Kristopher Moskal March 2, 2020 PIA Boardroom

Interviewer: Winston Gereluk Camera: Winston Gereluk

Q: Tell me what you do for a living, and your position in the organization you work for.

KM: I'm a paramedic here in Alberta. I've been a paramedic for 20 years, the last 15 of them fulltime here in Edmonton.

Q: Tell us about your background.

KM: I was born in Calgary. At the age of seven days I was brought home to Lloydminster, and that's where I grew up. K to 7 all the way to high school was in Lloydminster. From there I attended SAIT, I attended NAIT, I kind of portaged through all the different levels of the paramedic training. My dad is a lawyer and when he was younger, he was a crown prosecutor. My mom was a social worker in the public service, in Saskatchewan as it was, because of that weird border thing in Lloydminster. I learned a lot from my parents about the importance of public service.

Q: How did you end up in Edmonton?

KM: That's an interesting story. I was in a plane crash and decided I didn't want to do flight medivacs anymore, so I came back down to the city to stay on the ground. That's how I wound up specifically in Edmonton. The paramedic thing I just kind of fell into by accident, because it looked fun and it was the aspect of taking care of people and the challenge of a bit of a chaotic career which appealed to me. So here I am, not working in an office.

Q: What's it like to be a paramedic? Why is the work so important?

KM: The important part, if we're not there no one's there, when you talk about first responders. When you're out in the community, you're outside the established walls and the infrastructure of what would be healthcare or public safety. If you can't pick up the phone and call 911, then there's nothing. We fill the gap between your home and the place where that level of care that you need would happen. The job is not all blood and gore; it's quite largely not that, but when it happens it's a big deal. The work we do is certainly less exciting than how TV portrays our jobs. There's an extraordinarily human element to the work we do. We're in people's homes, in their intimate environments in what are quite often, some of the worst moments of their life or their family's life. A large part of the job outside of the direct medical care we do is just providing stability and reassurance to other people in the community that healthcare is here. As a society, we've come together to say this is a priority and this is a service that will be there for you if you need it. Without first responders, you're on your own. That's not a good way to go.

Q: What are some of the common calls you get?

KM: The most frequent? Largely the elderly for probably our largest patient population. Much has to do with chronic medical conditions. As you age you have more issues, and that can complicate your life. We meet elderly people when they've taken a fall, quite frequently. Sometimes it's just to help them get back on their feet, and they continue on about their day. Other times they've sustained serious injury, and of course then all healthcare becomes involved

in that. Anything to do with traffic – cars are driven by people and people get into collisions, so that's a large part of what we do as well. We do a lot of work around addictions and mental health. That forms a large part of the work we do as well, is incidents involving drug and alcohol and just people struggling and reaching out for help and not really sure where exactly that help can be found. If you call 911 someone always shows up to talk to you, at the very least. I would say within those portfolios that's probably the bulk of our work.

Q: What types of care do you offer when you answer a call?

KM: There's all of the usual things you'd expect you'd see. The common portrayals is: we will splint your broken bones, we will start IVs, we will medicate you for pain and things like that. The higher skill levels, Edmonton is where it's called the vital heart program and this is where we actually provide therapy to break up clots in the blood vessels in your heart to interrupt your heart attack and buy you the time to get into surgery so you can come out the other side of your heart attack without heart damage and just go back to your normal life with a couple of new medications. We provide advanced airway supports, like where you see on the TV shows when they're putting the breathing tube in; that's something we do. We have all sorts of interesting cardiac medications to speed up, slow down, stop, start, restart. It's very specialized and has evolved considerably over the last 20 years.

Q: What sort of training do you get?

KM: To go from, "Hi, I think I'd like to work on an ambulance" to the level of the advanced and critical care paramedics, you're committing maybe a little more than four years of your life. There are three levels of training that have practical portions both out on the street and ambulance and in a controlled setting of a hospital to learn and practise all of those skills. It's a solid four years and you're usually working fulltime through those four years while you're in school – practicums, mentorships, evaluations. It's a lot, and it's exclusively paramedic training. We don't do anything other than paramedic training in our programs.

Q: Is the drug scene out there as bad as they say on TV, or are we being fed a panic that's not there?

KM: I would certainly not say that the panic is false. A lot of the way it's talked about is a little bit inaccurate, from my perspective. The conversation drifts away from the people involved and the impact that is being had, and starts becoming a conversation of money and fault and blame. That's just not useful. Recently it's been opioids primarily, with the focus on constantly hearing more fentanyl that's been the focus. It is still a very challenging situation right now. We are still seeing a lot of it, but it has improved as compared to two or three years ago at the height. There were days where I personally would respond to the same address for overdoses multiple times in the same shift. When we started seeing government's level of interventions, like the Narcan kits, becoming widely available and distributed, when we saw a bit of a common rise with the supervised consumptions sites where we put a focus on community safety as opposed to the system responding to. . .

I don't know where the data stands, I can only speak anecdotally for myself, that I'm not going to life-threatening serious overdoses as frequently as I was. But we're still seeing them on a

pretty regular basis and there's still tremendous work to be done there. In terms of contrasting portrayal on TV compared to what it looks like in real life, this is one of the few times where TV doesn't do it justice. If those television programs that show overdoses in the community and how first responders respond to them portrayed the accurately, people would turn the TV off. It would not be something they'd want to look at. They're not fun places to be. The community impact is substantial, and you walk into a house where people are dead. Some of them you can resuscitate and some you cannot, and their friends and family are standing right there waiting for you to tell them which way it's going to go. It's not good for TV – good for documentary maybe, but not TV. But with the Narcan kits and the consumption sites, we've seen a reduction. But it's still there.

Q: What's happened in the last little while from a regulatory point of view to deal with this drug situation?

KM: The ideological divide that is apparent with this government contrasted to the last is there is seemingly not support for these supervised consumption sites or these safe consumption sites. As a healthcare provider who actually lives in this world, without a safe consumption site it's an alley, it's by themselves, it's alone. Addictions don't go away because somebody passed judgement on why you're addicted or how it should be treated. The consumption sites are evidence based. The evidence is clear that it reduces harm and saves lives. If we lose those, then lives will be lost and the drug use will just move back into other places in the community where it's not as safe.

Q: What have you experienced that would indicate that there's a need for universal pharmaceutical access?

KM: In terms of universal accessibility to medications, that's an all-the-time thing for us in EMS. People are utilizing EMS to access healthcare, which is almost exclusively an emergency department. They're suffering from side effects or the impact or the loss of control of whatever their chronic health conditions are – epileptics that can't afford their seizure medications and have a seizure, elderly folk that can't keep their prescriptions current due to cost. Their heartrate is not controlled, their blood pressure is not controlled. There are important reasons that physicians prescribe these medications, and it's to stabilize and maintain people's general state of health.

Without those medications, then, all the expressions of those serious medical conditions come forward. That's when phone calls are made and we become involved. The overwhelmingly most frequent reason is when somebody has an empty pill bottle, this ran out 15 days ago, can we refill this? The cost, I couldn't afford it. There are all sorts of barriers that always come back to cost, or most frequently I should say. Occasionally it's forgetfulness, but most of the time it's cost. More and more we're finding that that's becoming a thing with the elderly. Drug coverage used to be better than it is now for the elderly. There are successive rounds of conversations about what's important in a budget without the folks that it actually impacts; it's just all these these decimals and numbers on a spreadsheet. But more and more, we're seeing that people can't afford their medications, and the only access to healthcare they have is the emergency department, which is the most expensive access to healthcare that we can have. I don't know

how much it costs for one heart failure patient to go into the hospital and be stabilized because they couldn't afford what was called their water pill, but I imagine it's substantially more than just providing them that medication. It's a silly conversation that we don't do this.

Q: What does it cost the public for you and your team to answer a call and transport the patient to the hospital?

KM: There's probably a few different ways to calculate that. I know every time we take them to the hospital it generates a bill of several hundred dollars, whether that's paid out of pocket by the individual or it's covered by health insurance or Blue Cross. But we are hundreds of dollars per trip, and start multiplying that by how many times a day in how many communities all over Alberta when we're responding to someone whose primary concern is a manifestation of their health issues that they couldn't afford their medication for. It seems to me like we're on the wrong side of this financially at the very least, if not just from a taking care of each other point of view.

Q: When you answer a call and dispense medication, is it dispensed free to the client?

KM: Kind of what you're getting at is itemized billing?

Q: If I were to call an ambulance and you had to dispense some pharmaceutical to me, would that be the same as the free pharmaceuticals I get by virtue of Alberta Health Care billing?

KM: We're the weird blend of 'kinda-sorta-maybe-not-really' I think a bit. Everything with EMS is really poorly defined when you get into the structure of us. Here in the City, it is just flat rate billing, it's a standard fee. It doesn't matter what we do for you, it doesn't matter how much in terms of medication or supplies are used for your care; it's a flat rate. For instance, that clot busting drug that I mentioned earlier, that is thousands of dollars per dose, whereas if you break your leg and I split your leg and treat you with morphine for pain, morphine is pennies per vial. It doesn't change the billing rate. Coincidentally, if you happen to be an ambulance and a physician is requested because you're going from one site to another site, well that is now healthcare [AHCIP] and there is no bill. It's a little weird. From the perspective of practitioner, we kind of gripe about how it's weird that we have one foot in two worlds and nobody seems to quite want to claim us all the way. But at the end of the day, our job is our job and we don't care what it costs. Our job is to take care of people, and if there's a billing thing that happens afterwards, that's. . . We don't give or withhold based on what the cost might be.

Q: When you were part of that discussion circle, you told the story of one particular case where it was evident that there was an issue involved with people not taking their pharmaceuticals, probably related to cost. Could you recount that now please?

KM: So many times someone has said to me, "It ran out and I couldn't afford to refill my prescription." But this one was a construction site and the reason we were called was because a guy fell off a ladder right at the top of the roof. It was a two-storey home being built. When we got there, there was this poor guy laying in a pile of rubble. His injuries were significant and he was not conscious at the time we initially arrived. He wasn't able to tell us what happened, but he was part of a whole work crew there building a house. Naturally, we asked if someone could tell us what happened. You could see the ladder laying over there and we were kind of putting

two and two together, but we don't like to assume things. One of the other guys said, yes, he was right at the top of the ladder and had handed me a tool he'd gone down to get from the truck, and they were just getting ready to tie him off so he could step onto the roof. He's like, I turned and I put this thing down on the roof and turned back, and he was just gone. He said, I leaned over and looked over the side and saw him over there having a seizure, so I called 911. It was just this guy's worst luck ever. Had he just fallen straight down the ladder he would've just landed in the dirt at the bottom of the ladder, but due to the physics of how he was having a seizure, the ladder went sideways and kind of took him with it. He teetered down the length of the house and landed in this big pile of construction scrap and debris that had been collecting at the side of the garage. There were cuts of lumber and scraps of this and that, and there was a big piece of concrete in this pile, and that's what he landed on while he was having a seizure.

We did our paramedic thing and got him all packaged up and put in the truck. As we were driving to the hospital, he was kind of starting to recover from his seizure. As we were getting closer, he was now in the capacity to tell us lots of things hurt. Like I said, he had really significant injuries. But we were able to start asking some standard questions that we ask everyone: do you have any diagnosed health issues, are you on any prescribed medication, are you allergic to anything – the standard questions. He identified that he did have a seizure disorder, and when we asked him about the medication, he said he'd been off them for quite some time. We always ask why – is it the side effects, what's going on? He said straight-up, "I couldn't afford to refill it, I'm waiting to get paid."

So, we got him into the hospital and got him lifted over onto the bed, then that whole symphony of healthcare that happens with a really significant trauma, where there's 12 people in the room and they're all doing something different. The lead physician, trauma lead, is issuing all of the work that needs to be done, and is going down through the list and delegating all this work. As she's getting to the end of the list she stops and says, let's get a dose of dilantin into this guy because the last thing we need is him having another seizure. So, at the end of the day, healthcare paid for his medication, he just had to fall off a ladder and sustain life-threatening injuries to get it. When you start calculating the cost of that, the emergency response and everything that happens in the emergency department and the multiple surgeries that this guy is going to have, his recovery in the hospital, his rehabilitation and therapy. This is all to what outcome, we don't know; if he ever went back to his life, what kind of deficits he had from these injuries. These would be the kind he'd carry with him for the rest of his life. I suspect we could've just paid for his medication for many lifetimes over for that one incident. That is a single example that occurred on one day in one place in Alberta. It doesn't even begin to address the larger conversation. That one just always stuck in my mind, that it was so stupid that at the end of the day he got the medication in hospital, but he just had to fall off a roof to get it. It's so dumb. That'll be one of the last memories that I have as I age and start getting fuzzy on details. That one will hang with me.

Q: And that's not the only one.

KM: No, it's just a little more interesting than the average example of just the repetitive continuous nature of people calling 911 and it turns out they haven't been able to refill their

prescription. A lot of the times we're giving them the exact same medication in the ambulance, it's just in the context of a much more expensive setting. Plus, their health is at risk, because they're having an expression of whatever their health problem is.

Q: Are pharmaceuticals really that expensive?

KM: Personally, I don't know, I haven't had a single prescription medication in my life. I've gone through what my folks take. I'm 40, so they're old enough to have a few medications. I imagine, like anything else, the cost goes up every year. Pharmaceuticals are largely of a private industry, so there's always a profit margin that needs to be concerned about by a board of directors somewhere. We're seeing it more frequently. I don't remember 20 years ago when I started as a paramedic having someone look at me and say, my problem is this because I ran out of my medication. That wasn't something that was really common, and now far more than we used to. In terms of the cost, there are some prescription tags we see where it's $8 and some cents, and there are others that have three or four numbers in front of the decimal. I don't know how frequent or what percentage of, I just know that we're seeing people more frequently saying they couldn't afford their medication.

Q: As an Albertan, what would you like to see happen to this regime to deal with this problem of pharmaceuticals?

KM: The Pharmacare file aggravates me on a really personal fundamental level. I get stuck on that conversation around the Canadian identity. The way I see my country is that we are kind and compassionate people, that we value taking care of each other. When you see all of the evidence available around the conversation of Pharmacare, where not only does this provide the greatest benefit to the largest number of people possible, which I thought was supposed to be the yardstick that politicians use to measure their decisions, but it's not just people that take medication. If you're a person who has no problem affording your medication or if you're like me, I don't take prescribed medication, to have people never have costs as a barrier to their medication then they're not coming in to the emergency side of the system for care, and being admitted and needing care, or having significant medical insults t their health that result in even worse health.

If you interrupt that process by allowing people to have their medications, that frees up the rest of the system for everyone else that needs to access it. The people that need help with their medications get that help, other people that are accessing healthcare for the reasons that they need have that access more readily available to them. From that perspective that's enough for me, you've sold me, let's go do this. But then when you look at the data that says that this is billions of dollars in savings, billions of dollars, and the only reason it hasn't happened is because of partisan politics, it's infuriating. I feel like it's our disgrace as citizens that this hasn't happened and that we're not calling out all of our elected representatives for putting their personal political interests ahead of the wellbeing of the national as a whole. It absolutely drives me. There's just no reason not to accept. . . I mean, okay again, as a citizen that maybe pays a little bit of attention, it's clear to my mind that it's because corporate interest has corrupted our politics. That is the reason this hasn't happened, and the corruption is partisan in nature. It's

tragedy for the Canadian people that this hasn’t happened. This is a failure of our identity to take care of each other.

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