THE ORGANISATION OF EMERGENCY UNIT OUTRAM ROAD GENERAL HOSPITAL 1964 - 1968

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In August 1964 a new unit was formed in the Outram Road General Hospital. This unit is known as the Emergency Unit. The idea was mooted many years previously because the Casualty and Outpatient Department in the Outram Road General Hospital has become too congested for efficient and proper medical treatment. In early 1963 the yearly attendance was 394,000 i.e., more than 1,000 patients coming for attention per single day.

With the reorganisation in August 1964, the Government shifted the former Outpatient Department away from the Hospital with headquarters in Maxwell Road, controlling twenty-six Outpatient Departments distributed all over the Island.

The Emergency Unit thus formed is primarily for the treatment of medical and surgical emergencies. It also functions as a triage unit—making diagnosis and sorting patients to specialist departments. It undertakes minor surgery, resuscitation of the acutely injured before transfers to the wards and temporary emergency treatment of patients attending during off-duty hours when the specialist units are not fully functioning.

During duty hours (8.00 a.m. to 4.30 p.m.) the unit sees all patients referred from doctors in the Government Outpatient Dispensaries and private practitioners. In the case of Government Outpatient Dispensaries, non-emergency cases as assessed by the medical officer on duty are referred to the specialist clinics of the Hospital if they are medical cases, and if they are surgical cases they are given a date to come to the cold surgical clinic on Tuesdays and Fridays. In the case of private practitioners, non-emergency cases are either referred back to the private practitioners for subsequent referrals to the specialist units or if their economic circumstances are such that they cannot afford a private practitioner, they are referred to the Government Outpatient Dispensaries for further investigations and management.

After office hours (4.30 p.m. to 8.00 a.m.) all cases arriving at the Hospital are screened in the Emergency Unit. Emergency cases are either dealt with outright and if the cases are minor they are referred back to the nearest Outpatient the next day after treatment or admitted into the wards for subsequent management by the specialist unit on duty. In cases of doubt, patients are observed in the observation room after initial assessment. The maximum period for observation is 24 hours.

Not only does the Emergency Unit subserve the Hospital as a screening and filtering unit but it also organises itself as a casualty clearing station during major disasters and catastrophies occurring in the Republic, i.e., riots, severe multiple injuries in road, air and naval accidents.

FACTS AND FIGURES

Fig. 1 shows the relative number of all cases seen in the Emergency Unit from 1964-1968. It includes traumatic and non-traumatic cases as well as emergency and non-emergency cases as designated by the medical officer on duty in Emergency Unit. It is interesting to note that approximately 100,000 patients are seen and treated annually as compared to 394,000 patients in 1963, i.e., an average of 274 patients seen daily giving the doctor approximately 11 patients an hour to question, see, diagnose and subsequently treat or refer the cases.

Fig. 2 shows the relative number of cases referred from the Government Outpatient Dispensaries. In 1964 non-emergency cases are still referred by the Outpatient Dispensaries doctors in overwhelming proportions, but as experience is gradually learnt, there is now an even distribution of non-emergency and emergency cases referred. The ultimate aim is to reduce the non-emergency cases to the lowest minimum and to re-educate the public and the general practitioner section of the Government and private sector to be more self-reliant. It is, however, accepted that differences in opinion regarding emergency and non-emergency will perpetually arise among the medical profession, in view of the fact that litigation and medico-legal complications will increase in geometric proportions as society in Singapore becomes affluent and more sophisticated.

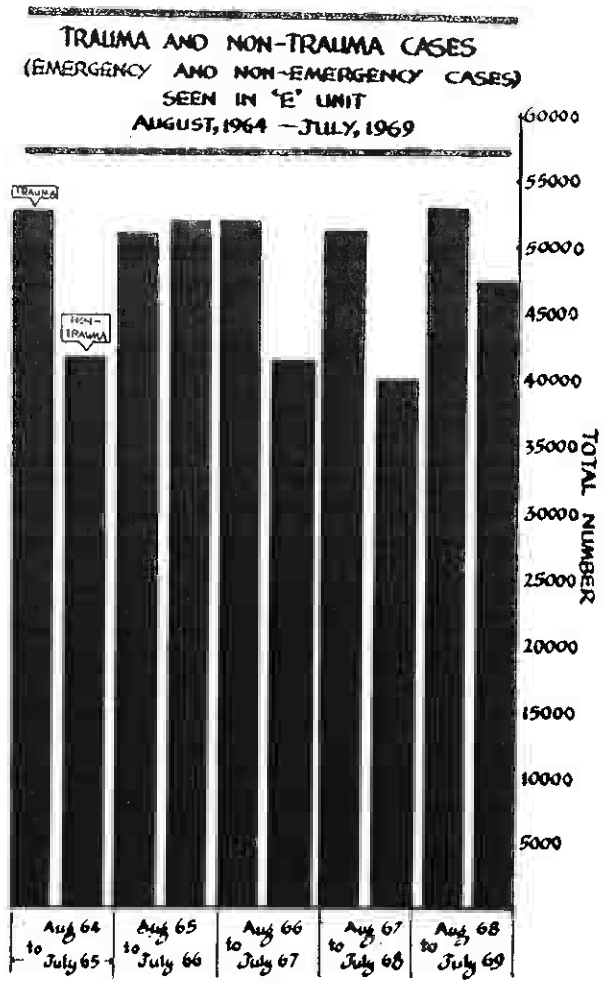

Fig. 1.

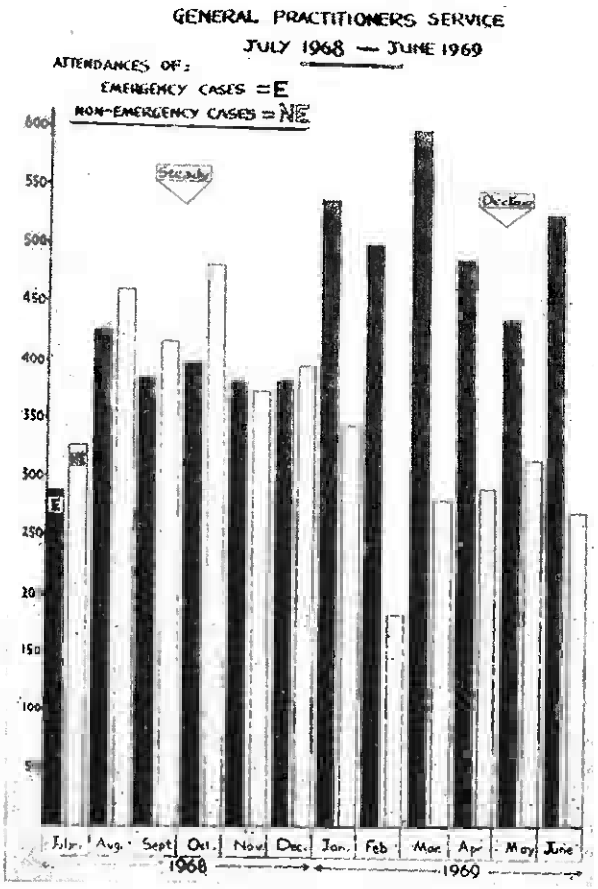

Fig. 3.

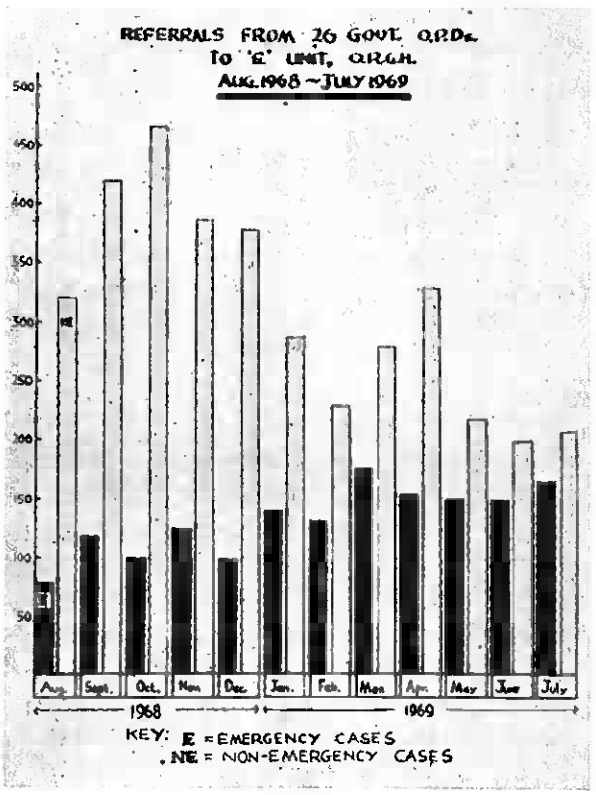

Fig. 2.

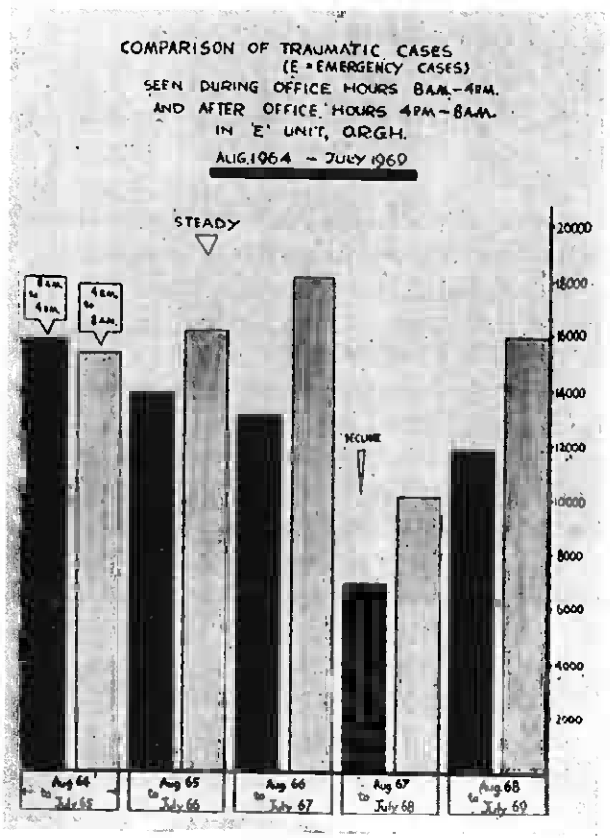

Fig. 4.

In contrast, Fig. 3 shows cases seen by self-employed private practitioners. Here there is a greater increase in emergency cases compared to non-emergency cases, illustrating the obvious fact that financial circumstances play an important role in the overall medical care of the community. The services rendered by the Emergency Unit is being highly appreciated by the doctor population of our community who are now beginning to realise that doctors in Hospital require more time to cope with the highly skilled and technological services required by patients in Hospital.

Fig. 4 shows the number of traumatic cases seen as emergency during and after office hours. The fact that after office hours more cases are seen is due to the minor traumatic cases being effectively dealt with by our twenty-six Government Outpatient Dispensaries. Apart from Thomson Road General Hospital with a 24-hour service, Emergency Unit in Outram Road General Hospital sees all traumatic cases after office hours. In 1968 to 1969, an average of 44 cases are seen daily between 4.00 p.m. to 8.00 a.m. as compared to 33 cases between 8.00 a.m. to 4.00 p.m.

Fig. 5 shows the number of traumatic cases classified as non-emergency seen during and after office hours. This includes minor wounds and abrasions, delayed injuries after a day or more, cases which can be easily treated the following day in the Outpatient Dispensaries and cases requiring only X-ray confirmation for negative evidences of fracture. In 1968 to 1969 after office hours an average of 35 cases are seen daily between 4.00 p.m. to 8.00 a.m. compared to 30 cases between 8.00 a.m. to 4.00 p.m.

Fig. 6 shows the acute non-traumatic medical and surgical emergencies seen during and after office hours. It is a curious paradoxical fact that more cases are seen during the night than the day, an average of 30 daily after office compared to 20 daily during office hours in 1969. The questions come to mind are:—

1. Are there more medical and surgical emergencies in the community in the evening?
2. Is there reluctance of the public to obtain medical advice during office hours because of the fear of losing their jobs?
3. Is there a distrust in the average common individual in the capabilities of the doctor outside the hospital and the worship of the public for the advanced technological paraphernalia in hospital.

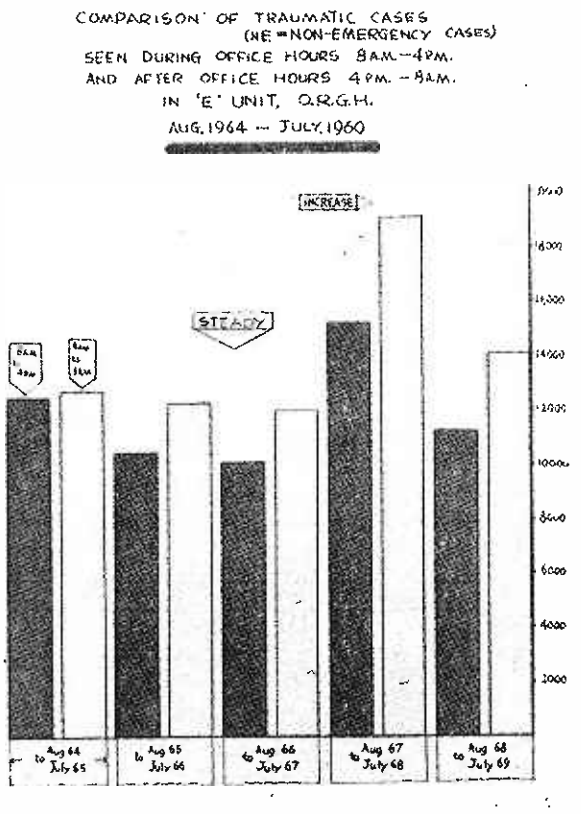

Fig. 5.

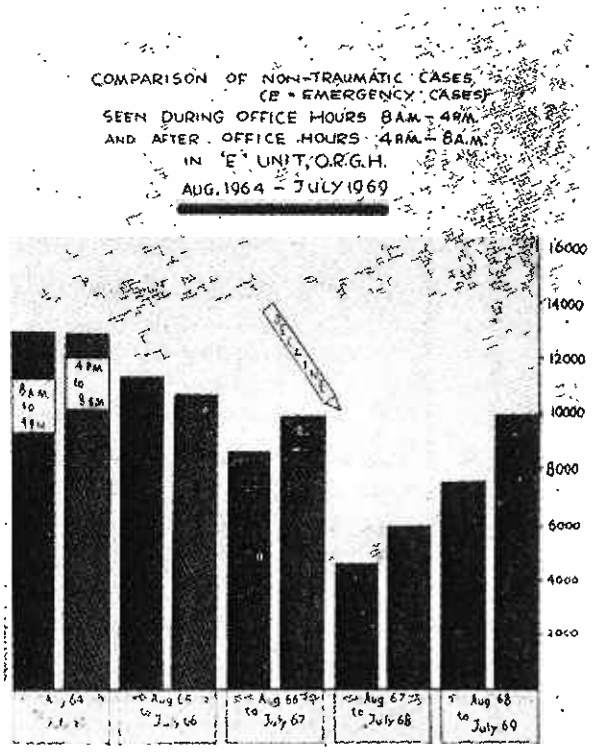

Fig. 6.

Whatever the answer to the problem, it is a mandatory function of the personnel in Emergency Unit to cope with the members of the public with firmness and courtesy.

Fig. 7. The number of non-emergency medico-surgical cases seen in Emergency Unit out-number the emergency cases during and after office hours. The average of 44 cases after and

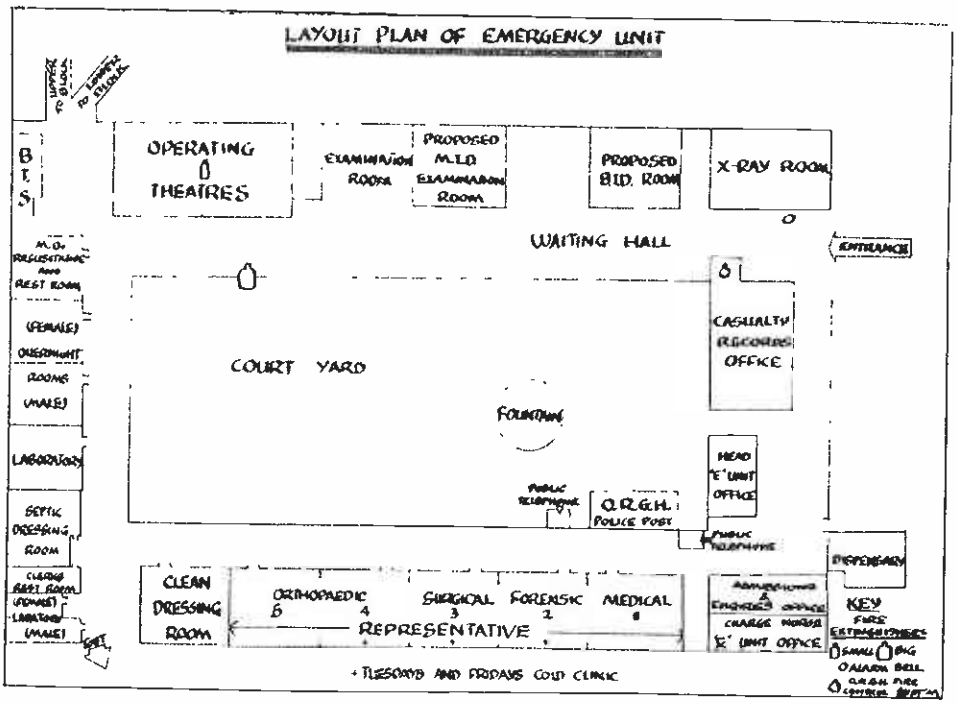
LAYOUT PLAN OF EMERGENCY UNIT
OPERATING THEATRES
EXAMINATION ROOMS
PROPOSED M.L.O EXAMINATION ROOM
PROPOSED B.I.D. ROOM
X-RAY ROOM
WAITING HALL
ENTRANCE
COURT YARD
FOUNTAIN
CASUALTY RECORDS OFFICE
HEAD 'E' UNIT OFFICE
O.R.G.H. POLICE POST
PUBLIC TELEPHONE
DISPENSARY
KEY
CLEAN DRESSING ROOM
ORTHOPAEDIC
SURGICAL
FORENSIC
MEDICAL
REPRESENTATIVE
+ TUESDAYS AND FRIDAYS COLD CLINIC

Fig. 8.

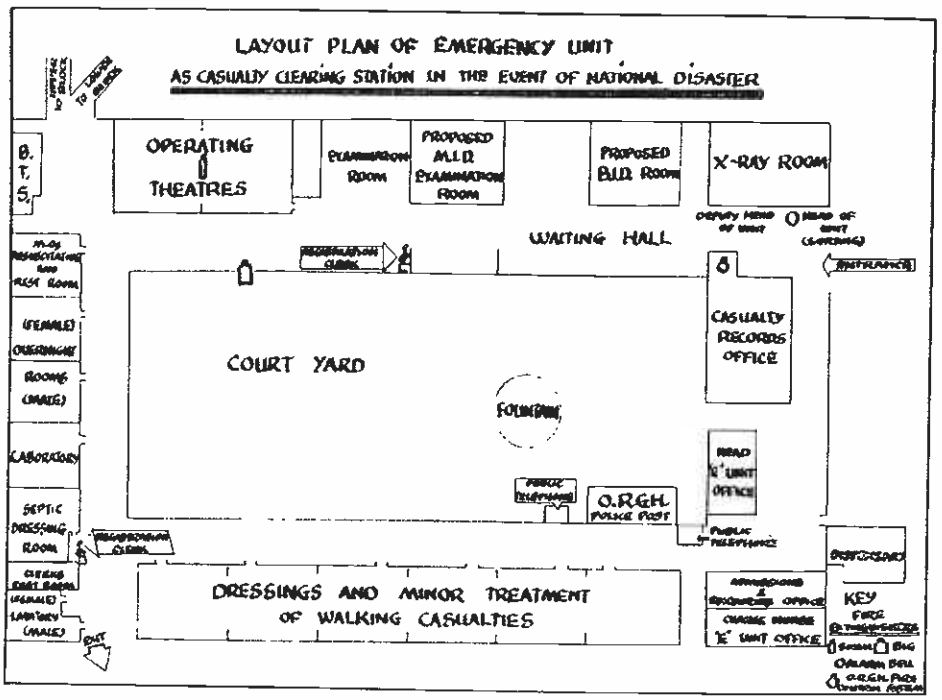
LAYOUT PLAN OF EMERGENCY UNIT
AS CASUALTY CLEARING STATION IN THE EVENT OF NATIONAL DISASTER
OPERATING THEATRES
EXAMINATION ROOM
PROPOSED M.L.O EXAMINATION ROOM
PROPOSED B.I.D. ROOM
X-RAY ROOM
WAITING HALL
ENTRANCE
COURT YARD
FOUNTAIN
CASUALTY RECORDS OFFICE
O.R.G.H. POLICE POST
PUBLIC TELEPHONE
DISPENSARY
KEY
DRESSINGS AND MINOR TREATMENT OF WALKING CASUALTIES

Fig. 9.

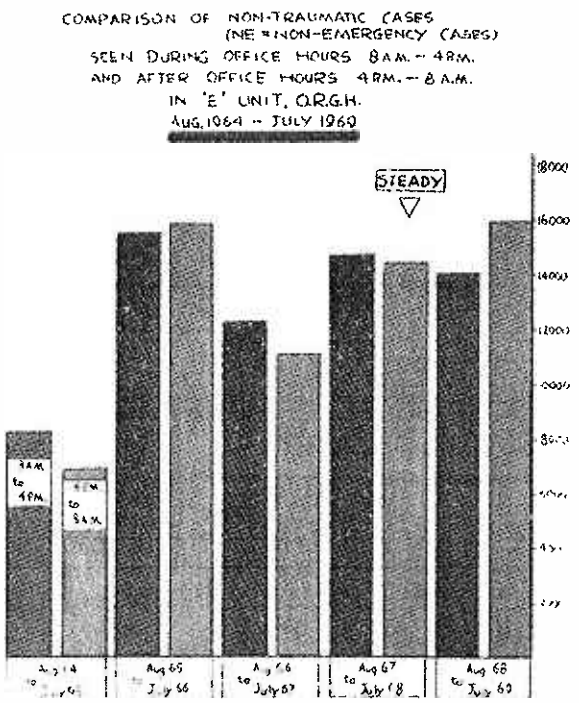

Fig. 7.

35 cases during office hours are seen as non-emergency as compared to 35 to 20 cases respectively in emergency cases. The statistics in this particular problem is indicative of the skill and dedication of the general practitioner service to the community whether they be in private or Government sector, and the progress or deterioration of this trend provides the Ministry with improved guide lines in the planning of medical care of the whole community.

Fig. 8 shows the normal layout of the Emergency Unit in Outram Road General Hospital. It is important to note that there is an entrance for ambulance cases and a separate entrance for ambulant cases. Representatives from specialist units are available in their rooms for referral from Emergency Unit doctor who may be in doubt regarding more specialised treatment or hospitalization.

Fig. 9. When an emergency is proclaimed, i.e., riots, air-crashes, naval accidents, the emergency bell is rung in the offices and the building is cleared of all patients and the Unit is then converted into a reception area on one side for major casualties brought in by ambulances and on the other side for the walking wounded for necessary first-aid and outpatient treatment. It is important to note that the registration of patients commences once the patient is brought to the entrance and finally when disposed to the ward or home. The building is fortunately so constructed as to enable enclosure to all persons except via the entry and exit doors. This drill for conversion is routinely instituted once a month to familiarise the staff and personnel of Emergency Unit especially so when there is a change of staff.

THE FUTURE

The formation of Emergency Unit has now been shown within five years of its existence to be an unqualified success. Much more is required to be done. However, with many imponderable factors, it is difficult to project our development in the forseeable future. The most important consideration is to maintain a high standard of efficiency as regards disposal of cases to the specialist units in a rapid and efficient manner and to prevent the increase in the non-emergency cases sent to Emergency Unit. The appointment of a highly qualified surgeon as head of Emergency Unit has gone a long way in improving the technical care of the Unit, giving the medical officers serving there a measure of confidence in their ability to sort out cases as well as in diverting cases back to the general practitioners in the private or Government sector. Medico-legal cases especially of a minor casualty nature is slowly being sorted out and although the day when there will be a doctor on demand by the public is still far away, the department must be prepared (exigencies of the service notwithstanding) to strive for the ideal in the proper, efficient and courteous care of the patients who seek medical attention.

"In its desire for radical rethinking about the provision of medical services the medical profession surely should not object if in the process some of its own shibbloeths are brought into question. Throughout this inquiry we have assumed that medical care has in every instance to be based on personal care by a general practitioner. Like so many others this assumption has never been tested in this country in the light of its value to the patient. As with the specialists' monopoly of the hospitals the general practitioners' monopoly of the patients is something bequeathed to us by the Victorians. Perhaps more than anything else we need to define the role of the general practitioner objectively in terms of twentieth-century circumstances, and having done that, make it possible for the role to be fulfilled."

Quoted from "Gateway or Dividing Line?"

REFERENCE

Gateway or Dividing Line? By Gordon Forsyth and Robert Logan.