

# Wilderness Patient Management Cycle

*‘Reinventing the wheel; around and around is better than just getting to the end.’*

## Author

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## Abstract

Although our environment is both beautiful and, at times, highly challenging, any mishap involving ourselves or others quickly shifts our focus entirely to managing the situation. In these moments, even if our first aid skills aren't fully current, the fundamentals tend to resurface when we need them most.

Most first aid training follows widely accepted frameworks such as DRcABC and SAMPLE. These provide a structured way to assess and manage life-threatening conditions in order of priority, helping to preserve life and guide decision-making under pressure.

But what if the way we approach this process could be improved? What if refining our approach could lead to better patient outcomes?

## Purpose

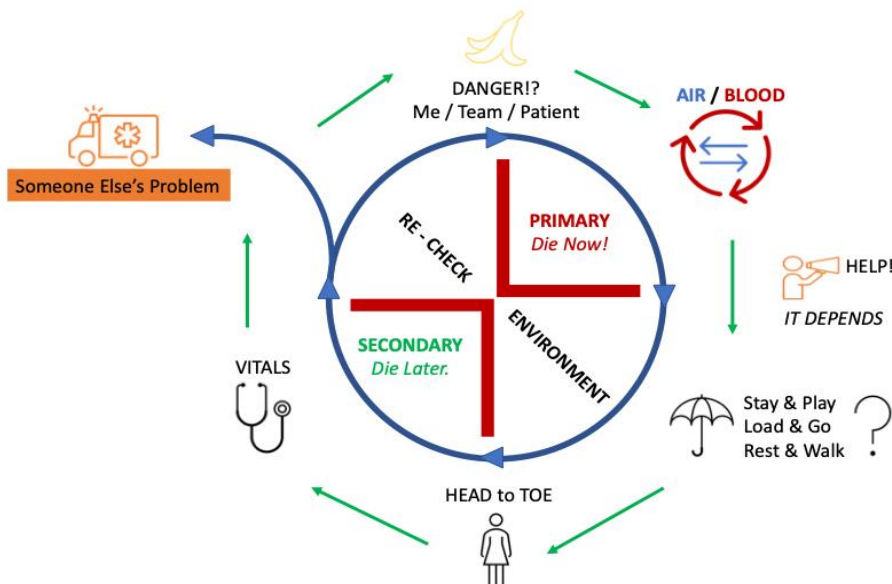
A key gap in many first aid courses—*possibly due to the absence of relevant NZQA standards?*—is the limited focus on long-term patient management in adverse environments.

This model addresses that gap by reinforcing that patient care is not a linear process, but a dynamic, adaptable cycle that continues until the patient can be transferred to a higher level of care.



## Delivery

The Wilderness Patient Management Cycle illustrates a refreshed approach to patient care that accounts for changes in environment and patient response over time. Critically, it recognises that patient management is not a linear process with a defined start and finish. Instead, it is cyclical driven by ongoing reassessment.



Rather than progressing from beginning to end and considering the task complete, practitioners must continually loop back through the cycle. Based on patient response, environmental factors, and elapsed time, this means returning to the “top” of the process and reassessing all elements to ensure care remains appropriate and effective.

*External to the cycle image are key priority reminders that guide patient assessment and management in the field*

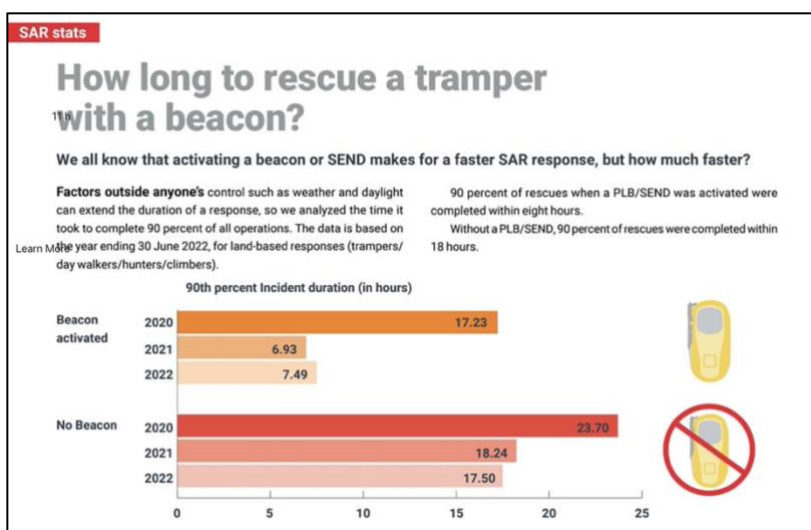
- **Danger?**  
Consider safety first: yourself, your team, and the patient. Address any immediate hazards before proceeding.
- **“Air in & out, Blood round and round” (CPR?)**  
Assess and manage airway, breathing, and circulation as immediate life priorities.
- **Send for help?**  
“It depends.” The decision is guided by the situation, available resources, and how best to communicate your needs or intent.
- **Manage the environment and decide on a plan\***
  - *Stay and play* – Immediate intervention required.
  - *Load and go* – The problem cannot be managed effectively in the field.
  - *Rest and walk out* – Minor or manageable issues with time.
- **Full head-to-toe secondary survey (“die later”)**  
Only once immediate threats to the patient and environment are controlled.
  - Includes vital signs, SAMPLE history, and further assessment.
- **Handover or restart the cycle**  
Transfer the patient to higher care when possible or restart the cycle. Any movement, repositioning, or change in condition should trigger a full reassessment of interventions and patient status.

The Internal circle indicates sequence of the critical needs or the ‘how much we care’ i.e.. **Die now, Environment, Die Later and Re-Check.**

- **Die Now** – reminds us that these key things are the priority over any other interventions at the time to maintain life
- **Environment** – one of the largest success factors to wilderness Pt management is the ability to manage the environment and thus increase the Pt. survival
  - *It is important to recognise that environmental management and patient stabilisation are more critical than often acknowledged. High-trauma patients who are cold or exposed to the elements are at increased risk of accelerated bleeding. Managing heat loss—even in moderate conditions—is essential for effective long-term patient care. Heat loss should be addressed in the following order: insulate from the ground (conduction), protect from environmental exposure (convection), and minimise radiant heat loss (radiation).*
- **Die later** – reminds us that if not assessed and managed the Pt. has the possibility to die later based on the information or additional treatments we gain or deliver i.e. Vitals and baseline checks once ‘stable’
- **Re-Check** – Once you have the opportunity to check the numbers and rework baselines, it’s a good time to confirm that all systems are still a go. This is especially important after the patient has been repositioned, packaged, received additional treatments or interventions, or been transported
  - *regular reassessment is essential until you can ‘Make it someone else’s problem’ and get them to higher care.*

## Summary

The ability to manage a patient beyond the timeframes typical of an urban setting is critical. Historical data shows that even under favourable conditions, a PLB activation may result in response times exceeding two hours—and in some cases extending beyond 24 hours due to weather or location constraints. In these situations, we must be able to stabilise the patient and maintain their condition as effectively as possible until care can be handed over.



A structured patient management system that supports ongoing monitoring and stabilisation is therefore essential. This contrasts with the more linear urban model, where patient care often concludes once emergency services are activated.

This approach also reinforces the importance

of effectively using available resources to manage a patient within the environment, particularly in mitigating heat loss through conduction, convection, and radiation.

## References

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