(AMRG Letterhead)

Reply to:
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David A. Carter, ASRC Chairman
TSAR ASRC Delegate
803 Townsend Court
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Dear Dave:

SUBJECT: **MRA Response by ASRC Teams**

Thanks for your letter. One advantage to letters over phone calls (in addition to being cheaper): we could keep copies together in a single place for those interested in the issue, and for future generations.

Yes, the "abandoned" line at the end of my letter was (a bit?) hyperbolic-- just trying for effect. I don't think that the ASRC has abandoned wilderness SAR, just put it on the back burner. This makes sense if you look at the number of, and type of, searches for which the ASRC is called.

Nonetheless, Gene, Ray and I set up the ASRC for wilderness SAR, of the "hard-core" type the MRA region espouses. I worry that an operational MRA Appalachian Region will take over as the prime wilderness SAR organization in the area, and relegate the ASRC to "non-wilderness" search. As you know, I was always opposed to separating the MRA region from the ASRC because I didn't want the ASRC to be squeezed out of wilderness SAR.

Well, anyway, nobody really cares too much what I think, and I think all I've really done is to bring a controversy out into the open. I think you and Peter discussed the MRA/ASRC issue and went away thinking you had understood each other when you really had different understandings. So, having expressed my minority

opinion on a philosophical point, I'll bow out of this discussion unless asked to contribute later.

However, let me pick up and keep on going on a related but topic that we've been discussing: backcountry medical care. If the ASRC does nothing but suburban/rural search, there's no need for any specialty wilderness/backcountry medical training or medical control for the ASRC. "Street" EMS training would suffice. However, if the ASRC still wants to preserve the capability for providing wilderness-backcountry medical care, as I think it still wants to keep a wilderness-backcountry SAR capability a la╣ MRA, then we need special training and medical control. If it's a rare occurrence, we don't need gobs of wilderness medical people, we just need a good but small system that can provide for the medical needs of an occasional patient.

As regards the numbers of backcountry patients, I've been surprised by the results of our investigations here in Pennsylvania. There are literally **thousands** of wilderness EMS calls every year. For the year 1992, I reviewed the state EMS database, culling out those calls that were less than 100 minutes. It was easy to pick out the calls with times in three figures, and I figured that short calls didn't really need special wilderness-backcountry EMS adaptations. Guess how many calls were left? **Over 500!** And a member of our Wilderness EMT Subcommittee within the Pennsylvania Emergency Health Services Council, who is with an ambulance service in a rural area, estimates that for his service, wilderness-backcountry situations are grossly under-represented, as he remembers about 40 such calls in 1992, and only one showed up in the state EMS database. So the problem exists on a large basis, but the SAR community and specifically the ASRC has done little to offer care to these people.

I had all along realized that National Cave Rescue Commission has more medically complicated rescues than the ASRC does above ground. What I hadn't realized was the numbers of wilderness calls answered by rural rescue squads, for the most part without any involvement of search and rescue teams.

Maybe we should give up on training ASRC and NCRC people as Wilderness EMTs and only train ambulance EMTs in rural areas? Well, it'll be hard to train WEMTs and provide wilderness-specific for every rural rescue squad. And, each squad probably only does a few wilderness calls every year, and I'll bet only about one or two of those patients need modified wilderness EMS training and medical control.

Part of the answer is expanding the wilderness training and medical control for certain rural rescue squads. These could meet some standards for wilderness-backcountry care, and provide

mutual aid for other nearby squads when they have a wilderness patient. But another part of the answer, I think, is expanding the role of SAR teams in the response to wilderness patients. SAR teams have many advantages in dealing with wilderness patients: they have more wilderness rescue expertise than local squads, and by virtue of a wide response area, and by both inclination and by being involved in long, medically complicated rescues, they can develop better skills at medical management of wilderness patients.

I'm enclosing a preliminary draft of letter describing a statistical analysis of the wilderness medical problem in Pennsylvania for your and those receiving copies of this, for review and not for further distribution. It explains in a bit more detail how we're approaching the problem in Pennsylvania, and I suspect that Virginia has similar statistics overall.

So, in conclusion:

1. You, Peter, and the ASRC Board of Directors need to discuss the MRA/ASRC relationship again.

2. Wilderness-backcountry medical problems are common, and the SAR community as a whole is not doing much to meet the need. And, though they are responding, I doubt the rural EMS agencies are delivering care in accordance with national standards for the backcountry. I think we (the SAR community and the ASRC in particular) have some expertise in the field and should carefully consider what we can do for this population at risk.

Thank you very much for your time and effort in continuing this correspondence. I think it will be worthwhile to our joint end goal, whether we call it "the victim" or "the patient".

Yours truly,

Keith Conover, M.D., AMRG ASRC Delegate
cc:Bob Koester, Gary Mechtel, Gene Harrison, Peter McCabe, Rich Worst, Chuck Kollar, Mike Kuga, Don Scelza