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The importance of word choice in the care of critically ill patients and their families

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Words are one of the primary ways we express and explain ourselves to our patients, patients' families, and our colleagues in the ICU. The words we choose are important to ensure we are understood and that our meanings are not misinterpreted. There are few places where this is more important than in talking with patients, families, and colleagues about the goals of care and about end-of-life care. These discussions are often complex, difficult, and emotional. We know that patients' family members often do not understand the words we use and that we miss important opportunities to be clear and empathic with them [1, 2]. Interventions designed to improve our ability to communicate with family members can have a profound effect on their symptoms of anxiety, depression, and post-traumatic stress after a patient dies in the ICU [3]. These issues become particularly important in the setting of family presence on rounds or during procedures like CPR [4]. Similarly, miscommunication with our colleagues can also lead to confusion, while good communication among ICU colleagues is associated with reduced ICU clinician burnout [5, 6]. The specific words we choose can have a profound effect on whether we are viewed as being clear in our communication and decision-making and whether we have empathy and are sensitive to patients', families' and colleagues' needs [7].

In this commentary, we have identified some examples of phrases in the English language that, in our experience, are commonly used in communicating with patients, families, and colleagues, and which we believe can convey unintended negative messages or which can be confusing to those with whom we are communicating (Table 1). We will briefly review each of these phrases and offer alternatives that we think more clearly convey our intent.

Although we may withhold or withdraw life-sustaining measures in the ICU, we should not withhold or withdraw our "care" for a patient and their family, and therefore we should not use the phrase "withdraw care." In the setting of withdrawing life-sustaining measures for a patient anticipated to die, we should continue our caring for the patient and the family, and we may even provide "aggressive" care for the patient, focused on symptom control and maximizing quality of life at the end of life. Rather than talking about "withholding and withdrawing care", we should discuss withholding and withdrawing life-sustaining measures. Similarly, we should avoid using the phrase "there is nothing more we can do." There is always care that can be provided to patients and their families, even if patient care is focused exclusively on the patient's comfort or the patient is actively dying.

Much has been written about the "moral and ethical equivalence" of withholding and withdrawing life-

Table 1 Words we should avoid in the ICU and some alternatives

Phrases we should not use	Replacement	Rationale
Withholding or withdrawing care	Withholding or withdrawing life-sustaining measure	We never withhold or withdraw our "care"
There is nothing more we can do	We will focus our efforts on keeping the patient comfortable	There is always additional care and support we can provide, even if our care will not sustain life
Withholding and withdrawing life-sustaining measures are morally and ethically equivalent	Withholding and withdrawing life-sustaining measures are both ethically and morally permissible	These two acts (withholding and withdrawing) are not the same, but they overlap practically and they are both morally and ethically permissible in the right circumstances
Consider an end-of-life decision	Consider continuing, withholding, or withdrawing life-sustaining measure	An "end-of-life decision" is not specific and presumes only one outcome. If the decision is made to pursue ongoing life-sustaining measure, it is not an end-of-life decision
No escalation of treatment	Make decisions about whether additional specific therapies are indicated	"No escalation" of treatment as a plan of care can be confusing, especially to physicians receiving handoffs, since the specific definition of an "escalation" can be subjective and arbitrary. In addition, an escalation cannot be specified for many ICU therapies.

sustaining measures [8, 9]. However, this phrase about "equivalence" has become confusing and, while it was a useful concept in the early years of withdrawing life-sustaining measures in the ICU [10], it now creates a confusing dichotomy focusing on the wrong point. In fact, withholding and withdrawing are not the "same"—one is an act of omission (withholding), while the other is an act of commission (withdrawing). Our point here is that the omission and commission of an act are different in a practical sense, and we are not specifically addressing the argument as to whether they are morally equivalent. Studies show that ICU clinicians and family members of critically ill patients do not view withholding and withdrawing as being the same or equivalent [11, 12]. This perceived difference is likely reinforced by the fact that patients die much more frequently after withdrawing life-sustaining measures than withholding them (93 vs. 68 % mortality within 72 h) and more quickly [13]. A more useful framing for this question is whether withholding and withdrawing life-sustaining measures are both morally and ethically permissible, and whether either or both are morally and ethically preferable to continuing life-sustaining measures in certain circumstances, such as when the burden of treatment outweighs the potential for benefit. The rephrasing of these common terms focuses us on the important issues of assessing the potential burdens and benefits of the treatments we offer.

A phrase commonly used in research about end-of-life care in the ICU is making an "end-of-life decision." This term is commonly used to describe a decision about withholding or withdrawing life-sustaining measures. However, this is a confusing term because, in the process of making such a decision, it is not yet an "end-of-life decision." It is only an "end-of-life decision" if the decision is made not to provide or continue life-sustaining measures. If the decision is made to provide or continue life-sustaining measures, there has been an important decision made about life-sustaining measures. This decision is certainly not an "end-of-life decision," yet it is an important decision to capture. Therefore, it is clearer to talk about making a decision to continue, withhold, or withdraw life-sustaining measures, in which case any decision—whether it is to continue, withhold, or withdraw life-sustaining measures—is captured by this phrase.

Another confusing phrase that is often used is "no escalation of treatment." This is a phrase used to describe a decision to continue current life-sustaining measures but not to add additional, intensive life-supporting measures. However, this is a confusing phrase because what constitutes an "escalation" is not clear and may vary dramatically from clinician to clinician. For a patient in septic shock on norepinephrine and vasopressin, clinicians may differ in whether increasing the dose of norepinephrine slightly or giving a bolus of saline would constitute an "escalation of treatment." Instead, it would be clearer to refer to such decisions as a decision whether additional intensive therapies are indicated given the prognosis and the patient's goals of care. Under this terminology, the potential risks and benefits of each new treatment are considered.

These phrases are intended as some common examples on how our words can be confusing or can be misinterpreted by patients, families, or colleagues. In addition to the words we choose, it is important that we are able to actively listen and to use our non-verbal communication to express empathy and support. However, it is also important that we are thoughtful about our choice of words and are sure that our words reflect our decision-making processes as well as the compassion and empathy we have for our patients, families, and colleagues. This is

especially important when discussing prognosis, goals of care, or the decision to withhold or withdraw life-sustaining measures. Careful word choices can facilitate better communication and quality care, as perceived by all those we work with and for in the ICU.

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