EDITOR'S NOTE

The Environment of Health Care: Primum Non Nocere

As a profession, we tend to neglect to reflect on the impact our environments of care may have on patients' experiences of illness. In particular, our emergency departments and inpatient wards tend to be chaotic maelstroms of human activity with few boundaries. To the unacculturated, these environments can be extremely frightening. Couple that with the terror of severe, life-threatening illness, and one can only imagine how distressing that might be. In this issue of the journal we are presented with provocative observational data that show an association between exposure to such an environment (in this case a crowded emergency department) in the midst of having a myocardial infarction, and an increased incidence of subsequent posttraumatic distress syndrome. This is a novel area of important inquiry and brings to our attention the question of how to optimally build structures and processes of care that may be more conducive to sensitive caring. This could include innovative designs of emergency departments and ward rooms, and triage processing of critical patients to environments that minimize exposure to the disruptive mayhem of other hospital activities. Of course, physicians should always be mindful of the patient's experience and work to optimize his or her comfort, both physical and emotional. But if we can build structures and develop processes that make it easier to care for patients in optimal environments, then we will be better able to care for patients. More work needs to be done to assess whether doing so results in less traumatic distress, among other outcomes. At the very least, our environments of care should not be contributing to morbidity.

Patrick G. O'Malley, MD, MPH

End-of-Life Care: Where Does the Standard Oncology Care Fail Our Patients and What Do We, as Oncologists, Need to Do Differently?

The study by Zhang et al1 presents the final results of the Coping With Cancer (CWC) study, which is the most comprehensive, prospective study on end-of-life (EOL) care to date, examining patients, caregivers, and health care system end points, and for this the authors need to be congratulated. It puts in order of importance the predictors for better quality of life (QoL) for patients at the EOL. It particularly identifies the standard oncologic care as the most important factor in the 9 predictors of better QoL for patients at the EOL. The study suggests that the most important inquiry and brings to our attention the question of how to optimally build structures and processes of care that may be more conducive to sensitive caring. This could include innovative designs of emergency departments and ward rooms, and triage processing of critical patients to environments that minimize exposure to the disruptive mayhem of other hospital activities. Of course, physicians should always be mindful of the patient's experience and work to optimize his or her comfort, both physical and emotional. But if we can build structures and develop processes that make it easier to care for patients in optimal environments, then we will be better able to care for patients. More work needs to be done to assess whether doing so results in less traumatic distress, among other outcomes. At the very least, our environments of care should not be contributing to morbidity.