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Futile Treatment in Hospital: Doctors' Intergroup Language

Cindy Gallois¹, Lindy Wilmott², Ben White², Sarah Winch¹, Malcolm Parker¹, Nicholas Graves², Nicole Shepherd² and Eliana Close²

Abstract

Treatment that will not provide significant net benefit at the end of a person's life (called *futile treatment*) is considered by many people to represent a major problem in the health sector, as it can waste resources and raise significant ethical issues. Medical treatment at the end of life involves a complex negotiation that implicates intergroup communication between health professionals, patients, and families, as well as between groups of health professionals. This study, framed by intergroup language theory, analysed data from a larger project on futile treatment, in order to examine the intergroup language associated with futile treatment. Hospital doctors (N=96) were interviewed about their understanding of treatment given to adult patients at the end of life that they considered futile. We conducted a discourse analysis on doctors' descriptions of futile treatment provided by themselves and their ingroup, and outgroup colleagues. Results pointed to an intergroup context, with patients, families, and colleagues as outgroups. In their descriptions, doctors justified their own decisions using the language of logic, ethics, and respect. Patients and families, however, were characterized in terms of wishing and wanting, as were outgroup colleagues. In addition, outgroup doctors were described in strongly negative intergroup language.

Keywords

intergroup health communication, linguistic intergroup bias, end of life, futile treatment

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¹ The University of Queensland

² Queensland University of Technology

Corresponding Author:

Cindy Gallois, School of Psychology, Faculty of Health and Behavioural Sciences, The

University of Queensland, St Lucia, Qld 4072, Australia

Email: c.gallois@uq.edu.au

Medical treatment for people at the end of life is a central issue in both health care and communication (e.g., Mohammed & Peter, 2009). In particular, there is a great need to understand the processes that allow or even encourage people to receive treatment that is not beneficial to them – sometimes called futile treatment (NHMRC, 2011). Whatever their own desires, the majority of people throughout the western world currently die in acute-care hospitals (Australian Commission on Safety and Quality in Health Care, 2013). This care comes at a considerable cost, in money and other resources, in a system where health-care resources are in short supply (Fleck, 2011). Thus, there is great interest in preventing futile treatment in hospital.

Intergroup Communication and Futile Treatment

Aggressive treatment that continues until the point of death can interfere with the precious time remaining between patients and their families. Thus, it is essential but difficult to understand end-of-life treatment and its full cost (emotional as well as financial) and perceived benefits. When people do not die suddenly, there are complex negotiations about the end of life between doctors, nurses, allied health professionals, patients (where they are conscious and competent), and patients' families. The importance of this negotiation has long been recognized (e.g., Slomka, 1992), but it is still a poorly-understood area of communication (e.g., Candrian, 2013). What is often not recognized, either by stakeholders or by researchers, is that this communication is intergroup, and people's social identities are salient to varying extents, depending on the situation and the groups involved. Thus, the lens of intergroup communication (Giles, 2012) provides a valuable way to examine the kind of language and communication used in deciding whether to continue to provide aggressive treatment to a dying person.

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The language used in discussing treatment that may be futile is complex. Solomon (1993) and others (e.g., Leuthner, 2008; Schneiderman, Jecker, & Jonsen, 1993) have noted problems with the very definition of futility; these issues still exist today, as Thompson (2011) pointed out in a poignant personal reflection on health communication at the end of life. For example, some doctors wish for a clear medical criterion that makes the decision to treat or to withdraw treatment straightforward. Others argue that benefit has to do with quality of life and significantly prolonging good-quality life, which are not entirely (or mainly) medical issues. Solomon (1993) also points to the important role of communication in determining definitions of futility, informal protocols for managing end-of-life treatment, and ways of talking to patients and their families. For example, Marck and colleagues (2014) recently found that futile treatment was predicted by the absence of discussion of options with patients.

In spite of the early interest in communication, there has been little research on doctors' understanding of futility in end-of-life treatment and care, and even less about language and communication in this area (e.g., Savulescu, 2013; Wilkinson, 2013). This is partly because the understanding of futile treatment requires the perspectives of many disciplines, including health, law, sociology, psychology, economics, and communication. It is relatively uncommon for interdisciplinary teams to tackle this area, although more research (including our own) has now commenced, along with an increased interest in patient safety and quality of care (e.g., Berwick & Finkelstein, 2010). There are now many new protocols, guidelines, and statements of goals concerning end-of-life treatment (e.g., Australian Medical Association, 2014; Institute of Medicine, 2014), and communication is a key feature of all of them. Indeed, there are guidelines for end-of-life care that emphasize the role of communication (e.g., Clayton, Hancock, Butow, Tattersall, & Currow, 2007). Unfortunately, not much progress in understanding communication in this context has been

made in the past twenty years, and communication about end-of-life issues has been described as a wicked and intractable problem (e.g., Raho, 2012).

On the other hand, there is a large literature on health communication in ageing, much of it drawing on well-established communication theory (e.g., Nussbaum & Fisher, 2009). Furthermore, recent research including our own indicates that the health sector is highly intergroup, and includes many examples of non-accommodative, even hostile, communication between doctors (e.g., Gasiorek & van de Poel, 2012; Hewett, Watson, & Gallois, 2009a, 2009b, 2013). Beyond this, the doctor-patient context has long been described as intergroup (see Watson, Gallois, Hewett, & Jones, 2012 for a recent review).

Other research has examined the organizational dynamics between health carers from different professions within work teams (e.g., Lingard, 2009), along with communication across different specialties within the same profession (e.g., Hewett et al., 2009a, 2009b, 2013). As in many areas of organizational communication, this research has revealed significant under-accommodation and counter-accommodation (Gallois, Ogay, & Giles, 2005), with significant consequences for patient care. All these intergroup arenas are relevant and salient in end-of life communication. This paper, as part of the larger project, reports an examination of doctors' descriptions of their communication with patients and their families, and with other doctors in different specialties or at different levels of seniority.

Intergroup Language and Futile Treatment

Much research on intergroup communication has been based on Communication Accommodation Theory (CAT: e.g., Gallois et al., 2005). CAT explains communication dynamics in terms of intergroup and interpersonal relations, attitudes, and motivations, and the consequent strategies, tactics, and reactions of speakers. The study reported here is broadly framed by CAT. In this case, however, we wanted to look explicitly at the language

used by doctors to describe their interactions, and the ways in which they used language to justify or criticize their own or others' actions. Thus, we also employed a related intergroup theory of language, Linguistic Intergroup Bias (LIB: Maass & Arcuri, 1992; Maass, Salvi, Acuri, & Semin, 1989), which was originally put forward as an application of the Linguistic Category Model (LCM: Semin & Fiedler, 1992) to intergroup communication. LIB posits that people use more linguistically enduring types of words (defined in LIB and LCM as abstract verbs and adjectives) to describe positive behavior by ingroup members and negative behavior by outgroup members. LIB also posits the opposite: concrete words (in particular, context-specific action and state verbs) for negative behavior by ingroup members and positive behavior by outgroup members. Maass and her colleagues argued that this use of language extends the well-known self-serving bias in attributions to intergroup language.

LIB has been employed successfully for many years to explain subtle linguistic shifts in talking about ingroups and outgroups (see Giles, 2012, for recent reviews). It has the advantage of being an unobtrusive way of examining language in conversation or other naturally-occurring contexts. This is important, because the issue of futile treatment is ambiguous and slippery, and we wanted to explore the ambivalence doctors might have about it. Therefore, the discourse analysis reported here was framed by LIB.

The Present Study

In this research, we turned an intergroup lens onto the language used by doctors about futile treatment by themselves and colleagues. We posed one research question for this analysis: What language do doctors use to describe treatment they believe may be futile? Because there is so little research on perceptions of futility, and even fewer studies in this area conducted with an intergroup perspective (effectively none on language *per se*), the study was exploratory. The discourse analysis was based on interviews with doctors, and so sheds

light on their perceptions. We expected that their language would be self- and ingroup-serving. Thus, we expected more positive language when doctors described giving futile treatment themselves (or when ingroup members did), and more negative descriptions when salient outgroups were mentioned.

Method

This study is part of a larger project on futile treatment for adult patients at the end of life, which also includes a law and policy review and a retrospective chart audit to evaluate how doctors understand futile treatment, why and how often they provide it (including the impact of laws and policies), and the economic implications of doing so (see <https://www.qut.edu.au/research/research-projects/futile-treatment-at-the-end-of-life> for information on the whole project).

Participants

We conducted semi-structured interviews with 96 doctors (68 men and 28 women) from three public-sector tertiary- and quaternary-care hospitals in Australia. Australia has a mixed health-care sector, and some but not all doctors are consultants at both public and private hospitals. Most medical training takes place in the public sector, so our study included both senior (consultants) and more junior doctors (registrars, or doctors receiving specialist training). In this study, 87 doctors were consultants, and 9 were registrars. Participants' ages ranged from 30 to 72 years ($M = 49$). Doctors had spent from 1 to 49 years working in Australia ($M = 19$; almost all doctors were Australian-trained). Doctors were recruited via a general email sent by their hospital heads of department; they volunteered to participate in the study. Thus, it should be noted that their views may reflect a higher than average level of interest in the topic of futile treatment.

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We used purposive maximum-variation sampling to recruit participants, concentrating on doctors in specialties that routinely deliver end-of-life care: emergency, internal medicine, geriatrics, intensive care, palliative care, oncology, renal, thoracic medicine, surgery and cardiology. Beyond these specialties, at least one medical administrator from each hospital was interviewed, in order to gain insight into system perspectives. We interviewed between 10 and 15 doctors in the most central specialties for end-of-life care (emergency, intensive, palliative, oncology, and renal medicine), 4 to 10 doctors in the other specialties, and 4 medical administrators. Each hospital contributed from 24 to 40 doctors, so that there was a reasonably representative spread across hospitals.

Interview Procedure

Interviews were conducted using the convergent interviewing technique. Convergent interviewing is an in-depth approach that is particularly useful to explore issues that are difficult to define (e.g., Driedger, Gallois, Sanders, & Santesso, 2006). The interviews began with a general question – asking doctors to describe a situation where *a person got treatment at the end of life, given by you or someone else, that you didn't think they should have had*, in order to encourage the participants to raise issues and talk about their experiences and perceptions with minimal prompting. When participants began to produce less spontaneous talk, the interviewer continued to explore key topics specified in the interview protocol, including patient or family requests for continued treatment, communication issues, the role of resources in decision-making, and the impact of law and policy on treatment. In addition, as the convergent interviewing technique requires, additional items were included in the protocol to explore areas of agreement and disagreement that had appeared in earlier interviews. Interviews continued until a stable pattern of agreements and disagreements was

evident and no new issues were revealed (saturation of ideas). Each interview lasted between 30 minutes and two hours, with most taking approximately one hour.

Data Analysis

All interviews were transcribed verbatim and the transcripts imported into QSR International's NVivo® qualitative data analysis software (Version 10). Because we were interested in language, and for resource reasons, we coded only language and not non-verbal communication. The framework approach to analysis was used; this method combines thematic and case-based analysis (Ritchie & Spencer, 1994). Thus, in addition to an explication of the themes that appeared in the interview transcripts, a matrix was created by writing short summaries of what each participant said about themes of key interest to the research team. Ethical approval was obtained from the human research ethics committees from the relevant hospitals, Queensland University of Technology, and The University of Queensland.

The case summaries and transcripts were read iteratively to locate extracts relevant to intragroup or intergroup references to futile treatment. In particular, we searched for areas of talk about times when (in the doctors' view) futile treatment had been provided by them or by a colleague in their own or another specialty. These extracts were then subjected to a detailed discourse analysis, which is reported in this paper. This analysis concentrated on the language doctors used to describe their own or colleagues' treatment.

Results

In the interviews, doctors were not provided with a definition of futile treatment; instead, we encouraged them to use their own working definition. Nevertheless, there was good consensus about the definition of futile treatment. We are currently undertaking a detailed

study of doctors' definitions of futile treatment (White et al., in preparation), and we will not discuss definitions further in this paper. For this reason, it is useful to keep standard definitions in mind, as these may have informed participants. One definition in common use in Australia has been provided by our National Health and Medical Research Council (2011, p. 35). In that definition, futile treatment is treatment that brings no benefit to a patient, or where burden to the patient (discomfort or suffering) outweighs benefit. Benefits include (a) slowing down the progress of a chronic condition, (b) sustaining the person's life, (c) reducing disability and improving health, and (d) relieving the person's distress or discomfort.

Who Gives Futile Treatment?

All doctors in the interviews described futile treatment as generally a negative event; this characterization, of course, is implied by the definition of futility. Even so, most of them (65/96) stated that they had provided treatment which they believed to be futile, although often they described this treatment as justified (see extracts in the next section). In many cases, they stated that this treatment had been in the past, and that they would no longer do so. As this extract indicates, some participants said that they had lacked the experience they now have to avoid futile and unjustified treatment:

Look, I think that most doctors would probably say that yes, they have provided it. Is it something that you have provided in the context of having all the information and knowing it was futile at that time, I think probably the honest answer is still that I have done that...I should clarify, as a consultant I haven't. So in junior doctor days absolutely, because I've been through the same learning experience...where you don't have the clinical ability and...authority at that point to make those decisions without

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some further input, and so absolutely I provided futile treatment (emergency medicine, female).

Participants also described their approach to treatment of people at or near the end of life. The largest number (36 out of 55 who talked about this) said that they would treat such patients conservatively, mainly with palliative care. A smaller number (8) said that they would continue to treat aggressively in the hope that this would benefit the patient. Finally, 11 participants described themselves as sometimes conservative and sometimes more aggressive, depending on the situation. A significant number of participants (23/96) also gave examples of colleagues' behavior. The next sections present analyses of doctors' descriptions of their own and others' futile treatment.

Futile Treatment Given by Oneself

The research question concerned the language doctors used to describe the provision of treatment they believed was futile. Our expectation was that this language would be self- or ingroup-serving, as LIB posits. Thus, we expected more positive language in descriptions of participants' own treatment or treatment from members of their own specialty, or at their own level of seniority (junior doctor or consultant).

The discourse analysis indicated that doctors used ethical and logical terms to describe their own treatment and that of ingroup members. In doing so, they invoked various outgroups, mainly patients, their families, or colleagues in different specialties or at different levels of seniority to themselves. As will be seen, while they used moral, logical, and respect language to describe ingroup behavior, they used the language of wishes and wants to describe outgroups. In the following extract the doctor named three outgroups as relevant to his moral rationale for providing treatment:

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So the first thing is the patient, the second thing is their family and the third thing is the community. So as long as it doesn't hurt the patient, it benefits the family and doesn't hurt the community too much then it's okay. If I start doing things like giving the patient a heart transplant because I'm trying to make the family better but that's really not going to make them much better and I'm upsetting - and that's costing the community thousands of dollars, then I have to take the community into account as well. (internal medicine, male; underlining indicates our emphasis)

This doctor emphasized benefit and harm to the patient, family, and community. He also considered the financial cost, which was relatively uncommon in self or ingroup descriptions. His rationale concentrated on weighing costs and benefits logically, and the words he chose (underlined in the extract) clearly illustrate his chain of reasoning to get to the conclusion that treatment which might otherwise be considered futile is “okay.”

Other doctors used words like “appropriate,” and “all right,” as well as overtly weighing the costs and benefits. In the extract below, a doctor reflected on her need to compromise with a consultant who prescribed invasive treatment that she believed was futile:

So rather than continually stabbing the patient, I said we'll give her it via this route, even though I don't think that...that...it didn't make any difference and I don't think that it was appropriate. But I rationalized it in my own head that I knew that I was inflicting very minimal discomfort by doing so and still satisfying [the] consultant's treating. (oncology, female)

In this case, the doctor was under pressure from her supervisor to continue aggressive treatment, but she described doing what she could to minimize discomfort to the patient. She described the consultant's behavior as not appropriate, and said that she “rationalized” her own behavior. Other doctors described similar conflicts with superiors, particularly when they were still in training. Even so, participants claimed that they had acted reasonably. For

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example, this surgeon described sometimes providing treatment that turned out to be futile, but where that was not his intention:

I don't think I've ever intentionally continued to treat somebody. (surgery, male)

Ethico-legal and logical language was especially evident when doctors invoked patient or family wishes in guiding and justifying their provision of treatment that might otherwise be considered as futile. In this context, the patient and his or her family are members of an outgroup, albeit one which the doctor wants to help. The level of intergroup tension is shown first by the fact that patient or family was the most frequently cited justification for giving treatment that might be considered as futile. Secondly, there was a contrast in language between descriptions of the self and those of the patient or family. As one doctor said:

It was the patient driving it. There may have been a couple of times where family have wanted to continue, but...that usually isn't a big issue...for continuing medium term, they've been mostly patients. You know, I'll always respect the competent patient's wishes, I won't go against them (renal, male)

This doctor described provision of very expensive and invasive treatment – kidney dialysis – in terms of the patient's wishes, which he always respects. Thus, his own behavior was described in rational and respect language, whereas his description of the patient used the language of wishes and wants, and may have indicated over-accommodation. As McDougall and Gillam (2014) point out, rational language is privileged in Western cultures, as it is perceived to reflect the highest forms of thought. Wishing and wanting, on the other hand, are perceived to reflect a less thoughtful, more impulsive, and more context-dependent way of thinking. Patients' behavior, thus, was described in more context-specific and concrete language; wishing by its nature reflects more ephemeral expression than reasoned decisions.

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Another doctor used similar language to describe his interaction with the family of a dying patient:

I probably have, where I've felt that maybe we should go down the end of life track and the family want a bit more time, but I think that's probably entirely reasonable (geriatric medicine, male)

In this case, the family wanted more time, and the physician considered it reasonable for him to provide it. He does not evaluate the logic of the family's wishes, but justifies his own behavior as "entirely reasonable." This attitude is poignantly illustrated in the extract below, where an intensive care physician described providing very expensive treatment entirely for the benefit of a family:

I would see that as appropriate if – because people come away with permanent deeply held memories about what happens in intensive care and if they get the sense that everyone's in a hurry and they want to pull the tube out and kill their mum, and their mum died when she shouldn't have died. That's 10 years of trauma for everybody. (ICU, male)

He described his own behavior as appropriate simply because of the emotional impact on the family. For this doctor, it was important to respect the wishes and emotions of the family, to help them cope with the death over the longer term.

Futile Treatment Given by Outgroup Doctors

In the previous section, we described intergroup language with respect to patients and families. As we noted above, the literature shows significant inter-specialty rivalry among doctors, which is often invoked using highly intergroup language. Thus, we expected that participants would also describe provision of futile treatment by members of other specialties more negatively.

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The same emphasis on wishing and wanting as had appeared for patients was also used to describe outgroup colleagues. In the following two extracts, participants described interactions with outgroup consultants:

He [consultant] wanted her to have her electrolytes corrected because they were quite deranged, and we just found alternate routes to give them, and similarly he wanted her also on antibiotics. (oncology, female)

Apart from this other doctor...But I think it was more the daughter pushing him. I didn't think it was terribly appropriate and said so. But he wanted it, so.... (renal, male)

Both extracts describe conflicts with consultants, and in both cases the participants say that they resisted the outgroup member's wishes. In the first extract, resistance was indirect, in that she found a less intrusive way to accede to the consultant's wishes. The second doctor stated that he did not think the treatment was appropriate, but nevertheless gave in to the consultant's wishes. The contrast in language between their own position and the outgroup member's desires is clear. Of course, others might dispute these doctors' characterizations of their own and the consultants' behavior; our emphasis is on the language they used to do so.

When participants were speaking more generally, their language sometimes became quite negative as they gave explanations for colleagues' behavior. For example, a surgeon described colleagues in cardiac surgery in the following terms:

You don't like to point fingers but some of our cardiology colleagues - patients getting very expensive technology. AICDs, the new endovascular aortic valve replacements in very elderly patients. Just because you can do something technically doesn't mean that you should be doing it. [Interviewer: Why do you think they are doing it?] I think they lack insight. (surgery, male)

Another doctor was condescending in his description of oncologists:

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Again, I don't mean that I see oncologists doing the wrong thing all the time. It's one part of modern medicine where there are increasing numbers of expensive drugs that can be documented to give again a life expectancy, but often at very high cost for a relatively short period of time. So, it very clearly falls heavily into that type of thing. (renal, male)

For these doctors, their colleagues were giving futile treatment because they could, and the descriptions of them (lack insight, not doing the wrong thing all the time) characterize their colleagues as not thoughtful or mindful. Interestingly, both these extracts were in interviews with members of specialties which themselves are often criticized by others for thoughtlessness or over-use of new techniques. For example, in the following extract, an intensive care physician made a very similar criticism about surgeons to the one above made of cardiologists by a surgeon:

Often we're just left with no option to at least provide short terms of futile care because someone has already started the process... so a 90 year old is in ED, they've got a tummy problem, I [a surgeon] can fix it, I've got the skills to fix it. So someone decides to do an operation. But if you don't think about the whole scenario of this 90 year old with 100 other problems, who can potentially be stuck in hospital for another two months with no realistic outcome, then it becomes tricky. (ICU, male)

Once again, this doctor described outgroup doctors as lacking insight, in this case into the picture of the patient as a whole person. He described surgeons as doing something because they could, rather than because they had thought carefully about the whole situation, and he pointed to the consequent high cost to the patient (stuck in hospital). The use of plain language adds emphasis to this participant's negative description of his colleague's motivation and behavior.

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Doctors invoked cost as an issue for themselves, and they described in moral language their own reasoning process concerning costs and benefits. This is shown in the extract above, which invokes cost to the patient, family, and community as considerations in that doctor's decisions about whether to provide or discontinue treatment. When they described others, however, doctors' language invoked cost in more negative ways, as the following extract shows:

Worst offenders are the haematology and oncology people who are still giving chemotherapy to people, \$20,000 a month when they're riddled with tumours basically everywhere. I think it's a criminal waste of money personally....I'd rather see 30 per cent less cardiologists and 100 per cent more palliative care people. Cardiologists are like flies, they're common as hell. (emergency medicine, male)

This emergency physician used the language of crime to characterize his colleagues' behavior. He pointed to several outgroups: oncologists as the "worst offenders," and then to cardiologists as "too common." In doing this, he pointed to a "criminal waste of money," and left no room for the kind of moral reasoning that doctors used for their own and ingroup behavior. In this way, he repeated the common complaint among emergency doctors that they are left to deal with problems created by others, who (in their view) had had time to think through the situation but did not do so. In fact, a number of doctors used words like "criminal" or "criminal waste" to characterize outgroup doctors' behavior.

Discussion

This study sheds new light on doctors' descriptions of futile treatment by themselves and others. Doctors described their own provision of futile treatment in ethico-logical and respect language, using enduring adjectives like "appropriate" and "reasonable." Furthermore, their

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main justification for providing this treatment was that patients or their families wished to have it. Patients were not described as making decisions or going through reasoning processes (cf. McDougall & Gillam, 2014). This difference in language points to over-accommodation by the doctors, which is an issue that should be explored further in future research. In contrast, when they described outgroup doctors (either more senior ones or members of outgroup specialties), their language was more negative and more concrete and context-specific, as LIB (and CAT) posits. They described outgroup doctors using words like “not thoughtful,” even “criminal.” It was clear that they were ready to apportion blame and sanctions to colleagues. Thus, our expectation that explanations of futile treatment would use self- and ingroup-serving language was borne out by the results.

The results of this study show the utility of intergroup communication theory, and in particular LIB, in showing subtle (and not-so-subtle) intergroup bias in doctors’ descriptions. Our results showed the use of enduring adjectives, along with abstract verbs like “respect” and “rationalize,” to characterize participants’ own behavior. By contrast, outgroups were described using less positive words and more specific verbs, such as “want” and “wish,” as well as negative language (“lack insight”; “criminal waste”). Furthermore, there was evidence of non-accommodation to both patients and their families and to outgroup colleagues.

LIB, CAT, and related theories have proved extremely useful in exploring the often-missed intergroup level in organizations. Too much research in health communication either concludes that communication failures are due to lack of individual skills or to very macro system variables. This is problematic, because lack of communication skills by individual health professionals is rarely a crucial issue in failures, and because system issues are almost impossible to deal with. Analysing intergroup communication permits us to see the ways in which group identity functions at the individual level, and to do something about it.

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In this case, more moral and logical words were applied to doctors themselves and their ingroup colleagues. In addition, their behavior was justified by pointing to good reasons for their treatment, mainly to do with patients and families. Patients and families were characterized by words about wishes and wants; McDougall and Gillam (2014) contrasted doctors' descriptions of their own beliefs and judgements, as against patients' wishes and wants, in other health contexts. This certainly shows an intergroup context, but perhaps a relatively benign one, where there is some over-accommodation. It is important for doctors to understand that their own judgements may be as subjective as those of patients, and to learn to negotiate about the end of life on equal terms with patients and their families. The start of this process is likely to be using similar language to describe ingroup and outgroup behavior.

The language reserved for colleagues in other specialties was negative, as Hewett et al. (2009a) also found in interviews with hospital doctors. Again, doctors were described in terms of wishes and wants; thus, participants were indicating the same attitude to them as toward patients. Given the expertise of doctors and their authority to make end-of-life decisions, this language points to counter-accommodation. Further evidence for this is provided by their descriptions of other groups of doctors in negative terms. Not surprisingly, doctors used the same language to describe outgroup colleagues as their colleagues used to describe them. It would appear that the language of organizational conflict has been imported into this arena, at least some of the time. Doctors in our study located unjustified and futile treatment in the behaviors of outgroup members. Health professionals need to understand this communication behavior and its consequences in futile treatment.

Conclusion

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It should be noted that this was an interview study, and therefore reflects doctors' perceptions rather than actual talk in hospital contexts. Nevertheless, the intergroup language doctors used about patients, colleagues, and more senior people in the hospital hierarchy may leak into their conversational behavior, and thence contribute to organizational tension, patient complaints, and a lower quality of care (Hewett et al., 2009a). It may also contribute indirectly to futile treatment, as doctors and other health professionals blame patients and each other, rather than taking on the consequences of their own actions. Future research is necessary to explore futile treatment as it occurs, and we believe that this research should also take full account of the intergroup situation. In particular, there is ample room to make a systematic study of accommodation and non-accommodation – over-, under-, or counter-, in the language of doctors and the health professionals towards patients and families, members of other professions or specialties, and people above and below them in the organizational hierarchy. In our own project, we are conducting an audit of medical records, in order to look closely at the variables predicting provision of futile treatment, its financial cost, and the kind of language and communication associated with it. Research like this has great potential to lead to interventions that are feasible and effective; we need to understand the intergroup language, and then to intervene to change it.

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Declaration of Conflicting Interests

No conflicting interests.

References

- Australian Commission on Safety and Quality in Health Care (2013). *Safety and quality of end-of-life care in acute hospitals: A background paper*. Sydney: ACSQHC.
- Australian Medical Association. (2014). *Position statement on end of life care and advance care planning* [Internet]. Barton, ACT, Australia: AMA (<https://ama.com.au/position-statement/position-statement-end-life-care-and-advance-care-planning-2014>).
- Berwick, D. M., & Finkelstein, J. M. (2010). Preparing medical students for the continual improvement of health and health care: Abraham Flexner and the new “public interest.” *Academic Medicine*, 85, S56-S65.
- Candrian, C. (2013). Taming death and the consequences of discourse. *Human Relations*, 67, 53-69.
- Clayton, J. M., Hancock, K. M., Butow, P. N., Tattersall, M. H. N., & Currow, D. C. (2007). Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers. *Medical Journal of Australia*, 187, 478.
- Driedger, S. M., Gallois, C., Sanders, B. C., & Santesso, N. (2006). Finding common ground in team-based qualitative research using the convergent interviewing method. *Qualitative Health Research*, 16, 1145-1157.
- Fleck, L. M. (2011). Just Caring: Health Care Rationing, Terminal Illness, and the Medically Least Well Off. *The Journal of Law, Medicine and Ethics*, 39, 156–171.

FUTILE TREATMENT AND INTERGROUP LANGUAGE

- Gallois, C., Ogay, T., & Giles, H. (2005). Communication accommodation theory: A look back and a look ahead. In W. Gudykunst (Ed.), *Theorizing about intercultural communication* (pp. 121-148). Thousand Oaks, CA: Sage.
- Gasiorek, J., & Van de Poel, K. (2012). Divergent perspectives on language-discordant mobile medical professionals' communication with colleagues: An exploratory study. *Journal of Applied Communication Research*, 40, 368-383.
- Giles, H. (2012). *The handbook of intergroup communication*. New York, NY: Routledge.
- Hewett, D. G., Watson, B. M., Gallois, C., Ward, M., & Leggett, B. A. (2009a). Intergroup communication between hospital doctors: Implications for quality of patient care. *Social Science and Medicine*, 69, 1732-1740.
- Hewett, D. G., Watson, B. M., Gallois, C., Ward, M., & Leggett, B. A. (2009b). Communication in medical records: Intergroup language and patient care. *Journal of Language and Social Psychology*, 28, 119-138.
- Hewett, D., Watson, B., & Gallois, C. (2013). Trust, distrust, and communication accommodation among hospital doctors. In Crichton, J., & Candlin, C. (Eds.), *Discourses of trust* (pp. 36-51). Basingstoke: Palgrave Macmillan.
- Institute of Medicine (2014). *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, D.C.: National Academy Press.
- Leuthner, S. R. (2008). Futility: Interpretation and usefulness in clinical practice. *Health Matrix Cleveland*, 18, 245.
- Lingard, L. (2009). Productive complications: emergent ideas in team communication and patient safety. *Healthcare Quarterly*, 15, 18-23.
- Maass, A., & Arcuri, L. (1992). The role of language in the persistence of stereotypes. In G. R. Semin & K. Fiedler (Eds.), *Language, interaction and social cognition* (pp. 129-143). Newbury Park, CA: Sage.

FUTILE TREATMENT AND INTERGROUP LANGUAGE

- Maass, A., Salvi, D., Arcuri, L., & Semin, G. (1989). Language use in intergroup contexts: The linguistic intergroup bias. *Journal of Personality and Social Psychology*, 57, 981-993.
- Marck, C. H., Weil, J., Lane, H, Weiland, J., Philip, J., Boughey, M., & Jelinek, G. A. (2014). Care of the dying cancer patient in the emergency department: Findings from a national survey of Australian emergency department clinicians. *Internal Medicine Journal*, 44, 362-368.
- McDougall, R. J., & Gillam, L. (2014). Doctors' "judgements" and parents' "wishes": Ethical implications in conflict situations. *Medical Journal of Australia*, 200, 372.
- Mohammed, S., & Peter, E. (2009). Rituals, death, and the moral practice of medical futility. *Nursing Ethics*, 16, 292-302.
- National Health and Medical Research Council (NHMRC, 2011). *An ethical framework for integrating palliative care principles into the management of advanced chronic or terminal conditions*. Canberra, ACT: NHMRC.
- Nussbaum, J. F., & Fisher, C. L. (2009). A Communication Model for the Competent Delivery of Geriatric Medicine. *Journal of Language and Social Psychology*, 28, 190-208.
- Raho, J. A. (2012). Improving communication in order to mitigate intractable conflict over medical futility. *The Internet Journal of Catholic Bioethics*, Winter.
(<http://www.sjubioethicsinstitute.com/journal/improving-communication-order-mitigate-intractable-conflict-over-medical-futility>)
- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analyzing qualitative data*, pp. 173-194). London, UK: Routledge.

FUTILE TREATMENT AND INTERGROUP LANGUAGE

- Savulescu, J. (2013). Just dying: the futility of futility. *Journal of Medical Ethics*, 39, 583-584.
- Schneiderman L. J., Jecker N. S., & Jonsen, A. R. (1993). Medical futility: Its meaning and ethical implications. *Annals of Internal Medicine*, 112, 949-954.
- Semin, G., and Fiedler, K. (1992). Properties of interpersonal language and attribution. In G. Semin and K. Fiedler (Eds.). *Language, interaction and social cognition* (pp 58-77). Newbury Park, CA: Sage.
- Slomka, J. (1992). The negotiation of death: Clinical decision making at the end of life. *Social Science and Medicine*, 35, 251-259.
- Solomon, M. (1993). How Physicians Talk about Futility: Making Words Mean Too Many Things. *Journal of Law and Medical Ethics*, 21, 231-237.
- Thompson, T. (2011). Hope and the act of informed dialogue: A delicate balance at end of life. *Journal of Language and Social Psychology*, 30, 177-192.
- Watson, B. M., Gallois, C., Hewett, D., & Jones, E. (2012). Culture and health care: Intergroup communication and its consequences. In J. Jackson (Ed.), *The Routledge handbook of intercultural communication* (pp. 512-524). London, UK: Routledge.
- White, B., Willmott, L., Winch, S., Parker, M., Gallois, C., Graves, N., Shepherd, N., & Close, E. (in preparation). *What does "futility" mean? An empirical study of doctors' perceptions and practice.*
- Wilkinson, D. J. C. (2013). Futile Treatment: The ethicist's perspective. *Medical Journal of Australia*, 198, 223-224.

Author Biographies

Cindy Gallois is a professor of psychology and communication at The University of Queensland (UQ), and a Fellow of ICA and the Academy of the Social Sciences in Australia. Her research centres on intergroup communication in health, organizational, and intercultural contexts, particularly communication accommodation by health professionals.

Lindy Willmott is a professor and Director of the Australian Centre for Health Law Research at the Queensland University of Technology (QUT). She researches in the area of health law, particularly end-of-life issues, and is currently undertaking a number of funded empirical research projects, including being a Chief Investigator on an NHMRC Centre of Research Excellence in End of Life.

Ben White is a professor and Director of the Australian Centre for Health Law Research at QUT. His area of research focus is the law, policy and practice of end-of-life decision-making, and he is currently undertaking four Australian Research Council funded projects in this area.

Sarah Winch is a health care ethicist in the School of Medicine at UQ, and CEO of Health Ethics Australia, a not for profit company focusing on improving death literacy and clinicians' compassion safety. She has published over 50 journal articles and chapters in ethics, evidence-based practice and research capacity building. Her most recent book, *Best Death Possible: A guide for dying Australians* (2013), is written for a lay audience.

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Malcolm Parker is a professor of Medical Ethics in the School of Medicine at UQ. He has published nationally and internationally in philosophy of medicine, bioethics, medical ethics, health law, and medical education.

Nicholas Graves is an NHMRC senior research fellow at QUT, developing health services research and managing the Australian Centre for Health Services Innovation. He has published in top journals (*Nature, JAMA, BMJ, AIDS, Lancet Infectious Diseases, Emerging Infectious Diseases, Clinical Infections Diseases, Health Economics*) and received \$25M in competitive external research funding since 2004.

Nicole Shepherd is a Senior Research Assistant at the Australian Centre for Health Law Research at QUT, and has published nationally and internationally on mental health care delivery.

Eliana Close is a Research Fellow and PhD student at the Australian Centre for Health Law Research at QUT. Her research centres on health care rationing and law and policy at the end of life.