Preventive health in the emergency department: Is our safety net becoming too big?

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Emergency medicine has developed processes to deal with high risk (chest pain unit) and high volume (fast track). We've introduced domestic violence screening and outpatient low-molecular-weight heparin programs, demonstrating our capacity to meet an ever-increasing list of unmet needs. But given widespread ED gridlock, surely we have to question how much more we can or should do. In today's constrained and overcrowded environment, emergency departments (EDs) are often unable to provide the timely, quality care we would want for ourselves, our friends and families. For this reason, many might view public health initiatives like ED vaccination programs as an inappropriate use of a limited resource. On one hand, it may be neither safe nor reasonable to expend limited ED resources on preventive health; on the other hand, it is undeniable that prevention has downstream benefits. If influenza contributes to ED gridlock, then prevention is in our best interest.

Previous US studies[1–3] have sparked debate as to whether EDs can be all things to all people. Wrenn and colleagues[4] evaluated ED influenza immunization and found that only 5% of ED physicians employ case-finding methods, and that many are hesitant to take on this role. The US Centers for Disease Control (CDC) has recommended that EDs provide immunizations. Health Canada has not. Perhaps Canadian officials assume (incorrectly) that our "universal" health care system has eliminated barriers to immunization and does not require any expansion of access.

Chiasson and Rowe[5] are to be commended for undertaking a study that examines the potential for delivering influenza vaccine in a Canadian ED. They found that 50% of at-risk individuals presenting to their ED had not yet been immunized and that 50% were not immunized the year before. This demonstrates that, at least in one community, the existing primary care and public health programs failed to achieve provincial targets. Suboptimal compliance rates confirm that there are flaws in the immunization process. Various strategies have attempted to improve immunization rates, but none are 100% successful. Many patients slip through the cracks, and these are often the same patients who tend to seek care in the ED. We have an opportunity to immunize high-risk patients, improve population health and reduce pressure on acute care services . . . pay me now or pay me later!

Unfortunately, expanding the scope of ED services may have negative effects. Offering comprehensive access to specialty services, sophisticated diagnostic modalities, rapid treatment and a growing list of preventive care modalities may create insatiable market demand and draw patients away from primary care providers who are better positioned to provide continuity of care.

The costs and benefits of ED preventive health programs have not yet been well defined. In view of current funding and operational issues, EDs clearly have a finite capacity to increase their scope of care. Nevertheless, the ED is a critical component of community health care delivery and has an important role in health promotion initiatives. Whether we like it or not, the ED "safety net" is still growing.

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