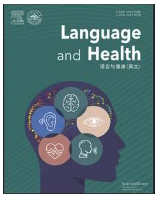
Language and Health 3 (2025) 100069

Contents lists available at ScienceDirect

Language and Health

journal homepage: www.sciencedirect.com/journal/language-and-health



“Waiting to Die”: Language, discourse and meaning in palliative care contexts in Kenya☆

Daniel Ochieng Orwenjo

Department of Information Science, Language and Communication Studies, The Technical University of Kenya, Kenya

ARTICLE INFO

Keywords:
Language
Discourse
Palliative care
Focused ethnography
Kenya

ABSTRACT

The contemplation of death is for most of us inherently disconcerting, making it natural repress such an unpleasant reality both on an individual and on a societal level. Language provides us with the facility for suppression of such thoughts, achieve different outcomes and construct different realities by words chosen and their shared meanings. This paper reports the findings of a study conducted to investigate the discursive construction of palliative care in the Kenyan context. The study was conducted in four hospices in Kenya, namely Siaya, Kisumu, Busia and Eldoret. Like in many African countries, palliative care is yet to be fully integrated into the mainstream healthcare system in Kenya, and these centres, although located within the proximity or sometimes within the premises of the respective county referral hospitals, were mainly operationally autonomous. Participants were selected for the study using purposive sampling. purposively selected for the study. Data was collected over a period of six (6) months using the principles of focused ethnography and guided by the study objectives and relevant theoretical framework. The care givers were all relatives of the patients who doubled up as care givers of during the hospitalization period. The findings of this study show that the language used in palliative care contexts in Kenya varies considerably and reflects diverse conceptualizations of illness, diagnosis, treatment and death. It emerges that these conceptualizations are constrained by cultural practices, religious beliefs, speaker identity and the goals of the palliative care facility.

1. Introduction and background

In our everyday interactions, we use language to achieve different outcomes. Discourse constructs social entities by words chosen and shared language. Within the medical context in general, language that is used to achieve different health outcomes can be broadly characterized as medical discourse- discourse in and about healing, curing, or therapy; expressions of suffering; and relevant language ideologies (Wilce, 2009). As modes of social action, medical discourses constitute and construct medical institutions, healthcare practices, and interpersonal relations within the healthcare context beyond mere patient- doctor encounters. Nowhere in the healthcare context is such discursively mediated interaction as critical as in End-of –Life Care contexts. This is because these are contexts in which death is imminent and the contemplation of death is a stark reality to the patients, medical practitioners and family. Talking about death therefore becomes not only normal, but an urgent imperative, yet the paradoxical urge to suppress thoughts about death, especially in “death denying “(Alexander, 2025; Rihs et al., 2025; Parry, 2024; Zimmermann, 2007; Zimmermann & Rodin, 2004) cultural contexts such as Kenya where there are numerous beliefs and superstitions about death, is also almost always present. Medical discourse is a type of institutional discourse and therefore characterized by unequal power relations arising from uneven access to various discursive resources. Medical practitioners, patients and family members in end –of-life care contexts are positioned differently, making language use in such contexts to be not only institutionally constrained, but also socially and culturally situated. The present study was therefore guided by the following questions: How do healthcare practitioners, patients and family members talk about and contemplate the inevitability of the death of a loved one or self? What lexical choices are made in such discourses? How do they carry particular power relations thus making language to have an enduring influence on our view of death and dying (O’Connor et al., 2010; Hadley, 2025; Wang et. al., 2024)? These questions are posed informed by the realization that the language we use to talk about end-of-life care matters because it conveys the values we attribute to life and death (Carter et al., 2021).

☆ This publication arose from a project financed by the Africa Multiple Cluster of Excellence at the University of Bayreuth (funded by the German Research Foundation under Germany’s Excellence Strategy – EXC 2052/1 – 390713894.

E-mail address: ochieng.orwenjo@tukenya.ac.ke.

https://doi.org/10.1016/j.laheal.2025.100069
Received 20 February 2025; Received in revised form 25 October 2025; Accepted 30 October 2025

Due to poverty, lack of resources and infrastructure, care provision at the end-of-life is scarce across the African continent (Abu-Odah et al., 2020; Harding and Higginson, 2005). Palliative care, in the manner it is conceptualized and delivered in the global north, is a relatively new phenomenon in Kenya, and perhaps, in other Sub-Saharan countries. A study mapping End of Life care initiatives reported by Clark et al. (2007); Knaul et al. (2025) and Bastos et al. (2025) for instance, showed that there were services in only 26 of 47 countries, and only in Uganda, South Africa, Kenya and Zimbabwe are services reaching a level of integration into the existing health system. There is an ever-growing need for palliative care services in Kenya, especially in the rural areas (Cartmell et al., 2023). The government of Kenya for instance, approximates that 800,000 people in Kenya require palliative care services annually, but only about 14,522 access these services (Ministry of Health, 2021). While Palliative Care is a relatively new discipline in Kenya and other African countries (Rhee et al.,2017), there have been remarkable improvements in service delivery in this critical sector (Hannon et.al, 2016). For instance, the government has integrated palliative care services into official healthcare policy, supported by the Kenyan Hospices and Palliative Care Association (KEHPCA), that works to increase PC access in Kenya using a multisectoral approach, bringing together healthcare providers, national and local governments, development partners, local communities, and patients and families in need of Palliative Care services. As a result, palliative care has presently been integrated in 78 health facilities in 42 out of the 47 counties. The present study should be viewed within the lens of these developments and be considered as a step in furthering them.

Palliative care and end-of-life care, although closely related, differ fundamentally in their timing, scope, and goals. Palliative care is an approach designed to improve quality of life for patients and their families facing serious or life-threatening illness, by preventing and alleviating suffering through early assessment and treatment of physical, psychological, social, and spiritual needs; it may begin at diagnosis and continue concurrently with curative treatments. (Salins et al., 2018; Indian Council of Medical Research, 2018; Aoun, 2023) In contrast, end-of-life care is a subset of palliative care focused specifically on individuals in the final months, weeks, or days of life when curative options are no longer viable, and the primary aim shifts toward comfort, dignity, and supporting the dying process rather than prolongation of life (Palliative Care & End-of-Life Care definitions, ICMR, 2018; Aoun, 2023). The distinction is evident in the transition of treatment goals: palliative care can be given alongside curative measures, while end-of-life care typically represents a shift away from curative intent toward exclusively symptom relief and psychosocial support (Indian Council of Medical Research, 2018; University of Western Australia, 2023). Understanding this difference is important to ensure appropriate timing of interventions, realistic expectations, and patient-centred decision making.

Despite these distinctions, the terms are frequently used interchangeably in both clinical and academic contexts, largely because end-of-life care is considered a natural extension or phase of palliative care (Radbruch et al., 2020). In practice, the overlap in care principles, provider teams, and patient needs means the boundaries between the two are often fluid. This terminological interchangeability has prompted Knaul et al. (2018) to observe that for the purposes of research particularly in studies examining holistic, person-centered care approaches in advanced illness (such as the present study), it can be appropriate to use the terms interchangeably, provided this is acknowledged and justified. This is the position that this paper adopts. Clarifying this usage ensures conceptual consistency while allowing for a nuanced understanding of the continuum of care in serious illness.

2. Review of related literature

Language is central to how people understand, experience, and manage dying. In palliative care, conversations between healthcare practitioners, patients, and family members do more than exchange information, they construct meanings, express moral positions, and reflect social hierarchies. This review synthesizes empirical studies on how people talk about the inevitability of death, the lexical choices used in such discourse, and how these choices encode power relations, with emphasis on evidence from Kenya and comparable contexts. In Kenya, just like in many African countries, much of the language surrounding illness and death is culturally loaded, which affects how patients and their families engage with the palliative care process Mensah (2024). Discourse in medical contexts often focuses on the biological aspects of death, leading to a medicalized view of illness (Engel et al., 2023). In contrast, families and communities might have more spiritual or culturally rich discourses about death (Borgstrom & Visser, 2024; Clancy et al., 2025). The term "waithood," as explored by researchers like Dobler (2020), refers to prolonged periods of waiting for a change in status or a major life event (such as marriage, adulthood, or death) and is closely tied to broader social and political issues in Africa. In the case of terminal illness, *waithood* can be conceptualized as the experience of waiting for death within a social framework that positions patients in a liminal state of suspended existence. This concept can be used to describe the collective experience of terminal illness, where the patient, family, and community are all waiting for death, yet the meaning attached to this waiting is far from neutral. For example, in the global north, the language used by doctors and medical professionals can significantly influence the emotional and psychological state of patients. Studies show that terms like “palliative care” and “hospice care” are associated with compassion and comfort, yet the more passive framing of "waiting to die" can imply a lack of hope and agency (Henderson et al., 2019). This duality of meaning in the discourse around death is important when considering how patients in Kenya might respond to the language used by doctors in palliative care settings.

The way illness is discursively constructed by patients, families, and doctors can deeply affect the course of palliative care and the emotional experience of dying. Discursive constructions of illness often reveal power dynamics between patients and healthcare providers, as well as the way individuals internalize social and cultural expectations surrounding death and dying. In Kenya, illness and death are often seen through a communal lens, where the illness is not only an individual experience but also one that involves family, community, and social networks (Gathaiga and Schwarz, 2017; Nganga et al., 2024). Thus, different families may construct illness narrative around concepts of *waithood*, framing the waiting period as one of suffering, but also of potential spiritual or moral growth. For instance, a patient in Kenya who is terminally ill may be framed by family members as “waiting for the final call” rather than “waiting to die,” which invokes a different cultural and spiritual perspective on death. This frame encourages a spiritual readiness, implying that the patient’s body is temporarily holding out for divine intervention, making the wait not just passive, but spiritually significant.

A growing body of empirical and analytic work, both globally and in East Africa, shows that talk about dying is shaped by culture, power, and institutional pressures. For Kenya, literature indicates prevalent indirectness and spiritual framing, clinician reliance on medicalized discourse, and structural constraints that shape interactions. The present study contributes to this body of knowledge by producing detailed, context-sensitive conversation-level evidence that links lexical choices to power dynamics and practical outcomes in palliative care decision-making. Empirical studies from sub-Saharan Africa show that direct naming of death is frequently avoided. Clinicians and families often engage in circumspect talk or avoid the subject entirely, treating death as taboo or using indirect language to “soften” the reality of impending death. Githaiga’s (2017) synthesis of East African studies for instance highlights that sociocultural norms and fears about uttering death render direct conversations difficult; clinicians report balancing cultural sensitivity with the need for clarity in care planning. A Kenya-specific landscape review of palliative care research emphasizes limited public awareness about palliative care and prevailing beliefs about death and treatment, which shape clinical conversations and decision-making. This evidence suggests that talk about inevitability is embedded in a matrix of cultural, spiritual, and health system constraints.

Quantitative and qualitative analyses of recorded family-clinician meetings show strong preferences for euphemisms and colloquialisms by family members and for medicalized terms by clinicians. Barlet et al. (2022) found that clinicians favored medical jargon and avoided words like "die" or "death," while families used colloquialisms ('pass on', 'no longer with us', "gone to be with the Lord" or "finished his journey"). This discursive pattern likely to be replicated in many settings where directness about death is culturally sensitive. For instance, in Kenyan and broader African contexts, spiritual and religious idioms (e.g., "called home," "God's will") are often used to place death within moral and cosmological frames, which can both comfort and shape expectations about medical intervention (Barlet et al., 2022). Empirical measures of "quality of dying and death" in Kenya also point to the centrality of religious/spiritual domains in perceptions of a 'good death' (Mwangi, 2019). Such lexical variation affects mutual understanding: euphemisms risk ambiguity, while medical jargon can alienate non-clinical participants.

Critical discourse analytic perspectives argue that language at end-of-life is never neutral: it enacts institutional power, normalizes particular moral positions, and can marginalize patients' voices (e.g., through paternalistic framing). Studies applying CDA and conversation analysis to end-of-life contexts show how institutional talk such as clinical guidelines, prognostic statements, euphemistic framing can relegate patient/family epistemic rights and shape decision pathways such as choices about withdrawal of treatment (Pattison, 2012)

Language in palliative care enacts institutional and interpersonal power. Critical discourse analyses reveal that clinicians' lexical dominance (through jargon, directive statements, and expert framing) can marginalize patient or family voices (Pattison, 2012). In resource-limited Kenyan settings, medical authority often intersects with social deference to professionals, producing asymmetrical interactions (Githaiga & Swartz, 2017). When clinicians employ bureaucratic or technical terms, they maintain epistemic control, whereas patients' emotive or spiritual vocabularies may be treated as peripheral. Such linguistic asymmetry shapes moral hierarchies of knowledge and responsibility, ultimately influencing care decisions and perceptions of a "good death." In low-resource settings such as Kenya, practical constraints such as limited palliative care access, understaffing often intersect with lexical and discursive practices: clinicians may adopt more directive language to conserve scarce resources or because families defer to clinician authority. Empirical work from East Africa reports that clinicians sometimes avoid explicit prognostic talk because of concerns about causing loss of hope or because of cultural norms that position clinicians as decision gatekeepers. (Githaiga & Swartz, 2017). When clinicians employ bureaucratic or technical terms, they maintain epistemic control, whereas patients' emotive or spiritual vocabularies may be treated as peripheral. Such linguistic asymmetry shapes moral hierarchies of knowledge and responsibility, ultimately influencing care decisions and perceptions of a "good death."

2.1. *Theoretical issues*

The present study views the Social Construction of Health and Illness theory (Berger & Luckmann, 2016; Craig, 1999, 2008, 2013) as an adequate explanatory model for language, discourse and meaning in palliative care contexts in Kenya. Grounded in sociology, social constructionism of reality is based on the concept of the dialectic between social reality and individual existence. Within this dialectic, the individual acts on accepted knowledge through language that creates for him or her and individualized world and its meanings. One of the key proponents of this theory, Robert Craig, has argued that communication can be viewed either as a transmission or a constitutive process that produces and reproduces shared meaning. With regard to the constitutive model, Sharf and Vanderford (2003) have clarified this distinction further:

In the context of health, illness and medical care, the application of the constitutive model of communication reveals the complexities of moderating between scientific truth derived from the physicality of organic disease and materiality of bodies, and the meanings of human suffering experienced by patients, their loved ones, and the health professionals who care for them. (p.11)

They explain that the emergence of the social construction approach to health communication is a direct reaction to the dominant biomedical perspective of health and illness, one in which science (objective, measurable and verifiable) has been given prominence over the non-verifiable, subjective experiences of ill people. This selective prominence has, inevitably, given rise two competing discourses in healthcare, namely the objective, scientific, and the subjective, humanistic. As Mishler (1984) points out:

The world as a meaningful reality is constructed through human interpretive activity [and] and whether or not a particular behavior or experience is viewed as a sign or symptom of illness depends on cultural values, social norms, and culturally shared rules of interpretation. (p.141)

The social construction of illness theory is therefore valuable to the present study in as far as it provides useful insights into how patients, and family members in palliative care contexts in Kenya socially construct their illness and frailty, and how such constructions differ diametrically from the dominant biomedical constructions of medical practitioners. Further the theory would help illuminate how such polarized constructions are discursively produced and reproduced in health communication in palliative care contexts, and how and what such discourses reveal unequal power structures and epistemological hegemony in palliative care contexts in Kenya.

3. Methods

3.1. *Study area*

The study was conducted in four hospices in Kenya, namely Siaya, Kisumu, Busia and Eldoret.

3.2. *Participants*

A total of 24 participants (16 terminally ill patients; four care givers; four palliative care nurses) were selected for the study using purposive sampling. The care givers were all relatives of the patients who doubled up as care givers of during the hospitalization period. Purposive sampling enables the researcher to select a specific group of individuals or units for analysis and is appropriate when the researcher has a clear idea of the characteristics or attributes they are interested in studying, and wants to select a sample representative of those characteristics (Campbell et. al.,2020). This was the case in the present study. Deliberate efforts were made to ensure a heterogonous sample in terms of gender. For palliative care nurses, a senior medical practitioner at the facility facilitated recruitment. Once recruited, palliative care nurses made the initial contact with the patients and their respective family members and caregivers.

Patients were from 65 years old and deemed to be frail and terminally ill. Terminal illness was determined using a combination of clinical assessment and standardized prognostic criteria consistent with international palliative care practice. Patients were classified as terminally ill if they had a life expectancy of six months or less, as judged by attending clinicians based on disease progression, functional decline, and symptom burden. The Palliative Performance Scale (PPS) (Anderson, et al., 1996) and, where applicable, the Functional Assessment Staging Test (FAST) (Reisberg, 1988) for dementia were used to guide this determination, with a PPS score of 50 % or below indicating significant loss of function and dependence consistent with terminal status. Clinicians also applied the "Surprise Question" (Moss et al. (2010). These combined criteria ensured that the study included participants who were clearly within the terminal phase of illness, thereby situating the analysis within authentic end-of-life care contexts. Informed consent was obtained from the patients where this was practically possible, and from a close relative, where this was not possible. Table 1 below is a summary of the demographic characteristics of the patients, including their respective medical conditions.

3.3. Data collection and analysis

Data was collected over a period of six (6) months from February to July 2024 using the principles of focused ethnography and guided by the study objectives and the theoretical framework explicated above. Within the ambit of focused ethnography, data collection strategies can be adapted and yet still produce rich data that preserves the ethnographic intent to reveal the common elements of culture such as values, beliefs, knowledge, skills, actions, and power dynamics. The present study took advantage of these affordances. Data collected comprised of field notes, a reflexive journal, focused interviews and audio tape recordings. The interviews were later translated, transcribed verbatim by a qualified transcription service provider and the transcriptions were counter-checked by the research team for validity. Data was analyzed iteratively following the procedures of Critical Discursive Psychology (Huma et al., 2020; Locke & Budds, 2020) as outlined below:

i. The first step involved a thorough reading and familiarization with the data corpus. This also involved the researcher immersing himself in the data and performing a line-by-line coding focusing on what is being said, what categories are being invoked, when and how?
ii. The second stage entailed identification of the discursive constructions of illness, frailty and death within the EoL care contexts. Prevalent themes in the data were identified and key words or repeated themes grouped together
iii. The next stage involved identification of the interpretive repertoires. According to Wetherell (2015), an interpretive repertoire is a discernible way of describing, framing or describing an issue that is discernible as such. Identification of interpretive repertoires entailed a deeper analysis of the data with a view to determining what the discursive constructions already identified are accomplishing in the context of the interactions. This involved asking questions such as: what kind of reality is being constructed? and, what kinds of constructions are being resisted.
iv. The fourth stage involved the identification of the various "subject positions" that are made available through the interpretive repertoires that are in operation. Subject positions are a key aspect of post-structuralist analyses and can be conceived of as "ways of being" (Grønvad, et.al., 2024). They refer to how the writer or speaker is both positioned and positions others and themselves in discourse.
v. The fifth stage focused on a micro-level analysis of the action orientation of the discourse by examining the ways in which the accounts are put together to achieve particular interactional effects. Additionally, the implications of the discourse were considered in terms of what interactional "business" is being done at the micro-level through the identification of linguistic and rhetorical devices.
vi. The sixth and final stage entailed a putting together of all the different aspects of the analysis and considering what this means to the topic under investigation.

Table 1
Demographics of the patients.

Patient	Age	Gender	Diagnosis	Care Giver	Hospice
1	65	Female	Breast cancer	Daughter	Siaya
2	73	Female	HIV/AIDS	Daughter	Siaya
3	71	Male	HIV/AIDS	Paramedic	Busia
4	83	Female	HIV/ AIDS	Daughter	Eldoret
5	56	Male	Melanoma	Spouse	Siaya
6	84	Male	Multiple Organ Failure	Paramedic	Kisumu
7	76	Female	HIV/AIDS	Sister	Eldoret
8	73	Female	Multiple Organ Failure	Paramedic	Busia
9	80	Male	Leukemia	Paramedic	Busia
10	81	Female	Cervical Cancer	Granddaughter	Siaya
11	82	Male	Chronic Lymphocytic Leukemia	Church pastor	Eldoret
12	66	Male	Multiple Organ Failure	Son	Eldoret
13	68	Female	Uterine Cancer	Church member	Kisumu
14	79	Male	Prostate cancer	Son	Kisumu
15	80	Male	Prostate cancer	Brother	Kisumu
16	77	Female	Cervical Cancer	Granddaughter	Busia

Having completed the six stages, the analysis moved into a categorization phase where data comprising of lexical items and other linguistic expressions used to talk about illness, frailty, treatment, medication and death was categorized thematically and emerging patterns determined based on their respective meanings within the contexts of use.

3.4. Ethical issues

DeCamp et al. (2022) underscores the need to observe unique ethical guidelines while conducting EoL research. He points out that engagement with patients and families throughout the research lifecycle is critical to ensuring it addresses the needs, priorities, and values of patients and families and suggests key ethical issues to be observed throughout such engagement namely: Giving patients and families the opportunity to participate as research partners – even very near life's end - and do so sensitively and with compassion; Proactively minimizing the burdens of patients and families participating as research partners by being thoughtful about when, where and how engagement activities occur and being prepared to manage "relationship ethics" as a result of the deep bonds that can form over time with partners.

Informed consent was obtained from the palliative care facilities, medical practitioners, family members/care givers and patients. Where the patient was incapable of providing informed consent, this was obtained from a close family member. Data obtained during the study was used strictly for the study purposed and was not made accessible to any third party. Finally, ethical clearance for the study was obtained from the Technical University Research Ethics Board. Additionally, the study observed the unique guidelines for conducting EoL care as proposed by DeCamp et al. (2022:5–8).

4. Findings

This section presents the findings of the study with respect to language use in the discourse of palliative care in selected facilities in western Kenya. This is done under the four thematic areas that were considered to be the key care milestones of palliative care, namely illness, diagnosis, treatment and medication, and death. Expressions used to describe the above milestones were analysed with a view to determining their various conceptualizations in the discourse. In the following sections, the findings of the study are presented in tabular form by indicating the source of the expression, followed by the expression (translated into English where necessary) and finally a token exemplification. This is done out of the cognizance that an anthropocentric orientation of cognitive terminology should essentially take into account not only the object of knowledge (the language of health care) but also the subject of knowledge (specialist, patient)

4.1. Discursive conceptualizations of illness/frailty

Analysis of data revealed that patients and family members used a variety of lexical items to talk about illness and frailty. Accordingly, illness and frailty was conceived of variously as“a possession’,“witchcraft”,“a curse”,“battle”,“death”“waithood” and“a burden”. Each of these conceptualizations are further discussed and exemplified in the Table 1 below:

Discourses surrounding illness and frailty in palliative care contexts revealed rich metaphorical and cultural framings that extended beyond biomedical explanations. Many participants articulated illness as a form of witchcraft or curse, reflecting deeply embedded local cosmologies that link suffering to moral and social transgression. Patients and families sometimes attributed chronic or terminal illness to malevolent forces, envy, or broken social relations, constructing disease as an external imposition rather than a purely physiological state. These framings often mobilized communal responses such as ritual cleansing, prayer, or reconciliation—as complementary to biomedical treatment. Such interpretations transformed illness from a private condition into a socially negotiated event that required moral and relational repair.

Other conceptualizations positioned illness as battle, death, or an act of God. The battle metaphor mirrored that used for treatment, emphasizing struggle, perseverance, and moral fortitude, but also revealing exhaustion and surrender in advanced stages of frailty. When illness was framed as death, it was often with resignation and acceptance, reflecting the perceived inevitability of decline in the face of limited treatment options. The act of God framing infused illness with theological significance, locating suffering within divine will and faith. Similarly, illness as burden evoked emotional, economic, and physical strain, while the concept of waithood, borrowed from youth studies, captured the liminal temporality of living while waiting, neither recovering nor dying. The metaphor of infection, finally, indexed both fear and stigma, as frailty became associated with contagion, moral decay, or spiritual pollution.

4.2. Discursive conceptualizations of diagnosis

Diagnosis was conceived of variously as “a discovery”, “a prophecy”, “a judgement” and “a punishment”

Across interviews, diagnosis emerged as a discursive site where uncertainty, revelation, and moral evaluation intersected. Participants frequently spoke of diagnosis as a discovery or a case, drawing on both medical and investigative metaphors. Describing illness as ’a case’ framed diagnosis as a professional unveiling, something doctors ’find out’ or ’name’ after careful inquiry. This language lent legitimacy to the biomedical process while also underscoring its distance from everyday experience. Similarly, viewing diagnosis as discovery suggested both relief and disruption thereby making it an unveiling of truth that simultaneously provided explanation and foreclosed hope.

Other discursive framings cast diagnosis in moral and spiritual terms such as prophecy, judgment, or punishment. When conceived as prophecy, diagnosis was described as foretelling a future that was both inevitable and divine in nature: ’*The doctor has spoken*,’ one participant, a family member, noted, equating medical pronouncement with spiritual revelation. The metaphor of judgment framed diagnosis as an authoritative verdict that classified individuals as either ’ill’ or ’beyond healing,’ often invoking a sense of guilt or moral accountability. In the punishment framing, diagnosis functioned as both social stigma and moral lesson, reinforcing local narratives of cause, consequence, and redemption. Collectively, these framings reveal how the act of naming illness is deeply entangled with cultural narratives of fate, morality, and divine justice.

4.3. Discursive conceptualizations of treatment and medication

Further analysis entailed a mapping out of how medical participants talked about the process of treating/ giving medication to their patients. This revealed that treatment was viewed variously as “journey”, “process”, “procedure”, “management” and “stimulus” as exemplified in Table 3. Below:

Analysis of interviews and field interactions revealed that participants in palliative care contexts in Kenya discursively construct ’treatment’ and ‘medication’ through a range of overlapping metaphors that shape how illness and dying are understood. The most prevalent conceptualizations positioned treatment as a journey, a process, or a procedure. The metaphor of the journey captured a sense of movement and continuity: patients spoke of being ’on treatment’ or ’continuing with the journey,’ signaling endurance, hope, and progress even in the face of terminal illness. Framing treatment as a process emphasized regularity and ritual, aligning medical routines with familiar social practices such as prayer, farming, or domestic chores. Conceptualized as a procedure, treatment evoked precision and expertise, situating medical interventions within an institutional logic of control and care.

A second cluster of metaphors cast treatment in more active or agentive terms such as management, stimulus, or battle. When discussed as management, participants drew on bureaucratic and organizational language, describing the body as something to be ’regulated’ or ’controlled’ through medication adherence and lifestyle adjustment. The metaphor of stimulus introduced notions of vitality and responsiveness, as treatment was perceived to ’wake up the body’ or ’encourage strength.’ Finally, framing treatment as battle reflected a moralized struggle between life and death, where medication symbolized both hope and resistance. This discursive framing positioned patients and caregivers as fighters, valorizing endurance and courage while simultaneously naturalizing exhaustion and failure when death ensued.

Table 2
Conceptualizations of Illness/Frailty.

Conceptualization	Source	Example
Possession	Patient	…mmh.this.you know ***this thing of mine***… I have been with it for a long time I am now…ehh like you see…getting used it, it doesn’t scare me any more”
“Witchcraft “	Patient	“this can’t be a normal illness. We have a land dispute and ***I am sure my feet have been picked***…mmm otherwise why would the illness affect only my feet”?
“Curse”	Caregiver	“***What wrong could grandma have committed to warrant…umh such a curse***…surely this is not normal”
“Battle”	Patient	“I have really suffered since I started becoming ill. Well…I am cannot give up now. ***This is a battle that I must win***”
“Death”	Patient	“this thing of mine is not …umm a disease. ***This is death, because a disease can be treated, but death is never treated*** even by the best doctors…”
“Act of God”	Caregiver	“ well…the bible says…***sometimes God decides to test our faith in him***, like he did to Job…so I am not bothered because my faith is strong
“Burden”	Caregiver	This illness is costing the family a lot both financially and psychologically…***it is a very big burden*** on us.
“Waithood”	Patient	“eeh getting used it, it doesn’t scare me any more…I know how it will end…***like a caged quail…I am just waiting to die***”
“Infection”	Medical practitioner	“… his illness is got worse when tests revealed that ***he was infected by TB virus***, which could be a result of compromised immunity arising from the original ***HIV infection***”

Table 3
Conceptualizations of diagnosis.

Conceptualization	Source	Example
“A Discovery”/ A Case	Medical professional	“**This case** had been admitted here because of diabetes. ***The discovery of leukemia*** has complicated things further”
“Prophecy”	Patient	I see this ***as a fulfillment of a prophecy*** by our bishop who saw me really suffering in a dream…but the good news is that in the dream…I end up being healed by the blood of Jesus
“A judgement”	Patient	With the news of this disease…well I felt that ***God was judging me for my past sins***…but now I am born again
“A punishment”	Patient	Surely…***I have been wondering what wrong eeh did I do to deserve this***…?

4.4. Discursive conceptualizations of death

Finally, we examined how death was conceptualized by participants in the EoL settings. It emerged that death is conceptualized as “surrender”/” losing a battle”, “relief’, “departure”, “failure” and “a pronouncement”. This is illustrated in Table 4. below:

Death, as represented in participants’ narratives, was discursively framed through a constellation of metaphors that reflected both struggle and transcendence. Many described death as losing a battle, extending the earlier framing of illness and treatment as combat. This construction conveyed a sense of finality and defeat but also valorized the patient’s endurance, thus framing death as the ultimate endpoint of a long and dignified fight. Others characterized death as relief or rest, emphasizing liberation from pain, exhaustion, and the burdens of treatment. This framing recast death not as failure but as release, aligning with local and religious idioms that valorize peace after suffering. Similarly, the metaphor of departure captured the liminal transition between life and afterlife, often expressed as ’going home’ or ’being called.’ Here, dying was narrated as a journey completed rather than a life cut short, imbuing death with continuity and spiritual meaning.

Alternative framings situated death within more institutional, moral, or theological registers. Conceptualizing death as failure reflected both medical and familial perspectives, where death marked the breakdown of care, hope, or biomedical efficacy. Health workers spoke of this with ambivalence, acknowledging systemic constraints while also internalizing loss as professional inadequacy. In contrast, viewing death as a pronouncement underscored the authority of medical and religious discourse: doctors ’declare,’ priests ’announce,’ and families ’receive’ death as an official event that transforms identity and social roles. The metaphors of surrender and capture by God infused death with sacred significance, positioning the dying person as yielding to divine will or being claimed by a higher power. These articulations reveal that in Kenyan palliative care contexts, death is not a single event but a discursive space where moral, spiritual, and biomedical meanings converge and where the end of life becomes both an ending and a passage.

Table 4
Conceptualizations of treatment/medication.

Conceptualization	Source	Example
“Journey”	Caregiver	“We have tried…yes we have done many things and visited many hospitals to help our grandpa. “***We have traveled a very long journey…***”
“Process”	Medical Practitioner	“…well, this looks very promising. We have performed a number of procedures but ***the tumour is still progressing***”
“Procedure”	Medical Practitioner	“…well, this looks very promising. Despite a number of ***procedures*** performed, but the tumour is still progressing”
“Management”	Medical Practitioner	“At stage four, it is so advance that all we can do is to ***manage*** the symptoms, but complete recovery from the cancer is now not likely”
“Stimulus “	Medical Practitioner	“We have subjected the patient to many chemotherapy sessions, but sadly, ***there is no positive response***”
“Battle”	Medical Practitioner	“We have subjected the patient to many chemotherapy sessions, but sadly, the patient is not responding”. I know this is very difficult for the family to accept but the truth is the “***battle will finally be lost.***”

Taken together, these discursive metaphoric constructions reveal that language in Kenyan palliative care contexts functions not merely as description but as a crucial medium for meaning-making at the threshold of life and death. ’Treatment,’ ’illness,’ ’diagnosis,’ and ’death’ are not isolated medical categories but dynamic discursive sites through which participants articulate moral agency, spiritual belief, and social identity. The metaphors of journey, battle, process, and management foreground the human effort to endure and restore order in the face of uncertainty. In contrast, framings of witchcraft, curse, prophecy, or punishment situate suffering within moral and cosmological frameworks that attribute causality and purpose to affliction. Finally, the narratives of rest, surrender, and capture by God recast dying as both an end and a transcendence, a moment of yielding to divine will and communal reconciliation. Collectively, these discourses illustrate how palliative care in Kenya is deeply embedded in moral, spiritual, and relational worlds where language mediates the experience of suffering and transforms clinical encounters into acts of cultural and existential negotiation.

5. Discussion

The findings of this study show that the language used in palliative care contexts in Kenya varies considerably and reflects diverse conceptualizations of illness, diagnosis, treatment and death. It emerges that these conceptualizations are constrained by cultural practices, religious beliefs, speaker identity and the goals of the palliative care facility. A number of studies have affirmed the role of religion (Efird et al., 2023; Masiga & Nambalriwa, 2025; Ezra et al., 2025), culture (Ojwang, 2018; Tunde & Orwenjo, 2022; Oloo & Orwenjo, 2022; Gerrard et al., 2021), speaker identity (Bohm et al., 2025) and speaker identity (Steinmann et al., 2020; Phenwan et al., 2025) in shaping the discourses surrounding not just palliative care, but healthcare contexts in general. The present study augments these discourses by providing nuanced insights into how illness, diagnosis, treatment and death, as major possible milestones of palliative care contexts, are conceptualized by patients, medical practitioners and caregivers.

With specific reference to conceptualization of illness and frailty, it can be observed that religious beliefs, cultural practices and speaker identity and role heavily constrained linguistic conceptualizations. Thus, illness and frailty are conceptualized as “witchcraft” and “curse”, as per the local cultural beliefs and practices, but as an act of God as per the Christian doctrine which attributes every happening (whether good or bad) in the lives of humans. Additionally, it is worth noting that patients have a highly personalized conceptualization of illness (“battle”, “death”) as opposed to care givers whose conceptualizations are rather detached (waithood, burden) and portray illness as disruptive and bothersome (*This illness is costing the family a lot both financially and psychologically*). This highly personalized view is made apparent when we consider the exemplification of these conceptualizations, where, for instance, in conceptualizaing illness as death the patient talks of illness as possession (“…*this thing of mine*…”) and as battle, illness is viewed from the first-person perspective and experience (*I have really suffered since I started becoming ill*). These conceptualizations have been reported in previous studies such as those of Lupton (2012) who argues that the conception of mental illness is highly constrained by culture; and Verginer & Juen who present spiritual explanatory models of mental

Table 5
Conceptualizations of death.

Conceptualization	Source	Example
"Losing a battle"	Medical Practitioner	"…the patient failed to respond to treatment despite the many procedures that we tried…and…finally he lost the battle…sadly!
"Relief/ Rest"	Caregiver	"At least our mother has now gone to rest…let her rest…. she was really suffering…she has endured a lot"
"Departure"	Caregiver	"Mum left us last night…she has gone to be with the lord"
"Failure"	Medical Practitioner	"…the patient failed to respond to treatment despite the many procedures that we tried…and…finally we lost the battle…sadly!
"A pronouncement"	Medical Practitioner	"…he was pronounced dead early this morning"
"Surrender"	Medical Practitioner	"… all I can assure the family as the doctor in charge is that we tried all we could…eh CT scan, radiotherapy, oxygen…ehh but still she succumbed…sometimes it's that way"
"Capture by God"	Caregiver	"…We loved her but God loved her more…she has rested…God has taken her from us"

illness in West Nile, Uganda. By equating illness to death, patients tacitly acknowledge and accept the impossibility of recovery and the concomitant inevitability of death in the near future, thereby aligning their expectations to expressly stated goals of palliative care, which are focused on management of symptoms, and not ultimate cure. It is also instructive to note that the conceptualizations of illness by trained medical practitioners is largely biomedical and contrasts diametrically with the other discourse participants who might be considered as "lay" in this context. It can thus be argued that the special training of the medical practitioners invests them with certain discursive resources which create hegemonic power imbalances in the discourses of palliative care contexts. As Ojwang (2018) observes, such power imbalances have the potential of influencing how lay people make medical decisions, which may be at variance with the dominant biomedical perspective, thereby creating the possibility of disrupting the goals of palliative care.

Conversely, the discourses of diagnosis, treatment, and medication reveal a different layer of meaning, one shaped by institutional hierarchies and biomedical authority. Healthcare practitioners' lexical choices often draw on medicalized and depersonalized language, constructing patients as cases rather than persons, and thereby reproducing power asymmetries inherent in clinical encounters. Yet patients and family members resist or reinterpret these constructions through alternative linguistic framings that reassert agency, morality, or faith. This negotiation of meanings illustrates how language operates as a site of struggle between biomedical rationality and local moral worlds, where competing epistemologies of illness and dying coexist and interact (Good, 1994; Mishler, 1984). The biomedical vs the religio-cultural divide manifested itself in the lexical choices made by interlocutors as per their discursive power such that for instance as per the examples in Table 2, medical practitioners conceived of diagnosis as a "discovery", while the patients conceived of it as "prophecy", "judgement" and "punishment". Whereas the medical practitioner's view of diagnosis implies a deliberate, systematic process driven, and replicable activity which is consistent with a biomedical view of health and medicine, the religio-cultural conceptualizations are highly subjective and unstructured as all the three lexical choices used do not connote any scientific method. These findings appear to reinforce previous studies that have emphasized the need to interrogate the language used in medical diagnosis (Kistner, 1998; Nickels et al., 2024; Phong & Ngan, 2016). Nickels et. al., for instance, emphasize the notion of "Linguistic Medical Knowledge" (LMK) and its critical role in theory and practice of medical diagnostics.

The study reported that medication/ treatment was linguistically conceptualized by medical practitioners and care givers members although there was no reported data on patients. This could be attributed to the nature of the facilities (palliative care centres) and the fact that the researcher decided to avoid interacting with the patients during their medication times on the request of the management of the facilities. medical practitioners were reported to have used a highly depersonalized language (Misra, 2025) in referring to medication ("Process", "Procedure" "Management" "Stimulus"). It is instructive to note that such lexical choices deliberately obfuscate agency and may distance patients and caregivers from the human aspect of the medication experience, which could affect patient trust, satisfaction, and ultimately health outcomes. An exception. Even in instances where there is no depersonalization ("battle"), medical practitioners viewed medical treatment as a battle to prevent death, but opted for syntactic choice passivisation (*"the battle will finally be lost*" instead of *"We/She/He/They will finally lose the battle"*) and thus fail to necessarily attribute agency. This is in sharp contrast to the language choices of the caregivers which was highly personal and reflective of closer bonds with the patients.

The study's findings also reveal that talk about dying and death in Kenyan palliative care contexts is often framed through metaphoric, euphemistic, and religiously inflected discourse, which functions simultaneously to soften the emotional impact of mortality and to sustain hope and moral coherence in the face of terminal illness. The biomedical perspective of death, mainly reflected in the lexical choices of medical practitioners conceived of death as a failure of modern medicine (Mazur, 2011; Truog, 2020). Such choices could be informed by their institutional roles as persons entrusted with the task of providing treatment (and thereby preventing death). The lexical choices of the medical practitioners appeared, unusually, to shift agency attribution from them (*"finally, he lost the battle"*; *"she succumbed"*) to their patients, perhaps in an attempt to avoid taking responsibility. It is intriguing that such a conceptualization of death would still persist given the widely accepted view that death is inevitable within the palliative (Sullivan, 2003; Zimmermann, 2004; Breitbart, 2017). This can only be interpreted as an enduring legacy of biomedical perspectives of medicine which view death as an adverse event whose incomprehensibility produces a cognitive dissonance by portraying it as morally wrong, yet biologically inevitable. Conversely, caregivers who were also family members) viewed death as a loss and a departure, underlining the affinal and consanguineal ties that hold between them and the patients.

Moreover, the study demonstrates power relations embedded in discourse become particularly visible in moments when silence, avoidance, or indirect speech is employed to manage the social discomfort of discussing death openly. As the data reveals, the choice to speak euphemistically or deferentially reflects not only politeness norms but also the asymmetrical distribution of communicative authority between patients, families, and medical professionals. Through the lens of the Social Construction of Health and Illness theory, such discursive patterns demonstrate how language both mirrors and sustains broader social hierarchies, reinforcing dominant understandings of who holds knowledge, who may articulate suffering, and who must remain silent (Foucault, 1973; Fairclough, 1992).

In situating these findings within broader scholarship, this study affirms that language is not a neutral vehicle for describing illness and dying but a constitutive force that shapes perceptions, emotions, and ethical stances toward mortality. Similar to observations in Western hospice contexts (Seale, 2000; Burr, 2015), the Kenyan data underscore that discourse organizes not only clinical communication but also moral reasoning about the value of life and the dignity of death. The Social Construction of Health and Illness theory thus offers a powerful lens for understanding how linguistic practices in palliative care enact cultural scripts of suffering, hope, and transcendence, revealing that to talk about death is, ultimately, to construct what death means.

6. Conclusion

In conclusion, the study reveals that the experiences of illness, diagnosis, treatment, and death are not merely biomedical phenomena but deeply discursive and metaphorical constructions shaped by social, cultural, and moral meanings. Patients, family members, and healthcare practitioners each draw on distinct linguistic resources and symbolic frameworks to make sense of suffering, care, and mortality, ranging from metaphors of battle and surrender to those of discovery, punishment, and release. These varied discursive constructions highlight the tensions and negotiations that occur in end-of-life communication, where competing moralities and worldviews converge. Additionally, theses diverging linguistic conceptualizations point to the different roles and perspectives each group holds in the treatment process and reveals palliative care units, not merely as neutral medical institutions, but as sites of power relations and discursive practices. Understanding these meanings is essential for fostering more culturally responsive and empathetic palliative care practices in Kenya, where language serves not only as a medium of care but also as a site of meaning-making, power, and moral positioning at the threshold of life and death.

CRediT authorship contribution statement

Daniel Ochieng Orwenjo: Writing – review & editing, Writing – original draft, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of Competing Interest

I hereby declare no conflict of interest

Data availability

Data will be made available on request.

References

Abu-Odah, H., Molassiotis, A., & Liu, J. (2020). Challenges on the provision of palliative care for patients with cancer in low-and middle-income countries: a systematic review of reviews. *BMC Palliative Care, 19*(1), 55.

Alexander, C.M. (2025). Mindfulness as a Buffer Against Death Anxiety: Implications for End-of-Life Care. University Honors Theses. Paper 1687..

Anderson, F., Downing, G. M., Hill, J., Casorso, L., & Lerch, N. (1996). Palliative Performance Scale (PPS): A new tool. *Journal of Palliative Care, 12*(1), 5–11.

Aoun, S. (2023, August 4). *What is palliative care and how is it different to end-of-life care*. The Conversation. Retrieved from University of Western Australia: ⟨https://www.uwa.edu.au/news/Article/2023/August/What-is-palliative-care-and-how-is-it-different-to-end-of-life-care⟩.

Barlet, M. H., Barks, M. C., Ubel, P. A., Davis, J. K., Pollak, K. I., Kaye, E. C., Weinfurt, K. P., & Lemmon, M. E. (2022). Characterizing the language used to discuss death in family meetings for critically ill infants. *JAMA Network Open, 5*(10), Article e2233722. https://doi.org/10.1001/jamanetworkopen.2022.33722

Berger, P., & Luckmann, T. (2016). The social construction of reality. *In Social theory re-wired* (pp. 110–122). Routledge.

Bohm, I., Åbacka, G., Hörnell, A., & Bengs, C. (2025). "Can we add a little sugar?" the contradictory discourses around sweet foods in Swedish home economics. *Pedagogy, Culture Society, 33*(1), 105–121.

Borgstrom, E., & Visser, R. (2024). *Critical approaches to death, dying and bereavement*. Taylor & Francis.

Breitbart, W. (2017). On the inevitability of death. *Palliative Supportive Care, 15*(3), 276–278.

Burr, V. (2015). Social constructionism (3rd ed.). Routledge. ttps://doi.org/10.4324/9781315715421.

Carter, C., Leanza, F., Mohammed, S., Upshur, R. E., & Kontos, P. (2021). A rapid scoping review of end-of-life conversations with frail older adults in Canada. *Canadian Family Physician, 67*(11), e298–e305.

Cartmell, K. B., Doherty, E. A., Gikaara, N., Ali, Z., Qanungo, S., Melikam, E. S., & Powell, R. A. (2023). Kenyan palliative care providers' and leaders' perceptions of palliative care research needs and support to facilitate rigorous research. *BMC Palliative Care, 22*(1), 135.

Clancy, M., Bradbury-Jones, C., Phillimore, J., & Taylor, J. (2025). Exploring the experiences of children's palliative care for forced migrant families in the United Kingdom: an interpretative phenomenological study. *Frontiers in Pediatrics, 12*, 1494938.

Clark, D., Wright, M., Hunt, J., & Lynch, T. (2007). Hospice and palliative care development in Africa: a multi-method review of services and experiences. *Journal of Pain and Symptom Management, 33*(6), 698–710.

Craig, R. T. (1999). Metadiscourse, theory, and practice. *Research on Language Social Interaction, 32*(1-2), 21–29.

Craig, R. T. (2008). Communication in the conversation of disciplines. *Russian Journal of Communication, 1*(1), 7–23.

Craig, R. T. (2013). Constructing theories in communication research. *Theories and Models of Communication, 1*(8), 39–57.

DeCamp, M., Alasmar, A., Fischer, S., & Kutner, J. S. (2022). Meeting ethical challenges with authenticity when engaging patients and families in end-of-life and palliative care research: a qualitative study. *BMC Palliative Care, 21*(1), 74.

Dobler, G. (2020). Waiting: Elements of a conceptual framework. *Critical African Studies, 12*(1), 10–21.

Efird, C. R., Barrington, C., Metzl, J. M., Muessig, K. E., Matthews, D. D., & Lightfoot, A. F. (2023). We grew up in the church": a critical discourse analysis of Black and White rural residents' perceptions of mental health. *Social Science Medicine, 336*, Article 116245.

Engel, M., Kars, M. C., Teunissen, S. C. C. M., & van der Heide, A. (2023). Effective communication in palliative care from the perspectives of patients and relatives: a systematic review. *Palliative Supportive Care, 21*(5), 890–913. https://doi.org/10.1017/S1478951523001165

Ezra, P., Goble, P., Trahan, M. H., & Clegg, J. (2025). The moderating effects of religiosity on depression and paternal involvement during early childhood. *Journal of Child and Family Studies*, 1–14.

Fairclough, N. (1992). *Discourse and social change*. Polity Press.

Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception*. Vintage Books.

Gerrard, J. M., Godwin, S., Chuter, V., Munteanu, S. E., West, M., & Hawke, F. (2021). Release of the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025; the impacts for podiatry in Australia: a commentary. *Journal of Foot and Ankle Research, 14*, 1–13.

Githaiga, J. N., & Swartz, L. (2017). Socio-cultural contexts of end-of-life conversations and decisions: bereaved family cancer caregivers' retrospective co-constructions. *BMC Palliative Care, 16*, 1–8.

Githaiga, J. N., & Swartz, L. (2017). Socio-cultural contexts of end-of-life conversations and decisions: Bereaved family cancer caregivers' retrospective co-constructions. *BMC Palliative Care, 16*, 40. https://doi.org/10.1186/s12904-017-0222-z

Good, B. J. (1994). *Medicine, rationality, and experience: An anthropological perspective*. Cambridge University Press.

Hadley, J. M. (2025). Communication and end-of-life care in dementia: insights from a close family member working in healthcare. *British Journal of Community Nursing, 30*(8), 380–387.

Harding, R., & Higginson, I. J. (2005). Palliative care in sub-Saharan Africa. *The Lancet, 365*(9475), 1971–1977.

Henderson, S., et al. (2019). The impact of communication on end-of-life decision-making in palliative care: A study in the United States. *Journal of Palliative Care, 34*(1), 22–28.

Huma, B., Alexander, M., Stokoe, E., & Tileaga, C. (2020). Introduction to special issue on discursive psychology. *Qualitative Research in Psychology, 17*(3), 313–335.

Indian Council of Medical Research. (2018). *National ethical guidelines for biomedical and health research involving human participants*. Indian Council of Medical Research. https://ethics.ncdirindia.org/asset/pdf/ICMR_National_Ethical_Guidelines.pdf.

Kistner, U. (1998). Illness as metaphor? The role of linguistic categories in the history of medicine. *Studies in 20th 21st Century Literature, 22*(1), 3.

Knaul, F. M., Arreola-Ornelas, H., Kwete, X. J., Bhadelia, A., Rosa, W. E., Touchton, M., & Radbruch, L. (2025). The evolution of serious health-related suffering from 1990 to 2021: an update to The Lancet Commission on global access to palliative care and pain relief. *The Lancet Global Health, 13*(3), e422–e436.

Knaul, F. M., Bhadelia, A., Rodriguez, N. M., Arreola-Ornelas, H., & Zimmermann, C. (2018). The lancet commission on palliative care and pain relief—findings, recommendations, and future directions. *The Lancet Global Health, 6*, S5–S6.

Locke, A., & Budds, K. (2020). Applying critical discursive psychology to health psychology research: A practical guide. *Health Psychology and Behavioral Medicine, 8*(1), 234–247.

Lupton, D. (2012). *Medicine as Culture: Illness, Disease and the Body*.

Masiga, S., & Nambalirwa Nkabala, H. (2025). The biblical discourse of disability and implications for religious communities in uganda: A hermeneutical review. *Journal of Disability Religion, 29*(1), 51–63.

Mazur, A. (2011). Conceptualizations of death. *Beyond Philology*, 21.

Mensah, E. O. (2024). Death is the cause of my predicament: A cross-cultural study of death-related personal names in Nigeria. *Death Studies, 48*(7), 641–651.

Ministry of Health. Kenya Palliative Care Policy 2021–2030. 2021. Available from: ⟨https://www.health.go.ke/wp-content/uploads/2021/10/KenyaPalliative-Care-Policy-2021-2030.pd⟩.

Mishler, E.G. (1984). The Discourse of Medicine: Dialectics of Medical Interviews. (No Title)..

Misra, S. (2025). The long walk back. *Journal of Pain and Symptom Management, 69*(2), e189–e190.

Moss, A. H., Lunney, J. R., Culp, S., et al. (2010). Prognostic significance of the "surprise" question in cancer patients. *Journal of Palliative Medicine, 13*(7), 837–840.

Mwangi, W. (2019). Evaluation of the quality of dying and death questionnaire in Kenya. *Journal of Global Oncology, 5*. https://doi.org/10.1200/JGO.18.0032

Nganga, N. W., Momanyi, R. O., Chemirmir, C., Biwott, H., Ayodo, G., Orero, M., & Kiaka, R. D. (2024). The potential role of cultural and religious healing practices in shaping community vulnerability to highly infectious diseases in western Kenya. *medRxiv*, 2024-04.

Nickels, L. C., Marshall, T. L., Edgerton, E., Brady, P. W., Hagedorn, P. A., & Lee, J. J. (2024). Defining diagnostic uncertainty as a discourse type: A transdisciplinary approach to analysing clinical narratives of Electronic Health Records. *Applied Linguistics, 45*(1), 134–162.

O'Connor, M., Davis, M. P., & Abernethy, A. (2010). Language, discourse and meaning in palliative medicine. *Progress in Palliative Care, 18*(2), 66–71.

Ojwang, B. O. (2018). Linguistic conceptualizations of disease among the Luo of Kenya. *Qualitative Health Research, 28*(3), 433–445.

Oloo, L. A., & Orwenjo, D. O. (2022). *Lost in Translation: Reporting About COVID-19 Pandemic by Community Vernacular Radio Stations in Rural Kenya. In COVID-19 and a World of Ad Hoc Geographies* (pp. 605–623). Cham: Springer International Publishing.

Parry, R. (2024). Communication in palliative care and about end of life: A state-of-the-art literature review of conversation-analytic research in healthcare. *Research on Language and Social Interaction, 57*(1), 127–148.

Pattison, N. (2012). Acceptance of dying: A discourse analysis of palliative care literature. *Palliative Medicine, 26*(7), 918–926. https://doi.org/10.1177/0269216312438

Phenwan, T., Sixsmith, J., McSwiggan, L., & Buchanan, D. (2025). Exploring advance care planning discourses in scottish dementia policies: A critical discourse analysis. *Social Sciences Humanities Open, 11*, Article 101302.

Phong, P. H., & Ngan, R. T. (2016, October). Linguistic approach in medical diagnosis. *In 2016 Eighth International Conference on Knowledge and Systems Engineering (KSE)* (pp. 37–42). IEEE.

Radbruch, L., De Lima, L., Knaul, F., Wenk, R., Ali, Z., Bhatnaghar, S., … Pastrana, T. (2020). Redefining palliative care—a new consensus-based definition. *Journal of pain and symptom management, 60*(4), 754–764.

Reisberg, B. (1988). Functional assessment staging (FAST). *Psychopharmacology Bulletin, 24*(4), 653–659.

Rhee, J. Y., Garralda, E., Torrado, C., Blanco, S., Ayala, I., Namisango, E., & Centeno, C. (2017). Palliative care in Africa: A scoping review from 2005 to 16. *The Lancet Oncology, 18*(9), e522–e531.

Rihs, M., Brodwolf, F. L., & Mast, F. W. (2025). Apocalypse now: Thoughts about human extinction under mortality salience increase death-thought accessibility but reduce worldview defense. *Death Studies*, 1–12.

Salins, N., Gursahani, R., Mathur, R., Iyer, S., Macaden, S., Simha, N., … Rajagopal, M. R. (2018). Definition of terms used in limitation of treatment and providing palliative care at the end of life: The Indian council of medical research commission report. *Indian journal of critical care medicine: peer-reviewed, official publication of Indian Society of Critical Care Medicine, 22*(4), 249.

Seale, C. (2000). Changing patterns of death and dying. *Social Science Medicine, 51*(6), 917–930. https://doi.org/10.1016/S0277-9536(00)00071-X

Sharf, B. F., & Vanderford, M. L. (2003). Illness narratives and the social construction of health. *In The Routledge handbook of health communication* (pp. 23–48). Routledge.

Steinmann, G., van De Bovenkamp, H., De Bont, A., & Delnoij, D. (2020). Redefining value: A discourse analysis on value-based health care. *BMC Health Services Research, 20*, 1–13.

Sullivan, M. D. (2003). Hope and hopelessness at the end of life. *The American Journal of Geriatric Psychiatry, 11*(4), 393–405.

Truog, R. D. (2020). Defining death: Lessons from the case of Jahi McMath. *Pediatrics, 146*(1), S75–S80. https://doi.org/10.1542/peds.2020–0818O

Tunde, A.H., & Orwenjo, D.O. (2022). (Eds.). (De) Constructing Corona: The Language of Conspiracy, Power and Indifference in Covid-19 Health Discourses. LINCOM GmbH..

Wang, N., Wang, K., Lu, X., Zhang, S., Sun, X., & Zhang, Y. (2024). Effects of family dignity interventions combined with standard palliative care on family adaptability, cohesion, and anticipatory grief in adult advanced cancer survivors and their family caregivers: A randomized controlled trial. *Heliyon, 10*(7).

Wetherell, M. (2015). Discursive psychology: Key tenets, some splits and two examples. In I. Parker (Ed.), *Handbook of Critical Psychology* (pp. 315–324). London: Routledge.

Wilce, J. M. (2009). Medical discourse. *Annual Review of Anthropology, 38*(1), 199–215.

Zimmermann, C. (2004). Denial of impending death: A discourse analysis of the palliative care literature. *Social Science Medicine, 59*(8), 1769–1780.

Zimmermann, C. (2007). Death denial: obstacle or instrument for palliative care? An analysis of clinical literature. *Sociology of Health Illness, 29*(2), 297–314.

Zimmermann, C., & Rodin, G. (2004). The denial of death thesis: Sociological critique and implications for palliative care. *Palliative Medicine, 18*(2), 121–128.