JAMA Network Open

Invited Commentary | Pediatrics

Use of Euphemisms to Avoid Saying *Death* and *Dying* in Critical Care Conversations—A Thorn by Any Other Name

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The study by Barlet et al[1] revealed that although death was a frequent topic during family meetings about critically ill infants, the word *death* was rarely spoken. In an analysis of 33 clinician-family meetings that took place in a neonatal, pediatric, or pediatric cardiac intensive care unit setting, among the 406 identified references to death, *die*, *death*, *dying*, or *stillborn* were used only 8% of the time. The authors categorized the remaining 92% of references to death as euphemisms, in which the speaker replaces a harsher word such as *death* with language they anticipate will be less blunt, such as *pass away*. The authors further broke down this classification into 4 different types of euphemisms: survival framing (eg, *not live*), colloquialisms (eg, *let her go*), medical jargon (eg, *code event*), and pronouns without a clear antecedent (eg, *it may happen soon*).

Frameworks for categorizing medical communication, such as the one Barlet et al[1] propose, can be an important tool in addressing how patients and their families understand their health, in this case directly impacting life-and-death decisions. Although clinicians acknowledge the importance of using clear, patient-friendly language, their use of medical jargon with patients remains common.[2,3] This mismatch of intent and action has been called jargon oblivion—a clinician's failure to recognize and mitigate their use of medical jargon despite having a broad awareness that patients may find it confusing.[4] Given that consensus guidelines recommend avoiding euphemisms when discussing end-of-life care,[5] the findings presented by Barlet and colleagues[1] further demonstrate the existence of this mismatch between clinicians' intentions and their actions. We have argued that unless we equip health care practitioners with ways to recognize words and phrases they use that may be poorly understood by their patients, they will continue to use language that creates confusion. Accordingly, we have published a classification system of 7 types of medical jargon to aid clinicians and health educators with a framework to recognize the nuances of their language choices and appreciate the potential for confusion these can generate.[4] Barlet and colleagues[1] provide further consideration of types of speech that may obscure a clinician's intended meaning or distract from their true point in the context of family discussions about critically ill patients.

What makes the findings of Barlet et al[1] so compelling is that euphemisms—the linguistic mechanism they revealed to be most commonly used when discussing death—are different from the other categories of jargon. The use of most jargon types (eg, technical terminology, abbreviations, medicalized English, and unnecessary synonyms) likely reflects jargon oblivion; the speaker is so accustomed to communicating within their field that they simply forget that not everyone understands the phrases they use. Substituting a euphemism for a word or phrase that may be difficult to hear, by contrast, is often an intentional choice. Unfortunately, euphemistic phrases aimed to be less harsh for patients to hear (eg, *pass on* instead of *die*) or to more politely address something that may be perceived as distasteful (eg, *voided* instead of *peed*) may still cause confusion among patients. In 1 study, for example, few patients understood cancer euphemisms such as *spots* or *seedlings* that health care practitioners may say in place of *metastases*.[6] Another study revealed that the use of terms such as *spots* or *shadows* to describe x-ray findings without further clarification can contribute to prolonged anxiety in patients.[7] Clinicians may also choose to substitute a euphemism to replace what they recognize may be poorly understood medical jargon, only resulting in further patient confusion. For example, a clinician may intend to be more patient-friendly by calling a

bacterial urinary tract infection "bugs in the urine," but patients may leave the encounter even more perplexed because they may visualize insects in their urinary system.

Although we included euphemisms as a category in our classification system of jargon types, Barlet et al[1] provided a valuable subanalysis of the types of euphemisms that are often used in clinical scenarios. Their category of colloquialisms in which *death* was replaced with more figurative language (*pass away* or *not make it*) likely reflects what most people consider as euphemisms being used to soften language. The authors' analysis revealed deeper subtlety, however, showing how commonly physicians stretch their euphemisms away from clear communication about death, for example, by using vague pronouns (*it will likely happen soon*).

It is worth noting that although we proposed euphemisms as a subcategory of medical jargon in our classification schema, Barlet et al[1] categorized them in the opposite way, identifying the use of technical medical jargon as a type of euphemism. They described the use of technical terminology (*cardiac arrest*) or physiologic language (*heart rate may drop and not recover*) euphemistically to avoid words such as *death* or *dying*. This is compelling and fits with the nuance that euphemisms tend to be intentionally chosen to avoid saying something that the speaker fears will be hurtful or overly challenging to hear.

The article by Barlet and colleagues[1] is also unique in that studies of jargon use in medical settings typically assess the language spoken by the clinician only. In their study, the authors revealed that both clinicians and families infrequently used words directly related to death, although families used them 3 times as often as clinicians. This pattern of use identified among the infants' families may indicate that despite the clinical recommendation that end-of-life discussions avoid the use of euphemisms,[5] it may be worth noting and responding to families' language preferences accordingly once it is clear they have expressed understanding that the clinician is speaking of death. It may not be an effective demonstration of empathic, family-centered communication for the clinician to keep responding with *death* and *dying* when the family is consistently choosing softer terminology. As the authors note, family preferences for this type of discussion are an important target for future research aimed at optimizing family-centered communication.

Ultimately, research like the study by Barlet et al[1] provides frameworks for evaluating how clinicians communicate and presents tools for instruction and self-audit. Simply telling health care practitioners to use less jargon or avoid euphemisms is less effective than providing concrete examples and classification schemes for consideration. Such frameworks and classifications will inform future study.[2,3] The work of Barlet and colleagues[1] provides a nuanced summary of how even when clinical conversations are quite literally life-and-death discussions, clinicians may rarely mention the latter by name.

ARTICLE INFORMATION

Published: October 5, 2022. doi:10.1001/jamanetworkopen.2022.33727

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Conflict of Interest Disclosures: None reported.

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