NATIONAL CITIZENS INQUIRY

Regina, SK **Day 1**

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EVIDENCE

Witness 4: Dr. Richard Schabas
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Shawn Buckley
Well, welcome back to the National Citizens Inquiry. Those clips from the mainstream media during COVID I find to be quite chilling and upsetting. But we thought it would be important just to remind people what we were experiencing. So we'll move on to our next witness. I'm very pleased to introduce our next witness, Mr. Richard Schabas. Richard, are you able to hear us?

Dr. Richard Schabas
Yes, I can hear you fine.

Shawn Buckley
Okay. And we can hear you. So I'd like to begin with the oath. Do you promise to tell the truth, the whole truth, and nothing but the truth?

Dr. Richard Schabas
I do.

Shawn Buckley
And can you please state your full name for the record, spelling your first and last name.

Dr. Richard Schabas
I'm Richard Elliot Schabas. R-I-C-H-A-R-D S-C-H-A-B-A-S

Shawn Buckley
Now, Dr. Schabas, you are a retired physician with specialist qualifications in public health and internal medicine, am I right?

Dr. Richard Schabas
That's correct, yes.

Shawn Buckley
You were the Chief Medical Officer of Health for the Province of Ontario from 1987 to 1997, is that correct?

Dr. Richard Schabas
Yes.

Shawn Buckley
So you served for a full ten years as the Chief Medical Officer for Canada's most populous province.

Dr. Richard Schabas
Yes.

Shawn Buckley
And so as Chief Medical Officer, you would have actually planned for pandemics.

Dr. Richard Schabas
Among other things, yes

Shawn Buckley
Right. You were also head of preventative oncology for Cancer Care Ontario, from 1998 to 2001?

Dr. Richard Schabas
Yes.

Shawn Buckley
And you were Chief of Staff for the York Central Hospital during the SARS outbreak in 2003.

Dr. Richard Schabas
Correct.

Shawn Buckley
Dr. Schabas, you have provided us with your CV. We will enter that as Exhibit R-180 in these proceedings. Now, I'm wondering if, I know that you've prepared a presentation for us that I'll ask you to launch into, but before you do that, can you just share with us what your experience with SARS was?

Dr. Richard Schabas
Yes, that was actually going to be a part of my presentation, but I could certainly do that now. In 2003, I wasn't actually working in public health, I was working as Chief of Staff at York Central Hospital, which is a large community hospital in Richmond Hill, Ontario, just north of Toronto. And by sheer chance, bad luck alone, we were one of a handful of hospitals that actually was hit by SARS. We had a patient who was transferred from Scarborough Grace Hospital for dialysis without any warning that the patient might have been exposed to SARS, spread SARS within our hospital within our ICU. And so we were right in the midst of that, and we were very active in SARS.

And I was involved in a number of publications regarding SARS and regarding what I thought was the better approach to SARS. There was at the beginning of SARS, like there was with COVID, there was this atmosphere of panic in the world. And I wrote a commentary that actually was published in the Canadian Medical Association Journal, which was entitled *SARS, Prudence, Not Panic*, and I think pointed the way towards a more sensible approach to SARS.

The whole experience with SARS though was, I think, particularly fascinating and particularly relevant with regard to COVID and with regard to this inquiry. Because one of my sort of key takeaways from my experience with SARS is that we made no serious effort—as a profession, as a country, public health as a group—made no serious effort to try to examine what had happened and to learn any lessons about what had happened. Public Health simply took the attitude that SARS had come, it had gone away. Therefore, we had done a great job, let's move on. And where I found that particularly problematic was in the area of the principal public health response to SARS, which occupied most of the energy of SARS, which was the use of quarantine.

Now, let me just pause and define my terms here, because, unfortunately, a lot of terms like "quarantine," "isolation," "self-isolation," get thrown around, and rather loosely. So basically in public health response to an infectious disease, there are two kinds of procedures: one called quarantine and the other called case isolation. And they have similarities, but they also have some very significant differences.

Quarantine. And the name, ironically enough, goes back to the Middle Ages and the 40 days of Lent, which was the original quarantine period. So you can see how well-based in science this concept was. Quarantine is the idea that you take someone who you think might have been exposed to the infection—not someone who you have any reason to think now is infected, but might have been exposed, and therefore might be incubating the infection—and you put them in some kind of isolation, either a quarantine hospital or what we called in COVID, self-isolation. You simply say stay in your room for—in the case of COVID it was for two weeks.

The other thing that public health does and hospitals do is case isolation. Case isolation is different because it's dealing with someone who you think or know actually has the infection, either is sick with the infection, or is in some way tested positive. So it's the difference between someone who speculatively might be incubating the infection and someone who you know is infected. And quarantine as an approach to handling infectious diseases was basically abandoned by public health a century ago.

When I trained in public health 40 years ago, we were taught to treat quarantine with disdain, that it had no use in modern public health. In contrast, case isolation remains a useful and obvious thing to do. And in fact, it was proper case isolation in hospitals that was what ultimately controlled SARS—nothing to do with quarantine.

So the problems with quarantine, I think, are pretty obvious. The first is that it's an immensely inefficient thing to do. If we take, for example, the quarantining we did in COVID at the borders, where we forced everybody who crossed into Canada to spend two weeks in quarantine, even though the conversion rate—the proportion of those people who we subsequently learned actually were incubating COVID—was in the neighbourhood of 1 in 200.5%. So if you do a little simple arithmetic: two weeks of quarantine per person, you had to isolate people for 400 weeks—that's like eight years of quarantine—to identify a single case of COVID at a time when we knew there were tens of thousands of cases of COVID already in Canada. So, immensely inefficient.

The other problem with quarantine is that it's highly ineffective, particularly with a disease that's like a respiratory virus that you can't possibly identify all the people who are contacts. You can't possibly put them all into quarantine, so you can't possibly control the infection. So for those reasons, quarantine was largely abandoned before 2003, in fact as I said, in the early part of the 20th century.

But when SARS emerged in January and February of 2023, well, where did quarantine come from? Well, they started quarantining people in China. I don't know why, but that's what they did. And then when it spread to Singapore, they started quarantining people there. So when it came to Canada, we just said, "Well, everybody else is doing it, we should quarantine people, too." It was the monkey see, monkey do phenomenon that was so prominent throughout COVID.

And so we started quarantining people even though there was no rationale, there was no evaluation, and it was an immensely wasteful and, in the context of SARS, entirely useless presentation. Because SARS wasn't actually even infectious until somebody was not only ill, but very seriously ill. So it was a complete waste of time and effort. But public health had no interest in learning that lesson. They were much, much more contentious to say, "Oh, look at the great job we did. Let's move on. Let's just forget about the whole experience."

I didn't let it rest there. I wrote a couple of papers, which I've included as exhibits, challenging that concept. And to some extent I won that battle because the World Health Organization, when it revised the *Control of Communicable Disease Manual*—which is sort of the bible of public health infectious disease control—when they revised it in 2007 for SARS, they didn't talk about quarantine. They didn't talk about using quarantine. So at that kind of intellectual level, I won the battle. And when the World Health Organization did its review of the non-pharmaceutical interventions to prevent influenza and pandemic influenza in 2019, they said, "Don't use quarantine under any circumstances."

But unfortunately, where I didn't win the battle was in the popular mind. And by popular mind, I even mean in the mainstream medical mind. People got it into their head: "Well, we've had SARS and we'd done quarantine. Here we go, those two facts must be connected. It must have been the quarantine that worked." And so when COVID started up, everybody else said, "Well, we've got to start doing SARS. We've got to quarantine," and we did. And the quarantine around COVID was immensely wasteful: the wastage of human potential, the wastage of people's lives. The time that was spent uselessly in quarantine was enormous. And I think it's in large measure because we didn't take the time to learn the lessons from SARS.

And I very much hope that that doesn't happen. I'm worried it might happen, but I'm very, very concerned that we have to work to make sure that in fact we take the time, we put the energy, we have the humility—as a country, doctors as a profession, public health as an

area of work—we have the humility to learn the proper lessons from COVID. Because otherwise, there is every chance that come along a similar situation, we will make exactly the same mistakes again.

Shawn Buckley
Now, as far as quarantine goes, so we've just been through the COVID experience. Are you aware of any research that you would consider to be reasonable or even unreasonable that in any way supports this use of quarantine?

Dr. Richard Schabas
Well, I'm not aware of any research that was done, as I say, previously, during, or post. And furthermore, I'm not even aware of any particular interest among public health authorities, among sort of the mainstream, the people who supported the basic COVID narrative—which was most public health doctors and most epidemiologists. I'm not aware of even any interest. Now I think the data is out there. I mean, one of the advantages—there are a lot of disadvantages—but one of the huge advantages of living in the information age is the data is out there. And one of the things that I'd like to make a very strong pitch for as part of my presentation is that we need to have a national investment in learning the lessons, of going back to the science.

I know there are probably many people on this inquiry who are tired about hearing about science, about "follow the science." As I'll try to explain, I think that's because most of what was presented to us as science was not good science at all. It was weak science versus misrepresented by bad scientists. But I think the answer to this lies in the data, lies in the information. The answer is out there, but it's not going to fall into our lap that we as a country should be investing time and energy and millions of dollars, because we wasted tens of billions of dollars on the last COVID lockdown. We don't want to do that again, not if it's the wrong thing to do. And the only way we'll know for sure which was worth doing, which wasn't worth doing, and also what the harms were, is investing in doing that.

Now, I'm aware of the Canadian COVID Working Group, which is part of an international consortium which is headed out of Oxford in England, headed by Jay Bhattacharya and Kevin Bardosh. I'm part of the Canadian steering group that's trying to do this. But we don't have a budget. We're a small group of people who are dedicated to stimulating research into the harms of lockdown, and I suppose also the benefits of lockdown, if there were some in terms of disease control. But I think what we really need is a national initiative that will bring together, and again, not just like-minded people. One of the huge problems with what happened—

Shawn Buckley
And Richard, can I just focus you for a second? Can I go back to the quarantine issue? So we have SARS come along. And even though it was understood public health wisdom that you don't quarantine, that you're really just going to do damage without good, because China did it and then Singapore, we just followed suit in North America. I've got that right?

Dr. Richard Schabas
Yeah. You do.

Shawn Buckley
Okay. And then you wrote about this, you published on this afterwards. And am I correct that the World Health Organization actually paid attention and then has confirmed after SARS that quarantine is not effective?

Dr. Richard Schabas
That's right. They did not include quarantine as one of the recommendations for handling any future SARS outbreaks.

Shawn Buckley
Okay, which would include our experience with COVID. So heading into COVID, quarantine has already been debunked by you as a public health expert and the World Health Organization after SARS, but before COVID.

Dr. Richard Schabas
Yes.

Shawn Buckley
Okay, so do you think the same thing happened again then with COVID?

Dr. Richard Schabas
It's worse than that. Because I made reference to the fact that in 2019, just by chance the World Health Organization sponsored a comprehensive review of what were called the non-pharmaceutical interventions for the control of pandemic influenza and seasonal influenza. And basically, that was drawing on all the information we had about what non-pharmaceutical measures—so all of the kind of social stuff that constituted lockdown—would be useful in the context, not just of influenza and pandemic influenza, but I think more generally in a respiratory virus pandemic. Which is, in fact, what happened not long afterwards. Now although COVID is not identical to influenza, the fundamental similarities greatly outweigh the differences in terms of public health control measures. And it went through a whole range of things and assessed the level of evidence. And for, I think, everything on the list, the summary was that the evidence was either weak or non-existent.

And there were a range of things. I'm going from memory here, but there was a range of things that the World Health Organization said we should not do under any circumstances because they were not just without evidence or with only weak evidence, they were contrary to the evidence. And those included things like quarantine, border closures, and contact tracing. And yet, within a matter of a few weeks after the onset of COVID in Canada and throughout the western world, what did we do? We started quarantining, we closed the borders, and we said, "Oh, don't worry, we'll control this with contact tracing," which, of course, was absurd.

So, yeah, you may well ask, why did we completely ignore the existing science? Why did we? And people didn't just say, they went on further and said, "Well, it's proven these things work." I remember that was with masks. Now, the evidence for masks was weak. And in the WHO document for 2019, they did say that we could consider using masks in the event of a severe pandemic, but they made it clear that that wasn't based on any strong evidence at all. And yet when COVID hit and they started saying "We've got to wear masks," they said, "Oh,

it's proven they work." Not true. It was never true. It was always, always very, very speculative, and people were misled about that.

Now, that doesn't necessarily mean that encouraging people to wear masks, at least for the short term, like an influenza pandemic at any given jurisdiction that's going to last six to eight weeks—the wave, and then it'll move on. So these things were never contemplated to do for years at a time. But even if you think that it's a reasonable thing to do in the short term when you're not sure what else to do, well, that's one thing. But to tell people it's proven these things work and that therefore they must do it by law, that's a totally different thing. Again, so not only were these things not based on evidence, but people were misled about the evidence supporting them.

Shawn Buckley
I think you're touching on a really important point, and my understanding is you view that as one of the mistakes we made in COVID is actually presenting evidence as if it's conclusive, when really it's extremely weak. And do you want to comment on that further?

Dr. Richard Schabas
Sure. I've been involved in medicine now for half a century, and I would argue that the most important advance in medical science in the last 50 years has been what we call evidence-based medicine. And that's because when I was in medical school 50 years ago, we were told things, told that this is right or this is wrong, and almost always it was just based on what the opinion was of our lecturer or our professor. We did what the professor told us, or it was based on studies that we now know were actually very weak, very problematic.

And so the key things about evidence-based medicine, one of the things that gets a lot of attention is that evidence-based medicine has really promoted the idea that the best thing is experimental evidence—what in clinical science we call randomized controlled trials. They're the gold standard. They're not perfect, but they're the most reliable way of testing things. Like approval of a new drug now requires not one, but two independent randomized controlled trials. And the wealth of other evidence, the vast majority of other evidence, and virtually all of the evidence that drove the COVID response is fundamentally weaker than that.

Now that doesn't mean it's of no value, but it means we need to be cognizant of the fact that the evidence is not strong and that we have to interpret its findings with caution. And that's particularly true for two kinds of evidence that were most prominent during COVID, two kinds of epidemiological evidence. And pardon me if I get a little technical here but I think it's important.

The first is what we call ecological studies. Those are like at a population level. You look at what happened in a school, in a city, in a country. You look at what happened with some intervention, like a mask mandate or something like that. And then you look at what happened at the same time or subsequently to the COVID rates. And we call that an ecological study. And in epidemiological terms, that's kind of like a satellite photograph. It's very, very high level in that sense.

And we like doing them because they're easy to do and they're cheap to do. But we also know—and this is something I was taught in my very first epidemiology class—we're also taught that they're highly unreliable. And the value of these kinds of ecological studies is: Is it generating a hypothesis? And then you then have to go on and test this hypothesis with

more rigorous means, either by doing more systematic reviews or by doing what we call case control studies, or ideally by doing randomized control trials. But you never base public policy on ecological studies, which is, of course, exactly what we did with COVID.

The other kind are basically just case reports, just anecdotes, just good stories. And in medicine, we're familiar with case reports. They get published, but nobody takes them very seriously because they're, well, they're by their nature idiosyncratic. So I remember the example of the two manicurists who wore masks and didn't infect their clients. And that was supposed to prove that masking worked. No, no, it doesn't. It's an anecdote, it's a story, it's interesting. You don't dismiss it out of hand, but you don't give it great weight either.

But if you go back through the COVID literature to the science, the so-called science, well, it is science. It's just weak science that we use to support policy. It's rife with those kinds of studies. And that's not the fault of the science, that's not even necessarily the fault of the studies. That's the fault of the interpretation that was put on the studies. It's the fault of the authors who weren't properly cautious. It's the fault of the journal editors who didn't edit this stuff out or put in warnings that this shouldn't be taken as being definitive. And mostly the fault of the decision makers—particularly the decision makers in public health who knew better, or who should have known better, or certainly were taught better as part of their training. Something they just completely ignored.

Shawn Buckley
And Dr. Schabas, if I can just maybe give an example. So when you're talking about an environmental study with masking—so for example it could be of a city—but, well they're saying that masking was introduced, and then within two months the COVID rate went down. But the study might have started in June, and we all know in June and July, the summer months, that we would expect the infection rates of infectious diseases like COVID to go down because it's summer. Is that the type of flaw in the studies?

Dr. Richard Schabas
Yeah, and that's exactly what happened. As you remember, masking was embraced with enthusiasm in April, May, and June of 2020, and a lot of places put in mask mandates. And guess what? The rates of disease went down over the summer because that's what respiratory viruses do, their rates go down. And so that "proved" that masks worked. And everyone conveniently didn't ask the same question in the fall when the weather turned and respiratory viruses normally get more active. And guess what? COVID got more active, regardless of whether we were wearing masks or not.

So yes, and I mean masking of course was the one area where in fact there was some effort, one of the very few efforts where there was an effort to do some randomized controlled trials. And there were two. There was one, a relatively small one, done out of Denmark by people who actually were great enthusiasts for masks and thought they were going to prove that masks worked. In fact, they didn't. There was a small trend to reducing infection with the use of surgical masks, but it didn't reach statistical significance.

There was a much larger study done in rural Bangladesh which had problems, a lot of problems with the methodology but was still, I think, a relatively sincere effort to look at the issue. And its conclusion was that cloth masks—which were the ones that were used overwhelmingly back in the spring and summer of 2020 when the ecological studies were claiming masks, they show masks work—show that cloth masks were completely

ineffective and suggest that there might be a small reduction in the infection rate for surgical masks.

Now that reached statistical significance with, I think, an effect size of about 10%, a very small effect size. But there were some methodological problems with that study that mean we should take it with a grain of salt. So the fact is that the mask mandates continued unabated, and the enthusiasts continued to trumpet their effectiveness, notwithstanding the fact that the evidence, even the high quality evidence, didn't really support that.

Shawn Buckley
Do you see any ethical problems with how we handled this COVID pandemic?

Dr. Richard Schabas
I see huge ethical problems. I'm very critical of my colleagues. Health professionals in general are supposed to be knowledgeable of basic medical ethics and key principles of non-malevolence. "Do no harm" is supposed to be a critical medical, a fundamental building block of medical ethics. And yet we did things like closing schools. We closed schools speculatively, speculatively. There was very little evidence that that was going to make any difference. And as time went on, in fact, I think the evidence built up that schools and children were not a main source of disease transmission.

But nobody thought, or thought very hard about the cost of that intervention. Nobody thought about the effect that closing the schools in Ontario— I mean, my granddaughters in Ontario missed the equivalent of about a year of in-school education. Nobody thought about the consequences, particularly the consequences for the more vulnerable kids, the more marginalized kids. You know, it was okay for my granddaughters who live in a big house and have computers and have parents who were highly motivated to help them. It was much harder for the kids who were locked in their little apartment in St. Jamestown with parents who were out working for Amazon or Uber Eats or whatever, providing the services, sleeping the halls in hospitals, I don't know, doing the things that kept our society going—totally different from them. So non-malevolence didn't just get forgotten about.

The other one that I find deeply offensive is the whole issue of autonomy. Autonomy of the person, the right of someone to control their own body, is extremely important. It is, for example, absolutely crucial in the debate about reproductive rights. People who defend a woman's right to choose, that's something that's based on autonomy of the person. And yet the same people were so willing to support and endorse vaccine mandates, for example, which basically coerced people into getting a vaccine which they had not chosen to get.

Maybe they were wrong not to choose it. I don't know. I think for some it was. For some it was, you know— I understand, it was a novel technology with a vaccine that was on emergency release. People, it's well within the scope of autonomy of the person, well within a reasonable person's decision—particularly a younger person who's at no meaningful risk of serious complications of COVID to begin with—totally reasonable to resist. And yet we abandoned autonomy.

And the logic, the arguments that were given to support it were, first of all, that the vaccine would stop transmission. Now I think we all hoped, certainly I hoped when the vaccines were introduced that they would stop transmission. But there was no evidence for that. It wasn't part of the clinical trials that the mRNA vaccines were based on. They didn't even look at that. So it was entirely speculative. And it became very clear very early on that in

fact there were lots of breakthrough cases and that the vaccines were not stopping transmission, and that whatever effect they had in transmission was relatively short-term and was very quickly eroded. So that was wrong.

The other argument that was put forward for the vaccine mandates is that they would increase immunization rates and protect our healthcare system. Well, I'm not sure that was true either, because even though when the vaccine mandates—for example, the federal vaccine mandate—was introduced, there was a little bump in immunization. Some people who were sitting on the fence to save their jobs decided that they would give in to this coercion and get a vaccine that they were undecided about.

But there was a whole other group of people who were undecided, and perhaps still people who could have been persuaded to accept the vaccines, who jumped the other way—people who were either fundamentally offended by the coercion or who became very suspicious of a government intervention that required this sort of coercion, and jumped the other way. And instead of being on the fence, they in fact were determined not to get the vaccine.

And we see the follow up from that now, because we now have this huge public resistance to just about everything public health says, including vaccines. Public health continues to flog the booster doses—again, based on essentially no evidence—continues to flog the booster doses, but public uptake is just about zero. It's vanishingly small. So the net result, I think, of the vaccine mandates was to undermine public confidence in public health. So that came from offending the principle of autonomy and also, of course, of informed consent.

I mean, again, informed consent means full and open information. The information about COVID, the risks of COVID, were greatly overstated and overplayed, particularly among young people. And there was a real reluctance of public health to recognize and identify some of the adverse effects of the vaccines. Probably the most dramatic of those is myocarditis, which overall is a relatively rare event with the vaccines. But in adolescent boys, it's actually not rare at all. And this is a group that get almost no benefit from the vaccine, virtually no benefit from the vaccine, and yet are facing a meaningful risk of serious harm. So that really flew in the face of the principles of informed consent as well.

Shawn Buckley
You were talking about: they basically weren't putting the risk in perspective for people. And what you mean by that is, as well, they're telling us be afraid, be afraid of COVID. But for many of the age groups, the risk was quite small of any danger. Am I right about that?

Dr. Richard Schabas
Yeah. It's not just that. I think even for older people, the risk was greatly overstated. Not that there weren't a lot of deaths, but the realities of getting older is that you get closer to death. I mean, I'm sorry, there's no nice way of putting that. And so what was never done was an attempt to put the risks of COVID in any perspective. And I had always regarded that as one of my most important jobs. Public health is supposed to look at the whole of society, the whole of population health. We're supposed to understand that health is more than just the absence of disease. We don't live our lives merely to avoid death. We lead our lives to— Because health is more than the absence of disease, certainly more than the absence of just one disease. It's supposed to be about mental, physical, social well-being. And in the case of COVID we basically threw all that well-being stuff out the window because of one disease.

And public health officials never made the effort, and frankly it's hard to do. It's really easy to scare people, particularly since if you look at COVID and you look at the literature on risk communication, COVID pretty much checks all the boxes of something that's going to be inherently scary to people. It's new, it's invisible, it's infectious, and it can kill you. And you add all those together, and it's not surprising that a lot of people were frightened of COVID. And then when public health turned around and said, "And you should be scared, and you should be scared, and even young people should be scared," then guess what? People got scared.

And then when you publish just raw numbers, again, if you're trained in risk communication, one thing you never do, you never just present raw numbers because people don't put them in any perspective. Well, that's what we did. That's what we did with COVID. Every day the Globe and Mail told us how many Canadians, cumulative, had died of COVID. We did everything to scare people, I think, because that was one way to get them to be compliant with these lockdown measures.

So let me try to put it in perspective. Even for older people, in fact particularly for older people—and risk communication on something like this is not easy to do, but I think it's important and it's something that we struggle with—so if we were to look at what happened in COVID in Canada in the first year, from basically February 2020 to February 2021, that's twelve months. And that's the period from when COVID first appeared to when vaccines were more or less readily available for anyone who chose to get them.

And at the very beginning of that, I went through the numbers in my head as I understood them and came to the conclusion that, yeah, COVID was there and there was a risk. But the risk actually to me—and I was then a healthy 68 year-old—the risk was actually quite small. Small enough that I was not going to let it interfere with my life, or rather, I was going to do as much as I could to lead a normal life in that bizarre world of 2020. I wasn't going to be crazy. I wasn't going to go looking to get myself infected. If I knew somebody else was infected or likely to be infected, I would stay away from them. But other than that, I was quite happy to pay my money and take my chances.

And so looking forward and looking back, let me just run through a few numbers for you, if you'll indulge me for that so I can explain what I mean by that. So, in that first year, Canada had about 18,000 reported COVID deaths, and Canada normally has about 300,000 deaths a year. So if you reduce that a little bit for people who in fact would have normally died anyway—because it tended to hit people who were very frail and very elderly—that's about overall a 5% increase in risk of death in that one year. But because of the way COVID was distributed in that first year, with up to 80% of the deaths being in long-term care facilities, for a Canadian who wasn't living in a long-term care facility, the increase in your baseline risk of death went up in that first year by somewhere between 1% and 2%. Now again, I don't want to sound too nerdy here, but I'm not talking about an absolute risk of 1% or 2%. I'm talking about a relative increase in the risk you faced before.

So what does that mean again? Okay, let me try to put that in some perspective. So for the average 70 year-old in Canada, your risk of dying in the next year is about 1%, about 1 in 100. But for every year you live—and this starts at about age 60—every year you get older, your risk of dying goes up by 10%. What that means—not in absolute terms, in relative terms—so it means if your risk of dying when you're 70 on average is 1%, your risk of dying when you're 71 is 1.1%. That's a 10% increase in risk. And it's something we just, I think, live with and accept. It's part of life. I think most of us understand that as we get older, risks increase.

So COVID, by comparison in that first year when there were no vaccines was the equivalent of being about a month older than you were in terms of risk. So if you were on your 70th birthday and you were worried about, you're thinking about your risk of dying, COVID made you not 70, but 70 plus one month. Now, that's not a good thing. Anything that increases risk of a bad outcome is not a good thing. But it's also not the sort of thing that would keep any rational person lying awake at night, or would lead a rational person to make dramatic changes in the way they led their lives. And yet that's exactly what people did. People were terrified of COVID. I think that made a huge contribution even to the decision making, because I think many of the decision makers were people who actually thought that they were going to die too—but they weren't.

So I think there are ways. And again, I'm not suggesting it's easy, and maybe if you want to ask me questions about the numbers I just ran through, I'd be happy to go back through them. But the actual increased risk, even to people, even to older people like myself, the actual increased risk from COVID was actually very, very small relative to the risks of just being a human being who's alive and getting older.

Shawn Buckley
And the public messaging to the older people was not: Okay, you're 71, so your risk is losing the same as you losing a month of life. So instead of living to 75, you're going to live to 74 and eleven months. It wasn't presented that way. What are your thoughts on— I mean, you've already told us they shouldn't have used fear in public health, so I guess you've already told us your thoughts. I mean, you think that's one of the ethical feelings, was the communication?

Dr. Richard Schabas
Yes, I think the use of fear, it's anathema to the basic principles of public health. We were always taught, we always had the principle of you don't use fear because you make people fearful, they become irrational. You give them the facts, you give them the balanced facts, and they deal with it. You don't say, "Run in panic," but that's what we did for COVID.

Shawn Buckley
Now, you had an experience of censorship during COVID. Can you share with us about your experience with the CBC?

Dr. Richard Schabas
Yeah, I have several experiences I'd like to share. One relates to the CBC, the other relates to work I did as an expert witness for some cases with some professional colleges: College of Physicians and Surgeons of Ontario and the College of Nurses of Saskatchewan. But let me start with the CBC.

So over my years in public health, I've frequently been approached by the CBC literally hundreds of times to comment on a variety of public health issues—and probably more laterally in the last ten years before I retired anyway—on issues that were related to infectious diseases, certainly around SARS, then around bird flu. Which you may recall there was a great panic about an imminent pandemic from bird flu in about 2004 and I was the one who said, "This is not based on good science. We have no idea if there's a threat. We should take it a little bit more cautiously."

And then around the H1N1 so-called swine flu influenza pandemic in 2009 where I made the case that, because of the dynamics of H1N1 and the immunity levels in older people, that although it was an influenza pandemic, it was the most benign on record and that the actual public health impact was very, very much smaller than people had expected—or that people were making it out to be during the pandemic. So I was a go-to guy for at least some of the producers in CBC on these issues.

And at the very beginning of COVID, even though I'd been retired at this point for about three years, I guess I wrote an opinion piece in the *Globe and Mail*. And I guess I was still on a few rolodexes because I did get some calls. I did a couple of interviews for *CBC Newsworld* for the B-team, but for the *CBC Newsworld*. And on the 22 March 2020—so remember, that's way back at the very beginning, just two days after Ontario announced its lockdown at the very beginning of the COVID lockdown period—I was asked to do an interview with *CBC Newsworld* in Halifax at seven o'clock on a Sunday morning. And I naively believed that a Newsworld broadcast at seven o'clock on a Sunday morning would have a viewership of about six people. But I was happy to do it because I thought it was important that there be some pushback, that people get the message out that we don't know what we're talking about with COVID and there's so much uncertainty, and we're busy doing things that make very little sense and we're not sure why we're doing it.

So I did the interview. And actually you can still see some of that interview on YouTube for the wonders of YouTube. It's an abridged version, so there's a lot of good stuff that I said that got cut out. But in fact with the wisdom of hindsight, I would stand by almost everything I said in that interview. And I think many of the things I said were quite pressing. It was a very friendly, easygoing interview.

Anyway, so I finished the interview and then I think I probably went back to sleep because it was very early in the morning for me. And then a couple of hours later, mid-morning, I got a phone call from my daughter, who's a physician in British Columbia, saying, "Dad, there's a firestorm." I don't think she used the word firestorm but, "There's a firestorm on Twitter," I don't do Twitter, I never did, "led by someone named Maureen Taylor that's attacking you for your interview and saying all kinds of terrible things about you."

And what transpired, and I now know what transpired, is that Maureen Taylor— Now Maureen was a former CBC correspondent. She'd actually been their correspondent that had dealt with a lot of the stuff around SARS in 2003, so I knew her. But after she left the CBC, she went and qualified as a physician's assistant and was working as a physician's assistant. And she led a campaign—I'm talking about something that happened over a matter of a couple of hours of her and some of her cronies criticizing what I had said—and saying I shouldn't be allowed to say these things and that my views were akin to those of a climate change denier. So I'm a climate change denier because I think we have uncertainties about COVID and uncertainties about lockdown.

Anyway, what happened—and I now know because I have the documentation which I've included as an exhibit—is that Maureen reached out to her former colleagues at the CBC. And based on Maureen say-so, one of the senior executives in *CBC News*—someone by the name of Tracy Seeley and somebody else named Jennifer H; I don't know her surname because that wasn't in the email—basically sent out an edict to *CBC News* producers that I was not to be interviewed. Neither I nor for some reason Dr. Neil Rau—who was another very distinguished infectious disease doctor who I published articles with in the past—neither of us should be interviewed on COVID. We were summarily canceled on the word of

a CBC executive taking advice from a physician assistant. And so two of the most prominent voices around public health and infectious disease control were simply stricken from the CBC with the stroke of a pen.

It was worse than that. They had put my interview up on their website. I guess somebody there thought it was a really good interview and people should see it. And that's probably what people were responding to. They took it down and airbrushed out any reference, any history. So it was a little bit like Joseph Stalin getting Leon Trosky out of the photograph—and airbrushed me out of the CBC history. And subsequently, I've not been interviewed by CBC on this in the four years since. I don't think that Neil Rau has either. And this, of course, is a publicly accountable agency. There was no suggestion that Tracy Seeley would go and get further advice or that you would examine it further. This was an arbitrary decision. We were canceled. We were out. They moved on.

And I don't know why. I don't know whether this was based on their fear, I don't know whether this was based on their ideology, or I don't know whether it was political cover because what we were saying was highly critical of what the federal government was doing. But the end result was that important voices—I think both Neil and I were important voices—were simply excluded. Canadians didn't know about those views because they were—

Shawn Buckley
Okay, Dr. Schabas, I'm just going to break in and pull up that email. David, can you throw that on the screen for us, please? Dr. Schabas, so this is the email that you were provided. So somebody leaked this to you in the subject. So this is the same day as your interview, March 22. And the heading is, "PLEASE READ" in big letters, "Experts to avoid in COVID-19 chase and news gathering." And when I look at the email list, it's CBC, CBC, CBC. So this is internally to CBC people to really make sure that you're not put on the list. And I'm just going to scroll down to the text because I want people to understand what was said. So she says:

> "Hi all, Please see below. NN unfortunately ran an interview with Dr. Schabas this morning and a clip was included in our web story. We took the viz out and had Encoder unpublish it completely. As you'll see below, these sources are considered the "climate change denier" equivalent of coronavirus prevention."

So you're actually being labeled as the equivalent of a climate change denier, which I think we all recognize is just an engineered term.

Dr. Richard Schabas
Worse than a child molester, I think, in the eyes of CBC, yeah.

Shawn Buckley
Right, right. Yeah, so we will enter that as an exhibit so that it becomes a permanent part of the record.

Dr. Richard Schabas
I should also say that when I did get this screenshot, this was someone at CBC who took the screenshot of the email and sent it on to Dr. Rau, who shared it with me. I did send a

complaint to the CBC ombudsman complaining about this sort of behaviour, this arbitrary behaviour in controlling editorial content, in canceling important people. And I contrasted it with some of the so-called experts, like Dr. Colin Furness who is Doctor of Library Science, who the CBC was touting as an expert, and how inappropriate that was. And basically the ombudsman wrote back and said, “There’s nothing I can do,” and never heard back from him after that. So CBC was supposed to have an internal mechanism to deal with this. Well, I can assure you it did not.

Shawn Buckley
Okay, so you’ve already told us that one of the things you think we should do is have full-blown inquiry into this. Before I turn you over to the commissioners, are there any other things that you think should be done? Clearly you think the CBC should be held to account.

Dr. Richard Schabas
And to be clear, I’m not talking about a full-blown inquiry. I’m talking about funding a robust research effort. I think that this may take months, it may take years to bear fruit. But I think we need to get scientists of all stripes, all shapes and sizes. We need to engage them in doing the research on the data, do the clinical trials that came in, do whatever research we can do to try to shed some light on this. I think there’s a lot of what to be learned out there, and I think it should be a national priority to do that.

Yeah. The other thing related, I was going to talk about professional colleges, because one of the things I really found shocking— And I’m focusing on the CBC and on the professional colleges because those are institutions that are publicly accountable. You know, if the Globe and Mail chooses to publish nonsense and chooses to publish op-ed pieces by people who don’t know what they’re talking about, nothing that I can do about that. They’re a private institution, all I can do is cancel my subscription.

But the CBC and the professional colleges are publicly accountable. And the professional colleges—and this was, I think, very common across Canada—I can’t say they all did it, but certainly many of them did it. And I was involved in the case with the College of Physicians and Surgeons of Ontario where they tried to discipline Dr. Kulvinder Gill because she’d been outspoken about aspects of lockdown, and actually took her to the brink of the discipline committee. And believe me, there’s nothing more intimidating for a physician than being taken to the discipline committee, because that can take away your license and take away your livelihood and taint you forever if that happens. They backed down at the last minute, but they were prepared to do that.

And actually, with the College of Nurses of Saskatchewan, I gave testimony for a nurse there who had tweeted critical of vaccine mandates, not critical of vaccines, critical of vaccine mandates—in fact, something I completely agreed with her on, but that’s irrelevant. The fact is that was well within a reasonable thing to do. They actually took her to the discipline committee, and she had a very extended hearing at the discipline committee before they fortunately threw out the charges. But the fact that the colleges would do this had a real dampening effect, a real chilling effect.

And let me just read to you something. This is from an official position paper of the College of Physicians of Ontario, and it says, “Physicians have a professional responsibility to not communicate anti-vaccine, anti-masking, anti-distancing, and anti-lockdown statements.” So any physician in Ontario who said anything critical of masking, of distancing, of lockdowns or vaccine mandates was running the very real risk of professional discipline.

And I think that is shocking. And I think we need to go back and look at the legislation that governs these institutions and make sure that they are prohibited from ever doing this sort of thing again.

The other area that I'd like to touch on relate to the independence of public health. I ask myself why my public health colleagues performed so poorly, in the sense that none of them, or virtually none of them, spoke out in any meaningful way based on the principles that we were trained in and that we espoused up to the beginning of COVID—things like health is more than just the absence of disease. Things like the importance of the social determinants of health. Things like the importance of putting health risks into perspective, as well as the basic ethical issues I've touched on. Where did all that go? Why did all that disappear?

Well, I think some of it was they were sort of swept along by this tsunami of ideology that played such a huge role. But I think also some of it was that they were just frankly intimidated by their bosses or afraid of losing their jobs. Bonnie Henry wrote a book about her experiences in the first year of COVID. And she as much as admits that one of the reasons she went along with the politicians was because if she got too far away from the politicians, I think were her words were to that effect, that she would lose her job.

So the only public health sort of organization, national organization, that I think performed with real credit throughout the developed world was in Sweden, where Sweden, in fact as you probably know, took a very different course: did not have lockdown as we know it, did a lot of voluntarism, but very few, very, very few mandatory measures. And those that were in place were short-term based on when the disease was active, and moved away from very quickly when they weren't.

The key difference with Sweden, I believe, or one of the key differences is that in fact the public health officer, the public health system, is independent, has an arms length relationship with the government, is under the aegis of an independent board. And that's something that I actually pushed for 20 years ago for the Public Health Agency of Canada when it was first created, that there be an independent board. They didn't do that. They made it an arm of government. I did the same when Public Health Ontario was created, again about almost 20 years ago. Same mistake was made. It basically operates in close proximity, or rather I shouldn't say that— The Chief Medical Officer of Health in Ontario should have been made part of Public Health Ontario so he could operate at arm's length from government. Didn't happen.

So I think we need to look at the structures of the governance of our public health system. I'm not sure that's going to be foolproof. I can't say for sure that public health in this country would have performed better if it had been independent. I hope it would have. It would have at least have removed one of the impediments to the bad performance, to good performance—one of the reasons why I think they perform so poorly.

Shawn Buckley
I'm just going to summarize what you said. So my understanding is, and you've indicated: So Sweden as a country, their regulatory person for public health is more separated from the government, and they chose not to lockdown, they chose not to have mandates for vaccines. And am I correct that today—now we're in on May 30, 2024—that we know Sweden had better health outcomes than Canada, and their climate is similar?

Dr. Richard Schabas
That's a complicated question. No, I mean, again, we're getting into— This is, again, we're falling into the anecdote. Sweden's COVID mortality rates was actually considerably higher than Canada's. It was, for example, comparable to Quebec. Quebec and Sweden, which are actually kind of similar population, had actually very similar experience with COVID and very similar COVID mortality rates. Canada as a whole had lower rates, but Sweden had among the lowest rates and the bottom third, I think, of COVID mortality rates in Europe, which is what you'd expect. It's an affluent Scandinavian country. You'd expect it to do well, just as you would expect Canada to do well.

So I can't draw too many conclusions. I don't want to say oh, yes, Sweden did better than us. By measures of excess mortality, Sweden did do better than Canada, or at least comparably well to Canada without having the lockdown. But these are immensely complicated scientific questions. We have to be careful not to kind of leap onto anecdotes, because that's falling into the same trap that led us into our sustained lockdowns. But the bottom line is that, yes, Sweden didn't do what everyone talked about: the Swedish disaster. Well, there was no Swedish disaster. By any COVID measure, Sweden and by any excess mortality measure, Sweden did comparably well to its peers and didn't go through all the trauma that many other countries went through.

Shawn Buckley
Thank you. I'm going to let the commissioners ask you questions now.

Commissioner Drysdale
Good afternoon. Thank you for coming Doctor. I have a couple of questions for you. You mentioned that you were Chief Health Medical Health Officer in Ontario for ten years. Were you familiar with the Canadian influenza pandemic plan?

Dr. Richard Schabas
I am familiar with that. I don't recall whether that was something that was there when I was Chief Medical Officer of Health, or whether I became familiar with it later in my career, which included some time in public health. But, I mean, I was by 2020 familiar with it, yes.

Commissioner Drysdale
Yes, it was my understanding from other testimony that it was authored in 2006, at least the last edition that we were presented with here at this commission.

Dr. Richard Schabas
That sounds right. That sounds right.

Commissioner Drysdale
Are you familiar with who was the major, or at least the signature author of that report?

Dr. Richard Schabas
I don't know that offhand.

Commissioner Drysdale
Would it surprise you that it was Theresa Tam?

Dr. Richard Schabas
No, it would not surprise me. Although my recollection is that it was a far, far more moderate document than anything that we ended up actually doing for COVID. I mean, we basically spent years developing the playbook for handling respiratory virus pandemics, and then threw out the playbook with COVID.

Commissioner Drysdale
My understanding from previous testimony was that pandemic plan that we had in place did not recommend quarantines, did not recommend masking, did not recommend shutting down schools. And so I'm wondering how we fundamentally shifted that philosophy from the point that that pandemic plan was put together. And when I said it was authored by Theresa Tam, I think there was eight pages of medical people across the country that were involved in it. So how did we— Was there research available that caused that change?

Dr. Richard Schabas
Well, as I say, it's worse than that because there was this comprehensive review done by the World Health Organization in 2019 published a few months before COVID started which reinforced all of this stuff about: don't do these things I mentioned, don't do quarantine, don't do border closure, and the evidence for the other stuff—even though some of the things that say you could in a severe pandemic do it, said you could be reasonable to close schools. But again, let me add the additional caveat that we were talking there about influenza, and influenza is a disease whose epidemiology we actually understand very well. So we know that influenza outbreaks in any given jurisdiction, a province, a city, whatever, are going to last in the neighbourhood of six, maybe at most eight weeks.

So if you talk about closing schools for an influenza pandemic, you're talking about closing schools for a few weeks. That's it. And you're right: and don't mask, don't do any of these other things. But nowhere was it ever contemplated that we would do these things for years at a time. In fact, if you'd ask a public health person in 2019, what's the most fundamental determinant of health in Canada? What's the most fundamental reason that we in Canada are enjoying this unprecedented, historically unprecedented level of health, and in global terms, such as excellent health? The most fundamental determinant of health is education, okay. Education is the most important thing that has driven our improvement in health over the last hundred years. And yet education, we just threw it under the bus without a second thought. How could that happen? I continue to scratch my head as to how all that happened without, it seemed, a second thought as to how long we do it for.

You should watch the clip of my infamous CBC interview in March 2022, because I raised exactly that—2020, rather—I raised exactly that point. I said, these things are unsustainable. How long are we going to keep it up? I never would have believed that we could have kept it up for three years, that we would contemplate the damage that we have done to our society. We're still seeing it, among other things.

Among many other things, we're still seeing a much higher level of death, generally now we call excess mortality, than we saw before the pandemic. We've done such fundamental

damage to our state of well-being, not just economic, but also social and health wise. And we're continuing to pay a price for that because people just did these things in a panic. They didn't stop and think, what are the harms? What are the costs?

Commissioner Drysdale
Well, that's a really good point you bring up, because when you were talking about the quarantines, I was thinking that as a professional, you need to consider all aspects of what you're asking a patient to do, or a client to do. And so when you close down schools and you put kids into quarantine, don't you have to consider where those kids are now going to be spending their time?

In other words, in a public school that has an air handling system with filters on it and is clean and is made out of concrete, is it not conceivable that some of those children would be going home to an environment that wasn't as healthy for them physically without clean filters with perhaps—I think Canadian Housing Corporation has said that 70% or 80% of homes have mold in them? Are you aware of them considering where they were putting these kids?

Dr. Richard Schabas
You're asking, was there rational thought put into this decision making process? And I don't think there was any rational thought. I think it was kind of a knee jerk, "Oh, let's close the schools." And then there was a strong lobby element, some of it from some of these modellers—I could talk all day about the modellers—but also from groups like the teachers union, who got it into their heads that it was in the best interest of their members to keep the schools closed. And, you know, but by way of comparison, in British Columbia—now I'm very critical of British Columbia for many of the things that they did in COVID—but British Columbia made the decision in the spring of 2020: They closed the schools in March like everyone else did, but they reopened their schools in June, and they didn't close them after that. I think they closed them for one week the following January, but basically my grandson in British Columbia, in contrast to my granddaughters in Ontario, after June, beginning of June 2020, he didn't miss any school.

And yet, so very different conclusion. And I think recognizing first of all the evidence, which was becoming quite, quite reasonable by June of 2020 that schools were not a major site of spread, and exactly as you said, sending kids home to spread the virus was not a solution to anything. All you were doing was crippling kids' education and putting a further additional strain on parents. That British Columbia, which overall had a COVID experience that was outside of them, outside of the Atlantic provinces, which was the most benign in Canada, and yet they kept the schools open. But other provinces, like Ontario, persisted with these prolonged closures. Yes, it makes no sense.

Commissioner Drysdale
On to the masks. You talked a fair bit about masks as well. And I'm not aware, and I'm asking you if you're aware, throughout the whole mask mandates I never heard of an official explaining how masks were to be disposed of, or how you were supposed to avoid touching them, and what did you do with them at the end of the day. Would the mask not be an infected piece of material? Would it not carry bacteria or germs on it? Did it not affect the carbon, the oxygen levels that people were breathing? I mean, were any of this considered. Do you know?

Dr. Richard Schabas
Again, I don't know what went into the decision making. I can tell you that there was actually quite a robust evidence of literature on wearing masks for the control of influenza. In fact, there was what we call a meta-analysis—that's a compilation of, I think, about ten randomized controlled trials, so experimental evidence, high-quality evidence, exactly the kind of evidence we're supposed to pay attention to—a meta-analysis of the use of masks in control of influenza, which was published in, it was May of 2020, just the right time. And it went through all of these studies and all the literature, and it concluded that masks were of no value in controlling pandemic influenza.

And the reason for that are multiple. I think it has to do with, obviously, the ineffectiveness of these masks in screening out virus particles, but all the other stuff: people don't wear them properly, people touch their face, people dispose of them improperly. It's a very complicated thing. It's very hard to kind of put your finger on why masks don't work, but they don't. At least that's what the evidence showed. They work very little or not at all. That's what the evidence showed. And subsequently, that's what the high-quality evidence on masking for COVID showed.

So why did we not only jump? I mean, it was one thing— As I say, I can understand why a Public Health Officer in the spring of 2020, when we're faced with this significant and novel threat, we're a long way away from having vaccines, would have said to people, "Listen, I don't know that this is going to work, but I think it's maybe a good idea for the time being that you wear a mask when in crowded indoor spaces." I mean, I get that so long as you're honest with people that it's not something that's robustly evidence based, and so long as it's a recommendation, that's okay. But that's not what we were told. We were told that there was strong new evidence, then we were told it was proven, and then we were told you must do it, and that's where it stayed.

And then masks became kind of this bizarre kind of talisman that you kind of showed whose side you were on when you wore a mask. I remember walking through a Costco store in Vancouver shortly before the mask mandate for indoor was put in place in British Columbia. And I think most people wearing a mask. Okay, I get that. Two or three of us weren't. We kind of winked at each other, because we were— And I guess it was the other way around where people wore masks, it was like a biker gang wearing its colours. You were going to show that you really cared because you were going to wear your mask. It acquired this kind of additional, kind of symbolic significance that was really quite strange.

Commissioner Drysdale
Well, this commission heard testimony from at least two witnesses who were beaten in public for not wearing a mask, even though they had medical exemptions. I want to talk to you a little bit about the Ontario—not necessarily the Ontario College of Physicians, but we did hear testimony on them in particular.

And my understanding of the issues surrounding informed consent is that particularly in Ontario—I don't know, but I imagine it's the same in other provinces—my understanding from testimony was that in Ontario, if a physician, part of the consent issue was if a physician suspected that their patient was being coerced into taking a procedure, then they were honour bound or legally bound not to provide that procedure. In other words, if they were being influenced by an outside body or being forced by somebody and the doctor knew of it, they couldn't administer the procedure. Is that your understanding of that?

Dr. Richard Schabas
I'm not expert enough in— I mean, as I understand that what you're saying is that if someone believes someone is not providing true informed consent, that they're not. You need informed consent before you can do a procedure. If you're not satisfied you're getting informed consent, then you can't do it. Yeah, that makes perfect sense.

Commissioner Drysdale
I mean, my next question related to that would have been: How do you think the Colleges of Physicians and Surgeons squared the circle where they knew people were being threatened with their jobs or threatened with other things to take a procedure vis-a-vis the injection, and yet they continued to give those injections.

Dr. Richard Schabas
Well, because the professional colleges like the CPSL and the College of Nurses in Saskatchewan, and I believe most of these bodies were seized with this sort of almost religious zeal that they knew the truth. They were on the side of the angels, even though of course there was huge uncertainty about many things. They were on the side of the angels, and they were leading the charge against misinformation, against quackery. And, yeah, I think they just were kind of blinded by their own self-righteousness and did things that I think history will regard as quite important. You know, that paragraph, that sentence I read to you is really quite shocking. I mean, in a profession like medicine where we thrive on discussion and dispute, that's how medicine moves forward. That's how science moves forward. And that, by the way, is also how fundamental Canadian democracy—

I had the very disturbing experience in the Saskatchewan case, where I was cross examined for more than a day by the counsel for the College of Nurses, who was trying to paint me as some sort of libertarian zealot—which I can assure you I am not—trying to paint a center of libertarian zealot because I thought that a nurse had a right to express an opinion on a vaccine mandate. It was just very strange. It was almost like speaking to the inquisition. And I think many of the people who were in leadership positions of governance of Physicians and Nurses in Canada were closer to inquisitors than to anything else.

Commissioner Drysdale
Well one of the things you talked about, which I found really interesting, and you used some terminology that I've certainly heard before, and that is you were talking about risk. And you talked about the term "absolute" or "relative risk." And I also heard them talk about that with regard to the efficacies of the injections, in that the public was told about relative efficacies of the vaccine as opposed to absolute efficacies of the vaccine, and that they didn't really understand what that difference was. And that seems to be similar to what you were talking about with regard to your absolute risk of mortality as opposed to that relative risk. You seem to be quite careful about making sure we understood that.

Dr. Richard Schabas
Well, I think that just underlines how difficult it is to present these numbers accurately, but also in a balanced way that people are going to understand, because these concepts are not easy. I mean, my classic example is the difference between absolute risk and relative risk is that if you buy one lottery ticket, we all realize that your absolute risk of winning the lottery is approximately zero. You're not going to win. If you buy two lottery tickets, your

relative risk is two. You've doubled your chances of winning, but you're still not going to win. And so we lose sight of that.

There was lots of stuff about COVID. Pregnant women were suddenly they had a relative risk that was higher than un-pregnant women. This was a huge national disaster. Well, no, because they were healthy young women. Or if you were a vast majority of healthier women, their absolute risk of getting into trouble with COVID was vanishingly small, but their relative risk was two or three. Yeah, so exactly, and I don't want to— It's hard to comment on the specifics, but I think it just goes to how hard it is. It's so much easier, almost easier to say, "Look, ten more people died, you know, and you're all going to die, so you should be worried," so much easier to present it that way than it is to actually go down and try to do it properly.

Commissioner Drysdale
Well my last question here is, again, you very well tried to put the risk of dying for somebody who was 70 years old, and you compared it to when COVID came. And I think you said something about it, perhaps taking a month of risk, or adding, and I compare that to what we heard testimony happened in our seniors homes, where these seniors were locked up and they were isolated and they were not allowed to have visitors. And I wonder if there's been any studies done as to how much risk of death that put on our elderly populations when we isolated them from their loved ones and locked them away for months and months at a time. And by the way, my understanding is it's still going on today.

Dr. Richard Schabas
Yeah. No, I mean again, thoughtless, shocking. Because if we look at something like long-term care homes—now nobody's supposed to say this, but I say lots of things I'm not supposed to—we have to understand that the risk of dying in a long-term care home regardless of COVID is very high. The annual mortality rate in long-term care homes is about 25%. People die in long-term care. In fact, in large measure, people go to long-term care because that's where they're going to die, and that's very sad.

And we, of course, want to make sure that people are comfortable and all well-cared for and all that. Of course. Of course. And nobody wants those people in long-term care to die any sooner than they have to or any sooner than their quality of life dictates. But their lifespan is limited, their time is limited, so you take people in long-term care and you deprive them of seeing their family for months or years at a time, well, they're going to die of something else and never see their family. So you will have saved their life, but for what purpose? There was no thought, no sort of holistic thought to that.

I know my parents were not in long-term care. They were in a retirement home. But basically, they were prohibited for seeing any of their five children. And I was able to speak to my father's family doctor and say, "Listen, my father is failing badly. I think he qualifies as being palliative, and if you declare him palliative, then his family will be able to visit him." And the doctor agreed. He said "Yes," and the palliative care team assessed him as, "Yes, he's palliative." And indeed, he did die within six months of that determination, so he generally was palliative.

But of their five children, I was the only one who would go and visit them in the long-term care home. And, you know, I think it was just it was my siblings were simply misled by their own fears and failure to accept the fact that life is a self-limited thing and that our parents were going to die—did in fact die. But at least they had the reward of being able to see one

of their children in those terrible months. They weren't completely isolated. But many people in those homes were in fact completely isolated, and that was a terrible thing. That shows, again, a complete lack of judgment.

And of course the irony is people are coming in and out of those homes all the time. There was a lot of talk back in 2020, "Oh, we aren't doing enough to protect the spread in long-term care," and I guess that's true. But if you spend any time in those homes, you realize that it's very, very hard to do that because people have to work in those homes. And those are, for the most part, poorly paid people who live in crowded conditions—exactly the people who are going to get COVID. And I'm afraid so long as they're going to continue to work there, they're going to bring COVID in. And so some of that, sadly, was inevitable. So to prevent what was inevitable anyway, we further penalized the people in these homes by depriving them of the things that were often most meaningful to them, which was seeing friends and relatives. Very sad.

Commissioner Drysdale
The dignity and the love of their loved ones.

Dr. Richard Schabas
Yep.

Commissioner Drysdale
Guys, got any questions?

Commissioner Fontaine
Yes. Thank you, Doctor, for your testimony. I have a question about the common flu. So we've been told by health authorities that essentially the common flu has disappeared in 2020-2021. And the reason for that, again we were told by health authorities, is that people were wearing masks, people were washing hands, people were social distancing, other non-pharmaceutical measures were applied. But we've heard in this commission that these non-pharmaceutical measures, they don't really work. And you also mentioned about the mask not working. So what has happened to the common flu, Doctor?

Dr. Richard Schabas
Well, again, let me be very clear what I'm saying. I'm not categorically saying these things didn't work. I'm saying we didn't have evidence—still for the most part don't have evidence they work. So they're not evidence-based interventions. And furthermore, among the ones—because there's a whole range of things that were done, some voluntary, some mandatory—and again, it's quite possible that some of them had an effect on virus transmission and equally possible that others didn't.

I mean, I would hark way back to the beginning, way back to the beginning of COVID in the first couple of weeks in March of 2020. The first large outbreak in North America was in New York City. You may remember that, got a lot of attention. And on about, I'm trying to remember my dates here, but towards the middle of March, maybe the 16th, 17th, 18th of March, something like that, the Mayor of New York went and announced a lockdown. And sure enough, within a couple of days the case count started coming down again. And of

course, everyone said, "Well, look, look." Well epidemiologists are a little smarter than that, and we know you've got to look at other ways of tracking the pandemic.

And probably the best way was to look at hospitalization rates, because that was a much more reliable indicator. And if you looked at hospitalization rates, they peaked within about five days of the lockdown. Now it's good that they peaked, but the problem is if you do the arithmetic and count back the incubation period and add in a few days that it's going to take someone to get sick enough to go to hospital, what that said is that the outbreak had actually peaked about a week before the lockdown was put into effect. So the lockdown didn't control the outbreak. The outbreak was already controlled, already on its way down before the lockdown was put in place.

And I had that debate with one of my colleagues, and he said, "Oh, yeah, that's because people started doing things voluntarily." And I said, "Well, yeah, of course, that's exactly right. People do do things like avoiding sick people and maybe keeping a little more distance from people voluntarily." And so certainly in the experience of New York, those were the things that seemed to have worked. So we don't know what worked.

What happened to influenza. There's no question that influenza rates— Influenza didn't completely disappear, but influenza rates were very low throughout the world—actually for the first two years, 2020 and 2021, much lower than we've seen in almost any year. We've had years before with very low rates, but this was quite extraordinary. Why was that? I think the fairest answer to that is, I don't know. Was that in fact a reflection of some or all of the control measures? Maybe. Certainly, certainly possible. Although it's worth noting that influenza rates were also very low in countries like Sweden that didn't do these things.

So which was it? What was it? We don't know. Was it competition among viruses? We don't really understand the ecology of respiratory viruses. We don't really understand why, when a new strain of influenza emerges, the old strain magically disappears. We don't understand why in most years you get predominance of one strain of virus versus another. We don't understand that. It's like there's some competition between viruses. So the answer is: it's a good question. Anyone who says they know the answer to that question is misleading you because nobody actually does.

A lot of it is, again, one of those things that we would do well to try to tackle seriously from a research standpoint. Because, indeed, it may be that some of those measures helped to control the spread of respiratory viruses, but that would still beg the question: By how much? Because they certainly didn't do the job with COVID. It's hard to understand how they worked so miraculously well with influenza and worked so poorly with COVID, which continued to spread so dramatically. And also it doesn't include the cost. Again, but at least if we knew which ones worked, which ones worked in terms of reducing the spread of viruses, and to what the degree of effect of working was, then we could begin to balance that with the costs and decide if they're worth doing in the future. But we're not even asking those questions now.

Commissioner Fontaine
Thank you.

Commissioner Robertson

Thank you. I know we've kept you here quite a while. The College of Physicians and Surgeons, isn't that for the protection of the public? And who makes up the College of Physician and Surgeons collectively? Because I don't understand why doctors do not have the power to make the correct choices for the public anymore.

Dr. Richard Schabas
Well the medical profession, again, I'm not an expert in this. The medical profession is what we call a self-governing profession. It's same with nurses and in fact many other health professional groups. And there is legislation, there is provincial legislation that in fact sets up a governance structure for these professions. So the college itself works under legislation. It's empowered by legislation to provide, basically to oversee the licensing of, for example, physicians in the Province of Ontario.

And the actual governing council of the College is a combination. Some of the people are elected by physicians, some are appointed by universities, and some are appointed by the Province, but they set up what is supposed to be an independent, or at the very least, an arm's-length body that oversees this. But unfortunately, these bodies were dominated by—almost I think without exception—dominated by people who felt a very special kind of missionary zeal around COVID and implemented these policies restricting freedom of expression by physicians or nurses that I think was reprehensible.

Commissioner Robertson
Thank you. I think these people need to be held accountable.

Dr. Richard Schabas
I agree.

Commissioner Robertson
It should be the doctors making the choices for the public, not public health people who are— I've heard there's lawyers involved with, and that's why the physicians are so frightened of the College of Physicians and Surgeons.

Dr. Richard Schabas
Oh, absolutely. Nothing terrifies a doctor more than the prospect of being disciplined by the college. Lawsuits were well covered by the Canadian Medical Protection Association. We don't like them, but we don't live in mortal fear of them. We live in fear of the College, because the College can take away your license. It can take away your livelihood. So when the College said if you criticize lockdown, if you criticize mask mandates or vaccine mandates, you can be disciplined, you can lose your license, it takes a very brave physician indeed.

I mean, Dr. Gill is the one that I know of, but very few doctors would have the courage to put their neck in that noose and take on the College. Because it was a very difficult thing to do, a very dangerous thing, professionally dangerous for doctors to do. And, yeah, I know many, many doctors who to greater or lesser degree share the opinions I've expressed, share my skepticism about lockdowns. But will they say something publicly? No way, no way, too dangerous, too hazardous.

Commissioner Robertson
What if you collectively got together and stood up?

Dr. Richard Schabas
Well, again, I'm not—

Commissioner Robertson
Easier said than done.

Dr. Richard Schabas
I'm not sure I'm at a stage in my life where I want to lead that sort of collective measure. But, yeah, but I think that rather than putting the onus on the individual physicians, these are publicly accountable organizations. They're governed by provincial legislation. I think we should go back and look at that provincial legislation and write into them clauses that, in fact, prohibit this sort of limitation of free speech. Colleges have shot themselves in the foot. I would not have thought of doing this five years ago, but now I think we have to do it because they've shown how they are capable of such abuse of authority.

Commissioner Robertson
Thank you.

Shawn Buckley
Thank you, Dr. Schabas, on behalf of the National Citizens Inquiry, thank you for coming and your willingness to testify. We certainly appreciate your evidence.

Dr. Richard Schabas
Well, thank you for listening to me. Good luck.

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