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. 

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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 al 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. Essentially the 9 predictors can be divided into 2 groups. The first group, ie, intensive care unit admission, hospital deaths, site of cancer care, use of feeding tube, and chemotherapy in the last week in life, reflects aggressiveness of EOL care. The second group, ie, patient worry, religious prayer or meditation, pastoral care, patient-physician therapeutic alliance, reflects psychological/religious-spiritual met or unmet needs and coping mechanisms.

Hence deficiencies in EOL care are identified. The underlying cause for these deficiencies in EOL care can be traced back to how standard oncologic care is for patients with advanced incurable cancer. A recent American Society of Clinical Oncology statement suggests that there is an increased focus on disease-directed therapy, often without realistic conversations about prognosis, the potential benefits and limitations of disease-directed therapy, and the potential role of palliative care. This results in increased aggressiveness of care, while neglecting to address physical, psychological, and spiritual consequences of disease and its treatment.