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FORUM

To the Editor:

I would like to congratulate Hnatow and Gordon for their excellent description of the handling of medical emergencies at mass gatherings during the San Antonio Papal Mass (Medical Planning for Mass Gatherings: A Retrospective Review of the San Antonio Papal Mass, *Prehospital and Disaster Medicine* 1991;6:443-450). They also presented data from other types of events showing a wide range in the number of patients per 100 spectators. Unfortunately, they made no attempt to correlate the reported casualty ratios for these events with other factors involved. De Lorenzo, Gray, Bennett, and Lamparella¹ reviewed the patient volume and level of care for many types of events at the 50,500 seat Carrier Dome in Syracuse, New York. They found that crowd size alone did not correlate to the patient volume and therefore should not be the sole determinant of medical personnel staffing ratios. Their rates of injury (two- to five-fold greater than those at the papal mass) for different events suggest that the nature of the crowd has an effect on casualties. Rates were much lower for sporting events than rock concerts. One concert in particular had a much higher patient rate than the others. This concert was characterized by the presence of a young crowd with a heavy metal rock band and lots of drug and alcohol abuse [by spectators] (De Lorenzo: personal communication).

This and the present report emphasize the need to individualize medical care coverage for these events. The San Antonio Papal Mass was held in extremely hot and humid ambient conditions, which produced a larger than expected number of spectator injuries and illness when compared to other papal masses. Considering the severe weather conditions, a rise in patient volume easily could have been predicted.

Using these types of articles, it should be possible to develop more flexible staffing guidelines for these events. The level of staffing should correlate with expected numbers and types of casualties rather than overall crowd size. A data bank and clearinghouse for these events perhaps could be set up at the National Association of EMS Physicians in Pittsburgh. Such a Large Event Data Bank (LEDB) could be set up by indexing the type of event, the number of patients expected, the intangible variables associated with environmental factors (temperature, humidity, altitude, etc.), societal factors (substance abuse), temporal factors (length of event), and crowd "performance" [demeanor]. This will allow reasonable planning for expected casualties at large events.

When a sudden, unexpected disaster occurs at one of these events (e.g., a crowd stampede, bleacher collapse, etc.), local and regional disaster plans can be called into play. This should not preclude pre-event preparation for a possible disaster which should be done for any large event. However, this would be more realistic and effective than always having enough medical staff available at all events to cover the most serious possibility.

This report [by Hnatow] has opened up the vista for a new look at how we can use our prehospital data to help plan for the best use of our resources in the future.

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1. De Lorenzo RA, Gray BC, Bennett PC, Lamparella VJ: Effect of crowd size on patient volume at a large, multipurpose, indoor, stadium. *J Emerg Med* 1989;7:379-384.