago, Peet found herself dealing with people who questioned the accuracy and validity of the tests, but those concerns have faded as testing has become more commonplace. “It’s a completely voluntary process,” she says, “so usually it’s not a major issue.”

Overall, Peet says the atmosphere at testing sites has been personable and even fun, with testers and patients alike happy to do their part. “You get to talk to a lot of different characters,” says Peet, who has criss-crossed the province in her role. At one site in central Nova Scotia, she says, the waiting room took on the feel of a dinner party, with people chatting and laughing as they waited on six-foot markers. “Everyone there was so community-minded, and so excited to be there. They kept telling me, ‘My neighbour told me to come.’ Then the next patient I would end up meeting would be that person’s neighbour.”

What began as a way for Peet to pass the time during the crisis has proven an opportunity to get out in the community and help Nova Scotians get through this together. “Years down the line,” she says, “if someone asks, ‘What were you doing in the pandemic?’ I can say, ‘I was helping. I was doing something good with my time.’” EMILY BARON CADLOFF
Wuhan and there were newspaper reports of asymptomatic transmission, Tam said no, bolstering her initial statement that, “for other completely asymptomatic people, currently there’s no evidence that we should be quarantining them.” Hajdu told a teleconference with provincial counterparts that “the risk to Canadians remains low.”

Even after the WHO declared COVID an emergency on Jan. 23, 2020, Tam was warning Canadian leaders against quarantines or travel restrictions, in keeping with WHO guidelines. Tedros had warned countries not to restrict travel more than was necessary: “We call on all countries to implement decisions that are evidence-based.”

Looking back with the benefit of hindsight, it is striking that many public health experts believed COVID-19 could be managed like previous threats—SARS, MERS, swine flu—that flared up, capturing headlines and provoking anxiety before being suppressed. COVID-19, with its easy person-to-person transmission and its long period of asymptomatic spread, would not be stopped as easily.

The same day Hajdu spoke to provincial ministers, Tam warned healthy Canadians against wearing masks. “Sometimes it can actually present risks as you are putting your fingers up and down your face when removing your mask and putting them near your eyes,” she said. She was not alone in this; at that time, neither the WHO nor the U.S. Centers for Disease Control and Prevention (CDC) were recommending that the public wear masks, either because the research was unclear on whether it was protective, or because officials feared that hoarding would disrupt the supplies needed in hospitals. In any case, masks would, of course, become a vital piece in slowing transmission.

Meanwhile, the virus moved around the world. University epidemiologists were sounding alarms. And there were countries, particularly in Asia, that were taking the threat seriously, and using the mask policies and border controls that the WHO and Canada were still not recommending. In early January, before there was a single domestic case, Vietnam’s government began monitoring the outbreak’s progress within China and, before long, introduced quarantines at airports, seaports and land borders. On Feb. 3, Japan ordered the cruise ship Diamond Princess quarantined in Yokohama after COVID was confirmed in a passenger who had disembarked in Hong Kong; soon there would be hundreds of infected passengers aboard. Researchers eventually revealed that asymptomatic passengers were carrying the disease, providing an illustration to media consumers around the world of the pernicious nature of the virus. On Feb. 5, Taiwan announced that Chinese nationals were banned from entering the nation; all other travellers had to quarantine for 14 days. By the end of the month, many schools in Japan had closed. After an outbreak in South Korea, the government there declared a red alert on Feb. 23, and other countries started imposing restrictions on Korean travellers.

By late February, the crisis had moved beyond Asia. Outbreaks were appearing in small Italian towns. Venice brought its carnival to an early close and the Italian government suspended sporting events.

All along, in Canada, the government was emphasizing the need for social harmony. There is a long, grim history of ethnic groups being scapegoated during disease outbreaks, and Trump’s anti-China messaging targeted Asians. Incidents of hate surged in the United States in 2020, and the Vancouver Police Department reported a spike in anti-Asian hate crimes in that city.

Images of devastation—and Italy’s attempts to stop the virus’s spread—ricocheted around the world.
That well-grounded fear, rather than the threat of a virus that would ultimately take a terrible toll on racialized Canadians, seems to have been top of mind for Canadian leaders early in 2020. At a health committee meeting in Ottawa on Jan. 29, Tina Namiesniowski, then the president of the Public Health Agency of Canada, told MPs the government needed to take care to avoid targeting communities. “This is a vital lesson we learned from our experience with SARS, when a situation arose in which some Chinese communities and individuals were the victims of racism and racial profiling. We must confront that problem,” she said. Tam, in answering MP Powlowski’s question about travellers from China, echoed that message. “The global effort to contain the virus requires the absolute commitment and engagement of the communities that are affected. Otherwise, they’ll be stigmatized,” she said.

Likewise, Trudeau’s first substantial comments about the virus came at a Chinese New Year dinner at a banquet hall in the Scarborough neighbourhood of Toronto on Feb. 1. “There is no place in our country for discrimination driven by fear or misinformation,” he said to applause.

There are indications that behind the scenes the federal government was starting to see the danger. On Feb. 3, as part of preparations for an emergency flight to airlift Canadians out of Wuhan, the Trudeau government made an order-in-council declaring that COVID-19 posed “an imminent and severe risk to public health in Canada.” But although the government had reached that conclusion, it was not behaving as if it was worried. During a teleconference with provincial health ministers and officials—leaders who would before long be struggling with the most serious pandemic to hit Canada in a century—Tam appears to have been focused on keeping everyone calm.

“In having been part of the WHO Emergency Committee’s deliberations,” she said, “I can say that the decision to declare a Public Health Emergency of International Concern was based on the need to enhance preparedness and response in vulnerable countries in particular, given the potential for the outbreak to overwhelm their health systems.”

In February, Canada shipped 16 tonnes of masks, goggles, face shields and other personal protective equipment (PPE) to China to help it contain the virus. China, which as the year went on was less and less helpful to Canada, thanked us for the equipment, but before long, people in Canadian long-term care homes were dying in part because staff didn’t have masks. We later learned the federal and Ontario governments had also let PPE emergency stockpiles dwindle, discarding them when they expired rather than replacing them. A CBC investigation discovered that two million N95 masks and 440,000 medical gloves were landfilled in 2019.

As February drew to a close, it was becoming increasingly clear the world was about to face an unprecedented threat. By Feb. 24, the day Cardy gave his grim presentation to New Brunswick Tories, Tam had stopped sounding quite as calm. “These signs are concerning,” she told reporters, “and they mean that the window of opportunity for containment, that is for stopping the global spread of the virus, is closing.”

Canada had failed to take the steps that might have stopped the virus from getting a foothold. COVID-19 was about to put the country through its worst crisis since the Second World War. Some countries saw the warning signs. Why didn’t we?

**There is a hint** of an answer in PHAC’s first public statement about the virus. On Jan. 6, when a spokesperson assured Canadians they were protected by a Canadian centre that
TO POLICE WHO suspected Mohammad Movassaghi might be hosting parties at his three-level Vancouver penthouse—a violation of British Columbia’s emergency health orders—the delivery driver showing up with 100 McDonald’s cheeseburgers no doubt pointed to something more than a small get-together.

It was the wee hours of a Saturday in late January, and this wasn’t the Vancouver police’s first visit to the suite. Earlier that month, they had received a 911 call reporting loud noises and party sounds. A week later, they got another about a large gathering at the condo. On both occasions, the police department was short on resources and sent no one, according to an application for search warrants. But the following week, the application said, “all noises ceased and the occupants refused to come to the door” after officers knocked.

They went to the suite yet again on Jan. 23, after a call from someone who claimed to have been invited to a party there, but left after what she saw: exotic dancers on a stripper pole, bartenders, a DJ booth, guests instructed to remove their shoes upon arrival to limit noise. Police allege that Movassaghi again wouldn’t let them inside, telling them through the door: “I refuse any charge you have against me.”

“There was no party here,” Movassaghi told the Vancouver Sun after fines were issued for that incident. “It was a few neighbours here and we watched the fights.” He later filed a complaint against Vancouver police, alleging they were occupying the fire exit hallway for hours and trying to film inside his unit via the peephole.

A final call to the cops came from the building’s concierge, according to warrants, and Movassaghi again refused to open his door. This was the weekend of the cheeseburger delivery, which was followed by a search warrant, the arrest of Movassaghi and charges against him of failing to comply with public health orders and of selling liquor without a licence. Some 77 guests at the suite—none wearing a mask, according to a police report—also faced fines.

The allegations have not been proven in court, and Movassaghi’s lawyer (who is also his brother), Bobby Movassaghi, did not return requests from Maclean’s for comment. But a previous statement from the lawyer reminded the public and press “that at this point in time these are unproven allegations, and like anyone else charged with an offence in Canada, he enjoys the presumption of innocence.”

A couple days after his arrest, a GoFundMe campaign launched under the name Mo Movassaghi. “I was arrested on Sunday, January 31st, 2021 in my home because of a party among consenting adults,” the webpage said. “Once upon a time before November 2020, parties were legal.” The campaign cited financial losses of $10,000 in cash, $5,000 in liquor, property damage, fines, legal fees—plus a “smear campaign” from “the powers that be.” The fundraising target was $100,000, but the campaign had reached only $260 when Movassaghi deactivated it. AARON HUTCHINS
describes itself as “an indispensable source of early warning for potential public health threats worldwide including chemical, biological, radiological and nuclear,” he was describing the Global Public Health Intelligence Network (GPHIN). But since 2019, GPHIN had not been functioning as it once did. Tam seems to have been flying blind.

GPHIN was established in 1997. In its heyday, it employed analysts and experts based in Ottawa and around the world, who scanned media, stock markets, open-source data and social networks for signs of health threats, acting almost like a high-tech health CSIS, repurposing information to find infected needles in haystacks. They shared those updates with health experts around the world. The system is still functioning, but Grant Robertson reported in the Globe and Mail in July 2020 that it had been downgraded by officials in 2018, who wanted it to focus on more relevant domestic issues, such as the health risks of vaping. Hajdu announced an independent review in February 2021, a tacit acknowledgement that it was broken.

Decision-makers had been warned. In 2018, PHAC epidemiologist Abla Mawudeku emailed international colleagues in despair. “I would like to let you know that, sadly, we have not been successful in convincing management of the critical value and role of GPHIN within and outside of Canada, and the indispensable relationship with the WHO,” she said in an email later obtained by the Globe. International experts, too, lamented the agency’s decline. “GPHIN has been a pioneer in what was, at that time, a totally barren field,” Philippe Barboza, a manager of the WHO’s Health Emergencies Programme, wrote in an email to Canadian epidemiologists. “I cannot understand that this is not recognized.”

GPHIN’s parent organization—the public health agency—had serious problems of its own. An internal audit made public in January 2021 is blunt: PHAC wasn’t ready for a pandemic. “The agency did not have the breadth and depth of human resources required to support an emergency response of this never-seen-before magnitude, complexity and duration,” auditors found, after interviewing “52 key informants.”

“Management noted multiple capacity and skills gaps across the agency,” the audit continued. “Primarily, most noted limited public health expertise, including epidemiologists, psychologists, behavioural scientists and physicians at senior levels.” As we faced the biggest pandemic in a century, the Public Health Agency of Canada didn’t have enough doctors.

When COVID hit Canada, dedicated staffs were working brutal hours, called on to acquire PPE, to help the provinces and territories get ready for contact tracing and set up quarantine sites, to help prepare prisons. But “there was a limited number of quarantine officers within the agency and it was a difficult position to staff quickly because it requires specific education and training,” the audit said. PHAC did what it could to fill the gap, but when Trudeau eventually closed the land borders and called Canadians home in March, there appear not to have been enough people to handle the traffic.

Tam was getting bad advice. “Her office noted that she often received information in the wrong format, with inaccuracies, or in an inappropriate ‘voice’ needed to convey information to a particular audience,” the audit reported. “The modelling information, critical to the public face of the response, and the foundation for strategic planning, was mentioned as being problematic in its initial stages, because of the lack of a coordinated or strategic approach to the work.”

The problems seem to go back to 2014, when then-health minister Rona Ambrose reorganized the agency, which was created after the SARS outbreak, with the chief public health officer in charge. The reorganiza-
A song in our hearts

Suresh Singaratnam saw a nation of people desperate for a bit of spiritual uplift and brought his musical vision to life

THE SONG FEELS like the musical embodiment of a lacy frost embroidering itself across a windowpane: delicate, intricate and ephemeral. Strings, woodwinds, a twinkling chime join in first, then dozens of voices layer in bit by bit—together but not, like everything over the last year—as *A Canadian Christmas* swells toward its choruses.

Shortly before Christmas 2020, the video for the song appeared online, performed by an array of professional musicians and singers and ordinary Canadians assembled into a virtual choral performance. Suresh Singaratnam, a trumpet player who lives in Toronto, originally wrote the song in 2017, partly in response to the ugly intolerance burbling up in the wake of Donald Trump’s election; he intended the song to celebrate a quintessentially Canadian Christmas through the prism of the country’s diversity. But although it was written a few years before the pandemic wiped out normalcy, some of the lyrics seem strangely prescient: *I contemplate the bittersweetness of these few short weeks of cheer, in a time so often wrought with fear / Despair returns when once again our world’s distress consumes my thoughts*…

Singaratnam’s mission for the song was that it would find its way to every school and orchestra, so that Canadian kids would grow up singing it every December and internalize its message of inclusivity. He’d always wanted to record it on a larger scale, and suddenly the pandemic made that seem possible. “In 2020, there were all these virtual choir and orchestra things happening,” he says. “And I realized, I don’t have to worry about travelling and finding the money.”

Maybe, he thought, with everyone stuck at home, they would join him in making something beautiful. He started recruiting participants in September, aware that it would be tough for anyone to summon up Christmas spirit any earlier than that. “I was pretty confident it was going to be pretty special when it was done,” he says, “but it’s hard to explain that to people.”

He created “click tracks”—audio recordings of each instrumental or vocal part, set to a steady click so everyone sings or plays the same tempo and their voices and instruments can be seamlessly layered together later—and coached people to record their individual audio and video. He then edited it all together with the help of a professional engineer. The final product—which included dozens of amateurs singing with professional vocalists Laila Biali, Janna Baty and Joey Niceforo, along with musicians including Karen Donnelly, principal trumpet with the National Arts Centre Orchestra, and Steven Woomert, associate principal trumpet with the Toronto Symphony Orchestra—was highlighted on CBC’s *The National* over the holidays and passed around online by Canadians who really needed a dose of joy and hope as 2020 wound down.

“Culture is what makes us human beings,” Singaratnam says. “It’s the thing that is going to sustain us when we’re just restricted to the essentials and we’re isolated.”

With our lives still largely restricted to the essentials, it’s worth remembering that a little beautiful goes a long way. SHANNON PROUDFOOT
Standing on guard
When the virus arrived, Chief David Monias and his northern community faced an unprecedented challenge

EVERY TIME a chartered plane takes off from Cross Lake Airport and passes over Pimicikamak Cree Nation, Chief David Monias pauses. “It breaks my heart,” he says of the flights, which take COVID-19 positive community members to Winnipeg for medical treatment and alternate isolation accommodations. “I feel for these people. I don’t want them to have to leave their homes or the community, but we’re left with no choice because we don’t have the medical resources or the infrastructure to take care of them here.”

Monias knew he’d face some tough hurdles when he was elected in 2019, but never imagined he’d tackle a pandemic. The First Nation—home to nearly 10,000 people—has been in some form of lockdown since last March and a complete lockdown since last October. Checkpoints monitor traffic, collect contact information and take the temperature of anyone entering Pimicikamak, also known as Cross Lake First Nation; only essential workers and those heading south for medical appointments can travel to and from the community.

But—despite a slew of proactive measures, including a curfew and food deliveries—the virus found its way in, pushing health-care workers to the brink as they test, treat, contact-trace and register patients for evacuation. At one time there were more than 200 active cases. Canadian Armed Forces members arrived in late February to provide respite and medical assistance, while the Assembly of Manitoba Chiefs has committed to sending 30 ambassadors to help take pressure off Pimicikamak’s essential service providers.

A critical lack of housing—Monias estimates 1,000 new homes are needed to alleviate overcrowding—makes physical distancing difficult if not impossible in many cases. Classrooms, gyms and even the local hotel have been commandeered to create quarantine facilities.

Monias knows people in his community are feeling cooped up and frustrated, but asks them to stay strong, providing information and encouragement via radio broadcasts and Facebook livestreams. He also relies on the personal touch: most people in the community have his cell number. In January, he received a call like no other. “I couldn’t understand what they were saying, all I heard was ‘baby,’ ‘washroom,’ ‘floor’ and ‘no ambulance,’ so I ran out the door with one sock, putting on my boots,” says Monias. “The things we do as chiefs, you would never see that with a mayor.”

He arrived at the same time as paramedics, and the child was delivered by its grandmother. As for his own grandson, COVID-19 restrictions mean Monias hasn’t seen him since his birth last September. Monias isn’t seeing much of his wife—a nurse with the community’s rapid response team—either.

But it’s concerns for the children and the Elders that keep him up at night. “I’m scared for mental health issues; what kind of impact will this have? Because there is a lot of anxiety, depression and suicidal ideation, so we’re dealing with all that kind of stuff,” Monias says. He knows the sacrifices people have made and thanks them for it, but says the only way to truly manage the virus is with the vaccine. More doses—about 200 people had been vaccinated by late February—can’t come soon enough, he says. SHANNON VANRAES

Harper’s government didn’t like being contradicted by scientists, so they changed it. “There was a very clear decision to make a chief public health officer the head of the organization, where that person would have all of the power and that person was empowered to speak to the public,” said Garner. By restructuring PHAC, the government had allowed the scientists to be subsumed by the culture of the amorphous Ottawa bureaucratic blob, which is not always entirely task-oriented.

On Jan. 27, when Tam testified before a Commons committee, telling them it was not necessary to quarantine travellers returning from Wuhan, she was introduced by Tina Namiesniowski, her boss at PHAC, a civil servant with stints over the years at the Privy Council Office, the Treasury Board, National Defence and Canadian Heritage. Namiesniowski, who resigned around the time the audit was written, said Tam was acting “to ensure an authoritative voice to all Canadians during a public health event, which is essential.” The audit said they worked well together, “standing constantly behind one another, supporting each other and sharing the pressure together.”

It seems fair to wonder if they were too close. Was the government listening to Tam, or was it just using her, as Namiesniowski said, as an “authoritative voice” for a government that wanted to project calm?

On March 5, the WHO’s Tedros was blunt: “This epidemic is a threat for every country, rich and poor, and as we have said before, even the high-income countries should expect surprises.” Five days later, in Ottawa, in an incident described by my colleague Paul Wells in an article for this magazine, a reporter coughed into her balled-up fist at a news conference; Hajdu reminded everyone that it’s safest to cough into one’s elbow and to stand two metres apart, which nobody in the Commons lobby was doing. “But I will also remind Canadians that right now the risk is low,” she added, twice.

Unlike Dr. Anthony Fauci, who often gave interviews contradicting the catastrophically dangerous COVID-19 advice of U.S. President Donald Trump, Tam’s comments have been in lockstep with her political masters. That close alignment of messages may be because the Liberals seemed to take Tam’s advice, unlike Trump, whose former adviser expressed a desire to behead Fauci. But it may also be because the Liberals were using her as a spokesperson.

“Does Theresa Tam have complete licence to call it exactly as she sees it?” asks Steven Lewis, an adjunct professor of health policy at Simon Fraser University. “If the answer is yes, then arguably Theresa Tam was overly optimistic about how this was going to go.
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* Marbling is the small flecks of white fat distributed throughout the meat. The amount of marbling influences beef juiciness, texture and flavour.
The messaging wasn’t sufficiently clear and there was just too much wiggle room.”

Lewis thinks she does not have licence, that her role is to stay onside with the government she serves. But the public statements Tam was giving weren’t that different from those of Fauci. They were both likely worried about looking like Chicken Little—a bad position for a public health leader. On Feb. 13, health reporter Helen Branswell, who was worried by COVID’s progress, pressed Fauci on why he wasn’t raising the alarm. Fauci asked how it would look if he was wrong. “I’m telling you we’ve got a really, really big risk of getting completely wiped out, and then nothing happens? Your credibility is gone.”

I started to worry about the virus on March 11, when I listened to a webinar by Dr. David Fisman, an epidemiologist at the University of Toronto. I was in Punta Gorda, Fla., at the time, fixing up an old sailboat I hoped to sail to the Bahamas. Sitting on my boat, with bad marina WiFi, I managed to download the Fisman webinar and soon found myself sweating, and not from the heat. Fisman had just revealed modelling that projected up to 70 per cent of Canadians could be infected unless we implemented measures to prevent the virus spreading.

Fisman began by explaining to his audience—the Canadian Society of Association Executives—that he was a “little nervous about what I’m going to bump into in the hospital over the coming weeks.” COVID-19 is a recombinant virus, Fisman explained, which means that it evolved while jumping between animal species before moving on to humans. It is “made up of different viral strains that sort of got glommed together into a recombined virus that turns out to be very virulent,” he said. “It makes people quite sick, but [it’s] also quite transmissible, so that each old case makes two new cases or three new cases before they get better.”

That means it can spread exponentially. That was the part that scared me—the terrible silent spread, leading to a sudden wave of illness that could overwhelm hospitals, as was happening in Italy.

“When we have epidemics presenting with deaths, what that means is it’s an old epidemic, because it takes people a while to get sick enough to die,” Fisman explained. “So, we have a bit of a heuristic. If you see two deaths, and we think case fatality is two per cent, those two deaths represent 100 cases, and they represent 100 cases from two weeks ago. So those 100 cases with a reproduction number of two means 200 cases the next week. So you’ve got a minimum of 700 cases in your population by the time you see two deaths.”

I emailed Fisman and asked him for an interview for a story. We spoke on the phone on March 12, the same day Ontario Premier Doug Ford told families they should not cancel their March break plans: “Go away, enjoy yourself and have a good time.” I had come to believe Canadians needed to be frightened. Fisman agreed. “Everyone should be very scared.” He was convinced that governments were acting too slowly, that leaders were failing to grasp the situation. “We have a choice here right now, which is we can be Hong Kong or we can be Italy,” he said. “We get to choose one or the other. We don’t get to choose the status quo. And the difficulty for the politicians is that if you shut things down now and it’s quiet and you achieve what you wanted to achieve, which is nothing happens, then you’re going to be excoriated for overreacting. You achieved what you set out to achieve, which is we didn’t kind of go through what the Italians went through and that’s why we
Calling for back-up

Yashoda Valliere and her fellow medical students turned helping health-care professionals into its own essential service

YASHODA VALLIERE, a fourth-year medical student at Western University, attended a microbiology class last March, where they reviewed antibiotic therapy. It would be the last time she and her classmates would ever be together on campus; a few hours later, the university sent an email declaring campus closed and in-person classes suspended as the COVID-19 pandemic encroached.

On a group chat, she and classmates shared their sense of shock, Valliere recalls, “feeling a little bit helpless, a little bit frustrated we couldn’t do much to help our colleagues on the frontlines.”

At one point, someone mentioned that Ontario schools would be closed for two extra weeks—this would become the never-ending March Break, but no one knew that then—leaving working parents scrambling for childcare.

Out of that conversation, a beautifully simple idea was born: as med students, they couldn’t yet head to the frontlines of this generational health-care battle—Valliere’s class was a few months away from graduating to become resident physicians—but they could backstop those who were there. Valliere and half a dozen other students in different years at the Schulich School of Medicine and Dentistry put out a call for volunteers, then announced on Twitter and through word of mouth that they would provide childcare, grocery and prescription pickup, or run essential errands for medical professionals who needed it. In those bewildering early days of the pandemic, it allowed medical students to give back and feel less powerless, while providing essential help at home for those fighting to get a grip on this virus. “I think it was something that gave people hope and a sense of solidarity, on both ends,” Valliere says.

With no experience organizing anything of this nature, the volunteer coordinators rapidly sorted out the logistical issues that came up—sending students in pairs to provide childcare for liability reasons, for example, and pairing volunteers with only one family to reduce points of contact. Soon, the idea took on a life of its own, rapidly spreading to 13 of Canada’s 17 medical schools. Western’s volunteer corps ultimately helped about 25 families, though they wish they’d been able to do more. “This is amazing and this made me cry tonight,” wrote one person who heard about the effort. “I don’t need your help, I just want the medical students to know this is a fantastic idea.”

The volunteer program was intended to buy parents some time to figure things out during what was initially a short-term school closure, so it wound down after two weeks because the student volunteers were still juggling their studies.

In June, Valliere graduated and began working as a resident physician at a family medicine practice in Kitchener-Waterloo, Ont. She’s grateful the volunteer program gave her and her classmates a way to feel useful and connected, and it’s been a relief to move from the sidelines to the frontlines. “There’s also definitely that sense of solidarity in the clinics and in the hospitals, this sense among me and my co-residents that we’re all in this together,” she says. “Years from now, we’re going to look back and remember we were the pandemic cohort.” SP
did that. And then people are going to say, bastards! You cancelled the NHL season. And then my restaurant got no customers for a month. You’ve ruined me!”

Fisman was beginning to be a target. The day before I spoke to him, he did an interview with the National Post in which he discussed his model. “The rage that came at me, it’s really something I’ve never experienced before,” he told me at the time. (He has experienced much worse since.) “I think people are scared and there’s a separate grieving thing going on here as well, where there’s denial and anger and all those emotions.”

Before we finished the interview, I decided to ask for Fisman’s advice about my own situation. I had been in Florida for a few months, where boardwalks remained busy and the waterfront bars were still packed with sunseekers drinking pitchers of Bud Light and listening to dad bands. Even after the NBA suddenly cancelled its games, the people I talked to in Florida were unconcerned, dismissing the virus as media nonsense. The Gulf Coast of Florida is Trump country, and the president was telling people not to worry. On March 10, he famously promised it “would go away.” I imagined the virus spreading, silently, and started hiding on my boat, trying to minimize my exposure.

I had started to worry about what would happen if I got the virus. How would I get medical care? How would I get home? I apologized for using an interview subject for medical advice, and asked Fisman what I should do. He pointed out that only three places in the entire state of Florida were doing COVID testing. And there are a lot of seniors in Florida. “If I were in your boots, I’d probably come on back.”

I moved my boat to storage, rented a car and made the long drive north, 2,400 km, from palm trees to snow, past many golden arches and Exxons, up Florida, through Georgia and the Carolinas, around Washington, D.C., then up through Pennsylvania and New York state. I listened to Albert Camus’s 1947 novel The Plague as I drove. I wore disposable gloves when I filled the gas tank. I avoided restaurants and bathrooms. When it got cold, in upstate New York, I parked at the edge of a truck stop and changed my clothes in the darkness of the parking lot.

At first, there were a lot of RVs, trucks hauling boat trailers. The parking lots in the malls and roadside barbecue joints were full. The further north I got, the more seriously people seemed to be taking the virus. In Pennsylvania and New York state, the digital highway signs—the kind that usually warn of congestion ahead—all had warnings about the virus.

I was part of an enormous movement of Canadians home—the flight of the snowbirds. On March 16, Trudeau had announced that Canada was finally taking dramatic action, closing its borders to most foreigners. “If you’re abroad, it’s time for you to come home,” he said.

About a million Canadians returned that week—in planes from airports around the world, and a huge wave from trailer parks and retirement villages in Florida and other U.S. states. It was an unprecedented influx. Trudeau had called us home, but somehow there was no plan to safely handle us. The airports were a mess. Travellers were jammed together in waiting areas. Masks were still not recommended, and few were wearing them, a shocking contrast for Canadians returning from Asia, where everyone was masked. Scott Grant and his wife flew from Thailand to Vancouver on an Air Canada flight, on their way back to Saskatchewan after a long holiday. When they stopped in Hong Kong, they had their temperatures checked repeatedly with thermal sensors. On the flight, everyone was masked. When they arrived in Vancouver from Mexico sent me a cellphone picture of the pamphlet he had received, which did not mention self-isolating.

It remains a mystery why the measures announced by Trudeau and Bill Blair were not being implemented. I sent questions to Public Safety and the PMO last March, which they have yet to answer. Off the record, officials will only say they were overwhelmed.

In Moncton, N.B., Roxann Guerrette, Cardy and Smith were solving the problem. Guerrette was then working remotely for Distributed Bio Inc., a San Francisco pharmaceutical start-up researching a universal flu vaccine. Both the company and Guerrette were featured in Pandemic: How to Prevent an Outbreak, a Netflix
Answering the call

When the need for PPE soared, Kacee Vasudeva retooled his company’s production lines and got to work

FLAVIO VOLPE FIRST met Kacee Vasudeva in the midst of a global financial crisis that threatened to bring down major automakers. Volpe was the chief of staff to Sandra Pupatello, Ontario’s economic development minister, and his job back in 2009 was to help prevent the unthinkable. Vasudeva, then vice-chair of the Auto Parts Manufacturers’ Association, was representing companies that supplied all the building blocks that go into each vehicle.

Automakers were struggling to pay the companies that fuelled their supply chains. Vasudeva, who immigrated to Canada from India in 1971 and has since joined two prime ministers on trade missions abroad, was a crucial player in a deal that saw his members get paid. “He does not have an off switch,” says Volpe, who is now president of the same auto parts lobby group.

That relentlessness came in handy when Canada plunged into an economic crisis all over again in 2020. Five days after the WHO declared a pandemic, and as governments scrambled for scarce PPE supplies, Volpe appealed to his members to “do our part and step up”—and retool production lines so they could spit out masks, face shields, gowns and even ventilators.

Vasudeva was one of the first to sign up. “When COVID happened, we knew our country was in trouble. What could we do?” he says. Plenty, it turns out. Vasudeva runs Maxtech, a Waterloo, Ont.-based manufacturer of braking assembly and battery coolant parts, as well as hand tools and power-tool accessories for retailers like Canadian Tire and Home Hardware. Another division of the company produces fruit fly traps, mosquito repellant and even a surge protector that doubles as a bedbug trap. He started Maxtech—then Maxi-Flow—from his garage in 1977, and claims to hold more patents than anyone else in Canada.

Within weeks of Volpe’s call to arms, fuelled by partnerships with every major post-secondary institution in Kitchener-Waterloo, Maxtech was working on prototypes for clear masks, tiltable face shields, a card badge with a slot for hand sanitizer (sanitizer sold separately), and a wearable infrared pendant that discourages face-touching by emitting a tiny electric shock if the user makes the wrong move. “We have applied for 12 patents in the last year,” he says. The company, which retooled before signing any contracts with customers, was selling everything to retailers (except the pendant, which is still in development) within three months.

NASA’s Jet Propulsion Laboratory is marketing a similar pendant, dubbed Pulse, but Vasudeva insists he was first to apply for a patent (and says he won’t hesitate to stand up for his intellectual property).

Rishabh Agnihotri, Maxtech’s sales communication manager, says the company’s next innovation involves a coating for face shields, developed in partnership with the Indian Institutes of Technology, that it says can kill the coronavirus on contact. That product still needs a green light from Health Canada. But the production lines are ready to go. NICK TAYLOR-VAISEY
Guerrette sent Cardy COVID-control protocols she had received from a colleague in Israel. She organized a billboard campaign to encourage people to wear masks, which she considered protective, while Tam was still advising people against them. She convinced her boss, scientist Jacob Glanville, to do a video warning New Brunswickers to practise physical distancing, which she and Smith shared on social media. She raised money to get protective equipment for health-care workers.

When Trudeau called people home, a dedicated group of New Brunswickers realized travellers would be bringing COVID with them. Léger, the chief of staff to the premier, said the province knew it had to tell the convoys of returning travellers coming over the border from Maine to isolate. They needed to be instructed to go straight home, without stopping to buy groceries or visit their relatives, but the Canada Border Services Agency wasn’t going to give the instructions. “Their job was to let people in Canada,” said Léger. “Once they are in Canada, that’s another ball game. So they were travelling to Canada, but as soon as they cross over, they’re already home.”

The province put game wardens on the roads in makeshift roadblocks to give health advice to the returning snowbirds. Civil servants weren’t sure. “Are you sure you want to do that?” Léger recalls some asking him. “Pretty much.” The premier was absolutely steadfast.

Cardy and Guerrette tackled the problem series released in January, just as COVID was about to go global.

On Jan. 25, Distributed Bio started working to “engineer a panel of anti-SARS antibodies” to treat what later became known as COVID. Guerrette, an Acadian from the northern New Brunswick community of Sainte-Anne-de-Madawaska, became aware from online conversations with colleagues in Europe that the virus could be a dire threat. “I just knew this would be a pandemic before the government started to act upon it,” she said.

Guerrette and Cardy, the N.B. education minister, had gotten to know each other when she was president of the university’s student union. She was impressed by his pro-science approach and in particular by a bill he had tried to get passed requiring mandatory vaccination for all New Brunswick schoolchildren, a measure narrowly defeated in a free vote in the legislature.

As he and Smith worked on their report for the premier in February, Cardy leaned on Guerrette for help understanding some of the scientific concepts. They shared a sense that Canada was failing to get ready. “Scientists have known for a while that this could happen, that there could be a virus that would take over the planet and we’d have to find strategies to mitigate it,” said Guerrette. “We had the Spanish flu. It’s something that can happen again. And Dominic Cardy kinda knew that this could happen again and the best way was to act fast.”

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Cardy and Guerrette tackled the problem at the Moncton airport. He wired her $250. She went to the Canadian Tire in Dieppe, N.B., where she bought tape, 20-litre jugs of water and bottles of bleach to mix to make disinfectant. They printed pamphlets advising people to self-isolate. She went to the airport, said she was acting on Cardy’s authority, and started organizing the arrivals area, getting hand sanitizer for the airport workers and putting tape on the ground to enforce social distancing, directing people over whom she had no authority in both official languages.

The returning travellers needed to be told what to do, she said. “It was a bit of a shock for them and they couldn’t understand that they couldn’t stop at McDonald’s to get a burger on their way home. And we literally needed to put tape on the floor because people wouldn’t listen to the six-foot-distance rule.”

Guerrette got some blowback. She endured social media attacks that still leave her bruised a year later and a country away. She is now working for a biotech company in Boston. “She was personally brave and ready to stand up and put her credibility on the line,” Cardy said. “She didn’t make herself any friends during that period, but she saved many lives.”

Cardy, too, made enemies. Parents complained when he ordered students who had been out of the country on March break to stay home from school for 14 days. Public health officials in New Brunswick opposed
“Made you look.
And yes, I’m wearing Always Discreet.”
the measure, and Dr. Rama Nair, a professor of epidemiology at the University of Ottawa, told the CBC he was being too cautious. Dr. Chris Goodyear, then the president of the New Brunswick Medical Society, said physicians did not believe the measure was rooted in evidence-based public health policy.

Looking back, it seems strange. Tam was wrong, as were many public health experts. On March 11, Steven J. Hoffman, a professor at York University and director of the WHO Collaborating Centre on Global Governance of Antimicrobial Resistance, praised Canada’s measured response on a TVO panel show. “It really highlights the decision that many governments, fortunately not Canada, but many governments out there where they are imposing travel restrictions,” he said. “We see many countries around the world are overreacting to this threat. The overreaction can actually cause more harm than the virus itself. For example, there are 180 million children in China who are not at school…”

Because of the stringent measures China took, that country has been largely free of the virus since March.

In January, Chinese officials were urging citizens to wear masks, part of the successful national measures that suppressed the virus. Tam didn’t advise Canadians to mask up until April, a few days after the CDC changed its policy. Until then, the research was unclear. Both Tam and the CDC were wrong. And because they didn’t advise wearing masks, warned against the risks, in fact, people got infected and died. But they didn’t know they were wrong. Perhaps they couldn’t have known.

It is difficult to remember now all the things we didn’t know then. On March 15, I was thinking about writing an article calling for the cancellation of St. Patrick’s Day, or at least the part most people like about it: drinking beer in bars and listening to Irish music. I emailed Fisman to ask his opinion.

“I’m framing that,” he replied. “Speed trumps perfection. The greatest error is not to move, the greatest error is to be paralyzed by the fear of failure.”

Looking back at the pictures Glen Canning took at Pearson airport, it is strange to see so many people without masks crammed together. There is no way of knowing how many people got infected in the crowded lines at Pearson, but likely a lot. And some of them likely died. A Statistics Canada report from April 2020 found a quarter of COVID cases were directly linked to travel.

A lot of highly educated, dedicated and motivated people failed to sound the alarm, and to heed it when others did.

It made me think of the disaster in Aberfan, a Welsh coal-mining town, where mine waste had been piled on top of streams on the hillside above the town. After a night of heavy rain, the pile of debris slid down the hill, where it crushed a school, killing 109 children and five teachers. The tragedy was dramatized in an episode of The Crown. I learned. But the part of the narrative that is less well-known is that the local council had complained for decades about the slag heaps, which repeatedly flooded parts of the village with dirty water.

In 1961, an engineer warned the National Coal Board: “The slurry is so fluid and the gradient so steep that it could not possibly stay in position in the wintertime or during periods of heavy rain.” But officials at the coal board, who were ultimately found responsible at a public inquiry, ignored the warnings, and so on Oct. 21, 1966, miners who started their day digging coal finished it digging the remains of their children out of what had once been a school.

The sociologist Barry Turner, in a 1976 study of man-made disasters, including Aberfan, found that organizations often have a “tendency to minimize emergent dangers.” Part of the problem is that officials reflexively discount the views of non-experts, like the villagers who warned the coal waste was ready to slide.

The people who see the danger are, like the mythical Cassandra who warned the Trojans there were Greek soldiers in the wooden horse, ignored because they are not part of the group in charge. Experts often respond with a “high-handed or dismissive response,” Turner wrote. Warnings from outsiders are “fobbed off with ambiguous or misleading statements, or subjected to public relations exercises, because it was automatically assumed that the organizations knew better than outsiders about the hazards of the situations with which they were dealing.”

I emailed that quote to Cardy when I came across it. “I’m framing that,” he replied.
When staff at a Tim Hortons in Regina wanted to pay confectionary tribute to Saskatchewan’s top public health doctor, the design was pretty obvious: two chocolate eclairs fused together with caramel icing trim and white “buttons” down the middle, to look like Dr. Saqib Shahab’s trademark brown knit cardigan vests. He’s amused they became his trademark—he’d only begun wearing them to health updates because early in the pandemic, when such appearances were daily, he didn’t have enough suit-jacket combos to keep up. So he began donning his many sweater vests, including the ones his wife’s aunt had knit for him, with matching ones for his kids.

The doughnut, introduced in February, was more than just a show of gratitude for Shahab, whose compassionate and to-the-point briefings made him a household name in Saskatchewan. (He cites a saying of his father’s, once a prominent civil servant in Pakistan: “Tell the truth, because then you don’t have to remember what you said.”) It was also a very Canadian show of solidarity after a small group of anti-restriction protesters picketed outside his house one Saturday. Premier Scott Moe called them a “group of idiots”; many families sent Shahab support messages and children’s drawings. “It gives wind to my sails, certainly, and that is what Saskatchewan is all about and what Canada is all about,” Shahab said at the next briefing.

He’s one of Canada’s longest-serving provincial chief medical officers, in his current post since 2012. Shahab started his career in Pakistan, where he helped create its first public health school—then he answered a job posting in the small city of Yorkton, Sask., and became enamoured with the Prairies’ relaxed pace and wide open spaces. There’s been little relaxing during the last year: he recalls, in the coronavirus crisis’s first months, that his research, reading and briefings only allowed him four hours of sleep per night. But he’s also taken more of the year to enjoy Regina’s outdoors, reckoning he’s walked and cycled farther in the last 12 months than he’s driven. He’s been pleased to see others doing the same: with a ban on indoor social gatherings over Christmas, “every inch of snow had footprints on it in open areas.”

Saskatchewan was compliant enough with the restrictions Shahab urged—and, let’s be realistic, lucky—that it had a negligible first wave, and a late and limited second wave this winter. Even though he is well distanced from the premier and media during briefings, Shahab insists on wearing a mask when he talks, to show frontline workers it’s no impediment to communicating. He’s preached restraint on lockdowns; Saskatchewan has had some of Canada’s lightest restrictions: “Every measure puts some burden on people and it has to be proportionate to the risk.” But there’s still pushback, and at one rally last fall, the criticism got racist. Shahab says the few who criticize him based on ethnicity need to resolve their issues, and he’s more concerned about those who face racism but who lack his own privileges and protections. Says Moe: “He could have chosen anywhere in the world to go and practise his trade, but he didn’t. He chose here, and Saskatchewan is certainly a better place because of the choice he made.” JM

**Prairie star**

A fortunate Saskatchewan has rallied around its top doctor, Saqib Shahab
Dr. Simon Demers-Marcil, an ICU physician in Calgary, calls a family to tell them a loved one has died of COVID-19.
CHAPTER TWO

The strongest bubble of all

‘What experience and history teach is this—that people and governments never have learned anything from history’ —Hegel, Philosophy of History

On March 29, 1919, in the middle of a pandemic that had started during a world war, the Montreal Canadiens faced the Seattle Metropolitans in the Stanley Cup final. It didn’t look good for the Canadians at the beginning of the third period in the fifth game. Les Glorieux had to win to have a shot at the cup, but they were trailing 3-0, and their best defenceman, scrappy Joe Hall, a man who once said he played so rough he was “giving a dog a bad name,” was too ill to finish the first period. They somehow rallied, led by Édouard “Newsy” Lalonde, who scored two goals to tie the game, before Jack McDonald put them up 4-3 in overtime. It was a thrilling conclusion to what the Vancouver Sun called “one of the best and fastest exhibitions of hockey ever seen here.”

The stage was set for Game Six, but it was not to be. Five Canadians were in the hospital with the flu. Hall died a week later. The Habs, without enough men, forfeited, but the Seattle side wouldn’t take the victory, and eventually this was engraved on the cup: 1919, Montreal Canadiens, Seattle Metropolitans, Series Not Completed.

Hall was one of about 50,000 Canadians to perish from the so-called Spanish flu, at a time when there were only 8.8 million Canadians. The flu’s impact, like COVID’s, was greatest on the vulnerable, people who couldn’t avoid infection, or count on proper care once infected. It cut a horrid swath through Indigenous communities, who were vulnerable thanks in part to widespread tuberculosis and federal policies that left them malnourished and ill cared for. And its second wave was worse. In 1918, the Canadian government repeatedly seeded the flu by dispersing infected soldiers around the country without considering the consequences. Vincent Massey, who would later become governor general, wrote a scathing report for prime minister Robert Borden, laying out the federal failure: the government, Massey wrote, “could have given specific directions and ensured that a uniform, coordinated plan was followed.”

A hundred years later, as Canada inclined toward the second wave of another pandemic, you could say much the same. Ottawa moved quickly last spring to provide income supports, hatching the CERB program within weeks of the country going into lockdown and providing up to $2,000 a month for those deprived of work. Other programs followed for businesses and individuals. They were all criticized for various reasons, but the money kept the economy moving, preventing terrible deprivations.

What the federal government didn’t do is impose a coordinated response on the provinces, as it might have done if it had invoked the Emergencies Act. In the ensuing months, Tam and Trudeau repeatedly called for provinces to take stronger action. The premiers of Quebec, Ontario, Manitoba, Saskatchewan and Alberta mostly ignored those warnings, as well as the lessons of history, and the failure to suppress the outbreaks belongs to them.

In late August, as Canadians visited gyms, bars, restaurants and shops, and schools geared up to reopen, the warnings from health experts grew more urgent. So did their calls for investing in rapid testing and contact tracing. By Jan. 15, without adequate measures in place, the second wave had crested. There were an average of 9,600 new cases a day across the country, about 1,000 of them in Toronto. It has been an ordeal, said nurse Kathryn Rego, who helped care for Canada’s first COVID patient in that city last March. “There was never a thought in my mind that we’d be in lockdowns a year later,” she said, “still fighting this thing and seeing the strain on the hospitals and the strain on the staff and just the burnout.”

On the other side of the world, Melbourne, Australia, a city of five million, was heading into its tenth day with no new cases. Steven Lewis, the health policy professor at Simon Fraser University, has spent the pandemic in Melbourne and thinks Australia did better because its leaders were bolder. Lewis, a long-time senior health policy professional from Saskatchewan, found himself in Australia when his partner got a job there. He has been functioning as “head of domestic affairs” for his family, spending his spare time keeping a close eye on pandemic management in both countries. Australian leaders, he found, did not count on everyone taking responsibility for their actions, the approach taken by Canadian authorities early on.

“The first obligation is to have a clear policy, and the messaging [in Canada] has been, for the most part, extremely ambiguous and always leaves a little wiggle room,” said Lewis. “So you get the chief medical officer saying, ‘We really would discourage people from having mass gatherings’ or ‘You really should restrict unnecessary travel.’ Well, what do you mean by that? Are we allowed to travel or not? And who defines unnecessary?”

Even some helping to make policy interpreted the advice loosely. Last November, Dominique Baker, surely the first acting manager at the Public Health Agency of Canada’s Office of Border Health Services to make headlines, took an all-expenses-paid trip from Air Canada to Montego Bay, Jamaica, to stay at an elite resort. She gushed about the luxurious experience on her style website, and her delight at riding a horse on the beach in beautiful Montego Bay is infectious. But she was travelling in the thick of the second wave, for non-essential purposes, while she had a crucial role in the white-knuckle business of managing travel.
Grief in plain sight
One candid photo of Dr. Simon Demers-Marcil conveyed the full weight of human suffering the pandemic has inflicted

He’s wearing a mask, of course. His raised left arm obscures the rest of his face, his palm cupped around his forehead, while his right hand holds a landline telephone to his ear. He kneels, his Nike runners splayed on the floor behind him and his entire body slightly curved in on itself.

Respirologist Dr. Simon Demers-Marcil is a big bear of a guy, and when he speaks, it is slow and deliberate and gentle. He may be exactly who you would want to help if someone you loved was hanging by a thread. But in the phone call Demers-Marcil was making in that photo, it was too late for anyone to help. His body language—simultaneously wrung-out exhausted and taut with tension—betrays the toll too many medical professionals have borne over the last year, as they have called family after family to say that someone has succumbed to COVID-19 or is on the brink. After Alberta Health Services released the photo (see it on p. 36) and described its circumstances in November, it rocketed around the internet as the pandemic’s Alan Kurdi moment: a single image of one person crystallizing a full narrative of human suffering, as the photos of two-year-old Alan’s lifeless body on a beach did with the Syrian refugee crisis.

Demers-Marcil and his co-workers at Calgary’s Peter Lougheed Centre were being shadowed by a media crew when someone snapped that image. “They asked if they could use that specific photo. At first, I admit I said no,” he says. “Because maybe I felt a bit vulnerable, being exposed like that on a picture.” But when the COVID case count rose, he told them to go ahead, because they thought the image might help people to understand what was at stake.

When he has to call a family to say that someone has died or the end is near, Demers-Marcil tries to make sure he conveys the necessary information without overwhelming someone in the midst of emotional shock. “I try to imagine what I would like to hear in a similar circumstance, although we’re all different,” he says. “I try to remember that although I’m emotionally involved too, I’m not the one who’s dealing with the loss of a loved one and I try to focus my energy on the person receiving the information.”

There are moments where he feels a tug of deeper connection to the person he’s speaking to, either because they or the patient remind him of someone he loves, or because he can hear in them a kindred spirit, and those calls are particularly difficult. He’s certain that every medical professional who has had that conversation has wept at one time or another. “It’s impossible to take out completely that emotional side you’re feeling,” he says. “And sometimes you’re also disappointed you weren’t able to provide a cure.”

At this moment, Demers-Marcil is cautiously optimistic; hospital and ICU numbers are falling as needles go into arms (he got his second vaccination in mid-February), and he senses that he and his colleagues are better protected for the fight they are in. “It feels like we’re not going to war empty,” he says. But the war isn’t over yet. SP
The aggressive action worked in the first wave: Australia had 4,559 cases at the end of March while Canada had 8,589—23 per cent less per capita. That difference only grew. Tough action all but eliminated the virus from Australia within a month, while cases in Canada kept climbing. Australia had the pandemic under control until June (the start of its winter), when sloppy private security guards at a quarantine hotel got infected, leading to hundreds of cases. The virus spread through asymptomatic people attending family gatherings. The second wave was getting out of hand, relatively speaking, until the state government brought in a tough 111-day lockdown in July, with most people confined to their homes—quite a feat in Melbourne, a city of five million. By August, residents had to observe a curfew and stay within five kilometres of their homes, which they were only allowed to leave for essential purposes or for an hour or two of outdoor exercise. Gyms and schools were closed. Restaurants were only allowed contactless delivery and takeout.

“...during a pandemic. She was not the most senior Canadian official to abandon her post to sneak away to a sun spot: Rod Phillips, the Ontario finance minister, decided to spend Christmas on posh St. Barts. Before he left, he recorded a series of holiday greetings for scheduled posting online that suggested he was still in chilly Ajax, Ont. More ill-advised jaunts came to light in the first grim days of 2021: Alberta MLAs in Hawaii and Mexico, the Niagara Health CEO Tom Stewart in the Dominican Republic. A number of those people lost their jobs. Some Canadian leaders in charge of protecting the health of the country obviously had other things on their minds.

From the beginning, Australia responded more decisively, shutting down travel from affected areas and enforcing measures meant to control the spread of the virus, with fines and spot checks when necessary. The state government in Victoria implemented a hotel quarantine order for out-of-country arrivals in March 2020, 11 months before Canada took a similar step.

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“You can’t say, well, because 80 per cent of the population believes the way we do, we’re going to be successful at pandemic control,” said Lewis. Everybody has to be ordered to comply, or the measures won’t work. Australian politicians were prepared to take dramatic steps. Prime Minister Scott Morrison mused about making vaccination mandatory (he later backtracked). Police in the state of Victoria issued more than 20,000 fines for COVID violations, which helped shut down transmission, although human rights groups complained the penalties were applied inconsistently, targeting more minorities. The measures were harsh and enforcement wasn’t perfect, but they worked.

That took political leadership. “You have an enormous political dimension to what is essentially a scientific and technical problem to solve,” said Lewis. The Australians found the political will. Canadian leaders didn’t. We have lost more than 22,000 people to COVID. Australia has lost 909.

Our disorganization and lack of political will...
The first call was scary—“like entering the unknown,” says Sheila Montague. It was January 2020, and she was assigned to case management and contact tracing of the first positive COVID-19 case in southwestern Ontario’s London-Middlesex Health Unit, and only the third in Ontario. “When I heard the test was positive, it was like, ‘What do we do?’”

Montague dialled the number on record, but there was no answer—so she turned up at the person’s doorstep. “She was jet-lagged and had turned her phone off,” Montague tells Maclean’s. “She took the news amazingly well. She just asked, ‘What do I do?’”

It turned out to be one of the easiest cases she would manage: a student at Western University who had returned from visiting family in China. The woman was asymptomatic while traveling, yet fully aware of the stakes of COVID spreading. She wore a mask throughout her journey, sat far from others and—miraculously—took the names and contact information of strangers on her shuttle bus ride from Toronto’s Pearson Airport to London, Ont. The next day, she woke up with a mild fever and cough, and took a taxi to the hospital—gathering the driver’s contact information, too. Montague checked in with the student every day. “Back then, I was making lines on a piece of paper with a ruler to record the temperatures,” she says. “Now it’s so streamlined.”

The term “contact tracing” was unknown to most Canadians when Montague started phoning up strangers. Within months, health units across the country were scaling up teams of people who learned on the fly about the dynamics of the virus—and about human imperfection. Their work was considered a vital tool that could allow Canadians to get back to something resembling normality. But as case counts rose sharply during the second wave, it proved too fine an instrument on its own. Contact tracers simply couldn’t keep up.

They’ve remained essential, though—not only in curbing the spread of the virus but in lending their ears to those anxious about a positive test result. “At first, people would ask if they were going to die,” says Montague, who eventually shifted out of contact tracing last year. “My job was constantly reassuring them.”

Some people would get upset when Montague told them they had to self-isolate for two weeks. Or that she couldn’t tell them the name of the person with COVID they’d been near: “They’d ask, ‘Then how am I supposed to stay away from them?’” Her answer: “Well, you’re going to have to stay away from everybody.”

Suffice to say, her job was more than being a bearer of bad news. She would check for symptoms, log temperatures and make sure those quarantined had access to food and medication. Many have been grateful. The Western student, for one, kept in contact with Montague long after there was any need from a public health perspective. The two became friends and, at one point last year, the student told Montague about passing her driver’s exam. As soon as COVID-19 is in the rear-view mirror, they’re going to go for a ride together. AH
means we got sicker and are poorer. “We’re paying a bigger economic price because we didn’t do it,” said Lewis. “It’s not that Australia chose to pay a higher economic and ancillary-health-concerns price in order to do this. They figured if we do it hard and we sustain it and we stick to our goals … until it is very clear we can reopen in the long run, we will be better off, not just health-wise, which is incontrovertible, but also economically.”

Crucially, Australia broke with the advice of the WHO early on, imposing travel restrictions while Canada was still following advice from a body that critics think was unduly influenced by China. Australian leaders were not afraid to act quickly and decisively. Canada was always behind the play. “You don’t even know what the puck is at the beginning, let alone where it’s going,” said Lewis. “So to anticipate is critically important and we’ve chased the puck. Canada’s still chasing. They still wait before they move to another level of lockdown.”

In July, I moved home to Nova Scotia after 15 years in Ottawa’s ByWard Market, a lively, pedestrian-friendly neighbourhood full of shops and restaurants that was suddenly empty and charmless in March. I was alone in my apartment, working on stories about the shooting rampage in Nova Scotia, struggling psychologically with the tragedy, frustrated at the distance, so I decided to move back.

The Atlantic provinces had restricted interprovincial travel starting in March, requiring most travellers entering the region to spend 14 days self-isolating, and discouraging internal travel during outbreaks. (“Stay the blazes home,” in the words of Stephen McNeil, then Nova Scotia’s premier.) But after a two-week quarantine in a seaside cottage, I was delighted to roam freely in a jurisdiction where everyone wore masks without complaint in the supermarket although there was virtually no infection—two active cases in the middle of July. It felt like a place apart, a land without COVID. Restaurants and bars were full. Real estate agents were overwhelmed with business from Upper Canadians seeking a seaside escape.

The dark side, if you could call it that, was a certain nosiness—part of the social cohesion that kept the region safe. One day, I stopped by the side of the road on St. Margarets Bay to look at an old fish shed—a shingled building on the rocks at the water’s edge. I walked across a lawn and asked the shed’s owner if she would mind if I had a look, and mentioned I had recently moved home from Ontario. She was friendly, and told me that was no problem. “But have you registered?” she asked. I had wandered into a campground, which she owned. Everyone leaving or entering the campground was required, by provincial order, to register. I could look at her shed after I registered, she said.

I agreed and followed her to the office, where I wrote down my name and number. She then asked for proof I had self-isolated, adding that many people were dishonest about the quarantine. She wanted to know I wasn’t fibbing. I declined to show her my travel documents, which I was not required to do, and left, both of us exchanging polite farewells through gritted teeth.

I didn’t like being quizzed by a self-appointed health inspector, but I am sure this kind of vigilance is part of why Atlantic Canada was able to avoid the worst of the pandemic. In Prince Edward Island, some cars with out-of-province plates were vandalized by local quarantine enthusiasts. Cortland Cronk, a New Brunswick software consultant and marijuana nutrients supplier, moved out of the province after he travelled for work, was blamed for an outbreak back home, and criticized online. Atlantic observers were skeptical of his narrative but he received solicitous treatment from the New York Times, which described pandemic shaming as “a worsening civic problem.”

Premier Stephen McNeil, who left office in February after presiding effectively over the pandemic, told me Atlantic nosiness may have been part of the success. “They would let us know if you weren’t isolating,” he said in an interview during his last week in the job. “But on the flip side, we had to tell people just because someone’s here with an [out-of-province] licence plate doesn’t mean they haven’t isolated. It doesn’t mean they don’t have a right to be here.”

“We tried to frame that in a positive way, communities caring for each other, supporting people,” said Robert Strang, Nova Scotia’s chief medical officer of health. “We’re not stressing the compliance if you will, but a bit of that ‘I’d better be careful because somebody may be watching me’ is probably helpful as well.”

McNeil said he and Strang acted decisively in part because they knew the limits of Nova Scotia’s health system. “I was terrified of what was going to happen to our health-care system and to Nova Scotians when it came in,” he said. “That’s why at the front end we were so aggressive.”

The provinces west of Rivièr-du-Loup, Que., even in the tightest lockdown in the spring, mostly declined to institute travel restrictions, arguing that the Constitution allows for free movement within the federation. A November study in *Nature Human Behavior* that analyzed responses around the world found travel restrictions were among the most effective measures globally in curbing the pandemic in March and April 2020, but Canadian politicians mostly declined to impose them. They faced pushback from voters who bristled at the prospect of being kept away from their cottages, which, after all, they own. The virus, which doesn’t care about our Constitution or the requirements of second-home maintenance, took advantage. The district that encompasses Simcoe-Muskoka, the beautiful cottage country north of Toronto (population 550,000), suffered 189 deaths, compared with Nova Scotia (population 970,000), which lost just 65 people, almost all of them at one large long-term care home.
Like many people, Sané Dube really started to pay attention to the spread of a new virus in late February 2020, when the wave of infections hit Europe. By March, death rates there skyrocketed.

“I have a very clear memory of an image out of Italy—coffins lined up,” says Dube, manager of population health and social medicine at the University Health Network in Toronto.

At the time, Dube was the policy lead focusing on Black health at the Alliance for Healthier Communities, a network of community health centres in Ontario. It hit her that this virus would be devastating—and that “some people would hurt more than others.”

One of the first impacts Dube saw was an increase in overdoses as people lost access to supports such as supervised injection sites. She was also paying close attention to reports from the U.K. and the U.S. that showed Black and other racialized groups of people were being hospitalized and dying at higher rates as a result of COVID-19 compared to the rest of the population.

While there was little to no collection of race-based data across the country at the beginning of the pandemic, early signs showed Black communities were also being impacted disproportionately here. Dube notes the Black community in Canada isn’t a monolith but there is a common factor—anti-Blackness has real negative impacts on people’s lives. In April, Dube and other community leaders urged governments to pay attention to how existing racial disparities in income, housing and health outcomes were affecting the Black community during the pandemic, writing in a statement: “COVID-19 does not flatten these disparities; it amplifies them.”

In May, the death of Leonard Rodrigues, a personal support worker at an assisted living centre in Toronto, shook Dube. She spoke with his wife, who told her the 61-year-old was buying his own PPE. He became sick after there was a COVID case at his workplace, and when his family took him to the hospital, he was sent home within hours. He died two days later.

“It was heartbreaking to me. It was telling a bigger story about the way that Black people are seen as disposable,” says Dube. “You work so hard, you care for people, you contribute, but at the end of the day, there is no care for you.”

The push by Dube and other community leaders, researchers and health practitioners has seen results: by June, Ontario announced it would collect race-based health data. And Toronto launched a plan in February to support Black residents, who have experienced the highest incidence of COVID cases: 26 per cent of cases, despite making up nine per cent of the population. Supports include access to mental health support and community-based testing.

The next big challenge Dube sees is equitable access to vaccines, and despite how long this year has felt, working with other Black leaders and seeing change happen energizes her.

“My commitment is to my people,” says Dube. “My commitment is to Black life.” SADIYA ANSARI
Eight nurses and two respiratory therapists work together to prone a patient at Peter Lougheed Centre, Calgary, on Jan. 13, 2021.
On Nov. 24, with Nova Scotia reporting 37 new cases of COVID, the province agreed to the industry’s request. Instead of tightening the rules, they ordered indoor dining shut. “We wanted to stay open,” Stewart told me. “The difficulty was, if you shut down and reopen, shut down and reopen, that can be very expensive. It’s expensive being closed, but it’s not as bad as being closed, reopened, closed, which has happened to many parts of Canada, and other parts of the United States and Europe.”

The restaurants and bars lost their busiest season—they remained shut through the holidays—but when they reopened in January, they reopened for good. “We knew if we locked down and made it tight, then that number would go back down,” said Stewart. “And that’s exactly what happened to us in Nova Scotia.”

Former health minister Jane Philpott thinks it is better for businesses if governments lock down hard enough to eliminate the virus. “I think many people would say, yeah, we would have rather been entirely shut down for a month or two,” she said in a recent conversation. “And not have the torture we’ve had over the winter of this long drip, drip, drip of economic challenges.”

Arguments about the social and economic costs of lockdowns really only apply to lockdowns that fail. Lockdowns that work are ultimately good for the economy. As it turns out, in Nova Scotia, according to Stewart, restaurant receipts in January 2021 were at about the same level as January 2020, before the pandemic hit. The province’s unemployment rate is lower than Alberta’s for the first time in memory.

There was a moment in the early fall, before the second wave, when provincial governments in most of Canada could have responded more decisively and shut down the virus. Canadians were flocking to malls and gyms and restaurants even as cases were starting to rise. University epidemiologists urged leaders to act. Instead, governments took half measures.

The second wave, like the first, arguably started in Quebec. In September, after a karaoke party at Bar Kirouac in Quebec City led to at least 72 cases, the province responded not by shutting bars but by banning karaoke, which...
led to angry complaints from bar owners. Quebec Premier François Legault waited until midway through December, when the health-care system was under strain, to take the harsh steps needed to slow the spread.

The Prairies had avoided high case counts in the pandemic’s first wave. Their conservative premiers were among the first to ease restrictions in the spring and summer, and they were reluctant to close again later. Manitoba, which often had no new daily cases in May and June, saw rapid spread start in August, settle briefly, then take off in September. It had had Canada’s highest COVID fatality and hospital rates outside of Quebec in spring. Premier Brian Pallister made an emotional presentation to Manitobans in December, urging them to follow the rules. “So I’m the guy that has to tell you to stay at home when the holiday season you celebrate… where you share memories and build memories,” he said, his voice breaking. “I’m that guy. I’m the guy who’s stealing Christmas to keep you safe because you need to do this now.”

In Saskatchewan, Premier Scott Moe cried foul when Trudeau called for provinces to tighten up on Nov. 10. “We can keep our economy open and people working by following sound practices that reduce the spread of COVID-19,” he said. There were 127 new cases that day. A month later, averaging 260 new cases a day, Moe brought in tighter rules. Saskatchewan would have been better off if he had heeded Trudeau’s warning.

British Columbia did better than all but the Atlantic provinces in the second wave. It had a better strategy to protect long-term care homes and a stronger public health system than other provinces. But cases grew there, too, in the fall as Premier John Horgan called an election and the government moved into “caretaker mode,” during which no major decisions are made. Voters gave Horgan’s NDP a majority and a second term on Oct. 24, but some criticized the election’s timing. “The question is whether B.C. deserved more than a caretaker mode from their government during a state of emergency,” said B.C. Green Leader Sonia Furstenau. In January, Horgan rejected calls to order self-isolation for travellers from out of province, which worked so well in Atlantic Canada. He also wouldn’t take action to stop visitors from travelling to Vancouver Island, although the island’s chief medical health officer asked for the measure. Cases have now spiked there.

Alberta had a miserable winter. By December, with 20,000 active cases, hospitals were filling up rapidly, and spillover field hospitals were being readied in Edmonton and Calgary. Premier Jason Kenney was forced to act, shutting down restaurants and gyms. Not everyone was happy about that. On Jan. 12, Kenney was a guest on Danielle Smith’s popular 770 CHQR Calgary talk radio show. Smith, the former leader of the Wildrose Party, peppered him with complaints about Alberta’s health restrictions: It’s not fair to rural people. Saskatchewan isn’t so strict. Allow curling like you did the NHL bubble! I can’t drop off Christmas gifts to my in-laws. “For heaven sakes, premier,” she protested, “I cut my own hair yesterday because I have no idea when you’re going to allow me to get a haircut again.”

Kenney had spent much of Alberta’s second coronavirus wave on Smith’s side of the argument, where much of his United Conservative Party base resides. He was forced to pivot to talking about the grim reality in hospitals. Six hundred COVID hospitalizations could quickly become 1,200 and 2,400, he told Smith. “We were on a fast train to a disaster in the health-care system.” But with case counts down thanks to restrictions, and the pressure on Kenney mounting, the province announced two days later that hairdressers and nail studios could reopen. After some rural restaurants defiantly opened in late January, Kenney eased dining restrictions, too. He is at a new low in public opinion polls. His management of the pandemic wasn’t effective enough to please Albertans aghast at hospitals under strain, and it was too intrusive to please the libertarians. A few of his party’s MLAs have joined a pan-Canadian group called the “end the lockdown” caucus. In late February 2021, there were rallies of unmasked anti-lockdown protesters in Edmonton and Calgary, some of them carrying tiki torches like those seen in the 2017 Charlottesville, Va., white nationalist rally.

In Ontario, Premier Doug Ford has likewise been caught between libertarians who hate lockdowns and doctors who blame him for being too slow to act. Ford ordered most of the Toronto area into lockdown in November, but it proved ineffective. While small businesses were closed, big box stores stayed open. National mobility data compiled by Environics Analytics for Maclean’s shows clearly why Ontario numbers kept going up in November: the restrictions didn’t keep people home.

Using anonymized mobility data drawn from cellphone apps of residents over the age of 15, the company measured what percentage of people are “out and about”—the term Environics uses for anyone who ventures more than 500 m from home. The overall number barely budged after a Nov. 23 lockdown: 61 per cent of people were out and about the week before; the number was only slightly lower the week after. Only when the province imposed a stay-at-home order in early January did those numbers drop, but just over 51 per cent were mobile.

Each city’s story is more complicated than topline numbers. Essential workers can’t stay at home, and the residents of wide swaths of suburbs on Toronto’s periphery—those in Scarborough, North York and Etobicoke—were more likely to be on the move. In Montreal, city-wide data from Environics shows that restrictions enacted on Sept. 23 had a moderate effect—65 per cent of residents were out and about before the new rules, and 59 per cent afterward. The real difference-maker was a province-wide curfew imposed on Jan. 9. The next week there was a 14 per drop.

Alberta was an outlier; in Edmonton,
Dr. Stephen Freedman, a pediatric emergency medicine physician, gives a COVID-19 swab to a five-day-old baby in Calgary on Aug. 14, 2020.
Environics data reveals stubborn resistance to government instructions to stay at home. Last March, in the thick of the province’s first lockdown, 56.6 per cent of Edmontonians were out and about. November’s restrictions brought a barely two per cent drop from the 67.6 per cent who were on the move.

What the analysis shows clearly is that curfews and stay-at-home orders were more effective at keeping people home than loose guidelines. The provinces west of New Brunswick had been too slow in the spring of 2020, and they were too slow again in the fall.

McNeil said his province succeeded because he and Strang had established their credibility in the first wave, making the right moves at the right time. “They’re reassured that if something happens, we’ll act very quickly,” he said.

In mid-December, there was an outbreak at the same Cargill meat-processing plant near High River, Alta., where around 950 employees had tested positive for COVID in the spring. Alberta had shut the plant on April 20, hours before announcing the death of 67-year-old Hiep Bui, an immigrant from Vietnam who had spent more than 20 years working there, picking bones from hamburger. Another worker, Benito Quesada, a 51-year-old who immigrated from Mexico, died in May. His daughter, Ariana Quesada, filed a police complaint against the plant in January, alleging the company made it impossible for workers to do their jobs safely. The RCMP is investigating. But when another outbreak occurred at the same plant in December, Alberta Health Services didn’t close the plant. It didn’t make the outbreak public until February, when there were 11 cases.

Here is a comparison from the other side of the country. On Dec. 9, just a week before Cargill’s outbreak, four workers tested positive for COVID-19 at Eden Valley Poultry in Berwick, N.S. McNeil closed the plant and sent in staff to test all employees and as many people in surrounding communities as they could manage. The plant reopened 10 days later.

In November, Andrew Morris became convinced that provinces were taking the wrong approach. Morris, the medical director of the Antimicrobial Stewardship Program at Sinai Health-University Health Network in Toronto, has played a key role in figuring out the best way to treat COVID-19 in Ontario hospitals.

He argued in his weekly email newsletter for a more aggressive strategy: stopping interprovincial travel and restricting travel between regions within Ontario, creating COVID-free bubbles. The premiers did not take his advice. “It’s all based on decision-making,” he said in an interview. “You know, you can close borders or you can take control of them. A strategy like the Atlantic Bubble, it’s harder in Ontario and Quebec, and B.C. to some degree. But these were decisions, right? These were absolutely decisions that were made to not try and control the virus.”

The inaction of the premiers had terrible consequences, and nowhere were they felt more than in long-term care homes.
Pulling off the impossible

Natalie Donaldson was torn between two essential roles: parent and sole family breadwinner.

AS CONCERN OVER the coronavirus ratcheted up last spring, so did Natalie Donaldson’s anxiety. “I quickly realized the kids were picking up on it, and it was making them anxious,” says the single mom of three who lives in Toronto.

As someone who works in social services, she decided to follow the advice she often gives others: focus on what you can control. The first thing she did was limit her news consumption—the 24-7 loop of the same information wasn’t helping her mental health. The next challenge was making decisions about her job at a community agency where she is a coordinator supporting children with autism. In the spring, she was redeployed to the residential program, which meant she couldn’t just switch to working from home. And as the sole breadwinner, she couldn’t leave her job to be at home with her kids.

Eight-year-old Isaiah and five-year-old Joshua were in school, which had shifted online; Donaldson’s youngest, Eli, is two. She decided to work evening shifts so she could be at home with her boys during the day, with her mother taking over their care in the evenings when Donaldson went to work. She also decided to focus on other income streams so she wasn’t reliant on her day job. She’s a licensed life insurance agent and met with clients over Zoom when she wasn’t at her main job, and in July she started working with Instacart occasionally. By the summer, she was burnt out.

The absence of her family’s typically vibrant social life was also taking a toll. Outside of work, Donaldson was only seeing her mother to keep the risk of infection at a minimum, and the same went for her kids except for one excursion to Niagara Falls, Ont., with their cousins. When things got tough, she spoke to a counsellor. “It’s a huge part of my self-care—especially as a single parent—being able to talk through scenarios that maybe other people talk through with other members of the household or their partner,” says Donaldson. “I don’t have that luxury.”

By August, some relief came. Donaldson returned to her regular role and support sessions moved online, so she was able to work from home. In September, Donaldson sent her two older boys to school in person and resumed home care for the little one. That helped create a familiar routine for a few months—getting everyone dressed in the morning and heading out the door.

Like most other families, their Christmas looked different. Donaldson usually spends the holiday with a family friend, but this year they stayed home. She worked hard to fill her table with all the fixings—turkey, macaroni pie, cheesecake—to mark the occasion for her kids.

Now Donaldson is trying to focus on what her family can do, rather than what they’re limited by. But she is hopeful for a future where the virus won’t loom as large. “I’m looking forward to a barbecue in the park, where the kids can run around, music is playing, everybody is safe,” she says. SA
The leading companies in the country know the importance of diversity, equity and inclusion, and it goes beyond simply checking a box.
"AS LEADERS, WE WANT OUR BEST MANAGED COMPANIES TO FEEL EMPOWERED TO ACT, PAVING THE WAY FOR BUSINESSES ACROSS CANADA. IF WE WANT TO PROSPER AND SUCCEED IN THESE VERY DISRUPTIVE TIMES, WE WILL NEED THE FULL STRENGTH OF THE CANADIAN DEMOGRAPHIC AND WE WILL NEED TO PIVOT FROM THE OLD PRACTICES."

CHINMAYA THAKORE
Special Advisor, Diversity, Equity and Inclusion to Canada’s Best Managed Companies
Partner, Deloitte Private

IN A FEW WEEKS, the 2021 list of Canada’s Best Managed Companies will be announced—and that’s something to get excited about. These companies are the high-performance businesses that energize our economy, even in the toughest of times. We’re looking into their DNA and what makes them outstanding in their field, and it is clear that one of those factors is a commitment to diversity, equity and inclusion. This year, for example, 24 per cent of the new winners have a CEO that identifies as a member of a diverse group. But it goes beyond that. Deloitte’s DE&I Special Advisor to the Best Managed Companies Program, Chinmaya Thakore, explains that, “as a first step, it is critical to understand what diversity, equity and inclusion does not mean—it’s not simply a matter of checking a box or filling a quota. This is about equitable sponsorship of everyone who has an aspiration to lead and progress. Therefore, a successful diversity, equity and inclusion strategy involves accepting and implementing it as a standard practice within the culture, training, policies, skills and every aspect of running and building a successful business.” To that end, here’s how some of these companies are prioritizing—and championing—diversity, equity and inclusion in their workspaces:

- Ensuring that clients are able to be served in their language of choice—meaning hiring staff that speak more than 50 languages
- Allowing and encouraging uniform modifications for religious purposes and celebrating holidays, festivals and traditions of all cultures
- Keeping a close eye on the percentage of marginalized and other underrepresented areas in their business and continuously creating opportunities where there are gaps
- Making an effort to go beyond stereotypical hiring and creating more opportunities for women in traditionally male-dominated roles
- Going above and beyond traditional hiring by looking globally and providing immigration support, language-skills training and team-integration assistance
- Committing to inclusion, equity and diversity beyond the workplace by donating to social justice organizations and encouraging employees to follow suit with a donation-matching program

Though diversity, equity and inclusion is not the only solution to a well-managed company, it is a common success factor among companies on this year’s Best Managed list. The Best Managed community is a platform to strengthen the bonds between like-minded companies and nurture new relationships—driving Canada toward a more prosperous future.
CANADIAN BUSINESS

Get ready to meet the new Canadian Business. Visit canadianbusiness.com/thenewcb to sign up for updates and to learn more about our exciting relaunch.
Advancing Women's Leadership

Why Gender Equality Is About More Than Gender

Stephania Varalli

Six years ago, the Oxford English Dictionary officially added the term “intersectionality” to its lexicon, and in 2017, Merriam Webster followed suit — because, as it explained, “Lately, the word seems to be popping up everywhere.”

Intersectionality was actually coined back in 1989 by Kimberlé Crenshaw. A civil rights activist and legal scholar, Crenshaw wrote a paper examining how feminism and anti-racism efforts were excluding Black women, because the issues were treated as mutually exclusive, rather than overlapping. In her own words, “the intersectional experience is greater than the sum of racism and sexism.”

At Women of Influence, we hosted our own Understanding Intersectionality panel discussion in early 2018, with the goal of not only defining the term for a broader audience, but also of making clear the impact that intersectionality has. For example, reporting on the gender pay gap in Canada typically compares the earnings of men with those of women but fails to include race in the discussion, such as the fact that racialized women earn less than both racialized men and non-racialized women.

After the events of 2020 — a pandemic that continues to shine a spotlight on the disparities of marginalized groups, and a reckoning on systemic racism — conversations on intersectionality are, or at least should be, moving from understanding to action. Any approach to gender equality must be conscious and inclusive of the overlapping experiences of all those other things that make us who we are, from race, to sexual orientation, to gender identity. In simpler terms: women make up half of the Canadian population, and we need to build programs and solutions that recognize that a group of 19 million individuals aren’t all going to be alike.
Diversity has historically been viewed through individual dimensions — such as race, gender, and sexual orientation — rather than through multiple or overlapping dimensions. As society learns more about shared experiences across dimensions and layers, the compounded impact is astounding. Intersectionality is increasingly becoming a focus for many, including organizations like TD.

Understanding and advocating for intersectionality

“There’s a growing understanding that we don’t just fit into one box or category,” says Vivian Abdelmessih, Executive Vice President and Chief Risk Officer of Canadian Banking, Wealth, and Insurance at TD and Chair of TD’s Women in Leadership (WIL) Committee. “We don’t just identify as a woman or LGBTQ2+ or as a person of colour. Our identities are layered and complex.”

Intersectionality is the understanding that there are overlapping, interdependent systems of discrimination or disadvantage, and it’s through this lens that we can understand the true depth of inequity and take meaningful action toward building greater inclusivity.

As a prime example, Abdelmessih points to the “she-cession” — the term being used to describe how the pandemic is overly affecting women. “We’re seeing women and under-represented groups — minorities, immigrants, youth, low-income, and lower-skilled individuals — disproportionately impacted,” she says. “Through an awareness of intersectionality, we can see the greater impact on diverse women who are experiencing the pandemic across multiple dimensions.”

This compounding effect is one of the reasons why understanding intersectionality is imperative to advancing gender equity.

Allyship: why listening and understanding matter

“TD has a longstanding commitment to diversity and inclusion for our colleagues, customers, and in the broader community,” says Abdelmessih. “It’s core to who we are. To nurture a culture of innovation and to deliver the best outcomes, we need to engage individuals across all backgrounds, all skill sets, and all mindsets.”

Allyship is central to supporting diversity, inclusion, and intersectionality at TD, Abdelmessih notes. It’s essential in helping to remove barriers and addressing inequities.

Geoff Bertram, Managing Director of Investment Banking and Head of Financial Institutions at TD Securities, and leader of the WIL Allies pillar for TD, agrees. “Allyship starts with being open to listening and understanding where people are coming from,” he says, noting the added imperative for people in leadership positions. “Individuals at all levels, especially those in positions of impact, need to take accountability and actively seek ways to help advance the interests of women and diverse groups.”

“We have to encourage diversity of viewpoints and diversity of thought. If people know they’re going to be heard, they’ll be more confident to speak up,” Bertram adds. “Allyship is a daily action that results in a more inclusive workplace with a greater diversity of views, opinions, and people.”

TD’s inclusive culture enables colleagues to bring their whole selves to work — and it all starts with an understanding of intersectionality.

Vivian Abdelmessih
Executive Vice President &
Chief Risk Officer of Canadian Banking,
Wealth, & Insurance,
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Geoff Bertram
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TD Securities

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This article was sponsored by TD Bank Group.
How Bell Supports Women in Tech

Having diverse talent, skills, and perspectives drives an organization’s ability to innovate. At Bell, diversity includes empowering women in tech.

Anne Papmehl

Bell Canada’s commitment to diversity and inclusion (D&I) has earned the communications company recognition as one of Canada’s Best Diversity Employers, Canada’s Top Family-Friendly Employers, and Canada’s Top 100 Employers.

A key part of Bell’s D&I strategy is promoting women to leadership positions, especially within the science, technology, engineering, and math (STEM) fields. Through proactive leadership, team member resources, networking opportunities, and partnerships with organizations like Catalyst, Women in Communications and Technology (WCT), and Women Business Enterprises (WBE), Bell is empowering women to make substantial strides into STEM leadership roles.

Outstanding women at Bell

Two such women leaders are Anuja Sheth, Vice President of Business Networks and Bell TV, and Sonia Brar, Vice President of Customer Operations Strategy, Design, and Delivery. Both were recently celebrated by WCT for their outstanding STEM contributions: Sheth received WCT’s 2019 Trailblazer of the Year Award and Brar received WCT’s 2020 Innovator of the Year Award.

Sheth credits Bell’s strong support for women — which starts at the top — for her career success. “The leadership fully appreciates the correlation between fostering gender diversity and the company’s overall performance,” says Sheth. Brar agrees, adding, “The culture at Bell is one that really supports you as an individual and your unique talents versus boxing you into something else.”

Inspiring women leaders in STEM

While D&I has removed some of the structural barriers to women’s advancement, both Sheth and Brar agree that it’s equally important for women to be proactive about showcasing their capabilities, especially in STEM fields where women are underrepresented. “Organizations can do their part in creating opportunities, but at the end of the day you have to step up, raise your hand, and bring that confidence in your abilities to the table,” says Sheth.

W

omen have been disproportionately impacted by the COVID-19 pandemic, and these impacts are amplified by other identity markers like race and economic status. Women have overwhelmingly shouldered increased demands for childcare and health care, with many stepping back from their careers to do so.

What can we do to ensure unpredictable shocks like this pandemic won’t reinforce gender-based barriers to achievement? It starts with building more resilient systems that strengthen pathways for girls and women to achieve more, while easing demands on parents and caregivers. TVO, a digital learning and media organization based in Ontario, takes a holistic approach to supporting the development of women leaders through learning experiences that value representation, equity of access, and recognition of value, helping to remove inherent bias. The seeds of leadership begin early in life. That’s why TVO prioritizes diversity and inclusion in TVO Kids series like 16 Hudson and Dino Dana and TVO mPower games like Amazon River Researcher.

Education plays a critical role in developing leadership potential. TVO helps to level the playing field for girls, providing role models and opportunities to acquire skills. It unlocks possibility through quality learning resources (TVO Learn), free one-on-one math tutoring (TVO Mathify), and Ontario’s premiere online high school (TVO ILC).

The pandemic has shone a light on gender-based inequities that continue to hold women back. Broadening access to learning, fostering leadership, and empowering the next generation to value inclusion and equity are keys to change. TVO proudly lights the way.

Read the full article at innovatingcanada.ca.
Consistently ranked as one of the world’s top 100 business schools for academic research, the Beedie School of Business at Simon Fraser University (SFU) is a shining example of what happens when business innovation and entrepreneurship meet real-world challenges head on.

“SFU is an incredibly interdisciplinary university,” says Elicia Maine, W.J. VanDusen Professor of Innovation and Entrepreneurship at SFU Beedie; Special Advisor on Innovation to SFU’s Vice President, Research; and Founder and Academic Director of the Invention to Innovation (i2I) program. “It’s very oriented on problem-solving. Our motto is ‘engaging the world,’ and our students, staff, and faculty really live that.”

Blending research with real-life practice
As part of this interdisciplinarity, SFU Beedie’s core research pillars include innovation, entrepreneurship, business in society, and sustainability. “These areas intersect to make this a business school that’s unusually engaged with other faculties and with pressing social issues,” says Maine.

Maine’s focus is on helping breakthrough inventions that have come from university laboratories into the world to make real impact — and developing entrepreneurial capabilities in students facilitates this process.

The ground-breaking i2I program founded by Maine supports new ventures tackling the world’s most critical challenges. “The program seeks to unlock the latent innovation potential in Canadian universities through developing entrepreneurial mindsets in graduate scientists and engineers, enabling them to make early-stage decisions that enhance chances for successful commercialization,” says Maine.

A graduate certificate program in science and technology commercialization, i2I is designed for various pathways, from scientist entrepreneurs to champions of innovation to academics heading to tenure track. Everyone gains new perspectives and skills.

A commitment to equity, diversity, and inclusion
SFU Beedie offers a number of unique programs for both undergraduate and graduate students, including graduate business education programs for Canada-wide prospective students. These accessible programs help research scientists develop innovation mindsets.

“We’re enabling a community of researchers who have highly-specialized skills and who disproportionately include immigrants to Canada and women researchers to be better-employed and more impactful in the innovation ecosystem,” says Maine.

SFU Beedie’s commitment to equity, diversity, and inclusion is strong. “It’s a pillar in the university,” says Maine. “It’s part culture, part role modelling, and part how we do our recruiting.”

SFU Beedie is currently searching for corporate partners seeking to create bespoke executive education initiatives.

To learn more about programs and partnership opportunities, visit beedie.sfu.ca.

This article was sponsored by the Beedie School of Business.

Elena Groppa
Invention to Innovation, 2018

PHOTO COURTESY OF SFU BEEDIE

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Teamwork and Success
Go Hand in Hand

As part of the co-founding team of Borrowell, the fintech company that started in 2014, Eva Wong has become one of Canada's greatest inspirations for entrepreneurs. Read her take on succeeding in the tech and entrepreneurial sectors.

What's something that helped you succeed?
I think the biggest thing was being part of a great team. My assumption is that people are sometimes scared of becoming an entrepreneur because they don't think they have all the skills they need to be successful — but in reality, nobody does. Being part of a team and having a great co-founder was key to Borrowell getting to where it is today.

What challenges can women in your industry face? How are you overcoming them?
Unfortunately, women are still under-represented in the tech industry. At Borrowell, we recognized that under-representation was a problem. As a company we've worked to build a gender-balanced team and also create an environment that allows people to thrive, no matter their gender. There's still more work to be done, but we're very intentional about our job postings, recruiting process, and promotion criteria. Ensuring we have a diverse and inclusive culture is embedded within key processes in the company.

Resilience in Entrepreneurship

Serial entrepreneur Laurie Clark is the founder of three fintech companies: Canchek, SmartDirect, and Onyen. She shares her perspective on the impact of the COVID-19 pandemic on entrepreneurs and women in fintech.

How have entrepreneurs had to adapt to the new normal?
Nothing about being an entrepreneur is ever normal. With COVID, entrepreneurs have two or three 'new' jobs: damage control for their current business, developing new services and gaining new clients, and, often, being more engaged with kids studying from home. Entrepreneurs must be more empathetic and support staff because stress levels are sky-high. As business and personal lives merge, we must recognize everyone's doing their best and cut ourselves some slack.

How can fintech companies help empower women?
We have to mandate the number of women in our boardrooms and at the executive level. There are plenty of talented and competent women — I'm one and know many others. Companies must create support mechanisms to grow talent, and a smoother on-ramp for women who are ready to lean back in after family commitments lessen.

Let the Women Speak — It’s Good for Business

In early February, Yoshirō Mori — President of the Organizing Committee for the 2020 Tokyo Olympic Games — complained that meetings tended to drag on because the “competitive” women in attendance “talked too much.” Public backlash to his comments caused him to resign shortly after.

Mori's remarks are evidence of the lack of value and respect for the female perspective and voice that much of society still holds, and his high-profile resignation is an opportunity to promote dialogue around the ongoing biases that are hurtful to all genders. We need to begin prioritizing open, clear, and honest communication in business by addressing four key areas:

1. The lack of respect and value for voices, skills, approaches, and perspectives that are considered to be traditionally feminine.
2. The social discomfort that prevents the exhibition of traditionally masculine traits or positions of power by women, and vice versa.
3. Men not understanding what it’s like to be discriminated against based on your gender, nor the long-term implications such treatment can have in terms of mental health and self-esteem.
4. The treatment of women in the workplace, in particular when it comes to the expectation that they’ll settle for less-senior roles and responsibilities than they’ve rightfully earned.

It’s a well-accepted concept that discussing opposing viewpoints and perspectives often leads to the most innovative and effective results. If we really want to progress and succeed, everyone needs to be invited to the table — and more than that, everyone deserves the chance to contribute. Let the women speak.
When colleagues are faced with a daunting and difficult challenge, they often turn to Marina Vasiliou for guidance. They know she’ll tackle the issue head on, look at it from new angles, and collaborate to come up with a winning solution.

This is the type of leader she is — a creative, forward-thinking individual with an innovative spirit. It’s fitting then, that Vasiliou is Vice President and Managing Director of Biogen Canada, a company that’s pioneering advances in the field of neuroscience, delivering much-needed treatments to people living with serious neurological and neurodegenerative diseases.

Like the culture fostered at Biogen, Vasiliou believes that strength and progress are fuelled by diversity and that an inclusive workplace creates better results. “Biogen is a place where people can be their authentic selves and I think this is what my brand of leadership brings,” says Vasiliou. “I’m not looking for people on my team to be like me. I believe diversity and plurality of ideas are what creates innovative solutions and a winning team.”

Vasiliou joined Biogen Canada after a long and successful career in marketing and sales in the pharmaceutical industry throughout the Middle East, Europe, and the U.S. She was attracted to Biogen’s mission to be a global leader in neuroscience, its inclusivity, and its unwavering focus on providing hope to patients.

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For Biogen Canada, a People-First Culture Is the Key to Success

For Marina Vasiliou, a diverse and empowered team is vital to transforming the lives of patients with neurological conditions.

Abigail Oukier

Moments of crisis can be moments of opportunity.

Vasiliou also saw that Biogen is a company that truly lives up to its pledge for diversity. Having women in leadership roles is an important element that feeds into this, with 70 percent of senior positions at Biogen Canada held by women. “I’m surrounded by a talented group of women leaders who are adaptable and empathetic but also willing to take risks,” says Vasiliou. “Biogen sees the value an individual brings to the team and doesn’t close doors because of gender, race, orientation, or background. We’re proud of the diverse and inclusive culture we’ve cultivated at Biogen, where everyone is genuinely inspired to make a difference in everything that we do, because we care deeply.”

Pioneering neuroscience into the future

Vasiliou is excited to lead Biogen Canada into the future and to advance the company’s mission of being pioneers in neuroscience. From its longstanding history in multiple sclerosis (MS) to introducing the first disease-modifying therapy for spinal muscular atrophy (SMA) and research in devastating diseases with unmet needs such as Alzheimer’s disease and amyotrophic lateral sclerosis (ALS), Biogen continues to pursue innovation to tackle life-altering neurological diseases.

Continuing to deliver vital, breakthrough medicines and to meet the needs of patients and physicians amid the COVID-19 pandemic is equally important, and Biogen is re-inventing ways to help meet needs and expectations. The company has adopted new models and digital technologies to support patients and health care providers, including adapting how clinical trials are conducted and virtualizing customer engagement. It also plans to bring biosimilars to Canada to provide savings and contribute to the sustainability of the health care system.

“The world is changing, and we’re learning every day,” says Vasiliou. “The pandemic is inspiring new, beneficial ways of serving patients, the medical community, and the health care system. The way I see things is that moments of crisis can be moments of opportunity.”

This is precisely the kind of leadership the world needs now.
Economic empowerment for girls and women across the globe begins with education — from elementary-level schooling to financial literacy and entrepreneurship training. In impoverished communities, the work of organizations like Plan International Canada — which targets barriers to education for children, especially girls, and runs economic empowerment programs — is critical, especially during a global crisis like the COVID-19 pandemic.

The pandemic has pushed nearly 743 million girls out of school, and 11 million may never return. Plan International Canada is working at multiple levels to Stop the Setback to girls’ and women’s rights. “We’re supporting virtual learning in 50 countries, partnering with parents and health care providers to make sure girls have the support they need, and working with governments to ensure girls’ education is prioritized in COVID-19 response,” says Lindsay Glassco, President and CEO of Plan International Canada. “We do this for the benefit of girls today but let’s not forget that they’re our women leaders of tomorrow — leaders within their homes, workplaces, communities, and countries. We can’t let COVID-19 threaten their futures.”

**Economic empowerment is key to stopping the setback**

In one economic empowerment program, Plan International facilitates educational workshops for children and youth of primary and secondary school age throughout Peru, starting as young as six years old. The Scotiabank-sponsored program teaches life skills such as financial literacy, budgeting, and entrepreneurship to ensure children have a strong foundation of financial education to seize opportunities and build successful futures — for themselves, their families, and their communities.

“Our economic empowerment programs aren’t just about access to income,” says Maria Paula Ballesteros Duarte, Economic Empowerment Advisor at Plan International Canada. “They’re about critical thinking, leadership, the power to make decisions, and teaching girls and young women that their voice matters.”

Learn more about how you can Stop the Setback by visiting plancanada.ca/stoptheclock-stoptheback.

This article was sponsored by Plan International Canada.
CHAPTER THREE

Canada’s shame

‘All I can say is that on this earth there are pestilences and there are victims—and as far as possible one must refuse to be on the side of the pestilence’ —Albert Camus, The Plague

The worst things that happened in Canada during the pandemic happened in long-term care homes in April 2020. The facts are so bad that it is normal to shrink from them, to turn the page. The facts are that many people died not of COVID-19 but from dehydration, starvation, injuries or improper care. The people in power in whom we entrusted care of our elders did not protect them from infection and then did not competently care for them when they were infected.

All of us will die. Some of those who died in long-term care homes would have died before long. Their deaths were tragic not simply because they died, but because they died neglected, alone and suffering. Their loved ones were prevented by law from being at their sides to offer support or ease their path.

They died in circumstances that would cause public outrage if they were revealed in a livestock operation. It would be wrong to say they died in conditions like those in the developing world, because many people in the developing world do a better job of looking after their elders.

Many in the developed world do, too. A report published in September by the U.S. National Institutes of Health found that the death toll in Canada’s long-term care (LTC) homes was by far the highest among 12 OECD countries studied; LTC home residents made up 78 per cent of our national COVID deaths, compared to the 12-country average of 47 per cent.

This is Canada’s shame.

The first Canadian to die of COVID-19, on March 8, 2020, was a man in his 80s living in a Vancouver care centre. By February 2021, when most LTC residents across the country were vaccinated, more than 14,000 had died. If it were not for our failure to protect long-term care residents, about 7,700 deaths would have occurred in this country.

Many of the deaths happened in Quebec and Ontario. Early in the pandemic, while other countries, and some Canadian provinces, were taking steps to protect LTC residents, their governments did not act effectively, even after the first grim signs of an unfolding crisis emerged. At Pinecrest Nursing Home in Bobcaygeon, Ont., in the cottage country north of Peterborough, Ont., residents started dying in March. The virus got in, perhaps brought in by a visitor or a staffer with what appeared to be an innocent sniffle. By the end, 28 of 65 residents of Pinecrest were lost to COVID.

On April 11, a report from Dorval, on the West Island of Montreal, made it clear how bad things would get. The Montreal Gazette’s Aaron Derfel learned that residents’ family members had observed a stream of funeral vans coming and going from Résidence Herron, a private home that was so badly off it had been abandoned by frightened workers. When inspectors arrived, they found few people working, and patients in filthy diapers, so dehydrated they couldn’t speak. Families, who were spending as much as $10,000 a month to keep their loved ones there, were horrified. Quebec’s coroner found 38 residents died at the home between March 26 and April 16. The outbreaks in Bobcaygeon and Dorval made it clear that many people would die in misery and squalor if things carried on the same way.

On March 30, Ontario Premier Doug Ford tweeted: “We’re putting an iron ring of protection around our seniors.” There had been 17 deaths in Ontario care homes at that point. On April 15, with 14,860 COVID cases and 487 deaths in his province, Quebec Premier François Legault asked Prime Minister Trudea to send military help for LTC homes. Trudeau said he was considering the request. I couldn’t understand the delay. Media reports were clear: the homes needed help.

The next day I called Annie Bouchard, a retired Canadian Armed Forces (CAF) colonel. I had met Bouchard in 2010 in Jacmel, Haiti, when she was serving with the CAF’s Disaster Assistance Response Team, treating Haitians after a devastating earthquake. I had been impressed by her warm-hearted but no-nonsense approach to the tragedy, her sangfroid in the midst of heartbreaking disaster. I reached her in Luxembourg, where she is now a civilian medical adviser to NATO.

“If the premiers of Quebec, Ontario and the Prime Minister of Canada decide this is the way to go, they could solve this in a heartbeat,” she told me over the phone. “It’s just that…they need to agree this is the way to go.” She was sure the military had the capability to handle it. “When we deployed to Sierra Leone, during the Ebola crisis in 2014, not one of us got infected,” she said. “Not one of those folks got infected with the virus. So, yes, we can use PPE in a very efficient way. We are soldiers. We can do anything.”

The difficulty, in her experience, is politicians who don’t want to ask for help. “They will have to admit they are overwhelmed. They don’t like to do that.”

At the time, Dr. Samir Sinha, director of health policy research of the National Institute on Ageing and director of geriatrics at the Sinai Health-University Health Network in Toronto, was talking to officials in Ontario, urging them to act. “I have the privilege of caring for a number of Holocaust survivors,” he told me in a recent interview. “Basically, it taught me…never stay silent when you feel lives are at risk.” Sinha believes politicians delayed calling in the Forces for political reasons. “They were ready to be deployed a month before Ontario applied formally,” he said.

Lt.-Cmdr. Heather Galbraith, a family physician at Canadian Forces Health Services Group in Ottawa, was baking a birthday cake for her daughter when she got the call telling her to pack her bag. She and Maj. Karoline Martin were soon off doing “recces”—site visits to hard-hit homes in Ontario and Quebec.
Laurent Duvernay-Tardif was on the field for the final play of Super Bowl LIV, in February 2020, as confetti started to rain down. He threw his arms around Patrick Mahomes, the Kansas City Chiefs’ MVP quarterback, as cameras—followed by other Chiefs teammates, their family members and their friends—swarmed around. There were 62,000-plus people looking on from the stands, and that crowd was nothing compared to the nearly one million Chiefs fans who showed up days later for Kansas City’s victory parade. Soon after, Duvernay-Tardif was back home in Montreal, where yet another parade honoured his status as the first Quebec-born player to win an NFL championship. It was a whirlwind of unforgettable moments, which took on greater meaning given the events that followed: “I have such vivid memories of the Super Bowl last year,” he says. “First, we won—but also, it was the last time we could get together.”

Duvernay-Tardif’s teammates call him “Doc.” The offensive lineman graduated from McGill University’s medical school in 2018, but had not yet completed his residency when the COVID crisis started in Quebec. Still, he put his NFL career on hold—deferring his US$2.75-million salary—and reached out to local health authorities to offer his help. That’s how a six-foot-five, 320-lb. star athlete wound up with a part-time gig as an orderly in a long-term care facility outside Montreal, where his duties included handing out medication, drawing blood samples and inserting urine catheters. “After seeing the impact of COVID-19 first-hand, it didn’t make sense for me to play football,” he says. “I didn’t want to regret that decision 10 years from now, looking back at 2020, thinking I was spreading the virus instead of trying to fight it.”

Duvernay-Tardif’s new teammates were exhausted by work that could be as soul-crushing as it was gruelling. In a long-term care facility, he notes, a single positive COVID test can throw the entire staff into overdrive. “You basically rush to [the patient’s] room and strip them of their belongings. They’ve been confined to their room for months, and suddenly you tell them they have to go to a red zone, which is often a cafeteria arranged with stretchers. And you know the odds of them coming back, which takes a toll on the patient, obviously, but also on everyone.”

As “Doc” watched football games from home—at least, those he could catch between orderly shifts and continuing his education online at Harvard’s T.H. Chan School of Public Health—he received applause for his contributions on and off the field. Sports Illustrated named him a “Sportsperson of the Year,” awarded this year to five activist athletes who also won championships; and he was co-winner, alongside soccer superstar Alphonso Davies, of the Lou Marsh Award, which goes to Canada’s top athlete. “I’ll never be as good an athlete as Alphonso. I can barely run,” says Duvernay-Tardif, laughing. “But this year it was important to acknowledge there was something bigger than sports.”

PHOTOGRAPH BY WILL LEW
Juanita and Harold Robinson use a phone to speak with family gathered outside the window at their LTC home, on April 3, 2020. Juanita and Harold died within five hours of each other, on April 6, 2020, in North Vancouver.
The homes they visited were among the worst. It was tough for the military personnel, Maj. Martin said later in a presentation to a commission looking into the Ontario LTC disaster, chaired by Justice Frank N. Marrocco. “Those clinicians, when they went into these facilities in crisis, were taken aback,” she told the commission. “They were taken aback because there was a significant deviation from the way they were used to practising medicine.”

CAF personnel recorded their observations in a report of what they saw at five LTC homes in Ontario that was made public in May. It paints a picture of neglect and maltreatment that is emotionally difficult to absorb. The homes had been understaffed for weeks. Skeleton staff, supported by temporary agency staff, could not maintain whatever standards of care had existed before the pandemic. Supplies were kept locked up by cost-conscious management. CAF personnel observed residents who were dehydrated, malnourished, dirty, suffering from untreated injuries. They saw cockroaches and flies, and stacks of stinking, dirty old meal trays left next to patients’ beds. Infected and uninfected patients were together. Disabled residents had not been turned, or put in their wheelchairs. Staff were not using PPE appropriately or disinfecting medical devices to prevent infection.

The businesslike medical language of the report is stark:

“Mouth care and hydration schedule not adhered to.”

“Wound care supplies insufficient or locked away.”

“Feed bottle not being changed for so long the contents of the bottle had become foul and coagulated.”

“Staff reported that medications are being reported/document as being given but they are not.”

“Staff report residents having not been bathed for several weeks.”

“Significant gross fecal contamination was noted in numerous patient rooms.”

“Expired medication.”

“Observation of incident that appeared to have contributed to patient death (code blue due to choking during feeding while supine—staff unable to dislodge food or revive resident).”

For the families who had loved ones in the care homes, the report gave terrible answers to questions they had been asking since March, when the province ordered the homes closed to visitors.

When Pamela Bendell read the report, she told Maclean’s, she understood what happened to her mother. June Bendell had died at the age of 91 a few weeks earlier, on May 8, in Orchard Villa Long Term Care Home, a privately owned home in Pickering, Ont., just north of Highway 401.

Pamela got a call on May 6 from a nurse, who said her mother wasn’t doing well.

“I said, what do you mean? And she said, ‘Well, she’s not breathing properly.’”

On May 8, she got a call from another nurse. “I think your mom’s passing away,” the nurse told her.

“I said, ‘Can I not come over? I’m a couple streets away.’ They said, ‘No, you can’t.’ She... died literally while I was on the phone.”

Bendell, who is part of a class action suit involving almost 100 Ontario institutions. It was, in those first few weeks of the pandemic, among the hardest-hit. According to Durham Region data, there were 71 deaths and another 135 infections among residents at Orchard Villa’s LTC home in spring 2020, with another seven deaths and 22 infections at the Orchard Villa retirement home next door. The families believe many of the deaths could have been prevented. In many cases, there continues to be confusion about how residents died, and families don’t trust the accounts from the home.

On Father’s Day last year, Christine Tappin dropped off a care package, complete with her dad Samuel’s favourite candies, at the front door. Then she made her way to his window and watched him open it, realizing she’d forgotten the card at home. They kept chatting as she rose to leave, got into the car and drove home. “Dad, I’m home now,” she said, after parking in her garage. “Let me hear you get through the door,” he said. She did. It was the last time they spoke.

Christine’s mother, Helen, had visited her...
As Derrick Rossi waited in line for his COVID-19 vaccine, everyone standing six feet apart, he reflected on the significance of the moment. Getting vaccinated against a virus that brought the world to its knees will be memorable for most people, but it has special importance to Rossi. The Canadian stem cell biologist at Harvard helped pioneer mRNA vaccines nearly 10 years ago as a co-founder of Moderna Therapeutics (though he’s no longer affiliated with the company). Modified mRNA is a key part of the COVID vaccine; when it successfully makes its way into our cells, it carries instructions to express a protein—in the case of the vaccines, the virus’s spike protein, which prompts the production of antibodies for COVID-19. It was Rossi’s experiments in 2010, with the goal of finding a way to create stem cells, that unveiled the therapeutic possibilities for mRNA technology.

While the Pfizer and Moderna shots are the first vaccines to use mRNA, he admits “it’s not the first time I’ve dosed myself with mRNA.” Before his eureka moment, he experimented on himself: he took mRNA encoding a jellyfish protein encased in lipoplex (used in gene therapy) and “smeared it really hard” on his arm in the hopes it would penetrate his cells and make his skin glow green. The experiment failed, but he guesses it would have worked had he used a needle—intramuscular delivery—like the COVID vaccines. “I couldn’t resist,” he says. “I think it might have been the first time we ever tried to go into any animal. The first animal might have been me.” Luckily, he tried again, this time with a firefly protein injected into a lab mouse. It worked—the mouse glowed. The discovery, which built on the work of other scientists, set Rossi and his collaborators on the path to founding Moderna.

“Others may have developed mRNA therapeutics, but they would not be here at this time,” says Rossi. “The work we did launched the whole industry.”

Moderna has been successfully raising money and making deals since its inception, but Rossi has always thought that once it made a medicine that “altered the quality of life for somebody,” he’d be truly satisfied. “I guess that time has now come,” he says. “I didn’t imagine that it was going to be a global pandemic. There’s literally going to be billions of people on the face of the planet whose lives are changed significantly because of this.” Now, he feels a sense of responsibility to inform the public on the science behind the virus and vaccine, and has spent much of his time in isolation answering daily media calls to do so.

When the time came for his vaccination through his affiliation with the Boston Children’s Hospital, it was the Pfizer-BioNTech mRNA vaccine that made its way into his arm. His friends find it very funny that the co-founder of Moderna didn’t get a Moderna vaccine, he says. But Rossi is pleased because it gives him the opportunity to tell people: get vaccinated. “Don’t pick and choose,” he says. “Even if a vaccine is only 60 per cent efficacious, it’s better than zero per cent.”
Ambulance attendants wheel a patient out of Floralies LaSalle seniors’ residence in Montreal amid a coronavirus outbreak at the facility.
sold it to Southbridge, a private equity firm that lists 36 Ontario homes in its portfolio. To handle Orchard Villa’s operations, Southbridge brought in Extendicare, which manages 96 homes in Manitoba, Saskatchewan, Alberta and Ontario, including the Tendercare home in Toronto, the site of a deadly COVID outbreak this winter.

Extendicare’s first home was in Ottawa, but it expanded into the U.S. in the 1970s. In 2015, it sold its American portfolio of homes for US$870 million. It left the United States after paying US$38 million in fines to the U.S. Department of Justice and eight states for false claims. The New York Times reported at the time, “Care was so inadequate, officials said, that some patients became malnourished and dehydrated and developed infections that led to unnecessary hospitalizations.”

Bendell said the food and the quality of care at Orchard Villa “started to go downhill” after 2015. Troy Wannan, who started at Orchard Villa as a nurse in 2001 and worked her way up to managing the retirement residence next door, observed changes, too. She said creature comforts and routine sanitary procedures were cut after the home changed hands. Monthly bus trips for residents were cancelled, as were the annual spring cleanings and laundering of curtains. Carpets were no longer professionally shampooed. Private rooms were no longer deep-cleaned in between residents. “There’s carpeting that had been in the building for years. So if we had incontinent residents, it should be professionally cleaned,” Wannan said. “I was not allowed to do that.” The emailed statement from Southbridge and Extendicare said there was “a robust recreational and activity calendar for residents” before the pandemic, and that they have “always maintained spending on cleaning and housekeeping services.”

Wannan said there was pressure on her to keep beds full, which ultimately meant bringing in residents who required more care than the staff could provide. But she said the company simultaneously reduced the number of
Beyond belief
The reeve of a formerly obscure Manitoba county took centre stage among COVID deniers, splitting his community

A retired chiropractor, presented as a doctor to the crowd of coronavirus doubters, finished his rally speech to hoots, whistles and car honks. He’d commented on debunked claims that vaccines cause autism and reprogram DNA, and he’d mused darkly about the agendas of Bill Gates and the United Nations. But the emcee of the “Hugs over Masks” event was particularly excited about the “courage” of the next speaker: “My heart goes out to this politician. My heart explodes for this politician. We’ve got La Broquerie’s reeve here!”

Lewis Weiss, an auto-detailing shop owner, 55-year-old grandfather and YouTube-loving elected official, took the flatbed trailer serving as a stage in Steinbach, Man., a town that neighbours La Broquerie, Weiss’s mostly rural community. It was Nov. 14, during the height of Manitoba’s pandemic wave, when such large gatherings were prohibited. Weiss told attendees about videos with alternative theories about COVID (banned from YouTube as misinformation); about unproven “simple medicines” that “fix” the virus; about how people die all the time for all kinds of reasons. “My council did not send me here to speak, although many of them share my views,” he claimed at the rally.

The anti-mask organizers wanted a politician, any politician, to attach to their cause. With Weiss, the cause got attached to the politician—with severe repercussions. The RCMP handed the reeve a $1,296 fine for violating health orders. Premier Brian Pallister likened him to flat-earthers, and urged Weiss to accept that the pandemic was active in his area (by mid-February, it had killed 15 people in the health zone comprising La Broquerie and another county). Weiss faced calls to resign.

But he’s remained defiant, repeating to Maclean’s his use of the term “plandemic”—a conspiracy theory suggesting the crisis was intentionally created for ulterior motives—and saying he won’t pay the fine. Weiss says he’d kept views to himself earlier on, but decided to speak up as residents’ economic anxiety re-emerged in the fall. “I assure you the majority of them by far are extremely happy somebody was finally willing to say something,” he says. In January, he attended another, similar rally.

La Broquerie councillors ordered a third-party investigation, and ultimately voted 5-0 to suspend him without pay for 45 days for violating his municipality’s code of conduct. Weiss attended the November rally despite warnings not to, says Deputy Reeve Ivan Normandeau, who leads council during Weiss’s suspension: “It kind of forced our hand.”

Weiss’s actions split the community—some are now for masks, others against. Normandeau says the reeve wasn’t previously known for doubting science, but the lousy publicity has carried beyond Weiss, souring relations with nearby municipal councils. At Normandeau’s banking day job in Winnipeg, people have asked him: “Hey, don’t you live in La Broquerie?”

Weiss vows to appeal his suspension. He continues to spout misinformation about vaccines, mask usage and science. And he wonders why fellow politicians don’t doubt accepted findings about COVID the way he does, saying, “I can’t believe they would believe it.”

JM
Members of the 4th Battalion, Royal 22e Régiment provided assistance to the residents of Villa Val Des Arbres in Verdun, Que., in May 2020.
personal support workers who could be on shift at any given time. “It was all money, money, money,” Wannan said. She had loved her job. “I loved the families, the residents,” she said. But the ever-increasing workload and the worsening environment led her to resign in September 2019.

Another nurse at Orchard Villa who spoke on condition of anonymity observed that after the home was sold, adult diapers, gloves and masks were kept under lock and key. In the morning, residents would often wait to have their undergarments changed while workers asked supervisors for supplies, who in turn asked the maintenance team to unlock supply areas. “They count everything you use,” said the nurse. Some staff would buy their own equipment.

When the pandemic hit, before there were any confirmed cases at Orchard Villa, staff were told not to use up the small supply of PPE, the nurse said. In one case, the nurse recalled a manager saying, “Why are you wearing masks? You’re scaring the residents.”

In their statement, Southbridge and Extendicare noted that supply logs show they “always maintained a good supply of PPE,” and that staff were trained in its proper use and “received ongoing education throughout the pandemic.”

One day in early April 2020, a nurse at Orchard Villa was attending to a patient with a fever. After work, the nurse received a call from a family member, who said that patient was now in hospital with COVID-19. Only later did the nurse hear from Orchard Villa about the possible exposure. The nurse tested positive. So did one of the nurse’s family members, who was later hospitalized. The outbreak had begun.

At the beginning of April, Cathy Legere, a retired infection control nurse who’d worked at a children’s hospital, arrived at Orchard Villa to volunteer her services. She knew the place because her father-in-law was a caretaker.

Villa to volunteer her services. She knew the place because her father-in-law was a caretaker. Legere said they started delivering meals to the residents. “I haven’t murdered anyone, but I’m in prison.”

After the first COVID case in the home, Legere said, she pleaded with staff to move and isolate the patient, who was sharing a room with three others. It didn’t happen. Soon, the others were infected. Residents still ate meals communally, although social distancing measures were in place. During her second week, Legere said they started delivering meals to their private rooms instead. Legere didn’t volunteer for a third week. She caught COVID-19 herself. When recovering at home, she was appalled to hear of the conditions endured by her father-in-law, Nick, who survived an asymptomatic case of COVID-19. He had been moved out of his private room into a shared room. When his roommate contracted a severe case of the disease, the man wasn’t moved out. For two days, Nick watched him struggle to breathe. And when the man stopped breathing, Nick was in the room with the body for “a long, long time,” Legere said.

“Orchard Villa implemented all protocols regarding the passing of a resident at a long-term care home,” the statement from Southbridge and Extendicare said. Since September, it noted that Southbridge has directly overseen frontline care and services at Orchard Villa. It has hired two epidemiologists to support staff at homes, has staff tested three times a week and, with support from Extendicare, has in place “strong policies to fortify the quality of care residents and families receive.”

For too many of the 160,000 people in LTC homes across Canada, the pandemic brought a dramatic decline in a quality of life that was already compromised. Given that 70 per cent of long-term care residents have dementia, workers struggled to keep the infected from mixing with others. In some homes, overworked staff took away wheelchairs and canes to keep residents put. In one assisted-living home near Oshawa, Ont., staff removed door handles to keep residents in their rooms. The effects of the prolonged isolation had “really extreme collateral damages” leading to rapid physical and mental decline, Stall told the Marrocco commission. “I have spoken to caregivers who, when they were finally allowed back in, their loved one no longer recognized them.”

One resident who survived a COVID infection described a long, grim year in Orchard Villa under lockdown, trapped in a private room: “I haven’t murdered anyone, but I’m in prison.”

The pandemic hasn’t been much easier for workers, many of them precariously employed racialized people who risk infection for as little as $14 an hour, dramatically less than the wages earned by equivalent workers in hospitals. More than 24,500 staff at Canadian hospitals.
care homes contracted COVID. A source who would only speak under anonymity for fear of retribution said that, even before the pandemic, the staff at Orchard Villa were dedicated, but stretched too thin. “I’ve never seen people work so hard. When I compare it to a hospital, when you look at the pay, when you look at the workload, when you look at the responsibility, I felt like it was vulnerable people looking after vulnerable people.”

**Last spring and summer**, as COVID-19 ravaged long-term care homes across the province, several of Ontario’s major operators of LTCs took action. They hired lobbyists. Most had connections to the Ford government. Stella Ambler, a former federal MP currently seeking a nomination with the Ontario PCs, registered as a lobbyist for Southbridge, which owns Orchard Villa and other homes. Leslie Noble, one of the most powerful lobbyists in the country, was hired to represent Chartwell Retirement Residences. Earlier in her career, Noble ran two campaigns for former premier Mike Harris, who is the chair of Chartwell’s board. Andrew Brander, former director of communications for former finance minister Rod Phillips, registered to lobby for the Ontario Long Term Care Association, and Melissa Lantsman, a former Ford campaign spokeswoman who is seeking a federal Conservative nomination, registered to lobby for Extendicare.

The lobbying effort tightened an already close relationship between Ontario PCs and the industry. Former PC premiers Ernie Eves and Bill Davis have both served on LTC company boards. Michael Wilson, who was the Ontario attorney general’s chief of staff until January 2020, is a more recent entrant. Wilson, who was subject to a one-year cooling-off period under the law that prevented him from lobbying his former boss, registered to influence “any future legislative changes impacting long-term care.” He declined to be interviewed for this story but told me in an email he did not lobby his former boss.

People are not the only resource connecting government and industry. A Huffington Post analysis found LTC industry lobbyists had donated more than $30,000 to the Ontario PCs. And in the first three quarters of 2020, the Toronto Star reported, Extendicare, Sienna and Chartwell received $138.5 million through provincial and federal pandemic funding. Over the same period, those three companies paid out nearly $171 million to shareholders.

When the Canadian Armed Forces report leaked, Premier Doug Ford looked rattled. “It’s so disturbing when I read this, it was hard to get through this,” he told reporters. “It was the worst report, the most heart-wrenching report I have ever read in my entire life.” He promised action. “There’s going to be justice. There’s going to be accountability.”

Gary Will, the lawyer for the families who have filed a $160-million lawsuit against Orchard Villa, Extendicare and Southbridge, was relieved by that response. According to Will, Orchard Villa had been investigated 19 times between 2017 and 2019 by Ontario’s ministry of long-term care, so under Ford, as well as premier Kathleen Wynne. The statement of claim notes that the ministry spent 43 days investigating complaints and issued 28 written warnings, 17 voluntary plans of correction and eight compliance orders. But there were no fines or charges.
A memorial of crosses outside a care home affected by COVID-19 in Mississauga, Ont., in May 2020
Will was heartened by Ford’s pledge. “He sounded very sincere that he was going to get to the bottom of it,” he said in a recent interview. “The police were going to investigate. Charges would be laid if appropriate. I thought, okay, this is a guy that is actually going to do something.”

One thing Ford did, in October, was table Bill 218, the “Supporting Ontario’s Recovery” act, which made it harder to sue individuals or businesses, including long-term care homes, with COVID-related claims. The act set a new standard for liability—gross negligence, which is as yet ill-defined—as opposed to good old-fashioned negligence. Many observers say the act would make it difficult for courts to find against homes if they made “an honest effort, whether or not that effort is reasonable,” to protect residents.

In June, when CBC first reported that the government was planning to move to protect the operators, Will didn’t believe the story. He didn’t think Ford would block lawsuits. “I said to myself, I don’t think he’s going to do that because I think he’s quite sincere about what he said.” The government passed the bill, over the objections of families and seniors’ advocates, which ought to make life easier for the lawyers preparing to defend the care homes in court. “I would bet the lobbyists basically wrote that law,” said Will.

The industry says the law was necessary, because many homes were facing the prospect of losing liability insurance, without which they can’t operate. “Liability protection is a necessary measure to stabilize and renew Ontario’s entire long-term care sector,” Donna Duncan, CEO of the Ontario Long Term Care Association, told Maclean’s in an emailed statement. “Without it, many insurance companies will cease coverage, as they have already begun to do, putting homes across the province at risk and jeopardizing their expansion and renewal.”

The bill was necessary, said Nicko Vavassis, a spokesman for Ontario Attorney General Doug Downey, via email. “We heard from stakeholders across various sectors that this protection was necessary for them to continue their operations,” he wrote. “That said, our government believes in holding bad actors accountable.”

The province says it moved quickly to protect residents in the homes when the outbreak started, spending millions on staffing and issuing directives to tighten infection control. Critics say the measures were too little to protect residents, and testimony at the Marrocco commission suggests provincial officials failed to properly allocate and coordinate resources for testing and PPE, leading to deaths in the homes. More than 4,000 long-term care residents have died in Ontario since Ford promised to put an iron ring around the homes. In Will’s view, Ford failed to protect the residents; the new legislation puts an iron ring around the owners of homes instead.

On April 14, with care breaking down in Quebec’s homes, and 435 total deaths in the province, Legault pleaded with Quebecers to volunteer to work in the homes. “I appeal to your sense of duty to help us protect our most vulnerable,” he said.

Ryan Hicks, a law student at McGill University, answered the call. “I had two grandparents who lived in long-term care near the end of their lives,” he told me in an interview. “I was personally aware of how important it is that our elders are cared for appropriately.” So he sent an email to the West Island health authority on April 19. “My name is Ryan Hicks—I am 17 years old, healthy and would like to volunteer.” They signed him up and, after an afternoon of training, he was sent to Grace Dart Extended Care Centre in Montreal’s East End, where dozens of residents had been infected.

I met Hicks a decade ago in Ottawa, when he was a producer on CBC’s Power & Politics show. A friendly, thoughtful guy with a self-deprecating sense of humour, he was popular on Parliament Hill. He later worked as a CBC reporter, in Charlottetown and then at the National Assembly in Quebec City. He soon starts a summer job at a New York City law firm.

The week before he got to Grace Dart, staff held a short memorial service to remember 64-year-old Victoria Salvan, who died of COVID after 25 years of work at the home, one of about 27 LTC workers who died during the pandemic. When Hicks arrived, a stressed-out coordinator sent him to change into his scrubs in a converted lunchroom. Then he went upstairs into the red zone—marked by red tape—where many patients were infected.

It was not an easy day. His first patient, a woman with advanced dementia, was screaming. “She’s grabbing the bed. You can tell she’s scared,” he recalled. “We’re trying to change her because who knows how long she hadn’t been changed for? And I had never done that. I don’t have experience with that.” Hicks did what was necessary, helping the personal support worker (PSW). The next day he was so exhausted—psychologically and physically—he paused outside before going in. He wasn’t sure he could face another day. It was difficult work. “After the fifth diaper change, the PSW,
who was fantastic, said to me, okay, so can you do this on your own? And I was like, I think it’s going to take me a little bit more time.”

Canadian Armed Forces personnel were dispatched to Grace Dart, and Master Cpl. Samuel Boulet, 27, a reservist from Quebec and a medical assistant, arrived there on April 27. As at Orchard Villa and other Ontario long-term care homes where the CAF helped, military personnel ended up working closely with permanent staff and the situation got better. Boulet said you could see the improvement in the patients. “I could see people getting better. They walk more. They talk more. There were patients in the hall. That’s a good way to see that elderly patients are doing well. They eat. They move. They talk.” By the end, Boulet said, he would have left his grandfather in the hands of the people he worked with.

**Lockdown opponents often** say we should protect seniors in care while letting the virus spread in the community. That may not be possible. “We know that the strongest risk factor for whether a home is going to experience an outbreak is the transmission of COVID-19 in the communities surrounding [care] homes,” said Nathan Stall, the geriatrics expert at Sinai Health. “These are not impenetrable environments despite the most world-class [infection prevention] measures. Suppressing community transmission of COVID-19 is really essential if you’re going to prevent outbreaks.”

If both operators and governments were unprepared for the first wave, they shouldn’t have been for the second. Stall had called for Ontario to repurpose empty hotels, to get residents out of the four-to-a-room facilities where hanging blankets separated beds. Ontario took some steps, but didn’t do the things that would have stopped a second wave. “The provincial government spent the summer doing a PR tour,” said Natalie Mehra, executive director of the Ontario Health Coalition. At least Quebec trained more staff, she said. “It still has not happened in Ontario we need more than 20,000 staff.”

Ontario lost more than 2,000 LTC residents in the second wave, after 2,072 deaths in the first, the National Institute on Ageing reported. In comparison, Quebec lost 3,103, down from 4,613. Ford has announced the government will build facilities for 30,000 eventually. Some of those beds—87 new units—will be at Orchard Villa, to the shock of families involved in the class action.

LTCs in the Western provinces were also hit hard in the fall and winter. Saskatchewan had only two resident deaths in the first wave, but 84 in the second. Manitoba had three, then 468. Alberta went from 153 deaths to 1,013. The province now leads Canada with the highest percentage of its homes experiencing outbreaks, the National Institute on Ageing’s Sinha noted; “They were [all] frankly asleep at the wheel.”

The crisis in long-term care homes was a long time coming. The problem is in part clearly shows they have worse outcomes across a wide variety of clinical and process outcomes,” said Stall, “whether it’s mortality or transfers to hospital, lower levels of quality of staffing, or complaints.”

But the horrors were not confined to for-profit homes—the disaster in Quebec happened largely in public homes. And some privately operated homes effectively protected their residents.

Everyone knows what is necessary: more beds; one bed per room, to cut down on seasonal viruses; better inspection regimes, with penalties for operators who provide substandard care; better home-care programs, to reduce the number of people in facilities; improved pay and conditions for workers, so they don’t have to hustle to work at multiple homes.

There just hasn’t been the will to do it. “It’s exposed an incredible, vicious ableism in our society,” said Nora Loreto, a Quebec City activist and journalist who, since the spring, has been compiling a database of deaths in long-term care homes across the country, spending hours every night doing volunteer data entry. “People in assisted living are not a priority. They’re not a political priority. They’re not a social priority. They absolutely are not an economic priority. The reaction to those deaths is sadness, and that’s it.”

Jurisdictional struggles get in the way of solutions. The federal NDP has called for national standards, a federal backstop, to accompany an infusion of new money. The federal Conservatives say the feds should stay out of it. Trudeau’s Liberals have called on the provinces to establish minimum standards, but they haven’t said what they will do if that doesn’t happen.

Political solutions depend on pressure, which is not likely to come from the residents. Unlike health care, long-term care is rarely an important election issue. That makes it, as Stall told the Marrocco commission, an easy sector to neglect. “The majority of people who live in long-term care, with 70 per cent having dementia and 90 per cent having cognitive impairment,” he testified, “are not necessarily able to advocate for themselves. Most of them may not vote, and a lot of them may not be alive for the next election.”

*(CONTINUED ON PAGE 87)*
Terry Fox’s Dream and Legacy Live On

Canadian athlete, humanitarian, and hero Terry Fox set out on his Marathon of Hope 41 years ago to raise money and awareness for cancer research. Terry left behind a dream to create a world without cancer — one that the Fox family continues to share. Mediaplanet spoke with Fred Fox, his brother and Manager of Supporter Relations for The Terry Fox Foundation, about Terry’s legacy.

What were some of Terry’s thoughts before his Marathon of Hope?
When Terry was diagnosed in 1977 with cancer — osteogenic sarcoma — I can honestly say that neither of us knew very much about cancer. When Terry first heard the word “cancer” he was shocked; when he was told he would lose his right leg he was devastated. Three days later, on the night before his amputation, I said to Terry, “Why do you have to have cancer? Your dreams of playing basketball at a high level and going to university are coming true.” By this time, he’d had some time to think about what was ahead and he replied, “Why not me, Fred? I’ve been told all my life that I’m not big enough, not good enough. This is just another challenge I have to overcome.” Over the next 16 months of chemotherapy, Terry witnessed pain and suffering in the cancer wards that he couldn’t ignore. Then he learned that cancer research was seriously underfunded in Canada. Terry decided he needed to do something about it and began training for a fundraising run across Canada, spending close to 15 months and running over 5,000 kilometres in preparation alone. Before his Marathon of Hope Terry wrote to a friend saying, “It took cancer to realize that being self-centered is not the way to live. The answer is to try and help others.”

How do The Terry Fox Foundation and the Fox family carry on Terry’s legacy?
Before his death on June 28, 1981, Terry had achieved his once unimaginable goal of $1 from every Canadian. More importantly, he had set in motion the framework for an event, The Terry Fox Run, that would ignite cancer research in Canada, raising more than $850 million since 1980, and bring hope and health to millions of Canadians. The Foundation has a dual mandate: to maintain Terry’s visions and principles while raising funds for cancer research. With only 10 offices and 48 full-time staff across Canada, the Foundation looks to its corps of over 20,000 community and school Terry Fox Run volunteers to lead the charge on the ground, supporting the participation of close to 4 million Canadians.

If Terry were still here today, what do you think his message would be?
On July 11, 1980, Terry spoke to a crowd of 10,000 in Toronto and said, “Even if I don’t finish, we need others to continue. It’s got to keep going without me.” Terry would be proud to know that people have taken up the challenge he issued that day. He would be even more proud to know that what he started has now raised more than $850 million for cancer research. However, knowing Terry as I do, he would also remind us that our work is not yet finished — that we have projects to fund and cures to find. Terry would never have stopped trying, and neither will we.
OICR’s Renewed Strategy for Cancer Research  
Abigail Cukier

The Ontario Institute for Cancer Research (OICR) is a leader in driving innovative, collaborative cancer research across the province and around the world. The organization is building on that foundation with a strategy that focuses on developing new research tools, diagnostics, and therapies to detect cancer earlier and treat it sooner and more effectively before it spreads throughout the body.

“One in two people are going to be diagnosed with cancer in their lifetime. And with an aging population, the cancer problem will only continue to get worse. By dealing with cancer as early as possible and proactively managing it, we can increase survival rates and decrease cancer’s burden on the economy and the health care system,” says Dr. Laszlo Radvanyi, President and Scientific Director of OICR since 2018.

Born and raised in Toronto, Dr. Radvanyi was previously a researcher and professor at the University of Texas MD Anderson Cancer Center. He was also the Senior Vice President at EMD Serono and founding Chief Scientific Officer of Iovance Therapeutics. This extensive experience in both academic and industry settings makes him the ideal person to lead OICR’s strategy.

Pandemic raises new cancer challenges
OICR is focusing on using imaging, clinical trials, genomics, and proteomics to treat cancer before it spreads to other parts of the body. The organization is also building its footprint in drug discovery through innovative, collaborative cancer research across the province and around the world. The organization is building on that foundation with a strategy that focuses on developing new research tools, diagnostics, and therapies to detect cancer earlier and treat it sooner and more effectively before it spreads throughout the body.

To learn more, visit oicr.on.ca.

This article was sponsored by the Ontario Institute for Cancer Research.

Dr. Laszlo Radvanyi  
President and Scientific Director, Ontario Institute for Cancer Research

New Vaccine Helps Boost Immunity in Cancer Patients  
Melissa Vekil

For people living with cancer, COVID-19 has serious implications. Cancer patients’ immune systems are compromised, making them more vulnerable if they’re infected with the virus. It’s also difficult for those undergoing cancer treatment to self-isolate—a key method in preventing infection—because of frequent visits to the hospital.

There’s also still uncertainty on whether vaccines against COVID-19 will be safe and effective in people actively undergoing cancer treatment.

“There’s an urgent need to protect people with cancer from severe COVID-19 infection,” says Dr. Rebecca Auer, a surgical oncologist and Scientific Director of the Cancer Therapeutics Program at The Ottawa Hospital Research Institute.

That urgency is why Dr. Auer and her team of researchers from The Ottawa Hospital launched an innovative clinical trial focused on strengthening the immune system of cancer patients, to better protect them against COVID-19.

Researchers worked with the Canadian Cancer Trials Group (CCTG) at Queen’s University to design and run the trial, and secured funding and support from organizations including BioCanRx, the Canadian Cancer Society, the Ontario Institute for Cancer Research, The Ottawa Hospital Foundation, The Ottawa Hospital Academic Medical Organization, ATGen Canada/NKMax Canada, and Immodulon Therapeutics.

The trial uses IMM-101, a bacterium that stimulates the first-response arm of the immune system. Dr. Auer and her team hope that boosting cancer patients’ immune systems with IMM-101 will protect them from developing COVID-19 and other dangerous lung infections.

“We know the immune systems of cancer patients are compromised both by their disease and by the treatments they receive, placing them at much higher risk of severe complications from COVID-19,” says Dr. Chris O’Callaghan, Senior Investigator with the CCTG, who will be overseeing the trial. “These patients are unable to practise social isolation due to the need to regularly go to the hospital to receive critically important cancer treatment.”

The national, phase III clinical trial, called CCTG IC.8, has been approved by Health Canada and is available at select cancer centres across Canada.

To learn more, visit BioCanRx’s fact sheet on IMM-101 at biocanrx.com/fact-sheet-solid-tumours-auer.

This article was sponsored by BioCanRx.

Dr. Rebecca Auer  
Surgical Oncologist & Director of Cancer Research, The Ottawa Hospital

Dr. Chris O’Callaghan  
Senior Investigator of the Canadian Cancer Trials Group, Queen’s University
OncoQuest Makes Innovative Advancement in Ovarian Cancer Treatment

Tania Amardeil

Ovarian cancer is one of the most serious of women’s cancers as most patients aren’t diagnosed until the disease has reached an advanced stage. Each year, roughly 3,000 Canadians are diagnosed with this life-threatening disease. Innovations in ovarian cancer treatment are desperately needed, and research on immunological treatments is showing great promise. One such hope is OncoQuest’s oregovomab, currently in a phase III clinical trial.

OncoQuest is a clinical-stage biopharmaceutical company focused on the development and commercialization of tumour-specific products for the immunological treatment of cancer. Its lead asset, oregovomab, is an experimental murine monoclonal antibody that binds to an antigen called CA-125 in the body and on cancer tumour cells. This approach is expected to treat multiple types of cancer, including ovarian.

Promising results lead to phase III trial

OncoQuest has completed a phase II randomized study assessing first-line chemotherapy (carboplatin-paclitaxel) versus simultaneous chemoimmunotherapy (carboplatin-paclitaxel-oregovomab) in patients with stage III/IV epithelial ovarian, adnexal, or peritoneal carcinoma following optimal debulking surgery.

Potential substantial benefit from the addition of oregovomab treatment to standard-of-care, carboplatin, and paclitaxel chemotherapy in frontline treatment of the patients was supported by the magnitude of improvement evidenced by the clinical outcome endpoints in this multi-site study. Subjects treated with simultaneous chemoimmunotherapy had a clinically-significant improved progression-free survival (median 41.8 months) compared to the current standard-of-care (median 12.2 months), without clinically-significant additional side effects.

The phase III trial (FLORA-5) is now underway. It’s a double-blind, placebo-controlled, multi-centre study that’s intended to confirm the results of the phase II study and, if successful, to register the product with regulatory authorities globally and make it commercially accessible to physicians and patients.

Cancer Patients Need Access to Care Services

Jackie Manthorne

The Canadian Cancer Survivor Network commissioned Léger to conduct a second survey on the COVID-19 pandemic’s disruption of cancer care in Canada. The study showed that the pandemic continues to impact the ability of cancer patients and those in the pre-diagnosis stage to access essential cancer services.

Seventy-two percent of respondents experienced a major impact on their emotional health, with cancer patients more concerned than ever about their ability to receive care. Physical health is also impacted by delays.

Early diagnosis and treatment are key to better patient outcomes. That’s why it’s important for those with cancer or suspected cancer to re-engage with the health care system for regular screenings, follow-up appointments, and treatments as needed.

It’s critical to plan for continued cancer care during future pandemics as well as other crises that may affect Canada, including pandemics and natural disasters. Safe and timely access to essential cancer care must remain a top priority across Canada during any crisis.

Visit survivornet.ca to get involved.

Prevent and Protect Your Skin From Cancer

Melissa Vekil

More than 80,000 Canadians are diagnosed with skin cancer every year, and 8,000 of those cases are melanoma, the most deadly form of skin cancer. In 2021, it’s estimated that 1,300 Canadians will die from melanoma.

The majority of skin cancer is caused by exposure to UV radiation, including natural sunlight and indoor tanning beds. The good news is that skin cancer is very treatable if caught early.

Save Your Skin Foundation, a national non-profit organization dedicated to the fight against all skin cancers, recommends the following precautions to reduce the risk of developing skin cancer:

- Always use SPF 30+ sunscreen, even on grey days
- Wear protective clothing with long sleeves, hats, and sunglasses
- Limit your sun exposure between 10 a.m. and 4 p.m.
- Don’t use tanning beds

Check your skin monthly for any abnormalities and call your doctor if you notice any changes or new moles.

Be sun safe and check your skin — it could save your life. Learn more at saveyourskin.ca.
How Servier Canada Is Pouring New Investment Into Cancer Care

As the world looks to the pharmaceutical industry for hope, Servier Canada is redefining itself as an ethical research leader with a broad mandate.

D.F. McCourt

When Chantal Boucher first left nursing for the pharmaceutical industry, her friends and colleagues questioned her decision of leaving her role as a front line worker, taking care of patients. But, in her new role as Oncology Division Head at Servier Canada, she’s found a team and a company with a patient-focused mission that leave her confident that her work is actively improving the lives of patients in Canada and worldwide.

Founded in France in the 1950s, Servier has built a name for itself as an independent leader in ethical pharmaceutical research. For over 40 years, Servier Canada has been the company’s primary North American hub, serving as a major pillar in its global operations as it diversifies beyond the fields of cardiology and diabetes care and into new frontiers such as oncology.

“We’re a privately-owned international pharmaceutical company operating in 150 countries and governed by a non-profit organization,” says Boucher. “Our independence is important, because we aren’t driven by the pressure of shareholder interest. We are able to reinvest our profits back into the company and right now, 23 percent of our proceeds go directly to research, amongst which 50 percent will be dedicated to oncology. We can do what needs to be done and remain patient-centric, as per our mission.”

New perspectives for a new mission

Boucher isn’t the only new face to join the ranks of Servier Canada’s leadership during this time of transformation and expansion. The changes go all the way to the top, with Servier U.K. and Australia alum Arnaud Lallouette taking over the reins as CEO, with a vision that carves out a large role for oncology.

“As the prevalence and severity of cancer have increased, the drug landscape has shifted and at Servier, we had to adapt,” says Lallouette. “Oncology drug launches are increasingly critical and require a dedicated approach. To be able to bring innovative solutions to patients in this therapeutic field, we need agility and speed. Operating in an agile governing model is allowing for early entry and faster approvals. To ensure prompt and effective access to innovative drugs for patients, we must know how to demonstrate value, be braced for increasingly difficult negotiations, and effectively manage the evolving stakeholder landscape.”

“Oncology drug launches are increasingly critical and require a dedicated approach. To be able to bring innovative solutions to patients in this therapeutic field, we need agility and speed. Operating in an agile governing model is allowing for early entry and faster approvals. To ensure prompt and effective access to innovative drugs for patients, we must know how to demonstrate value, be braced for increasingly difficult negotiations, and effectively manage the evolving stakeholder landscape.”

A moment of inflection for pharma

For Boucher and Lallouette, the global COVID-19 pandemic has been the backdrop for beginning their tenure at Servier Canada, and the changing role of the pharmaceutical industry in today’s society has played a considerable part in the development of new strategy. “This health crisis has reminded us just how essential our efforts are in the research and development of innovative therapeutic solutions for treating patients and saving lives,” says Lallouette. “During the pandemic, the Servier Canada team has worked diligently to ensure that we maintained support for patients, the health care professionals we serve, and our employees.”

In addition to securing supply and access for the life-saving drugs in its portfolio, Servier also partnered with Innovative Medicines Canada members to donate 100,000 N95 masks for frontline health care workers. It was a move emblematic of its broader mission to put patient and community health first in order to improve health and quality of life in Canada and abroad. For Boucher, it’s just one more piece of the puzzle reaffirming her decision to contribute to the well-being of Canadian patients by joining Servier.

“The mission of our team at Servier Canada is to always do the right thing for patients,” says Boucher. “Being an ethical pharmaceutical company means that we’re really focused on patient needs and driven by our commitment to improving the lives of patients.”

Learn more about how Servier Canada is ensuring high-quality health care for Canada’s future by visiting servier.ca.
The Next Steps for Precision Oncology in Canada

Exactis Innovation is a pan-Canadian research network that was founded in 2014 through a public-private partnership supported by the Business-Led Networks of Centres of Excellence. Its mission is to accelerate biomarker-led clinical and translational research in areas of high-unmet medical need.

Dr. Gwyn Bebb
Director, POET Program & Professor of Medicine, University of Calgary

POET Partnership Boosts Precision Oncology Opportunities

Targeted treatment has significantly improved outcomes in several advanced cancers. Unfortunately, the precision oncology revolution has yet to impact most cancer patients. Sporadic genomic testing capabilities and delayed approval for coverage of targeted drugs create an uneven national landscape. Most patients’ cancers don’t harbour targetable mutations. Disappointingly, even when accessible, these treatments aren’t curative.

The Precision Oncology and Experimental Therapeutics (POET) program at the University of Calgary has taken on this challenge. It incorporates immune response, inflammatory state, microbiome makeup, and metabolomic milieu into the equation. Fostering a relationship between Exactis and the university has been pivotal: it has generated new genomic and polyomic testing capabilities where there were few before, increasing opportunities for oncologists and patients to participate in precision medicine.

Such capability is simultaneously attracting additional investment from industry and slowing the drain of money paying for those tests outside Canada. The result is more equal access to precision oncology testing across Canada through the disbursement of federal funds.

Precision Medicine in Cancer Care

The past decade has seen the emergence of precision medicine, a complicated method of cancer treatment in which different molecular variants found in tumours guide oncologists to the use of specific therapies that target the cellular growth triggered by the variants. More than a single mutation or variant likely determines the growth of most cancers, however, and more than one single drug is necessary to gain the dramatic therapeutic benefit we need. The main challenge in expanding precision oncology in Canada is the development and implementation of better, more creative partnerships with the bio-pharmaceutical sector so that Canada’s powerful fundamental and clinical research capability, combined with rapidly-emerging tumour analytic technologies, can be optimally leveraged. While much effort, time, and money have been focused on each component individually, now is the time to establish these new and valuable partnerships for the benefit of Canadian cancer patients — and the Exactis Networks of Centres of Excellence aims to do just this.

Now is the time to establish these new and valuable partnerships for the benefit of Canadian cancer patients — and the Exactis Networks of Centres of Excellence aims to do just this.

This article was sponsored by Exactis.
NUCLEAR MEDICINE:

Ushering in a New Era of Cancer Care

D.F. McCourt

Cancer is a many-faced beast and no two cancer patients are alike. It’s a complex problem, but researchers from the field of nuclear medicine, previously known primarily for cancer diagnostics rather than treatment.

This innovation has provided a launching ground for a multi-disciplinary revolution in cancer care. With highly-trained specialists from the nuclear medicine field joining oncologists, surgeons, and nurses on the cancer team, patients can be assured that every angle of attack is being covered.

“Until recently in the cancer world, nuclear medicine was really a diagnostic field,” says Dr. François Lamoureux, President of the Canadian Association of Nuclear Medicine. “But in the last two or three years, we’ve developed new radioactive agents that can selectively kill the cancerous cells while limiting the effect on healthy cells. This is a major advancement in treating certain cancers as there’s no invasive intervention — there’s no surgery, no incision.”

**From diagnosis to therapy in one technology**

The new treatment, known as radioligand therapy, is a triumph of theranostics, a blending of diagnostic technologies with therapeutic applications. Radioligand therapy takes the same radionuclide-tagged compounds that are used to highlight cancer cells in positron emission tomography (PET) imaging and weaponizes them against cancer. Now, in addition to pinpointing the cancerous cells within the body, these compounds can be used to deliver a targeted payload that destroys these cells directly.

“The use of radioactive agents to diagnose cancer goes back 40 or 50 years,” says Dr. François Lamoureux, President of the Canadian Association of Nuclear Medicine. “But in the last two or three years, we’ve developed new radioactive agents that can selectively kill the cancerous cells while limiting the effect on healthy cells. This is a major advancement in treating certain cancers as there’s no invasive intervention — there’s no surgery, no incision.”

**The potential to treat other types of disease**

Early applications of radioligand therapy in neuroendocrine cancers have been such a game-changer that its potential is now being investigated for other types of disease. Of the many new doors radioligand therapy opens, one of the most significant is the possibility of truly effective cancer treatment with a more easily-tolerated burden of care.

“Quality of life and the burden of treatment are ongoing concerns in all types of cancer care,” says Dr. Singh. “Every patient is different, of course, and they will each have their own preferences and tolerances in terms of a treatment path. That’s why it’s so valuable to have new options available to us to create a treatment plan that works for each patient. Moving forward, this will become a very powerful option to have at our disposal.”

**A bright new day in cancer care innovation**

With the world’s top scientists and brightest minds forging bold new developments in cancer treatment technology, there’s genuine cause for optimism that tomorrow’s cancer care, and even today’s, will be even more advanced and effective. And, critically, from the patient perspective, it will also be significantly easier to tolerate. For those battling cancer, this represents a huge leap forward in both quality of life and quantity of life.

It’s rare for a new technology to deliver on so many levels, so it’s with good reason that radioligand therapy is being held as a beacon of promise for cancer care and cancer research alike.
A Phase III Clinical Trial (FLORA-5) for Advanced Ovarian Cancer

Ovarian cancer is categorized as advanced once the cancer has spread away from its site of origin in the pelvis. OncoQuest is grateful to all the listed investigators in Canada for participating in FLORA-5, which begins enrolling on May 1, 2021. Many clinical trials are currently taking place to look at new ways to prevent, find, and treat ovarian cancer. Talk to your health care team to find out if you’re a candidate for clinical trials.

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For more information, visit clinicaltrials.gov.

Kidney Cancer Canada: By Patients, for Patients

Vladimir Belochkin & Christine Collins

Two patients with kidney cancer, Deb Maskens and the late Tony Clark, met by chance in a Princess Margaret Cancer Centre waiting room in 2006. They made a goal — to form a small, onsite support group. From two patients, it became four, and by 2011 their group numbered over 2,000 members across Canada.

Kidney Cancer Canada continues to grow and thrive — a national community of patients, caregivers, and health professionals who work together to provide every Canadian touched by kidney cancer with support, information, education, and advocacy for treatment options. Programs and services are bilingual. An annual national forum and webinars feature medical and treatment information from Canada’s top kidney cancer doctors as well as resources on cooking, nutrition, exercise, mindfulness, and stress management. Peer support and Coffee Chats offer a safe environment for patients and caregivers to meet virtually and discuss all topics. Kidney Cancer Canada’s website has a wealth of information, like the Video Knowledge Library, which provides information and answers to every question by leading doctors.

“The support received, from informal Coffee Chats to updates on the latest research and treatments, has been a lifeline,” says member Eve N. “Just a phone call away, Kidney Cancer Canada connects us all, so you know you’re not alone.”

Kidney Cancer Canada also funds innovative research through support from generous donors including patients, caregivers, family members, friends, and the Warren Y. Soper Charitable Trust, teaming with the Kidney Cancer Research Network of Canada, a nation-wide collaboration of doctors and researchers committed to finding better diagnosis, treatment, and hopefully a cure.

This article was sponsored by Kidney Cancer Canada.

We’re Here to Help

Virtual National Patient & Caregiver Annual Forum - Spring 2021

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Donations gratefully accepted
Research Is a Lifeline for Children with Cancer

Melissa Vekil

Ashton was five years old when he was diagnosed with stage IV thyroid cancer — unusual and very rare in children, especially with the level of progression that was found. Ashton’s treatment involved a difficult surgery to remove the tumours and multiple doses of radioactive iodine therapy. While he resumed normal life for a couple of years, the treatments were ultimately unsuccessful.

Luckily, Ashton had access to an incredible care team of doctors, surgeons, oncologists, and endocrinologists who immediately began exploring alternate treatment options. His doctor found a new clinical trial, and through the perseverance of his team, Ashton was enrolled. Suddenly, a new lifeline opened for Ashton.

Last October, Ashton’s scan showed a dramatic difference and a reduction of his cancer, and he is back to himself again — an active 11-year-old boy who loves gaming, soccer, and horseback riding.

Stories like Ashton’s are the driving purpose for Childhood Cancer Canada, a foundation dedicated to creating victories for children with cancer through investment in lifesaving research, education, and community programs. Since 2006, it has been the primary charitable funding partner of the C17 Council, which focuses on improving outcomes and quality of life for children and adolescents in Canada with cancer and blood disorders.

Gabby’s story

Gabby was a fun and bouncy child. She loved baking, reading, and spending time with her big sister. Just after her fourth birthday, Gabby experienced heart failure, a symptom of leukemia. She was diagnosed with acute lymphoblastic leukemia, and considered high-risk because of her extremely high white blood cell count.

Gabby went through two years of intense chemotherapy before a routine procedure uncovered leukemia cells in her central nervous system.

Gabby’s doctors suggested a clinical trial with the Children’s Oncology Group, which would introduce a new immunotherapy medication.

Gabby was the first child in Canada to join the clinical trial and receive the treatment. Her quality of life quickly improved — she was able to go to school and visit with friends, and she appeared to have the quality of life of a healthy child. Access to quality care changed Gabby’s life — she’s been off medication and in remission since 2017.

Cancer treatment is never one size fits all. That’s why access to research and clinical trials is critical for patients like Ashton and Gabby.

For support and resources, join Bladder Cancer Canada’s community at bladdercancercanada.org.

This article was sponsored by Bladder Cancer Canada.

Anybody Can Get Bladder Cancer. Know the Signs.

Breanna Perkins-Weston

On Nov. 27th, 2020, I lost my husband and father to our three-year-old daughter to metastatic bladder cancer. John was 37. When he was diagnosed 11 months prior with stage III bladder cancer, his urologist told us that he was “one in a million” because healthy, young men don’t get this disease. He was a personal trainer and group fitness instructor, worked out daily, and chased after our young daughter. When he started chemotherapy in January 2020, he didn’t complain — he just wanted to close that chapter so he could begin the next.

In April, John had his bladder removed and a new one reconstructed. His recovery was smooth and he returned to teaching. Just after Thanksgiving, he felt a pain in his back and an MRI showed that the cancer had spread. In November, he lost the use of his legs and underwent emergency surgery. He died three weeks later. For our family, and the lives he touched, his loss is immeasurable. John was an incredible father, husband, son, friend, and teacher.

For support and resources, join Bladder Cancer Canada’s community at bladdercancercanada.org.

Blood in the urine is the most common symptom of bladder cancer. Don’t ignore this warning sign. Not even once.

If you see red, see your doctor.

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Donations gratefully accepted.
Going full circle

James Jones recharged his career by introducing TikTok audiences to a cherished part of his Cree heritage.

PANDEMIC BOREDOM AND UNDEREMPLOYMENT led Canadians to bake sourdough, learn cross-stitch or play Animal Crossing. James Jones became a TikTok sensation.

An accomplished hoop dancer who’s performed internationally, Jones saw a calendar full of gigs and in-person youth engagements wiped out last March, and found himself housebound in Edmonton. He’d downloaded TikTok on his phone, but the 34-year-old felt a little old and uninterested in a social media app dominated by short, trendy dances. But he found a corner that intrigued him: Indigenous TikTok, where artists like him conveyed educational and cultural messages with a liberal dose of wit and self-effacement. He donned the moniker @notoriouscree and tried it out.

After his first few videos got little traction, he joined a trend that invited users to dance to the Weeknd’s hit Blinding Lights. He shook it in full regalia and three hoops in each hand, forming wings. The post exploded, with 500,000 views overnight. “It sent my account into high gear, and set everything off,” Jones says. “It’s definitely allowed me to share my story and share my message with a lot more people.”

He now has 2.6 million followers tuning into his near-daily clips. To say he’s a poster child for TikTok success is to speak literally—he was featured in an ad campaign for the app last fall that included a billboard in Toronto’s Yonge-Dundas Square.

Though he was born in Alberta’s Tallcree First Nation, closer to the Northwest Territories than any city, Jones got into traditional dances as a teenager in Edmonton’s hip hop and breakdancing scene, exposed by friends who were also powwow dancers. A mentor taught him the hoops when he was in his 20s, and his talents have landed him everywhere from the 2010 Vancouver Olympics and the Sydney Opera House to So You Think You Can Dance Canada and a world tour with the musical group A Tribe Called Red. Within weeks of the pandemic zapping much of Jones’s livelihood, his TikTok fame had relaunched his career right from his living room. The attention has brought requests for virtual performances, online speaking gigs, and various advertising campaigns and influencer sponsorships.

Hoop dancing to pop songs forms a mere fraction of his posts. More often, he’ll dance to traditional drum songs—and they draw more views. Many offer messages about Indigenous culture, ranging from pride in his long hair and braids, to land rights, to cultural appropriation.

Jones says he hears from young non-Indigenous followers who were scarcely aware of the issues he makes videos about. He hears from young Indigenous Canadians—and Americans—grateful to be reconnected with the ceremonies and traditions of their peoples, knowledge they might not have grown up with. With his hoops, and with his furniture cleared away from one end of his living room, he’s thriving on TikTok on his own terms. “We can raise awareness and tell our stories the way we want to tell them on these platforms,” he says, “just like anybody else can.” JM
Karilynn Simpson waits in the schoolyard with her son William on his first day of Grade 4 in Calgary, on Sept. 2, 2020.
CHAPTER FOUR

Next time

‘The health of the people should be the supreme law’ — Cicero

On April 17, just five days after British Prime Minister Boris Johnson was released from hospital, where he had been treated for COVID-19, the U.K. government made an announcement: it had established a vaccine task force, whose members included Sir John Bell, a Canadian immunologist and professor at Oxford University. It had been a challenging spring for Johnson, who had made a point of shaking hands against public health advice, and wagered on a herd-immunity approach that would allow the virus to move through the community without overwhelming the health-care system. Midway through April, after a report from Imperial College London predicted disaster if things continued as they were, the government changed gears.

Dr. Alan Bernstein watched the announcement with interest. A month earlier, the U.S.’s Food and Drug Administration had approved clinical trials for Moderna. “I read about the vaccine task force in the U.K. and I know people who were on that,” he said later in an interview. “So I talked to them and that’s when I decided to write [to the Canadian government].”

Bernstein is the president and CEO of CIFAR, a Canadian research granting organization. Before that, he headed an HIV vaccine organization in New York, and the Canadian Institutes of Health Research, a federal agency. He knows a lot about vaccines, and a lot about how government works. He sent an email to Canadian officials suggesting that Canada follow the U.K. lead. “The government acted very quickly,” he said. “There was a mandate and co-chairs were put together and it went through cabinet... It took them about three or four weeks to do all that, which for the government is pretty fast. And we started, and it ruined my summer, basically.”

Bernstein and the other task force members—pharma executives and scientists—met online twice a week, going through submissions from would-be vaccine manufacturers—hundreds of pages of documents—looking for winners. There have been complaints from unsuccessful Canadian applicants, but the task force members say they were prioritizing companies that had the capacity to produce. They found them. The task force made recommendations to the government, which negotiated the deals. That led to contracts with eight companies, including five that by February 2021 would either be distributing vaccines or awaiting Health Canada approval: Moderna, Pfizer-BioNTech, AstraZeneca, Johnson & Johnson and Novavax.

Canada ensured access to huge numbers of vaccines—eventually. In February, Canada was trailing not just Israel, the United States and Britain, but France, Germany, Morocco, Turkey, Serbia and Chile. Canadians could see, every day, evidence of rapid progress in the United States. For most of the pandemic, Canadians watched the U.S. bungle pandemic management: the United States had three times Canada’s death rate, and a number of Americans poisoned themselves with bleach after one particularly inane comment by their president. But, as if by magic, when Trump left, the U.S.’s pandemic response improved dramatically. Within a few weeks, the New York Times was asking if the Biden administration was being ambitious enough in administering 1.7 million vaccines per day; it quoted experts who thought three million a day was a feasible goal. As of Feb. 19, Canada had distributed 1.8 million vaccine doses. The United States government had distributed 78 million.

The opposition attacks wrote themselves. “Let’s say then the U.S. is 10 times the population,” he said. “So they have 10 times the buying power we do. So where we’re buying a total from any one company of 40 million vaccines... Let’s say then the U.S. is buying 400 million. If you’re the company, who are you going to pay more attention to? I think the answer’s obvious.”

When cranky Canadians were asking Trudeau to explain the delays, the pharmaceutical industry had an answer: federal drug policy. A few days after Christmas, the industry complained. “New drugs are not being launched in Canada, clinical trials have declined and investments in our vital life sciences sector are being scaled back,” warned an industry lobby group called Innovative Medicines Canada. In January, just before Pfizer announced delays in planned vaccine deliveries, the Financial Post ran a scathing op-ed by Paul Lucas, the retired head of GlaxoSmithKline. He blamed generations of Liberal governments for “hollowing out” pharmaceutical innovation in Canada by eroding patent protection and favouring generic producers who sell cheaper drugs.

Sharon Batt, a writer and researcher in Halifax who focuses on the role of patients’ advocacy organizations in pharmaceutical policy, pointed out that big companies oppose reduced prices. “They obviously don’t want to lose money. The whole idea is to pay less for drugs,” Batt said. “Why would the industry want that? They’re fighting tooth and nail.”

Big pharma doesn’t like the new pricing measures proposed by the Liberals for the Patented Medicine Prices Review Board, a federal agency established in 1987 to keep drug costs down. They are likely also unhappy with the 2019 Liberal election promise to “take the critical next steps to implement national universal pharmacare,” which can be expected to be bad for drug companies (if the Liberals actually do it—most Liberal MPs voted against an NDP motion calling for pharmacare in February).

As Pfizer cut January vaccine deliveries, it called for Ottawa to cut corporate taxes, and criticized the CRA for being too aggressive in
Leo is out playing softball on a warm February afternoon near Phoenix. Infielders are required to wear masks, while outfielders stand far enough from other players that they can take theirs off. The benches are empty; everyone has to sit in their own lawn chair. And bring their own bat. “I’m not a home run hitter, but I can still run fast at my age,” says the 69-year-old from southern Ontario. “I usually play back home, too, but not this past year.”

His wife, Elaine, also 69, stays active with cycling and water aerobics, and the two go on walks without fear of slipping on ice.

Elaine and Leo were among a shrunken flock of snowbirds to fly south this winter—and “fly” is used literally in this case. With the Canada-U.S. land border closed to non-essential travel, they had to take a plane for their ninth winter down south. They had their car shipped to meet them.

The Canadian Snowbird Association estimates that 70 per cent of would-be travellers stayed home this year, and those who forged on paid a price in social media backlash. It began when a few sunseekers made tone-deaf complaints about having to quarantine upon return: the critics piled on, some saying returning snowbirds would put others at risk, some simply venting their envy. (Elaine and Leo’s adult children warned them that speaking with Maclean’s would expose them to abuse; we agreed not to use their last names.)

“People are so viciously negative about snowbirds, as if we’re criminals,” Elaine says. “We didn’t break any laws. We were free to leave the country and return.”

They arrived in mid-October, just as Arizona’s second wave was starting, riding out the worst of the pandemic in their over-55 community where they own a second home. They don’t eat at restaurants—not even on patios. They wear masks and invite only one couple at a time to visit. This despite relatively lax restrictions in their region: “Everything is open here. You can do anything—but we choose not to,” says Elaine. “We chose to stick by the rules we lived with all summer in Canada.”

A few people in their community tested positive, including friends who were sick for weeks. But whatever fears Leo and Elaine had about contracting the virus dissipated after early February, when they drove to the Arizona Cardinals’ football stadium parking lot for their second dose of vaccine, which they received without having to step out of their car. “It felt liberating,” Leo says.

Elaine is disturbed by Ottawa’s new requirement that travellers to Canada arriving by air stay several nights in a hotel while awaiting COVID test results, describing it as “forcing people into imprisonment.” But the rule won’t affect them, because they’re driving home. They need only provide Canadian border security with a recent negative COVID test result, take another test at the border, then self-isolate at home for two weeks. Leo says they’re happy to comply.

In all, they have no regrets—save their concern, as Elaine puts it, “that some people back home paint us with a bad brush.”
Dog days

We all know who the real star of this intolerable year has been: your loving, Zoom-bombing pet.

FOR ALL THE tales of scientists and snowbirds, frontliners and queue-jumpers, deliverers and delinquents, every stay-at-home knows, deep down, who the main character is in their pandemic story.

No, you have abjectly not been the lead in your own quarantine show. Your partner? Your roommate? Your kids? Your loud neighbours? Your new-found, Zoom-background-enhancing plant friends? These are but supporting actors.

We all know who the real star is: your pet.

For your dog, these are the glory days. If there used to be other sorts of days, when you left the house for ungodly hours at a time, when she could not rest her chin on your knee at any moment, she has wiped them from her short memory.

The rare occasions when her human “goes on an errand” or “attends an outdoor gathering” raise serious alarm bells. Obviously, your prolonged departure—more than five whole minutes now—indicates you have passed away from this world, never to return. Let the grieving process begin, one baleful howl at a time.

All is forgiven upon your return, because never has a pup experienced such a wealth of attention. Excuse me, you can play in the middle of the day? Wait, you’re free for another walk? Can I have another treat? Can I? Can I? Never has a pooh ever experienced such bliss.

Now that you share a prison, your cat has seized every opportunity to bend you to his will or, as he sees it, enforce the correct way of things. Daily activities such as “working remotely,” “being on the phone” or “doing exercise” cannot compete with his affections. (It turns out the space beneath a downward dog is particularly comfortable.) No, you are not authorized to remove him from any of his favourite spots. As a fully fledged member of the household, he will be taking up an entire couch cushion, thanks. A “cat bed”? How dare you. But also, how dare you remove it; it is pretty cozy.

Your feline must approve any departures from the room, so that he may accompany and monitor you. You may without notice be summoned to open the outside door, so that he may position himself on the threshold, two feet inside, two feet outside, and contemplate life. Yes, it is imperative that your warm lap and warm keyboard remain available for sitting at any time. Yes, he will keep trying to eat the plant—even after you unforgivably moved it to higher ground. And, oh yes, he has been practising his vocal skills in the quiet of night. So nice of you to notice.

You may have joined thousands of your fellow citizens in adopting a furry companion during the pandemic, to stave off loneliness and add joy to your day-to-day. Or maybe your critter was already a long-standing member of the family. Either way, one thing’s for sure: during a time of so much monotony, stir-craziness, grief and boredom, they couldn’t be happier to have you wrapped around their little paw.
Think You've Been Harmed by Products Containing Imerys Talc?

Your Rights May Be Affected and Your Injury Claims May Be Eliminated. Your Vote Will Help Determine How Injury Claims are Treated.

Submit Your Vote by March 25, 2021.

IF YOU HAVE A TALC PERSONAL INJURY CLAIM, your rights are affected by an upcoming vote on a plan of reorganization (the “Plan”) as part of the bankruptcy proceedings of Imerys Talc America, Inc., Imerys Talc Vermont, Inc. and Imerys Talc Canada Inc. (collectively, the “North American Debtors”). Imerys Talc Italy S.p.A ("ITI") may also file (but has not yet filed) a chapter 11 case in the United States. “Debtors” means the North American Debtors and, if it files a chapter 11 case before the Plan is confirmed, ITI. Capitalized terms used but not otherwise defined herein have the meanings ascribed to them in the Plan, which is available at ITArestructuring.com (the “Case Website”).

THE DEBTORS FILED A DISCLOSURE STATEMENT (available at the Case Website) containing information that will help you decide how to vote on the Plan, which proposes to set up a trust to resolve all Talc Personal Injury Claims. Your legal rights will be affected if the Plan is approved.

Only holders of “Talc Personal Injury Claims,” or their attorneys on their behalf, are entitled to receive a ballot to vote on the Plan.

IF THE PLAN IS APPROVED BY THE BANKRUPTCY COURT AND THE DISTRICT COURT, all Talc Personal Injury Claims will be channeled to the Talc Personal Injury Trust and resolved pursuant to the Trust Distribution Procedures. If you are the holder of (a) a Talc Personal Injury Claim and you vote to accept the Plan, (b) a Claim that is presumed to accept the Plan, (c) a Talc Personal Injury Claim and you vote against the Plan and do not opt out of the releases, or (d) a Talc Personal Injury Claim entitled to vote for or against the Plan and you do not vote for or against the Plan and do not opt out of the releases provided in the Plan (subject to certain limitations described in the Plan), you will be presumed to grant the “Releases by Holders of Claims” set forth in Article XII of the Plan. Please read the Plan and other Plan Documents carefully for details about how the Plan, if approved, will affect your rights.

YOU HAVE THE RIGHT TO OBJECT TO THE PLAN. The deadline to file an objection is May 28, 2021 at 4:00 p.m. ET. There are requirements that must be followed to file an objection, which are set forth in the Voting Procedures Order. Objections received after the deadline may not be considered by the Bankruptcy Court and may be deemed overruled without further notice. You can obtain additional information or instructions, review the Plan Documents, or obtain a solicitation package with a ballot to vote, by contacting Prime Clerk.

Imerys Ballot Processing Center
c/o Prime Clerk LLC One Grand Central Place
60 East 42nd Street, Suite 1440 New York, NY 10165.
Visit: ITArestructuring.com
Request More Information: imerysinfo@primeclerk.com
Request Ballot with Solicitation Package to Vote on the Plan: imerysballotrequests@primeclerk.com
Call: (844) 339-4096 (Toll-Free) / +1 347 919 5767 (International)
Karl Kuhnlein, 90, wears a party hat to receive his vaccination on Feb. 25 in Calgary; he’s looking forward to playing pool with friends.
that in August. “What vaccine was he talking about and what capacity was he referring to?” he asked. “It must have been that project with CanSino.”

The government is renovating the Montreal facility, and has reached a deal to produce vaccines there for Novavax, although not until later this year. “I’m not going to get into a discussion about whether you guys did the right thing or the wrong thing,” Bell told CTV’s Evan Solomon in January. “The reality is you don’t have enough vaccine. You know you need to get on with it.”

Whatever the government needed to do to get vaccines on time, it didn’t do.

The two big countries that have done the best on pharmaceutical solutions—the United Kingdom and the United States—failed in every other way to deal with the pandemic, and lost many more people. They bungled the non-pharmaceutical interventions—like masking and social distancing—and succeeded with pharma. Governments can’t necessarily walk and chew gum and roll out national income-support programs and manufacture vaccines all at the same time.

Canada handled the beginning and the middle of the pandemic better than the U.K. or the U.S., but those countries are having a good ending. They will likely emerge from the pandemic months before we do. Their citizens will likely be taking in concerts and football, visiting relatives, singing in church and knocking back pints at the pub while we are still huddled in our homes, gaining weight, going deeper into debt and worried about variants that might cause a terrible third wave. Canada finishes the pandemic as we started it—behind the play. We have never been where the puck was going.

Dominic Cardy, who was right when a lot of people were wrong, said recently that Canadian politicians have been afraid to lead. “You’re elected to do things that are difficult,” he said. “And the failure of a lot of governments to do anything vaguely difficult in the beginning left them in a position where they were left with horrible choices from the summer onwards. And the part I found kind of shocking was a total failure to learn from experience.”

It has been a failure that has cost us dearly. By the time the pandemic is over, it will likely have cost about 25,000 Canadian lives. We faced the biggest national challenge since the Second World War, when we lost 44,000 lives, and we didn’t do as well as we could have.

We did better than a lot of countries—better than Germany, worse than Denmark—but we have so many advantages that it feels like a failure. We could have been like Australia, which lost fewer than 1,000, or South Korea, which lost 1,600, or Taiwan, which lost nine.

A lot of the countries that did well are used to worrying about threats to their national security—particularly threats from China to their national security. The people in those countries are psychologically quicker to recognize a threat because they are used to fretting about them.

Canada, for its part, is among the most blessedly peaceful countries on the planet. We have few, if any, enemies. We are rich and comfortable, and not used to having the government make us do things. That makes us slow to notice a threat on the horizon, and bad at organizing a response. It struck me that some of the people I spoke to for this article who were quickest to see how COVID could damage Canada—like Dominic Cardy, Julie Smith and Jane Philpott—have worked in developing countries, where people can’t take it for granted that everything will always be okay.

The capacity to recognize a threat and respond through collective action—more than resources—seems to have been the key. In 2019, the Johns Hopkins Center for Health Security teamed up with the Nuclear Threat Initiative and the Economist Intelligence Unit to create the first Global Health Security Index, to rank 195 countries for their theoretical ability to deal with the “emergence and spread of pathogens.” Of the top 10 countries on that list—which included the United States, the United Kingdom and Canada—only Thailand and Australia actually stopped COVID.

The U.K. and the U.S. are on the top 10 list of countries that did well are used to worrying about threats to their national security. The people in those countries are psychologically quicker to recognize a threat because they are used to fretting about them.

Canada, for its part, is among the most blessedly peaceful countries on the planet. We have so many advantages that it feels like a failure.
Cry until you laugh

YouTube star Julie Nolke used comedy as pandemic therapy—and found millions of followers along the way

Julie Nolke has been experiencing the pandemic in two very different ways. Like the rest of us, she’s worried about the scars the virus will leave behind. But at the same time, her career as a YouTube entertainer, writer and actress has skyrocketed.

This theme of duality is a big feature in her claim to fame from early on in the pandemic: a viral YouTube video that spawned a few sequels. They feature two Julies: one from the present explaining the pandemic and the roller-coaster 2020 that followed to the other, her past self. Her first video from April 2020 tapped into the grim and incredulous mood of the beginning of the crisis. It was shared widely and has 18 million views just on YouTube. Nolke’s channel exploded to more than 800,000 subscribers to date (and she was profiled in this magazine). Now, months later, her acting training is coming in handy as she starts a supporting role in a major feature film. Her success in the midst of this *annis horribilis*, she says, has been “wonderful but also surreal and challenging to juggle.”

The Calgary-born Torontonian considered ending her “Explaining the pandemic to my past self” series after part two, which aired as protests against racism took place against the backdrop of the health crisis. “I didn’t want to be known as the girl who makes pandemic videos,” she says. But it was clear the relatability of her videos hadn’t run its course just yet. The year delivered on awful news, and she would receive messages from viewers every day, asking when the next episode would grace their screens. “I had to put that pride aside because that’s what people needed. It’s what brings them joy.”

The series alone has received a total of 31.6 million views on YouTube (her total channel views hover around 95 million). The success of her series might go beyond relatability and entertainment. Watching innocent past-Julie assume things can’t possibly get worse, while sharing the headspace of the wiser, often traumatized (and sometimes drunk) present-Julie, gives the viewer power during a time they’ve been stripped of it. “I do think that comedy is therapeutic, and my videos have been a way for people to process,” she says. The viewer is in on the joke, she says. They don’t feel like it’s made at their expense, which works when “people’s psyches are so fragile.” Rewatching her videos months later is like opening a time capsule from the worst year ever, packaged as a laugh—just in case you’d forgotten that Beirut blew up and a certain “Notorious RBG” died.

Part four, released at the end of 2020 when vaccine approvals were in the news, makes a cheeky nod to Nolke’s ironic real-life situation: as the world’s circumstances improve, her career-boosting series will likely come to an end. “I hope you brought a parachute, because we’re going to nosedive into obscurity,” says December Julie.

Still, a lot has changed since that last video: the U.S. Capitol riots and the more contagious virus variants brought new fears to the masses—more than enough fodder for another video. “I think I might have to make a part five,” she says. “But boy, I wish I didn’t have to.”
not political ones.” The government didn’t mean to dismantle our pandemic alarm system, in other words. It happened, as many things do, secretly, apparently without the knowledge of our elected representatives, who might have found out about it if they were interested. But it was not the government’s fault. Federal bureaucratic institutions are reflexively secretive, because openness leads to accountability. MPs of all stripes put up with this, often because it doesn’t serve their partisan ends either to delve into the details.

The provincial record was no better. It may be bad luck that the pandemic, which hit cities hardest, happened when all the provinces from Quebec to Alberta were governed by parties dominated by rural caucuses. Caught between public health advice and a desire to please voters bridging at restrictions, they opted for “balance,” which meant ineffective measures, which led to more contagion, more restrictions, more deaths.

There is reason to fear that worse pandemics lie ahead. Mike Ryan, the Irish doctor in charge of WHO’s emergency response to COVID—who eloquently warned leaders to be proactive back in March 2020—warned in February 2021 that, because of climate change, we are creating the conditions in which epidemics flourish. “We’re writing cheques we cannot cash as a civilization for the future,” he said. “Someday when we are not here, our children will wake up in a world where there is a pandemic that has a much higher case fatality rate, and that could bring our civilization to its knees.”

It would be nice to think we would learn from this and be better prepared for that next, inevitable threat. After Ottawa mismanaged the Spanish flu, Vincent Massey called for the establishment of a federal health department, and the government responded. We can likely count on governments responding to this disaster, too, with new measures that will improve our resilience, but none of the fixes will be eternal. Our governments are run by politicians, whose primary goal—however much they talk about making decisions for

the right reasons—is winning votes, for the excellent reason that they can’t do anything if people don’t vote for them.

Responding to catastrophes is better politics than preventing them. A 2009 paper by American political scientists Andrew J. Healy and Neil Malhotra analyzed American electoral history in regards to natural disasters. The professors learned that voters reward incumbent politicians for spending money on disaster relief but not for disaster preparedness, because voters are myopic and to help one another. There were a lot of those people, and the good they did made a huge difference: health-care workers who slept in the garage rather than risk infecting their families; frontline workers, volunteers and Canadian Armed Forces personnel who bravely risked contagion and PTSD in hellish LTCs; people who made thousands of masks for frontline workers; the silent majority who dutifully complied with public health guidelines and stayed isolated for months.

In April 2020, when I called David Fisman to talk to him about the then-lively debate about masks, he mentioned something heartening, about the support he and other health workers were getting. When he was working long hours on models to show the public how the pandemic would move, friends would drop by with soup or samosas. “We have a friend who works in the catering industry. She’s been hitting us up repeatedly now to say, ‘Well, who do you know who works in intensive care units? Cause we want to deliver them some hot meals.’”

Fisman and I got to talking about how this pandemic compared to the Spanish flu, what life must have been like at a time when people were more accustomed to mass death than we are now, and about the lessons plagues teach us. Fisman opened his copy of Camus’s The Plague, the book I’d listened to on my drive home from Florida. A beautiful and difficult novel, it explores the suffering of a town beset by disease, and the love and solidarity that arises in the face of that suffering.

There was a passage Fisman wanted to read aloud. He flipped to the last page and found it: “Dr. Rieux resolved to compile this chronicle, so that he should not be one of those who hold their peace but should bear witness in favour of those plague-stricken people; so that some memorial of the injustice and outrage done them might endure; and to state quite simply what we learn in a time of pestilence: that there are more things to admire in men than to despise.”

With files from Marie-Danielle Smith, Nick Taylor-Vaisey and Jason Markusoff
Our commitment to you

As the world continues to change, our commitment and focus remains the same – helping to ensure the Canada Pension Plan Fund is there for generations to come. Over the past two decades our active management strategy has allowed us to build a widely diversified and resilient portfolio, designed to weather market turmoil and generate long-term returns. The sustainability of the CPP Fund remains secure.

For an update on the health of the CPP Fund, visit cppinvestments.com.

Notre engagement à votre endroit

Pendant que le monde continue d’évoluer, nous poursuivons le même objectif et restons fidèles à notre engagement : contribuer à assurer la pérennité du Régime de pensions du Canada pour les prochaines générations. Au cours des deux dernières décennies, notre stratégie de gestion active nous a permis de bâtir un portefeuille largement diversifié et résilient conçu pour résister aux turbulences du marché et générer des rendements à long terme. La viabilité de la caisse du RPC n’est pas remise en question.

Pour une mise à jour sur la santé de la caisse du RPC, consultez le site investissementsrpc.com.
They Were Loved

The magnitude of COVID-19’s impact on Canadians’ lives is difficult to fathom. Canada has already lost more than 20,000 people to the pandemic; each of those losses has cascaded through families and communities, leaving many more thousands bereaved.

They Were Loved is a years-long project to commemorate everyone who has died of COVID-19 in Canada, and every Canadian who has died of the disease abroad. In partnership with Carleton University’s Future of Journalism Initiative and journalism schools across the country, Maclean’s is striving to capture the richness of each life lost.

To read the hundreds of obituaries written to date, visit macleans.ca/they-were-loved/

If you would like your loved one to be included, please contact us at theywereloved@macleans.ca