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Navigating the Final Path: Linguistic Strategies for Mediating Terminal Prognosis and End-of-Life Goals in Shona Oncology Care

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ABSTRACT

This study investigates the linguistic strategies employed by clinicians in Zimbabwe to mediate the communication of a terminal cancer prognosis and end-of-life care goals for Shona-speaking patients. In this cross-cultural setting, where biomedical practice operates in English and patients' lived experiences are framed in Shona, clinicians face the critical task of navigating the transition from curative to palliative intent. Using a qualitative descriptive design, we conducted in-depth, semi-structured interviews with a purposive sample of oncologists, palliative care specialists, and Social Workers in Harare. Data were analyzed using reflexive thematic analysis to identify recurring communicative patterns. Our findings reveal a repertoire of sophisticated strategies clinicians use to negotiate this sensitive interface, which include the strategic re-framing of therapeutic goals from a "battle" to a "journey," the careful selection of lexicon to discuss death and comfort, and relational positioning that affirms non-abandonment and incorporates the family. This research demonstrates that clinicians act as essential cultural-linguistic mediators who develop a nuanced discursive toolkit to bridge biomedical reality and patient values. Documenting these strategies is a vital step toward developing culturally-competent models of communication that aim to ensure the end of life is guided as much by cultural resonance as by clinical evidence, thereby honoring the profound journey from biologic truth to a dignified lived reality.

Keywords: End-of-Life Communication, Palliative Care, Cultural Linguistics, Shona, Oncology, Medical Mediation, Terminal Prognosis, Qualitative Research, Zimbabwe.

Dedication

We dedicate this work to the memory of our loved ones, whose own battles with cancer are the deeply personal foundation of this academic inquiry.

Their journeys illuminated the profound chasm that can exist between a diagnosis written in a chart and the lived experience of the patient and family. In their honour, we sought to understand that space, to study the words that can either build bridges or deepen divides.

It is our hope that this research contributes, in some small way, to making the path for others less arduous, and that the conversations at the end of life are filled with more clarity, more compassion, and more peace.

They are forever missed, and forever our inspiration.

INTRODUCTION

In the precise realm of modern oncology, the histopathologic diagnosis serves as the definitive biological anchor, initiating a carefully plotted course of treatment (Smith & Jones, 2020). The journey of this diagnosis from a written report to a patient's understood reality is not a simple translation but a complex act of cultural-linguistic mediation. Clinicians bear the weight of bridging the technical, Anglo-centric domain of biomedicine with the lived, experiential world of the patient. While the authors acknowledge that palliative care encompasses a broad range of serious illnesses beyond oncology, this study focuses specifically on its application within the context of terminal cancer, where the transition from curative to palliative intent is often sharply defined.

This mediating function faces its most profound test when the pathology report indicates a terminal prognosis. Terms like "widely metastatic," "end-stage," or "refractory" signal an immutable pivot in the clinical pathway: the end of curative intent and the beginning of end-of-life care. This moment creates a potent nexus of ethical, communicative, and cultural tensions. The Western biomedical principle of patient autonomy and truth-telling often collides with cultural norms in many Shona communities, where values such as protecting a loved one from despair (kuodza mwoyo) and family-led decision-making are paramount (Gombe et al., 2023, p. 3).

Consequently, the clinician's task evolves. It is no longer solely about conveying a biological fact, but about orchestrating a fundamental re-framing of therapeutic goals. They must guide patients and families from a paradigm of "fighting" for a cure to one of "achieving" comfort and peace. While the challenges of breaking bad news and cross-cultural communication are documented (Bernabe et al., 2022; Norris et al., 2014), there is a critical gap in understanding the specific linguistic mechanisms used to navigate this transition in African contexts. How do clinicians linguistically dismantle one reality to co-construct another?

This study therefore asks: What are the dominant linguistic and narrative strategies used by clinicians in Zimbabwe to negotiate the shift from curative to palliative intent and to discuss end-of-life goals with Shonaspeaking patients and their families? By answering this question, we seek to illuminate the sophisticated, often unspoken, communicative work that defines palliative care in a cross-cultural context, moving beyond identifying barriers to explicating the very tools used to overcome them.

LITERATURE REVIEW

The Linguistic Landscape of Prognosis and Metaphor in Western Oncology

Communication about life-limiting illness in Western medical contexts has been extensively framed by the concept of "breaking bad news," often operationalized through structured protocols like SPIKES (Setting, Perception, Invitation, Knowledge, Empathy, Strategy/Summary) (Baile et al., 2000, p. 302). While these provide a valuable framework, they often focus on the process rather than a deep analysis of the language used. A critical linguistic feature in Western oncology discourse is the pervasive "war" or "battle" metaphor (Sontag, 1978/2002, p. 5). Patients are described as "fighting" cancer, undergoing "aggressive" therapy, and either "winning the battle" or "succumbing" to the disease. This metaphor, while potentially empowering by framing the patient as an active combatant, carries significant drawbacks. It can imply that survival is a matter of personal courage and that death is a form of failure, potentially inducing guilt and shame in those whose disease progresses (Reisfield & Wilson, 2004, p. 424). In response, alternative discourses have emerged within palliative and supportive care. These include "journey" metaphors, which frame the experience as a path to be walked with companions, and a focus on "living well" until death, thereby shifting the measure of success from survival to quality of life and meaning (Kellehear, 2014, p. 45). This body of work establishes that the metaphorical and narrative framing of terminality is not merely decorative but fundamentally shapes patient and family understanding, coping mechanisms, and the very experience of illness.

Palliative Care Communication: A Toolkit of Strategic Discourse

The communication paradigm in palliative care has evolved into a sophisticated discipline that moves far beyond the simplistic notion of "using euphemisms." It encompasses a suite of strategic discursive goals. A central strategy is Hope-Oriented Communication, which involves a delicate negotiation to shift the object of hope, from the often-unrealistic hope for cure to the achievable hopes for symptom control, a pain-free death, reconciliation with family, or spiritual peace (Clayton et al., 2008, p. 883; Back et al., 2003, p. 441). This is closely tied to Affirming Non-Abandonment, a critical communicative act where clinicians use explicit language to assure patients and families that they will not be deserted, thus mitigating one of the greatest fears at the end of life: facing it alone (Wentlandt et al., 2012, p. 1356). This is often realized through phrases like "I will be with you through this" or "We will continue to care for you here." Furthermore, effective palliative communication requires Goal Re-alignment, a process of engaging patients in discussions about their priorities for their remaining life. This necessitates a specific lexicon to discuss symptoms, functional capacity, legacy, and what constitutes a "good day" (Steinhauser et al., 2000, p. 826). This literature provides a vital framework for analyzing clinician strategies, shifting the analytical focus from isolated words to the higher-level conversational objectives that language is employed to achieve.

Cultural Scripts, Personhood, and the "Good Death"

The concept of a "good death" is not a universal biomedical fact but a deeply cultural construct, varying significantly across societies (Kellehear, 2009, p. 12). In Western, individualistic contexts, a "good death" is often characterized by ideals of patient autonomy, awareness of dying, pain control, and the completion of practical affairs (Meier et al., 2016). This contrasts sharply with models of personhood and dying in many African sociocultural contexts. Drawing on philosophies like Ubuntu in Southern Africa ("I am because we are"), personhood is often viewed as relational and contingent upon one's embeddedness within a community (Gelfand, 2019, p. 105; Mbiti, 1990, p. 356). Consequently, anthropological work suggests that a "good death" (kufa kwakanaka in Shona) is profoundly social and spiritual. It typically involves being surrounded by one's kin, having one's affairs (both material and social) in order, being at peace with one's ancestors, and leaving behind a positive legacy for the lineage (Kielmann & Cataldo, 2010, p. 603; Van der Geest, 2004, p. 84). Conversely, a "bad death" is often one that is sudden, solitary, unanticipated, or the result of witchcraft or social transgression, leaving the deceased and the family in a state of spiritual peril (Abashem, 2021, p. 21). Understanding these deep-seated cultural scripts is essential, as they form the interpretive backdrop against which patients and families hear and make sense of a clinician's words about the end of life. Effective communication must resonate with, or at least sensitively navigate, these foundational beliefs.

The Identified Gap: Mediation at the Cross-Cultural Interface

While the literature separately addresses prognosis communication in oncology, discursive strategies in palliative care, and the anthropology of death and dying, it lacks integration at the specific cross-cultural interface of African clinical practice. Studies on language barriers in healthcare, such as those by Flores (2005) and Karliner et al. (2007, p. 401), overwhelmingly focus on the role of professional interpreters in Western immigrant populations, a resource largely absent in many African public health systems. Research within Africa, such as work by Fadare et al. (2024, p. 20) in Nigeria or Mwanga & Mugo (2022, p. 22) in Kenya, rightly identifies language as a key barrier to care but often stops at this identification without delving into the granular, in-situ linguistic strategies that clinicians naturally develop to cope in the absence of formal interpretation services. No study has yet systematically documented and analyzed the specific metaphors, narrative frames, and lexical choices used by clinicians to mediate between the biological fact of terminal cancer and the cultural ideal of a good death for Shona-speaking patients. This research seeks to fill this critical gap by empirically investigating the lived discourse practices of clinicians, conceptualizing them not as flawed interpreters but as skilled culturallinguistic mediators who have developed a pragmatic and nuanced toolkit for one of medicine's most difficult tasks.

METHODOLOGY

Study Design

This study employed a qualitative descriptive design, chosen for its suitability in providing a rich, straight description of a poorly understood phenomenon, the specific language used in end-of-life conversations (Kim et al., 2021, p. 2). The approach is naturalistic, seeking to understand the strategies from the perspective of those who use them daily.

Setting and Participant Recruitment

The study was conducted in Harare, Zimbabwe. Using purposive sampling, we recruited clinicians from major tertiary healthcare institutions who met the following criterion: regular responsibility for communicating terminal cancer prognoses to Shona-speaking patients. The final sample consisted of 8 participants, including medical oncologists (2), palliative care doctors (2), palliative care nurses (2), Social Workers (2). Recruitment continued until thematic saturation was reached.

Data Collection

Data were collected through in-depth, semi-structured interviews conducted in English and Shona. An interview guide ensured key topics were covered while allowing for emergent themes. Open-ended questions included:

"Could you walk me through how you approach a conversation when you know a patient's cancer is no longer curable?"

"How do you introduce and explain the purpose of palliative care?"

"What words or phrases have you found most effective in these discussions? Can you give examples in Shona and English?"

"How do you talk about the goals of care when the goal is no longer cure?"

"What are the most important concerns for families, and how does that shape what you say?" Interviews

were audio-recorded, transcribed verbatim, and averaged 15 minutes.

Data Analysis

Data analysis followed Braun and Clarke's (2022) reflexive thematic analysis. This involved:

1. Familiarization: Repeated reading of transcripts.
2. Coding: Generating initial codes that identified interesting linguistic features and communicative moves.
3. Theme Development: Collating codes into potential themes by identifying patterns of shared meaning across the dataset. This involved iteratively moving between the coded data, the entire dataset, and the developing thematic map.
4. Reviewing and Refining Themes: Ensuring themes accurately reflected the dataset and told a coherent story about the strategies used (Braun & Clarke, 2022, p. 87).

Rigour was ensured through peer debriefing and maintaining an audit trail of analytical decisions.

Ethical Considerations

All participants provided written informed consent. Given the sensitive topic, the interview guide was designed to minimize distress, and participants were reminded of their right to pause or withdraw. Data were anonymized during transcription.

Findings

Thematic analysis revealed a sophisticated repertoire of linguistic and communicative strategies used by clinicians to mediate the transition to palliative care. Clinicians function not as mere information conduits, but as active cultural-linguistic mediators. Five dominant, overlapping themes emerged, outlining a structured yet deeply nuanced communicative process.

4.1 Theme 1: **The Adaptive Use of a Structured Protocol (SPIKES)**

A significant finding was that clinicians across specialties explicitly and consistently reported using the SPIKES protocol as a foundational structure. However, its application was not rigid; it was dynamically fine-tuned and culturally mediated. Participants explicitly stated, *"I use the SPIKES strategy depending on the type of patient I am dealing with."* The data reveals how each step was adapted:

S (Setting): This was expanded beyond physical privacy to include the crucial element of relational presence. Ensuring the patient "is not on their own" and has family members present was non-negotiable, reflecting the communal ontology of Ubuntu.

P (Perception): This step was leveraged to diagnose not just medical understanding, but also "preconceived ideas" and "myths" surrounding cancer, thus uncovering cultural beliefs before delivering new information.

I (Invitation): This step was used to navigate complex family dynamics, where clinicians balanced family requests for non-disclosure with the ethical imperative of truth-telling if the patient asked directly.

K (Knowledge): The "warning shot" was a vital technique. The delivery of knowledge itself was then filtered through culturally-sensitive euphemisms and metaphorical reframing.

E (Emotions with Empathy): Empathic responses were tailored to address the profound fear of abandonment (kuodza mwoyo), with assurances of non-abandonment being a primary response.

S (Strategy and Summary): This step was used to frame palliative care as the active, positive strategy of "adding life to days," presented as a collaborative plan with the patient and family.

This adaptive use shows clinicians are not merely applying a Western model but are critically engaging with it, localizing its steps, and enriching it with cultural intelligence.

4.2 Theme 2: **Diagnostic Prelude and Eliciting the Patient's Narrative**

A consistent initial strategy, emphasized by all participants, was to diagnose the patient's existing understanding before delivering the prognosis. This aligns with the SPIKES 'Perception' step but was deeply adapted. The goal was to "know what they think about their illness so that they know what the patient knows already." This involved open-ended questions to uncover "preconceived ideas" and "myths." This strategy establishes a collaborative communicative space, allowing the clinician to identify gaps, correct misinformation gently, and tailor subsequent explanations to the patient's unique cognitive and emotional landscape.

4.3 Theme 3: **Metaphorical Re-framing: From Battle to Journey**

Participants consistently described a conscious effort to move away from the lexicon of combat, which was found to be culturally incongruent and stigmatizing. Instead, clinicians employed a journey metaphor that resonated with local values. One oncologist explained: "We stop talking about 'kukunda' [conquering/defeating] the cancer... Instead, we talk about 'kufamba nenzira' (walking the path) together." This re-framing involved a temporal shift from a future-oriented "cure" to a present-oriented "quality of life," epitomized by the philosophy of "adding life to the days rather than adding days to the life." It dismantles the paradigm where success is defined by survival and constructs a new one focused on quality and meaning, directly addressing the fear of abandonment that the "battle" metaphor exacerbates.

4.4 Theme 4: Lexical Mediation and Culturally-Sensitive Euphemism

The data revealed a nuanced awareness of the power of specific words. Clinicians demonstrated a sophisticated toolbox of specific word choices to discuss difficult concepts.

Indirect Lexicon for Death and Dying: The direct term *kufa* (to die) was almost universally avoided. Instead, participants reported using terms like "kusimuka" (to depart), "kuzorora" (to rest), and "kupera" (to end). As one surgeon noted, "Saying 'kufa' is like a hammer. 'Kuzorora' is softer; it suggests a release from suffering." This practice translates a biological endpoint into a culturally coherent spiritual transition.

Active, Positive Language for Palliative Care: To counter the perception that palliative care was "giving up," clinicians used active, positive verbs. They spoke of "kudzora marwadzo" (controlling pain), "kugadzirisa" (fixing/managing symptoms), and "kutsvaga rugare" (seeking peace). This framed palliative care as a proactive and valuable intervention.

4.5 Theme 5: Aesthetic and Narrative Tools for Eliciting Wishes

A fifth, particularly sophisticated strategy emerged: the deliberate use of poetry and music as mediating tools. This represents a pinnacle of cultural-linguistic mediation, where the form of the communication is as strategically chosen as its content. A poignant example was an oncologist who uses a personally authored poem titled **"When my time comes".**

This practice constitutes a form of complex narrative reframing, actively dismantling the "clinical script" and reconstructing the encounter within a "humanitarian script" centered on life review and legacy. It is a masterful application of culturally-grounded indirectness, providing a sanctioned channel to discuss profound truths without the clinician being the direct bearer of a distressing message. Finally, this tool facilitates deep, valuebased elicitation. The rhythmic, metaphorical language of poetry engages emotions and values, creating a shared emotional space that gives the patient permission to explore and voice their own deepest priorities for a "good death" (kufa kwakanaka).

4.6. Synthesis and Relative Frequency of Strategies

Based on the self-reported data from participants, the Diagnostic Prelude (Theme 2) and Metaphorical Reframing (Theme 3) were the most frequently and consistently described approaches, forming the bedrock of the communicative process for all clinicians interviewed. These were closely followed by the Adaptive Use of SPIKES (Theme 1) and the conscious Lexical Mediation (Theme 4), which were reported as integral, daily practices. The use of Aesthetic and Narrative Tools (Theme 5), while representing a highly sophisticated and impactful strategy, was described by a smaller subset of participants, indicating it may be a specialized tool developed through extensive personal reflection and experience, rather than a universally common practice.

DISCUSSION

This study reveals that clinicians negotiating terminal prognoses in a Shona context are not merely translators but architects of meaning, deliberately using language to build a bridge from a medically hopeless situation to a culturally meaningful conclusion. The five strategies we identified function synergistically to achieve this.

The widespread, conscious use of the SPIKES protocol (Theme 1) provides a critical counter-narrative to the assumption that cross-cultural care is inherently unstructured. Instead, clinicians show agency and expertise by using SPIKES as a flexible scaffold, systematically adapting each step to honor communal decision-making, pre-empt cultural myths, and reframe goals. This finding significantly extends the literature on SPIKES by detailing its concrete localization in a non-Western, resource-constrained setting.

The core linguistic work of mediation happens within this structure. The strategy of beginning with a Diagnostic Prelude (Theme 2) shows that effective communication requires diagnosing culture and belief as assiduously as disease. This moves beyond simply identifying language as a barrier (Fadare et al., 2024; Mwanga & Mugo, 2022) to showcasing the active method clinicians use to overcome it: they first listen to the patient's narrative before imposing the clinical one.

The conscious Metaphorical Re-framing (Theme 3) from "battle" to "journey" and the core philosophy of "adding life to days" provides a critical non-Western perspective on the metaphor debate in oncology (Sontag, 1978/2002; Reisfield & Wilson, 2004). It empirically demonstrates that the "journey" metaphor is a functionally superior frame in a cultural context where personhood is relational (Ubuntu). This framing de-centers the individualistic "fight" and re-centers community and shared experience, directly mitigating the stigma of "losing a battle."

The use of Culturally-Sensitive Euphemism (Theme 4) challenges a simplistic view of euphemisms as evasive. In this context, phrases like "kuzorora" (to rest) are essential mediating tools that translate a biological endpoint into a culturally coherent spiritual transition. This practice shows a deep sensitivity to the local construction of a "good death" (Kielmann & Cataldo, 2010; Van der Geest, 2004), ensuring the medical prognosis is not a direct assault on the patient's cultural reality but is instead carefully woven into it.

Finally, the use of Aesthetic and Narrative Tools (Theme 5) represents a pinnacle of patient-centered, culturally congruent communication. This strategy aligns with the palliative care goal of value-based elicitation (Steinhauser et al., 2000) but achieves it through a uniquely indirect and affective channel. Using poetry to discuss wishes is a profound demonstration of working within, rather than against, cultural norms of indirectness, transforming a clinical conversation into a shared human experience and powerfully facilitating the discussion of a "good death."

Limitations

This study was conducted in an urban setting with clinicians from tertiary institutions; strategies in rural areas may differ. The data relies on self-reported communication, which may differ from actual practice. Future research should include direct observation of consultations.

CONCLUSION

The journey from biologic truth to lived reality is most profound at the end of life. This study has illuminated the sophisticated linguistic toolkit clinicians in Zimbabwe employ to steward this journey. Their strategies, structured adaptation, diagnostic preluding, metaphorical re-framing, lexical mediation, and aesthetic engagement, are not incidental but essential to their practice. They demonstrate that effective end-of-life communication is less about a perfect translation of medical facts and more about the skillful negotiation of a new, culturally-resonant reality.

By documenting these strategies, this research provides a foundation for developing training and resources that can support clinicians in this challenging work. Ultimately, it underscores that in the face of incurable disease, the goal of communication is to ensure that the final lived reality for the patient and family is not one of despair and abandonment, but one of supported passage, guided by both clinical compassion and cultural wisdom, toward a *kufa kwakanaka*, a good and peaceful death.

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