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When We Document End-of-Life Care, Words Still Matter

To the Editor:

In the September 2018 edition of the *Journal of Pain and Symptom Management*, the study "Language used by health care professionals to describe dying at an acute care hospital" focused on specific word choices when documenting end-of-life care.[1] They accurately note that, in acute care settings, the patient's medical record often becomes the primary mechanism for communication between providers. Imprecise documentation can lead to poor transfer of knowledge and even implicit bias.[2] Wentlandt et al. describe the "implied state" category as most frequently used by nonpalliative care providers, which labels patients by the care they receive (e.g., "he receives comfort care") without clearly indicating estimated prognosis. Specific terms such as "dying," "die," and "passing" (a word that many would characterize as an inexact euphemism) were only documented 24.7% of the time.

Words still matter. Provider discomfort compassionately employing clear, direct terms (e.g., "your father is dying") has been well described.[3,4] The unintended consequences of using oblique terminology (e.g., "your father is transitioning") certainly include miscommunication ("you mean my father has been moved to a different room?") and missed or delayed opportunities to engage in the grieving process. What this study underlines is the remarkable extent to which provider discomfort talking about death and dying extends away from the patient/family encounter to the clinical chart: we are anxious to say these things even to each other.

We applaud the efforts of Dr. Wentlandt and colleagues to shine the light onto our communication practices within the medical record. Perhaps, these findings offer the opportunity for our own hospice and palliative care field to clearly define best communication practices. For example, the *Journal of the American Geriatrics Society* recently took a stance on language by requiring its authors to use the term "older adult" when referring to someone aged 65 years or older rather than seniors or elderly.[5] We suggest *JPSM*, and other discipline-specific journals consider adopting similar word choice policies related to terminology of death and dying—let's set a standard for others to follow.

Sincerely,

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https://doi.org/10.1016/j.jpainsymman.2018.09.015

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Response to Hyoscine Butylbromide for the Management of Death Rattle: Sooner Rather Than Later

Dear Editor:

I read the recent paper regarding death rattle treatment with great interest.[1] The authors are commended for giving consideration to this naturally occurring patient noise that is distressing to clinicians and families.

Clinicians have largely believed there is no patient distress as death rattle develops in the context of declining consciousness. We established that there is no patient distress associated with the development