



# Cross-cultural serious neurological illness communication: qualitative analysis of multidisciplinary perspectives

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**Background:** Cultural competence is important in approaching serious illness communication with diverse patients about goals of care. Culture colors patients' perspectives on many healthcare issues, including end-of-life care, and impacts how clinicians make decisions with patients. Communication about serious neurological illnesses can be additionally challenging due to disease impact on patients' cognition and decision-making abilities. We aim to understand provider experiences regarding cross-cultural serious neurological illness communication with diverse patients and families.

**Methods:** Using non-stratified purposive and snowball sampling, we conducted semi-structured interviews with 17 multidisciplinary participants, including neurosurgeons, neurologists, and social workers, who provide care for patients diagnosed with serious neurological disorders, at three hospital settings between 2021 and 2022. We used standard qualitative content analysis methods with dual review.

**Results:** Five themes reflected provider perspectives about serious neurological illness communication with diverse patients and families. Theme 1: providers recognize that patients' personal biases and lived experiences impact attitudes about healthcare and communication. Theme 2: challenges in communication can arise when providers miss chances to identify important cultural values. Theme 3: understanding how to engage with family members is important for effective communication about serious neurological illness. Theme 4: providers want to accommodate patients. Theme 5: cultivating trust builds a strong patient-provider partnership, even when racial or cultural discordance is present.

**Conclusions:** Our study highlights elements of cross-cultural communication and opportunities for providers to approach diverse patients and families within a racial or culturally discordant context. Effective communication, fostered through respecting individual experiences and variation, eliciting cultural perspectives, engaging family, and cultivating trust reflects processes and learned skills required of high-quality teams caring for patients with serious neurological conditions.

**Keywords:** Culturally competent care; healthcare disparities; goals of care; neurological disorders

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## Introduction

Finesse in cross-cultural serious illness communication is a critical skill. Serious illnesses carry high risk of mortality with negative impact on a person's quality of life or significant caregiver strain (1). Among patients with serious illnesses, people diagnosed with neurological conditions like brain cancer, traumatic brain injury and stroke face unique challenges from cognitive and functional deficits (2). Due to impaired decision-making, these patients benefit from timely incorporation of palliative care practices, including goals-of-care discussions, which clarify preferences for care received (3,4). However, specialists caring for these patients may feel inadequately prepared to conduct goals-of-care planning (5).

Culture, which refers to a group's racial or ethnic identity as well as "a collection of beliefs, values...ways of thinking and communication" particular to a group, impacts patients' views about illness and health (6). Clinicians commonly encounter cultural identities different from their own, influencing healthcare delivery (7). Racial discordance when providers and patients do not share racial identities

also heralds worse perception and poorer quality of care compared to racially concordant dyads (8,9). As such, providers may find goals-of-care discussions with patients of different backgrounds additionally challenging. Minorities are significantly less likely to have discussions with their physicians and to have documented directives (10,11). Correspondingly, people from minority groups are more likely to pursue aggressive interventions even if they may extend life for only a few days, and are more likely to die in a hospital (12,13). Sparse data focus on understanding etiologies underlying and interventions to address these disparities for minorities (14). It is unclear if differences are primarily mediated through linguistic barriers, inadequate healthcare literacy, cultural beliefs about death, or differing levels of familial involvement near death (15-17).

Adapting serious illness communication by providers to fit cross-cultural contexts therefore may lead to greater understanding of healthcare topics by patients and foster more equitable end-of-life outcomes (6,18). Improved understanding of communication with diverse groups will also allow for implementation of strategies to promote quality serious illness communication.

Our study aims to inform care of diverse patients by eliciting multidisciplinary providers' experiences with serious neurological illness communication within racial and culturally discordant encounters. We present this article in accordance with the COREQ reporting checklist (available at <https://apm.amegroups.com/article/view/10.21037/apm-24-37/rc>).

## Methods

### *Study design and data collection*

The interview guide was developed and reviewed by a multidisciplinary research team with clinical (neurosurgery, palliative care) and methodological expertise (A.W., K.F.G., K.A.L.) (19). Semi-structured interviews were conducted by a MD-trained female neurosurgery resident (A.W.) trained by a PhD-trained researcher with qualitative methods background (K.F.G.). All participation was voluntary and conducted in English. Verbal consent to participate and audio-record interviews was obtained at the beginning of each session. Identifying information was removed from transcripts. Study protocols were approved by the Veterans Affairs and Stanford Institutional Review Boards (IRB#62142). The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013).

The interview guide was created with principles

### Highlight box

#### Key findings

- Themes reflected provider perspectives about serious neurological illness communication with diverse patients and families.
- Challenges in communication within provider-patient encounters arise when cultural values are not identified or lived experiences are not appreciated.
- Partnering with family members and establishing trust in provider-patient relationships are aspects of effective communication despite racial or cultural discordance.

#### What is known and what is new?

- Patients with serious neurological conditions benefit from timely goals of care planning.
- Interviewed healthcare professionals who care for patients with serious neurological illnesses describe barriers and challenges in serious illness communication with patients and families from racial or culturally discordant backgrounds.
- Providers acknowledge various important aspects of effective cross-cultural communication, including respecting individual cultural values and building trust.

#### What is the implication, and what should change now?

- Our study highlights opportunities for multidisciplinary providers to engage in effective serious illness communication with diverse patients and families.
- Our study may serve as the basis for future work on cross-cultural communication.

from Levesque *et al.*'s conceptual framework of access to healthcare (20). The interview guide included specific probes about how providers perceived barriers to and handled challenges of communicating with diverse patients in serious neurological illness communication (Table S1) and pilot-tested in two interviews.

### Participants

For this study, we focused on interviewing providers who care for patients with serious neurological illnesses between December 2021 and June 2022. Patient/family perspectives were collected for a separate analysis. Interviewed participants included neurosurgeons, neurologists, radiation oncologists, advanced practice providers, and social workers employed at Stanford, Santa Clara Valley Medical Center, or Veterans Affairs Palo Alto. Providers practiced in diverse settings, including inpatient wards, intensive care units, and outpatient clinics. Following email recruitment, interviews occurred over a private commercially available teleconferencing platform with one interviewer (A.W.). Recordings were transcribed through an encrypted service. Some participants were recruited based on the interviewer's prior knowledge of their healthcare experience. Other participants were identified through snowball sampling. Non-stratified purposive sampling method was used to create a group of interviewees with a range of specialty backgrounds (21). Two people approached for interviews cited scheduling conflicts. There was no predetermined target number, and participants were recruited until thematic saturation could be achieved, which occurred after 13 interviews (22). No follow-up interviews were conducted.

### Data analysis

The evaluation team included one neurosurgeon (A.W.), one palliative care physician (K.A.L.), one PhD-trained qualitative methodologist (K.F.G.), and an analyst (G.D.R.C.). Our analysis leveraged both inductive and deductive approaches, where codes were applied across transcripts (23). We summarized interviews on the day of completion with structured templates (24). We used the information from structured templates to draft an initial code list with definitions. Additionally, we (A.W. and G.D.R.C.) open-coded three transcripts to identify emergent concepts. We iteratively and collaboratively developed a codebook with definitions and finalized

the codebook by group consensus (25). Subsequently, transcripts were coded by A.W., with code review by other investigators. Codes were applied using Dedoose (version 9.0.17), a qualitative analytic software.

Research team members met bi-weekly over six months to reconcile discrepancies in coding by consensus. One of the codes was "cultural identity", which was assigned to any excerpt that specified the cultural background of patients and families involved in serious illness communication. This code was assigned to 125 excerpts. We inductively developed and described emergent themes from these excerpts through three rounds of discussion and consensus. Through adherence to rigorous qualitative methodologies throughout the study, including data collection, coding, analysis, and review by team members who did not conduct interviews, our study reflects trustworthy data based on credibility, transferability, dependability, and confirmability (26).

### Results

Across three sites, 20–45 minutes (average length: 35 minutes) semi-structured interviews were conducted with 17 healthcare providers including 12 physicians from neurosurgery, neurology or radiation oncology; three advanced practice providers; and two social workers. Interviewees also reflected diverse backgrounds as summarized in Table 1. Providers identified as White (8, 47.0%), Black (3, 17.6%), Asian (5, 29.4%), and multi-racial (1, 5.9%) people, with 17.6% of the cohort identifying as Hispanic. Represented sites included a large academic tertiary referral medical center, a Veterans Affairs site, and a major county hospital.

Thematic analysis elicited five themes pertaining to cross-cultural communication about serious neurological illness with diverse patients and families. Additional illustrative excerpts are included in Table 2. Included quotations reflect providers' impressions and reflections in reference to racial and culturally discordant clinical encounters.

#### ***Theme 1: providers recognize that patients' personal biases and lived experiences impact attitudes about healthcare and communication***

Interviewees acknowledged pervasive effects of their patients' unique lived experiences on interactions with providers. Cultural background and prior experiences with the American healthcare system impact patients

**Table 1** Provider and site characteristics

Characteristic	N	%
Provider type		
MD	12	70.6
Neurosurgery	7	58.3
Neurology	4	33.3
Radiation oncology	1	8.3
NP/PA	3	17.6
Neurosurgery	3	100
Neurology	0	0
Radiation oncology	0	0
Social worker	2	11.8
Neurosurgery	1	50
Neurology	0	0
Radiation oncology	1	50
Gender		
Female	10	58.8
Male	7	41.2
Race/ethnicity		
White	8	47.1
Black	3	17.6
Asian	5	29.4
Multi-racial	1	5.9
Hispanic	3	17.6
Non-Hispanic	14	82.4
Site characteristic		
Academic Tertiary Referral Center	12	70.6
Veteran's Affairs	4	23.5
County	1	5.9

MD, medical doctor; NP, nurse practitioner; PA, physician assistant.

and families' desire for and readiness to process medical information as well as other aspects of serious illness communication.

Patients from minority backgrounds face various, harmful biases that limit access to and quality of healthcare received. "They assumed that because he was a Black middle-aged guy...that he was uninsured and...sent him to the general

resident clinic...he wasn't seeing the specialist epileptologist." (Interview 3).

Indeed, patients' mistrust in providers and the system was often cited as an underlying challenge in communication: "They've never gotten a fair shot in our healthcare system and faced when doctors pull the plug too easily. ...American medicine has marginalized communities all the time with that kind of sentiment." (Interview 8). In such cases, providers may encounter divisive interactions with families that erode effective relationship-building as "there can be a lot of distrust...I think they were very 'We should get someone else's opinion.'" (Interview 1).

Communication about devastating neurological illness may be complicated by medical concepts that are wholly indescribable in some cultures. One provider described that "the family was Japanese, ...no matter how much we explained it to them, it was just that they didn't have this construct for what brain death was." (Interview 15).

Another example of culture influencing serious illness communication concerned preferences for information exchange. Providers expressed discomfort when facing families holding cultural beliefs about nondisclosure: "The idea of not telling the ill patient that they're ill or that they have cancer...can be a very strong cultural belief. I find that particular interaction to be quite difficult." (Interview 10). Even so, professionals aimed to honor patients' autonomy and preferences while providing sufficient information: "I told the family the details because she wanted that, but, with the patient, ...I didn't go into details of diagnosis but I did discuss possible outcomes and risks associated with surgery." (Interview 6).

### **Theme 2: challenges in communication arise when providers miss chances to identify important cultural values**

Cultural values are integral to attitudes about medical care, including end-of-life care. Providers described difficult interactions with patients and families when critical cultural beliefs were missed. These attempts at communication were often characterized by ineffective and repetitive exchanges. One provider reflected on an encounter with a Catholic family during a discussion about brain death: "They wanted multiple family meetings and multiple proof...they didn't believe us." (Interview 2).

Often, these situations were remedied with open-ended and direct questions that explored preferences and goals explicitly: "They wanted to ensure the patient had ceremonial garb on prior to dying. What ultimately changed it was...

**Table 2** Illustrative excerpts

Theme	Example	Interviewee role	Exemplary quote
Theme 1: providers recognize that patients' personal biases and lived experiences impact attitudes about healthcare and communication	Biases against patients	Neurosurgery MD	"I think that the healthcare system still thinks of minority elderly, in particular, in different ways, like the presumptions around language. [They] are both PhDs and fully fluent English speakers. It's impacting their interaction with the healthcare system."
	Mistrust of American healthcare system and/or providers	Neuro-oncology MD	"Culturally, I would say the harder conversations there are the palliative care discussions. I think that as a society we've done so much damage to trust in physicians that even if you have a good relationship with those families, there seems to be a lack of trust."
	Preferences for nondisclosure	Neuro-oncology MD	"A separate but very important issue is when a patient's families want to withhold information from patients and there is a cultural element to that. And that patient will cite themselves that it part of 'my belief system, my upbringing or my tradition'."
Theme 2: challenges in communication can arise when providers miss chances to identify important cultural values	Indescribable medical concepts	Neurosurgery APP	"We had a recent patient, who was brain dead. I know in some families like Hispanic culture, or very Catholic, very religious cultures—they have so much faith. For them, it's really hard to explain scientifically. I think that was a really big difficulty that we faced because we didn't know how else to explain to them."
		Neurosurgery MD	"In the end, they basically thanked the attending and said, 'We only have one request. In our culture, we believe that you're reincarnated with what you're buried with.' So, they wanted the [skull] bone back. It just tells you no one would've known if they didn't ask."
Theme 3: understanding how to engage with family members is important for effective communication about serious neurologic illness		Neurosurgery APP	"They wanted multiple family meetings and multiple proof that there was no function. They didn't believe us. Radiologically, everything was showing that the patient couldn't regain any function or have quality of life. ...it's tough for family to hear it over and over. They're just advocating for their family member. You can't fault them for what they're doing. But, at the same time, there are only so many ways we could say that this patient wasn't going to have a meaningful recovery."
	Range of roles and role assumption within families for medical communication and decision-making	Neurosurgery MD	"I have definitely seen, much more in Asians than others, especially older parents who don't speak English. The kid wants to translate but they don't actually want to tell the parents the diagnosis."
	Diversity of family structures	Neurosurgery MD	"I know the family unit is important, because his daughter was calling to offer support. ...Now the whole family—two daughters, the gentleman and his son—came. I booked them for double the time, so they had time for ample questions. You can feel that you have one unit between the daughter and the son and that consensus is that doing nothing is not an option for them."
		Neurosurgery APP	"But I would say I think that the family structure just a little bit different. I give the information to the husband and the son, but then the daughter is also very involved on Zoom. So they were all kind of helping share information with the group."

**Table 2** (continued)



Table 2 (continued)

Theme	Example	Interviewee role	Exemplary quote
Theme 4: providers want to "go the extra mile" to accommodate their diverse patients		Social worker	"I think it's important to respect, even if you don't agree with them. In this case, it seems like a very small thing...doing a blood transfusion...and other things that we're doing are so much more invasive. But it's really important to be mindful of the values that people have for their lives, because we just see a very small piece of who they are through the medical lens, but they're very diverse in other parts of their lives."
		Neurosurgery MD	"I think to me, basically, really getting a sense of where they're at and trying to accept any cultural, diverse differences and helping them through that...and trying to put myself in their shoes and think about things that are culturally very important to them."
Theme 5: Racial or cultural discordance may not matter when there is a strong patient-provider connection built on trust	Patient-provider racial/cultural-concordant background	Neuro-oncology MD	"As a physician of color myself and as a physician who speaks Spanish, I admit to feeling comfortable with having conversations with my patients from Latino background and Spanish speaking background. I've had feedback from those patients that they feel comfortable having those conversations with me because of my background. But I also acknowledge that not every physician they see is going to align or have concordance in their ethnicity or racial background. So it's important for patients and families to feel empowered to ask questions of their providers."
	Patient-provider racial/cultural-discordant background	Social worker	"if I feel like I'm not connecting, I do tend to follow the patient's lead. I don't push things. I think that can cause the patient to close off more. So, depending on the situation, I might ask if it's okay to reach out to another person to talk to and if they give me permission, sometimes I can get somewhere with a family member or if I can ask another provider."

MD, medical doctor.

one of the palliative care attendings who asked an open-ended question about what do they value?" (Interview 14). This interviewee's experience also highlighted the benefits of a multidisciplinary approach to difficult conversations by involving palliative care specialists.

Some providers also identified the important role medical interpreters can play as cultural broker. When communication difficulties arise, it could be due to factors beyond the serious illness discussion itself: "It's been a couple of meetings, and they're having a difficult time. Then the Mandarin interpreter asked me, 'Is there another room that we can use? This conference room is 444.' In Chinese culture, the 4's are essentially synonymous with death." (Interview 4).

### **Theme 3: understanding how to engage with family members is important for effective communication about serious neurological illness**

Serious neurological illnesses may compromise patients' cognition, decision-making abilities, and level of consciousness. As such, providers frequently describe interaction and communication with families. An interviewee describes a racial-discordant encounter with a Chinese patient with a non-English primary language and a new diagnosis of glioblastoma, which caused aphasia: "What you are facing is one patient who can't communicate well, but he also has the son there. ...if you just talk to the son, the father will basically feel that he's already irrelevant." (Interview 17).

Establishing balance in serious illness communication requires understanding family unit structures and cultural dynamics. According to another clinician's experience, "When I talk to our Hispanic families, there tends to be a lot of people involved. [During] our family meeting, there'll be a lot of different family members." (Interview 1).

Benefits of effectively engaging with family members include allowing providers to explore patient preferences through the people who knew the patient best. One physician "found it useful to let the family bring in as many voices as they can and spend a couple minutes listening to them and telling me who that person was and what was important to them." (Interview 8).

### **Theme 4: providers want to accommodate diverse patients**

Despite challenges, providers want to "go the extra mile to ensure that we provide access to all knowledge to all patients." (Interview 9). Interviewees made efforts to accommodate patients, particularly those with difficulties comprehending

medical concepts concerning neurological illness. Providing time and flexibility for discussion and information exchange was a common tactic: "I have patience. ...You may have to repeat it multiple times and bring teaching aids or incorporate other people, like nurses, social workers, other doctors." (Interview 11).

Providers recognize that additional time for communication is also necessary to establish trust: "They want more time to make sure...So you have to try to see where people are coming from and meet them halfway." (Interview 8). In other encounters, providers respected preferences regarding information sharing when "people come from cultures where they don't want to hear prognosis. ...I [make sure] that they're receptive to hearing what I had to say before I just launch into my spiel." (Interview 15). For some patients, such as Jehovah's Witnesses who cannot accept transfusions of blood products, providers engage in shared decision-making to honor patients' personal values when discussing elective neurosurgery and "tell them that their belief comes first. And let's work around that for your medical care." (Interview 12).

### **Theme 5: cultivating trust builds a strong patient-provider partnership, even when racial or cultural discordance is present**

While serious illness communication can be complicated by different viewpoints and cultural values regarding healthcare and medical decision-making, discordance ultimately may be overcome when a patient-provider relationship is based on accumulated trust. Multiple providers believed that strong connections are important for communication. Some effective relationships were quickly created based on shared background: "I was much more connected to the patient because we are part of the same racial background. ...He said he is more comfortable with me because I'm Black as well, and ...the types of questions he asks feel more relaxed." (Interview 6).

However, despite discordant backgrounds, providers were still able to interact effectively and surmount challenges in communication when rapport was established. One interviewee described a family declining to change providers: "You've spent so much time with us, we appreciate that. We're comfortable.' He actually said that, even if there were a doctor who was Chinese, they wouldn't care. They just wanted good care for their father." (Interview 17).

## **Discussion**

We found that healthcare professionals in different roles continue to struggle with serious neurological illness

communication but also that concrete actions and skills could mitigate challenging cross-cultural communication. Our findings are informative as society and healthcare becomes increasingly multi-cultural and as healthcare professionals and systems recognize the pressing need for culturally sensitive care (27). These cultural challenges are heightened in addressing goals-of-care planning and serious illness communication (28,29).

Communication about serious neurological illnesses poses challenges for providers, yet education is lacking. Neurologists and neurosurgeons who commonly encounter patients and families facing serious neurological illnesses do not feel adequately prepared during training for serious illness communication, much less within a cross-cultural context (30,31).

One implication of our findings is that the diversity of patients should be reflected among providers, particularly as racial concordance is associated with better patient experience and fosters rapport (8). Unfortunately, the workforce continues to reflect low proportions of underrepresented minorities, though efforts are being made to foster a pipeline for increased diversity (32-35). However, cultural concordance itself may be crucial to consider, such as in communication with some patients who regard brain death with a lens distinct from Western medicine (36-38). Language discordance also impacts communication, and providers commonly cited the importance of medical interpreter availability (39).

Another conflict involves patient/family preferences for disclosure of medical information, diagnosis, and prognosis. Prognostication for many neurological conditions remains uncertain, complicating decision-making, and underscoring why this subject must be addressed with care (40,41). A study of Japanese living in Japan, 1<sup>st</sup> and 2<sup>nd</sup> generation Japanese-Americans revealed variation in preference for disclosure based on American acculturation; more acculturated participants generally favored disclosing bad news, although each group demonstrated a range of preferences (37). Other studies show that older Korean and Mexican individuals preferred not to disclose news of terminal illness to patients (42,43). Variation and complexity embodied in this research suggests the importance of approaching patients and families as individuals, and the need to incorporate cultural context in serious neurological illness communication.

Another common thread among our interviews concerned the mistrust in American healthcare system held by minorities. Coats *et al.* described that successful

communication was related to higher reported trust in clinicians (44). Their findings suggested that demographic differences associated with trust were mediated by the quality of patient-provider communication. Arguably, the existing trust a patient and family have in their clinician can also impact the effectiveness and ease of serious illness communication. Whether through patience, active listening, or empathy, providers in our study were able to establish trust and bridge differences in cultural values and perspectives even in difficult discussions about poor neurological prognoses.

Providers generally acknowledge the importance of engaging with families in serious illness communication, citing unique family structures and dynamics of different cultures. Families report high amounts of distress because of their roles in communication and medical decision-making, particularly when facing uncertain prognoses for patients diagnosed with serious brain injuries (45-47). Providers should also be attentive to discrepancies in patient versus family preferences for treatment that can contribute to conflict in decision-making (48).

Fields that treat patients with serious neurological illness require an aptitude for culturally sensitive care and communication. Importantly, culture is not a monolith or capable of being distilled into a singular entity. Kagawa-Singer and Blackhall articulate that successful cross-cultural communication is akin to a balancing act as providers must avoid both extremes: on the one hand stereotyping, and on the other, imposing personal cultural values on others, or “cultural imperialism” (49). While participants name specific cultural groups in anecdotes, the underlying themes extracted from their experiences are informative for any provider encountering diverse patients and families.

### *Limitations*

Our sample size is small but standard for qualitative studies, and, through purposive sampling, we interviewed participants with a range of backgrounds and professional experiences, although our cohort does not include all provider types, notably bedside nurses. All providers were employed and reflected on experiences in the San Francisco Bay Area, though we recruited participants from different healthcare systems. Providers described specific anecdotes about patients from different backgrounds, but we were not able to comment on data specific to a minority group due to insufficient sampling. In addition, this particular study does not include perspectives from patients and caregivers facing



serious neurological illnesses. Future work could focus on qualities and values particular to specific minority groups and cultural identities.

## Conclusions

In an increasingly diverse society, there is a growing need for culturally-attuned care, particularly in serious neurological illness. Inadequate serious illness communication perpetuates disparities in healthcare provided for patients from minority groups. By recognizing biases and values held by both patients and providers, healthcare professionals caring for patients and families facing serious neurological illness may approach cross-cultural communication and relationship-building in an effective manner.

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## Footnote

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Table S1 Providers interview guide

Questions	Second-Level Questions
0. Please describe your role and how long you have been in this role at this facility.	
1. I'd like to specifically talk about your seriously ill patients. What are some of the important decisions that you've discussed with patients and families?	What are additional important decisions you think that families and patients should consider?
2. What were some challenges you faced when communicating with patients about next steps in their course?	How did you talk about your recommendations for the patient and family? How do you talk to a patient or their family when they don't agree with your recommendations?
3. I'd like to now focus on "goals-of-care planning" – the discussion between a provider and the patient about their hopes, fears, and values. Some people propose that with a serious illness, this should happen regularly. Can you discuss whether you think that's a good idea or not?	
4. If we were going to try to make these goals-of-care conversations more common, how would you recommend we go about that?	Who should initiate or do the bulk of goals-of-care planning discussions with the patient? How and when should palliative care specialists be involved?
5. If you have done so before, what were some challenges you faced while addressing goals of care, particularly those with a different background from you?	Did you have problems with: -Lack of time? -Comfort level with goals of care discussions? -Difficulty inserting language about goals of care? Which part was especially challenging: -Interaction with family? -Patient health literacy? -Patient cultural values?
6. I'd like us to think about a specific patient you've had. Can you recall and share an example when that patient's identity was important to their care?	Can you share examples of when their identity influenced decision-making and your conversation? Was this patient's background different or like yours? In what ways? How did you navigate that interaction?
7. What worked best when addressing challenges you had communicating with diverse patients, particularly those with a different background from you?	Do you ever bring up aspects of your patient's identity during shared decision-making?
8. What could we do to better prepare clinicians for addressing diverse cultures that we encounter when providing care?	What programs for improving cultural competency does your workplace offer?