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Palliative Care Professionals' Experiences of Providing Culturally Responsive Care in Portugal: A Qualitative Study

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Abstract

Background/Objectives: Cultural competence is an important component of person-centered palliative care, yet limited evidence is available on how palliative care professionals from different disciplines in Portugal experience and respond to cultural diversity. This study explored professionals' perceptions of cultural competence, their approaches to culturally responsive care, and the challenges encountered in clinical practice. Methods: A descriptive qualitative study was conducted with ten palliative care professionals working in hospital- and community-based settings in Portugal. Individual semi-structured interviews were conducted between January and March 2025. Data were analyzed using a primarily inductive, codebook-supported approach to thematic analysis informed by Braun and Clarke. Results: Three overarching themes comprising 14 subthemes were identified: professionals' cultural competencies; the care process in culturally diverse settings; and professionals' perceptions of patients' and families' cultural needs, beliefs, and preferences. Participants reported openness to learning and adapting care despite limited training in cultural competence. Language and interpretation barriers, institutional constraints, and socioeconomic challenges were perceived as complicating care delivery. Family expectations, patient autonomy, spiritual beliefs, personal habits, and end-of-life rituals further highlighted the importance of recognizing individual preferences rather than making assumptions based on cultural affiliation. Conclusions: The findings suggest that culturally responsive palliative care requires reflective professional practice alongside organizational support. Continuing education, access to qualified interpreters, appropriate communication resources, institutional flexibility, and interorganizational collaboration may help address the challenges identified, although their effectiveness was not evaluated. Further research incorporating patients' and families' perspectives is needed to inform equitable, culturally responsive palliative care in Portugal.

Keywords: cultural competence; palliative care; cultural diversity; healthcare professionals; qualitative research

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1. Introduction

Cultural competence (CC) is increasingly recognized as a relevant consideration in person-centered palliative care (PC). The need to strengthen CC has also been highlighted

among hospice and PC volunteers [1]. More broadly, culturally responsive models of PC emphasize the importance of addressing the needs of patients from culturally and linguistically diverse backgrounds [2]. Such approaches involve recognizing and respecting patients' individual beliefs, values, and preferences, alongside ongoing professional learning [3].

In this study, culture is understood as a dynamic and multifaceted process shaped by social contexts, individual experiences, values, beliefs, and practices. Following Kleinman and Benson [4], cultural backgrounds are not treated as fixed determinants of patients' needs or preferences. Culturally responsive care therefore requires attention to each person's individual circumstances rather than assumptions based on nationality, ethnicity, or religion.

In PC, cultural values and preferences may influence communication, therapeutic relationships, and experiences of dying and bereavement [5,6]. Recent qualitative studies highlight challenges related to communication, family expectations, and professional preparedness when supporting patients and families from diverse cultural backgrounds [7–9]. A multicenter study in Germany further suggests that access to PC is shaped by intersecting structural, communicative, familial, and cultural factors rather than cultural affiliation alone [10]. Spiritual support is another relevant dimension. A recent systematic review identified individual, relational, and organizational factors affecting its implementation at the end of life [11]. A scoping review of models of care also emphasized culturally responsive practice, family and community engagement, and interdisciplinary approaches, while noting limitations in the available evidence of effectiveness [2].

Over recent decades, migration and mobility patterns in Portugal have evolved, reflecting the combined effects of emigration, immigration, and return migration [12]. According to the 2025 Migration and Asylum Report, published in 2026 by the Portuguese Agency for Integration, Migration and Asylum (AIMA), Portugal recorded 1,585,854 foreign residents as of December 31, 2025 [13]. In addition, a national study involving migrants living in Portugal identified heterogeneous health and digital health literacy profiles, including difficulties in navigating healthcare services and obtaining professional support [14]. These findings do not imply that nationality or migration background determines individual beliefs or preferences; rather, they reinforce the relevance of individualized assessment and accessible communication in healthcare.

Insufficient cultural sensitivity may contribute to misunderstandings and inequitable healthcare experiences, including at the end of life [6,15,16]. Professionals' own values and assumptions may also influence healthcare decision-making [17]. Portuguese research has identified difficulties in PC provision associated with care coordination, health literacy, and the availability of professional and family support [18]. A national regulatory assessment published in 2026, based on 2024 data, identified 21 hospital-based PC inpatient units and 13 additional PC inpatient units contracted with social and private providers. It reported a ratio of 42.1 PC inpatient beds per million inhabitants in mainland Portugal. The assessment also documented territorial disparities and limitations in access to PC services, although it did not specifically assess CC or migrant populations [19]. These findings underline the importance of recognizing the broader service context in which culturally responsive care is delivered. Recent research also points to the potential contribution of professional education and organizational support to culturally responsive care [3,8].

Conceptual frameworks can support efforts to understand and develop CC in healthcare. Campinha-Bacote's model conceptualizes CC as an ongoing process involving five interrelated constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire [20]. Other contributions include McGee and Johnson's discussion of CC in PC [21] and Purnell's model of CC [22].

Beyond individual professional development, implementing culturally responsive care requires attention to organizational conditions. Institutional procedures, resource limita-

tions, language-related challenges, and barriers to organizational change may constrain efforts to accommodate patients' individual needs and preferences [9,23,24]. Evidence from Portugal on access and service coordination reinforces the importance of considering professional and system-level factors together, without equating general access problems with culturally specific barriers [18,19].

Although previous international research has identified cultural, linguistic, relational, and organizational challenges in PC, less is known about how these challenges are experienced by PC professionals from different disciplines within the Portuguese healthcare context. Portugal provides a relevant setting for examining these experiences in relation to cultural diversity, access to communication resources, professional preparedness, and the organization of hospital- and community-based care. Rather than identifying entirely new categories of challenges, this study seeks to provide context-specific insights into how professionals perceive, interpret, and respond to cultural diversity in their everyday practice.

Exploring CC in PC may therefore help clarify professionals' experiences and identify opportunities to improve culturally responsive care. Accordingly, this study aimed to explore PC professionals' perceptions of CC, their approaches to providing culturally responsive care, and the challenges encountered in clinical practice in Portugal.

2. Materials and Methods

This study adopted a descriptive qualitative design, consistent with Sandelowski's approach to qualitative description, to explore PC professionals' experiences of providing care to individuals from diverse cultural backgrounds [25,26]. The study was conducted between September 2024 and June 2025. The initial phase, from September to December 2024, involved preparing the study, reviewing the literature, developing the interview guide, and completing the ethical procedures. Data collection took place between January and March 2025, during which ten individual interviews were conducted and the analytical process was initiated. Data analysis continued between April and June 2025, alongside the preparation of the manuscript. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [27,28].

2.1. Participants

The study included a convenience sample of ten PC professionals from different geographical regions of Portugal who worked in hospital-based and community-based care settings. Participants were eligible if they worked in healthcare, social care, psychology, or spiritual care, had at least one year of professional experience in PC in Portugal, and had provided care to individuals from diverse cultural backgrounds. Professionals who were not proficient in Portuguese, those holding administrative or operational support positions, and volunteers were excluded.

Participants were recruited through convenience sampling, complemented by participant referrals (snowball recruitment). Potential participants were identified through professional contacts, healthcare institutions, and recommendations from other participants. Recruitment was conducted by the principal investigator and the coordinator of the master's program, with invitations also sent by email. A total of 25 professionals were approached, of whom ten participated in the study (more details and characteristics of the study participants are reported in Table 1). The remaining 15 did not respond to the invitation; no explicit refusals were reported, and the reasons for non-participation are unknown.

The final sample comprised professionals from four disciplinary groups and included six participants working in hospital-based PC teams and four in community-based teams. Although participants were recruited from different geographical regions of Portugal,

detailed regional information was not reported to minimize the risk of indirect identification within this small and specialized professional sample.

Sample adequacy was considered in light of the exploratory and descriptive nature of the study, its focused objectives, and the participants' professional experience in PC [29]. The inclusion of professionals from different disciplines, geographical regions, and care settings provided a range of perspectives relevant to exploring experiences of CC in clinical practice. Recruitment difficulties prevented the inclusion of additional participants. Sample adequacy may also be considered retrospectively in light of the information power framework proposed by Malterud et al. [30]. Although the focused exploratory aims and participants' relevant professional experience supported the relevance of the accounts collected, the relatively short interviews, heterogeneous professional backgrounds, and breadth of topics explored limited the depth of the available information. Therefore, the sample is considered appropriate for a preliminary, exploratory understanding of the issues investigated, rather than for comprehensive coverage of experiences across professional groups.

The emergence of new information and themes was monitored throughout data collection and analysis. After approximately eight interviews, the final two interviews provided additional examples and contextual details but did not introduce new overarching thematic dimensions. This observation was descriptive and was not considered formal evidence of data saturation. Given the relatively short interviews and the small, unevenly distributed multidisciplinary sample, the depth and breadth of the perspectives collected may have been limited.

All ten interviews were included in the final analysis. The study did not aim to achieve statistical representativeness, and the limitations associated with sampling and recruitment were considered when interpreting the findings.

2.2. Data Collection

Data were collected between January and March 2025 through individual semi-structured interviews conducted in Portuguese via Zoom®. The interview guide was developed based on the study objectives and a review of the relevant literature, but was not structured around the constructs of Campinha-Bacote's model. Prior to the main data collection, the guide was reviewed by the research supervisors and pilot-tested in four preliminary interviews with healthcare professionals working in PC to assess the clarity, relevance, and comprehensibility of the questions. Based on these preliminary interviews, the guide was revised to improve the wording, sequence, and organization of the questions, including the removal of some questions and the introduction of new ones. The revised guide was subsequently used consistently throughout the main data collection, and no additional questions beyond those established in the guide were introduced. The four professionals involved in the pilot interviews were not included in the final sample of ten participants, and their interviews were excluded from the thematic analysis. The interview guide is provided as Supplementary Material S1.

Participants' sex, care setting (hospital-based or community-based), and geographical region were recorded through the informed consent documentation approved by the Ethics Committee, rather than through the semi-structured interview guide. These data were used to characterize the study sample. Detailed geographical information was not reported to minimize the risk of indirect identification of participants.

All interviews were conducted by the principal investigator, a male Brazilian researcher with training in PC and qualitative research methods. At the time of data collection, he held a bachelor's degree, was enrolled in a master's program, and worked for a company operating in the social sector. Participants were informed of his status as a master's student conducting academic research on CC in PC. The investigator had no prior personal or

professional relationship with the participants. Each of the ten participants was interviewed once, with no repeat interviews, and only the principal investigator and the respective participant were present during each interview. Portuguese was the language used throughout data collection.

The principal investigator's motivation to explore CC arose from his previous professional experience in PC and in supporting individuals from diverse cultural backgrounds, particularly from the challenges he had observed in delivering culturally responsive care. Although this experience familiarized him with the clinical and cultural issues under investigation, it was also acknowledged as a potential influence on his perspectives and interpretation of participants' accounts. Despite being Brazilian and interviewing healthcare professionals working in Portugal, the principal investigator did not perceive his nationality as having a significant influence on the interpretation of the findings. Nevertheless, the analysis and interpretation were discussed collectively within the research team, allowing different perspectives to be considered and contributing to the refinement of the thematic structure.

Interview duration ranged from 6 min and 18 s to 16 min, with a mean duration of 8 min. All interviews were audio-recorded in MP3 format, and participants were assigned alphanumeric identifiers (P1 to P10) to protect their identities and maintain confidentiality. Field notes were taken after each interview to complement the audio recordings and interview transcripts. Following transcription, the transcripts were returned to participants for review and possible correction, and no participants requested any changes.

Data collection concluded after ten interviews, as further participant recruitment was not feasible. The limitations of the resulting dataset were considered when interpreting the findings.

2.3. Data Analysis

All ten interviews were audio-recorded and manually transcribed verbatim in Portuguese by the principal investigator, who listened to the recordings and entered the transcripts into Microsoft Word®. No automated transcription software was used. All interviews were conducted, transcribed, coded, and analyzed in Portuguese.

Thematic analysis was informed by Braun and Clarke's methodological approach [31] and followed a primarily inductive, codebook-supported process within a topic-focused interview framework addressing CC in PC. Although the interview guide explored predefined areas of interest, including professional preparedness, challenges, barriers, and opportunities for improvement, initial codes and themes were developed from participants' accounts rather than predetermined theoretical categories. Nevertheless, the researchers acknowledged that the topics addressed in the interview guide may have influenced the range of experiences and perspectives discussed by participants.

The analytical process began with familiarization with the interview transcripts, followed by independent initial coding of all ten transcripts by three researchers: the principal investigator and the two master's supervisors. Coding and data organization were conducted manually using Microsoft Word®, without specialized qualitative data analysis software. Initial codes were generated from meaningful segments of participants' accounts, and a codebook was progressively developed, incorporating code labels, definitions, and illustrative excerpts to support the organization and interpretation of the data. Related codes were subsequently reviewed, grouped, and consolidated into preliminary subthemes and overarching themes.

The final thematic hierarchy, comprising three overarching themes and 14 subthemes, is presented in Table 2. To improve analytical transparency, we have additionally provided a participant-by-subtheme matrix, retrospectively reviewed and validated by the research

team, as Supplementary Material S2. A complete code-by-code coding tree is not available as a separate record; therefore, we have not attempted to present a retrospective reconstruction as the original coding tree.

Following initial coding, the researchers compared their codes and interpretations during team meetings, discussing differences until consensus was reached. Pseudonymized transcripts, coding materials, and the preliminary thematic structure were also reviewed by the co-authors to support critical examination of the emerging interpretations. Through collective discussion, the definitions, boundaries, naming, and conceptual coherence of the themes and subthemes were progressively refined. This collaborative process aimed to strengthen analytical depth and coherence rather than establish statistical agreement between coders; therefore, no statistical measures of inter-coder agreement were calculated.

Given the use of independent initial coding, progressive codebook development, and team discussions to reach consensus, the analytical procedure is described as codebook-supported thematic analysis rather than as reflexive thematic analysis in light of the methodological distinctions discussed in Braun and Clarke's later publications [32,33].

Reflexivity was considered throughout the analytical process, and the researchers acknowledged that the principal investigator's professional background, experience in PC, and training in qualitative research could influence the interpretation of participants' accounts. Independent examination of the data and collective discussions within the research team provided opportunities to reflect critically on analytical decisions, consider alternative interpretations, and refine the thematic structure.

Although the researchers were familiar with Campinha-Bacote's model of CC [20], its five dimensions were not used as predefined coding categories. Instead, the model was explicitly considered after the initial development of the thematic structure, serving as an interpretative reference to support the conceptual contextualization and naming of the identified themes. It was not used to assess participants' levels of CC, nor were the themes intended to correspond directly to the model's five dimensions.

Only participant quotations selected for inclusion in the manuscript were subsequently translated into English by the principal investigator, who was proficient in both Portuguese and English. Translation prioritized fidelity to participants' original wording and expressions. The research team reviewed the translated quotations against the original Portuguese transcripts to assess their accuracy and consistency with participants' intended meanings. No external independent translation review was undertaken.

The final thematic findings were not returned to participants for review or validation.

The analysis resulted in three overarching themes: (I) professionals' cultural competencies; (II) the care process in culturally diverse settings; and (III) professionals' perceptions of patients' and families' cultural needs, beliefs, and preferences.

2.4. Ethical Considerations

The study was approved by the Ethics Committee of the Polytechnic Institute of Leiria (now the University of Leiria and Oeste) on 3 December 2024 (approval reference: CE/IPLEIRIA/107/2024), prior to the commencement of data collection in January 2025. All participants received information about the study and provided written informed consent by signing and returning the consent form via email before their individual Zoom interviews. The written informed consent also covered the scientific publication of interview material. Quotations included in the manuscript are attributed to participant codes (P1–P10) and professional categories, without disclosing participants' names or workplaces, to reduce the risk of identification. To protect participants' identities and ensure confidentiality, interview data were pseudonymized using alphanumeric identifiers (P1 to P10).

Access to the original audio recordings was restricted to the principal investigator, while pseudonymized interview transcripts and coding materials were shared with the co-authors exclusively for analytical review. Access to these materials was limited to the research team, and confidentiality was maintained throughout the research process.

Audio recordings were destroyed following transcription and data processing.

3. Results

The findings presented in this section reflect healthcare professionals' perceptions and experiences of culturally diversity in PC. Participants' accounts of cultural, religious, and personal practices are interpreted as context-specific experiences rather than characteristics that can be generalized to all members of a particular cultural, national, or religious group. Individual preferences and circumstances should therefore be considered when interpreting these findings.

3.1. Participant Characteristics

The study included ten PC professionals, comprising four nurses, two physicians, three social workers, and one psychologist (Table 1). All participants had received training in PC. Two participants reported educational experiences relevant to CC: one described postgraduate coursework that included CC content, while another referred to attending professional conferences on CC in end-of-life care. These experiences differed in format and scope and should not be regarded as equivalent forms of specialized CC training. Most participants were female (n = 9).

Table 1. Sociodemographic and professional characteristics of study participants.

Participants (n = 10)	Variables
	Sex
9	Female
1	Male
	Profession
4	Nurse
3	Social Worker
2	Physician
1	Psychologist
	Care setting
6	Hospital-based
4	Community-based
	Years of experience in PC
2	3 years
2	4 years
1	5 years
1	8 years
2	9 years
1	10 years
1	16 years
	PC training
10	Yes
0	No
	Reported educational experiences addressing CC
2	Yes
8	No

Note: n = number of participants.

Regarding their professional settings, six participants worked in hospital-based PC support teams, while the remaining four were members of community-based PC support teams. Participants worked in different geographical regions of Portugal, ranging from the north of the country to the Algarve (south of the country).

In terms of professional experience, most participants had worked in PC for fewer than 10 years, with a mean of 7.1 years of experience in this field.

3.2. Thematic Analysis

The thematic analysis identified three overarching themes comprising 14 subthemes (Table 2). The first theme, Professionals' Cultural Competencies, addresses professionals' knowledge, attitudes, care practices, and emotional experiences. The second theme, The Care Process in Culturally Diverse Settings, focuses on the challenges and processes involved in providing culturally responsive PC. The third theme, Professionals' Perceptions of Patients' and Families' Cultural Needs, Beliefs, and Preferences, explores patients' and families' individual needs, preferences, and practices, as perceived and reported by healthcare professionals. Together, these themes highlight the interplay between professionals' cultural competencies, challenges in care delivery, and patients' and families' individual preferences, as reported by participants. They emphasize the importance of relational, communication-related, and organizational contexts in providing culturally responsive PC.

Table 2. Themes and subthemes resulting from the thematic analysis of the data.

Subtheme	Description
I. Professionals' Cultural Competencies	
1. Cultural knowledge	Cultural knowledge acquired through formal education and clinical experience, including perceived knowledge gaps, educational opportunities, and training needs.
2. Culturally responsive care practices	Reported efforts to adapt care to patients' and families' individual cultural, religious, and personal preferences, including spiritual support and collaboration between professionals and services.
3. Motivation and openness to culturally responsive care	Professionals' willingness to acquire cultural knowledge, recognition of personal limitations, openness to unfamiliar practices, and motivation to provide culturally responsive care.
4. Frustration and perceived helplessness	Emotional responses associated with perceived limitations in meeting patients' individual needs, including frustration, helplessness, and uncertainty.
II. The Care Process in Culturally Diverse Settings	
5. Sociocultural and relational challenges	Challenges involving family dynamics, expectations regarding clinical information, therapeutic relationships, and perceived attitudes toward cultural diversity.
6. Structural barriers	Organizational procedures and institutional requirements perceived as limiting or complicating the accommodation of individual cultural and end-of-life preferences.

Table 2. *Cont.*

Subtheme	Description
7. Language and interpretation barriers	Communication difficulties arising from language differences, limited access to interpretation, and concerns about conveying sensitive information accurately.
8. Social circumstances and care-planning challenges	Challenges reported by professionals in responding to individual care needs, including patients' and families' understanding of PC and advance care planning, socioeconomic difficulties and access to social support, and limited family assistance during care planning and communication.
9. Returning to the country of origin at the end of life	Experiences concerning patients' wishes to return to their countries of origin during advanced illness, including clinical considerations, coordination between services, and preferences regarding place of death.
10. Patient autonomy	Professionals' experiences of respecting patients' autonomy, including informed decision-making, religious beliefs, family expectations, and individual care preferences.
III. Professionals' Perceptions of Patients' and Families' Cultural Needs, Beliefs, and Preferences	
11. Cultural and personal dimensions of suffering	Professionals' perceptions of how individual cultural backgrounds, family expectations, and personal habits may influence the expression and communication of suffering and the sources of comfort valued by patients.
12. Beliefs and values	Participants' accounts of patients' individual spiritual and religious beliefs, the importance of recognizing these preferences, and perceived challenges in identifying and accommodating spiritual support needs.
13. Personal habits	Participants' perceptions of differences in everyday habits and individual care preferences, including food, hygiene, physical contact, and caregiver-related preferences, highlighting the importance of individualized assessment.
14. Diversity of funeral rituals	Participants' accounts of individual preferences concerning care of the body after death, funeral practices, and mourning, including efforts to accommodate these preferences and perceived limitations in professional knowledge and institutional arrangements.

3.2.1. Professionals' Cultural Competencies

This theme comprised four subthemes addressing professionals' cultural knowledge, reported care practices, motivation and openness toward cultural diversity, and emotional responses to perceived difficulties in providing culturally responsive PC.

(1) Subtheme: Cultural knowledge

Participants described cultural knowledge as an important component of person-centered PC, highlighting the contribution of clinical experience and professional education to understanding patients' diverse backgrounds, values, and preferences. Their accounts emphasized the importance of recognizing individual differences and remaining attentive to cultural aspects that may influence care experiences and therapeutic relationships.

Clinical encounters were perceived as opportunities to broaden cultural understanding. One participant expressed an interest in further developing their knowledge: "[...] it is an area in which I would also like to deepen my knowledge [...]" (P1, Nurse).

Participants described different educational experiences relevant to CC, including postgraduate coursework that addressed this topic and attendance at professional conferences on CC in end-of-life care. The importance of continuing professional development was also emphasized. Some participants perceived that CC received limited attention in professional education, with one describing it as "[...] a topic that is little addressed and little talked about [...]" (P7, Nurse). Others identified the cost of educational opportunities as a potential limitation to accessing further training (P3, Social Worker). Overall, these accounts highlight the perceived value of combining clinical experience with ongoing educational opportunities to strengthen professionals' understanding of patients' individual cultural needs.

(2) Subtheme: Culturally responsive care practices

Participants described efforts to adapt care practices to patients' and families' individual cultural and religious preferences. These accounts highlighted the importance of identifying specific needs, facilitating spiritual support, and mobilizing professional resources to provide person-centered care.

One participant described efforts to accommodate patients' spiritual preferences by facilitating access to religious representatives: "[...] whenever we realize that it is important for the patient [...] to have there [...] some important figure from their belief, their religion, we try, we make a space completely available for the person to come [...] we always try to collaborate" (P3, Social Worker). Another participant described a situation in which the care team sought assistance from a different healthcare service to accommodate a patient's preference regarding the gender of the professional providing care. As the participant explained, "[...] we had, for example, a person [...] who was of Muslim origin and whose care could not be provided by women, and the team is all women. So, we managed to find a nurse at the health center [...]" (P9, Psychologist). These accounts illustrate practical efforts to accommodate individual preferences through flexibility and collaboration between professionals and services. They also highlight the importance of exploring each patient's needs rather than assuming that cultural or religious affiliation determines care preferences.

(3) Subtheme: Motivation and openness to culturally responsive care

Participants emphasized the importance of remaining open to cultural differences and adapting care to patients' individual needs. Some accounts also reflected a willingness to seek additional knowledge when encountering unfamiliar cultural practices.

One participant acknowledged limitations in their knowledge and described an intention to seek information and engage with families: "I may not know about certain practices or rituals [...]. I will seek further information on the subject and speak with the families. That is why it is essential to approach these issues not so much with patience, I would say, as with sensitivity and care" (P5, Physician).

Another participant emphasized the importance of understanding patients' cultural contexts and individual values: "We need to know their culture, we need to understand

the context and what they value, what they don't value, so that we can provide good care" (P7, Nurse).

Professional openness was also discussed in relation to uncertainty when encountering unfamiliar situations. One participant acknowledged that new experiences could generate insecurity and fear, while emphasizing the importance of maintaining a person-centered approach: "[...] And since everything that is new is challenging and generates some insecurity and fear, right? But I think it is important that we always keep our goals in mind, to provide the best care centered on the person and on the needs of each person, and culture is a specificity that must be respected" (P9, Psychologist).

Another participant highlighted the importance of professional openness: "[...] this is important, we, as professionals, to be open [...]" (P10, Social Worker).

Together, these accounts illustrate participants' willingness to acknowledge cultural differences, remain receptive to unfamiliar perspectives, and consider individual preferences when providing PC. They also distinguish intentions to acquire knowledge from accounts of learning or adaptation arising from clinical encounters.

(4) Subtheme: Frustration and perceived helplessness

Some participants described feelings of frustration and helplessness when difficulties encountered in clinical practice limited their perceived ability to respond to patients' individual needs.

One participant reported frustration associated with difficulties in obtaining social support for a patient with limited financial resources. These difficulties were further complicated by language barriers, which affected communication and the patient's understanding of the situation. The participant stated: "I remember that it was extremely frustrating for the lady, and for me as well [...]" (P3, Social Worker).

Another participant described a sense of helplessness when unfamiliar cultural practices and limited opportunities to understand patients' needs made it difficult to provide the support they considered appropriate: "[...] we also feel a sense of helplessness because perhaps we could have done more, but we did not know how [...]" (P10, Social Worker).

These accounts illustrate how perceived limitations in responding to patients' needs may be accompanied by emotional challenges for professionals. Rather than suggesting that cultural diversity itself generates frustration, these experiences highlight the emotional implications of communication difficulties, limited resources, and uncertainty in culturally diverse care situations.

Together, these subthemes highlight the interplay between cultural knowledge, professional openness, and efforts to adapt care to patients' individual preferences. They also reflect the frustration and helplessness experienced by some professionals when difficulties limit their ability to provide culturally responsive PC.

3.2.2. The Care Process in Culturally Diverse Settings

Six subthemes described barriers, practical challenges, and responses arising in the delivery of PC to patients from diverse cultural backgrounds.

(5) Subtheme: Sociocultural and relational challenges

Participants described challenges associated with understanding patients' and families' expectations, particularly in relation to family dynamics and the communication of clinical information. These accounts highlighted the importance of recognizing individual perspectives and negotiating differences within therapeutic relationships.

One participant referred to difficulties in understanding certain family dynamics: "[...] there are some blockages, let's say, that have to do with the fact that we do not really understand the dynamics [...]" (P2, Physician).

Another participant expressed concern about the possibility of resistance to cultural diversity among healthcare professionals, while clarifying that this had not been observed within their own team: "[...] I am very afraid that there is a barrier within each person, you know? I have not found this in my team [...]" (P9, Psychologist).

Participants also reflected on perceived attitudes toward cultural diversity. One participant expressed the view that "[...] sometimes there is some resistance in adapting to different cultures" (P1, Nurse).

These accounts reflect challenges related to communication, family expectations, and perceived attitudes toward cultural diversity. They also underline the importance of understanding such difficulties within individual care situations rather than attributing them to particular cultural or religious groups.

(6) Subtheme: Structural barriers

Participants described organizational constraints that could complicate efforts to accommodate patients' and families' individual preferences, particularly in hospital settings and in situations involving end-of-life care.

One participant referred to difficulties reconciling institutional procedures with certain practices surrounding death: "Some habits related to perimortem and post-mortem care are sometimes difficult to fit into the area where I work here, in a hospital inpatient setting. [...] The challenge lies there and sometimes we really must comply with the rules" (P5, Physician).

Another participant perceived greater flexibility in community-based care: "I believe that in the community, it's not so difficult [...] to respect the cultural specificities. In the hospital, it's different, isn't it?" (P9, Psychologist).

These accounts highlight the need to negotiate between institutional requirements and individual preferences. These perceived differences between care settings reflect participants' experiences and do not establish systematic differences in their capacity to provide culturally responsive care.

(7) Subtheme: Language and interpretation barriers

Several participants described language differences as a challenge to communication with patients and families from diverse backgrounds. These difficulties were perceived as affecting the exchange of information and the understanding of individual care needs.

One participant described the additional challenges associated with language differences: "Even in the specific situations we have had, it has not been easy and with the language difference, it sometimes makes things even more difficult" (P4, Nurse).

Difficulties accessing interpreting services were also reported. One participant described difficulties obtaining interpretation support for a patient: "[...] we had to try [...] to get a translator at the hospital but [...] it was not possible [...]" (P10, Social Worker).

Beyond interpreter availability, one participant expressed uncertainty about whether the meaning and tone of sensitive conversations were adequately conveyed through interpretation, particularly when interpreters were unfamiliar with PC (P3, Social Worker).

Participants also described efforts to develop alternative communication resources. One participant referred to visual materials being developed to support care-related communication when language barriers arise (P2, Physician). Together, these accounts highlight challenges involving language differences, access to interpretation, and communication in sensitive care situations, alongside reported efforts to facilitate understanding. The effectiveness of these visual materials was not evaluated in this study.

(8) Subtheme: Social circumstances and care-planning challenges

Participants described a range of challenges they encountered when attempting to respond to patients' and families' individual needs. These included difficulties related to

understanding palliative care and advance care planning, socioeconomic circumstances and access to social support, and the availability of family assistance during care planning and communication.

Some participants highlighted difficulties associated with patients' and families' understanding of PC and its objectives. One participant stated: "Perhaps it is a lack of understanding of the specific nature of palliative care and trying to demystify [...] culturally, what is practiced here in Portugal and abroad [...]" (P6, Social Worker). Another participant emphasized the need for greater awareness of PC and advance care planning: "It is essential for the public to understand what PC is, what its aims are, and how it can contribute to people's well-being. PC is not limited to the final stage of life; it also involves an anticipatory approach, a shift in mindset, and important decisions throughout the course of illness. This understanding may influence how people participate in decisions [...], including those concerning the end of life [...]" (P5, Physician).

Socioeconomic circumstances and difficulties accessing social support were also described as challenges to care provision. One participant recalled a situation in which obtaining financial assistance was particularly difficult: "[...] Asking for support and subsidies was extremely complicated, and we ended up never getting anything, not a pension, not a solidarity supplement, nothing. [...]" (P3, Social Worker).

Finally, limited family support was identified as an additional difficulty in some care situations. One participant described a patient whose circumstances complicated communication and the identification of care needs: "[...] as we did not have family to help us, he himself had some periods of confusion there [...] it was difficult for us to reach him [...]" (P10, Social Worker). Taken together, these accounts illustrate how participants perceived difficulties in understanding PC, accessing financial and social support, and obtaining family assistance as challenges for care planning and communication. These concerns reflect distinct clinical and social circumstances rather than a single culturally specific pattern, underscoring the importance of assessing individual needs and available support in each care situation.

(9) Subtheme: Returning to the country of origin at the end of life

Participants described experiences involving patients who wished to return to their countries of origin during advanced illness or toward the end of life. These situations highlighted the importance of respecting individual preferences while addressing clinical, communication, family, and organizational considerations.

One participant (P10, Social Worker) described a patient who wished to return to her country of origin at the end of life, despite initial concerns about her clinical fitness to travel. The participant recalled that "[...] she wanted to die in her homeland because she knew that she would be buried here and it would not be how she would have liked" (P10, Social Worker). The same participant described communication difficulties associated with the initial lack of a suitable interpreter. Once interpretation support became available, the healthcare team was better able to understand the patient's wishes. P10 also emphasized the importance of identifying appropriate community resources: "[...] we will never be able to cover all religions or all languages [...] but above all, we need to know whom we can turn to [...]" (P10, Social Worker).

In a separate case, P3 (Social Worker) described another patient who returned to her country of origin. Although P3 was not directly involved in the patient's care, the participant reported: "[...] she asked for our collaboration and eventually returned to her country [...] she died close to her family" (P3, Social Worker).

Another participant described a case from a previous clinical setting involving a patient who wished to spend the end of life near family in her country of origin. The participant reported that coordination with external services helped support this preference and that

confirmation was subsequently received that the patient had died close to her relatives (P4, Nurse). This experience occurred in a setting where palliative approaches were provided, rather than within a specialized PC team.

Together, these accounts highlight the importance of respecting patients' preferences regarding their place of death, alongside the clinical assessment, communication, family involvement, and coordination required to support such wishes.

(10) Subtheme: Patient autonomy

Participants described challenges related to respecting patients' autonomy in situations involving previously documented care decisions, family expectations, religious beliefs, and end-of-life preferences. Their accounts emphasized the importance of patients' understanding and involvement in decisions affecting their care.

One participant discussed experiences involving patients whose decisions had been influenced by religious beliefs, expressing concern about their understanding of previously documented choices: "[...], but some of the most difficult cases involve Jehovah's Witness patients, who [...] have well-decided, relatively well-documented living wills and have very well-defined ideas. Not only what they want but also what they don't want. But in all the cases we have had as a team, the decisions that people make are not theirs, they have not understood them very well, they do not understand the implications, and, in a phase of extreme fragility, they are very confused about what was decided for them [...]" (P5, Physician).

The same participant described tensions between previously expressed decisions and what the care team considered beneficial for patients' comfort: "[...] and that conflicts with what we could bring in terms of comfort and quality of life and that they simply reject, because yes, but then they don't really understand why, and it creates situations [...] it even created situations of some conflict between family and congregation. Because people make decisions that they don't understand what they imply" (P5, Physician).

These observations reflect P5's interpretation of specific clinical experiences and should not be generalized to Jehovah's Witness patients as a group. As the study did not include patients' perspectives, it cannot independently establish how these individuals understood or made their decisions. The account therefore highlights the professional's concerns about informed decision-making rather than demonstrating that religiously influenced decisions necessarily reflect a lack of autonomy.

However, the participant distinguished these situations from decisions personally made and understood by patients, even when they differed from the team's preferred approach: "[...] there were situations involving decisions that patients made and accepted themselves, which were difficult for the team to understand, but which were respected [...]" (P5, Physician).

The importance of understanding the implications of care decisions was further emphasized: "[...] I am not saying that people should make different decisions; I am saying that the decisions were not made by them [...]" (P5, Physician).

Another participant described situations in which relatives preferred that patients not be informed about their diagnoses, emphasizing the patient's right to information and participation in decisions: "[...] it is the patient's right to be the person who holds that information and decides how and to whom they wish to disclose it, or whether we disclose it on their behalf, and not the other way around [...]" (P2, Physician).

Respect for individual preferences was also highlighted in decisions concerning the preferred place of death. Reflecting on a patient's wish to return to her country of origin, one participant stated: "[...] it is not what we wish, it is not what we want. It is what the patient wishes. It is what they think and want for themselves, and that is important [...]" (P10, Social Worker).

Together, these accounts highlight the importance attributed to informed decision-making, respect for individual preferences, and patients' involvement in care decisions. The concerns expressed reflect participants' professional experiences rather than characteristics attributable to particular religious or cultural groups.

Together, these subthemes highlight the sociocultural, structural, linguistic, and practical challenges encountered in providing culturally responsive PC. Participants' accounts also emphasize the importance of interprofessional collaboration, family involvement, and respect for patients' preferences and autonomy when addressing these challenges.

3.2.3. Professionals' Perceptions of Patients' and Families' Cultural Needs, Beliefs, and Preferences

Four subthemes captured the cultural, religious, and psychosocial dimensions of patients' and families' experiences described by participants.

(11) Subtheme: Cultural and personal dimensions of suffering

Participants described how individual cultural backgrounds, family expectations, and personal habits could influence the experience, expression, and communication of suffering in PC.

One participant recalled encounters with patients who, in the professional's experience, were reluctant to verbalize pain: "[...] they do not [...] verbalize that they are in pain [...]" (P2, Physician). The participant perceived this as a challenge in assessing and alleviating suffering, while recognizing the need to better understand patients' individual perspectives.

The same participant described situations in which difficulties sharing information or discussing illness could contribute to additional suffering: "[...] By not sharing this pain with other loved ones, the pain suffered by the patient is made even greater [...] also when [...] family members do not want the patient to know about their diagnosis" (P2, Physician).

Another participant emphasized that personal and cultural habits could become particularly meaningful during serious illness: "These people are in great suffering, and there are certain cultural details that are more important to them at these times. And they cling very closely to these cultural aspects, to certain habits they have. Because even though it may not seem like it, these habits, which have to do with each person's individuality, comfort them, right?" (P1, Nurse). Together, these accounts highlight the importance of attending to individual expressions of suffering, communication preferences, and sources of comfort. The experiences described reflect participants' perceptions of specific care situations rather than differences that can be generalized to entire cultural or national groups.

(12) Subtheme: Beliefs and values

Participants highlighted the importance of recognizing patients' individual beliefs, values, and spiritual needs in PC. Their accounts emphasized that spirituality may be relevant to patients' well-being, whether or not it is associated with a particular religious tradition.

One participant stressed the importance of considering the spiritual dimension of care: "[...] not only in its physical dimension, but also its social, psychological and spiritual dimensions, whether or not [spirituality] takes the form of a religion [...]" (P2, Physician).

Similarly, one participant described situations in which the team explored whether patients would welcome support from a representative of their faith: "[...] we have had situations involving patients who were not Catholic and followed other religions, and we asked whether it would make sense for the pastor of their religion to come to our hospital to be with them [...]" (P10, Social Worker).

Although religious support was available in some settings, identifying individual preferences remained a challenge. One participant explained: "We even have a list for Catholics,

for Muslims [...], but basically that is what we have [...] now the specific identification for that person, from that culture, wants this, or that [...] no, that is a big gap that I feel" (P1, Nurse).

Together, these accounts highlight the importance of recognizing spiritual and religious preferences as individual dimensions of care, while also identifying challenges in understanding and responding to patients' specific needs.

(13) Subtheme: Personal habits

Participants described differences in patients' personal habits and care preferences, including those related to food, physical contact, hygiene, and the gender of caregivers. These accounts highlighted the importance of recognizing individual preferences when providing PC.

One participant reflected on differences they associated with cultural backgrounds: "[...] the specific habits of certain cultures [...] taking care of a Muslim, an Indian person, is very different from taking care of an [...] African person [...] that culture likes to eat this, does not like to be touched by men, does not like to be taken care of by men or only likes to be taken care of by men [...]" (P1, Nurse).

This account reflects the participant's use of broad religious, national, and geographical categories when describing perceived differences in care preferences. Such generalizations should be understood as the professional's perceptions rather than as characteristics shared by all members of these groups. They also illustrate a tension between categorizing patients according to cultural background and the commitment to assessing each person's individual needs.

The same participant emphasized the importance of identifying each person's habits directly: "[...] it is very important to always identify their needs. To ask how they like to do this or that, to identify people's habits. Then we try to respond accordingly [...]" (P1, Nurse).

Another participant referred to differences in customs and expectations: "[...] Cultural differences, particularly certain customs of different cultures, even sometimes in managing expectations, are different [...]" (P6, Social Worker).

A further participant described differences in everyday practices, including eating habits and personal hygiene: "[...] differences in the way people behave, differences in food, differences in customs, differences in something as simple as hygiene care [...]" (P8, Nurse). The participant also emphasized the importance of respecting individual preferences: "[...] above all, it is about respecting them and responding to their needs, provided that this does not put the patient's health at risk [...]" (P8, Nurse).

Together, these accounts highlight the relevance of individual habits and preferences in everyday care. Although participants sometimes described these differences in relation to cultural backgrounds, their accounts also emphasized the need to identify each patient's preferences rather than assume them on the basis of cultural or religious affiliation.

(14) Subtheme: Diversity of funeral rituals

Participants highlighted the importance of recognizing individual preferences concerning care of the body, funeral practices, and mourning. Their accounts reflected both efforts to accommodate these preferences and challenges arising from institutional procedures or limited familiarity with practices.

One participant recalled experiences involving a Chinese patient and a Muslim woman, explaining that some expectations regarding care of the body were difficult to accommodate in a hospital setting. Referring to the latter situation, the participant stated: "[...] she was Muslim, but I no longer remember exactly which country she was from [...] It was not an easy situation, particularly regarding care of the body [...] Certain procedures had to be

respected, particularly regarding hygiene, preparation of the body, and how it was wrapped [...]" (P5, Physician).

Nevertheless, the participant described how some preferences were accommodated: "[...] it was still possible for people to come, not from the congregation, but female friends, to touch the body in a particular way. It was possible to comply. Sometimes it is not possible [...]" (P5, Physician).

Another participant emphasized the importance of understanding practices surrounding death and bereavement: "[...] care during the final days of life, care of the body at the time of death and afterwards, funeral rituals and mourning, after death [...]" (P9, Psychologist). The same participant stressed that "[...] funeral rituals [...] are very important and must be taken into account [...]" (P9, Psychologist).

Funeral preferences were also relevant to the patient's wish to return to her country of origin described by P10, as presented in Subtheme 9.

Together, these accounts highlight the importance of exploring patients' and families' individual preferences concerning death-related practices and mourning, while recognizing the challenges professionals may face in accommodating them within existing care arrangements.

4. Discussion

The findings of this study provide context-specific insights into how PC professionals understand and address CC in clinical practice.

The three overarching themes capture professionals' knowledge, attitudes, reported practices, and emotional experiences; the sociocultural, relational, and organizational challenges encountered in delivering culturally responsive care; and professionals' perceptions of patients' and families' individual needs, beliefs, and preferences. Although participants expressed a willingness to respect cultural diversity, they also identified gaps in their cultural knowledge and limitations in the communication resources and organizational support available to them. These findings suggest that culturally responsive PC involves not only individual professional attributes but also therapeutic relationships, multidisciplinary collaboration, and the conditions in which care is provided.

Although no participants explicitly rejected the importance of culturally responsive care, their accounts revealed tensions between the intention to accommodate individual preferences and the practical limitations imposed by communication difficulties and institutional constraints. This lack of explicitly dissenting views should also be interpreted cautiously in light of the small, self-selected sample.

The first theme highlighted the importance of cultural knowledge, professional motivation, and willingness to learn. Although all participants had received training in PC, their educational experiences related to CC varied. Clinical encounters were described as opportunities to deepen professionals' understanding of patients' preferences, while also revealing gaps in their knowledge of unfamiliar cultural and religious practices. These accounts can be interpreted in light of Campinha-Bacote's conceptualization of CC as an ongoing process involving cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire [20]. They also highlight the importance of professional learning, openness, and experience in culturally diverse clinical settings. Recent studies have similarly identified a lack of targeted training and limited professional preparedness as challenges in culturally diverse end-of-life care [7,8]. An integrative review of CC in nursing care for migrant populations also identified continuing education, multicultural clinical experience, and organizational support as relevant factors in developing culturally responsive practice [3]. Taken together, these findings suggest that clinical experience may be strengthened by structured education and opportunities for critical reflection.

Participants described efforts to adapt their practices to individual preferences, particularly regarding physical contact and religious practices. Their accounts illustrate that behaviors intended to convey compassion may not be appropriate or welcomed by every patient, underscoring the importance of recognizing professional assumptions and respecting individual values [17,22]. At the same time, participants reported frustration, helplessness, and uncertainty when communication difficulties, insufficient resources, or unfamiliar circumstances constrained their ability to respond to patients' needs. Comparable emotional and practical challenges have been identified among professionals caring for culturally diverse populations [8]. These experiences suggest that professional openness and reflective practice should be considered alongside the educational and organizational resources available to support care [3,8].

Importantly, CC should not be equated with familiarity with the characteristics of particular cultural or religious groups. The findings instead emphasize acknowledging the limits of one's knowledge, remaining open to unfamiliar practices, and actively exploring patients' individual preferences. This interpretation is consistent with the complementary concepts of cultural humility, cultural safety, and cultural responsiveness. Cultural humility emphasizes ongoing self-reflection, awareness of personal assumptions, and willingness to learn from patients [34], whereas cultural safety draws attention to power relationships, discrimination, and the experiences of those receiving care [35]. These perspectives help professionals avoid cultural stereotyping and reinforce the importance of person-centered communication. However, because this study included only professionals, it did not directly assess patients' experiences of cultural safety. The findings also suggest that culturally responsive care depends on institutional practices and resources, rather than on professionals' attitudes and skills alone. Structural competency further emphasizes how institutional arrangements, socioeconomic conditions, and unequal access to resources can shape care experiences beyond individual clinical encounters [36].

The second theme concerned sociocultural, relational, and structural challenges in providing culturally responsive PC. Participants described difficulties related to family dynamics, individual preferences, and institutional procedures, particularly when accommodating practices associated with death and dying. International studies have similarly highlighted the interaction among sociocultural expectations, communication, and organizational factors in culturally diverse PC settings [9,10]. In Portugal, previous research has identified challenges in care coordination and service organization [18], while a recent national regulatory report documented geographical inequalities and limitations in access to PC [19]. Although these sources did not specifically assess CC, they provide relevant context for understanding the organizational constraints described by participants. Accommodating individual preferences may therefore require institutional flexibility while maintaining clinical safety and quality of care.

Language barriers and limited access to interpretation services were particularly prominent in participants' accounts. Participants perceived these difficulties as affecting communication, therapeutic relationships, and their ability to identify and understand patients' needs. Their implications may be especially significant in PC, where conversations often concern prognosis, symptom management, and sensitive end-of-life decisions. Previous research has also documented linguistic barriers, difficulties accessing professional interpreters, and risks of misunderstanding in culturally diverse PC settings [8–10]. The difficulties participants described in obtaining interpretation support illustrate how limited linguistic resources can complicate individualized care. Participants also mentioned possible communication strategies, including visual materials being developed to support communication when language barriers arise. Such resources may offer supplementary means of communication, but their effectiveness was not assessed in this study, and they should not be regarded

as substitutes for qualified interpreters during complex clinical discussions. Access to appropriate linguistic support remains an important consideration when tailoring care to each patient's communication needs.

Other challenges concerned socioeconomic vulnerability, access to social support, limited family networks, understanding of PC, and attitudes toward cultural diversity. Participants described situations in which individual care plans required adjustment to accommodate these circumstances. Notably, difficulties understanding the purpose of PC were not perceived as exclusive to people with migration backgrounds. These accounts indicate that culturally responsive care must address social circumstances and available resources alongside cultural or religious preferences. Recent research has identified social and organizational barriers affecting access to PC among people with migration backgrounds [9]. In Portugal, research has highlighted challenges in healthcare navigation and health literacy among migrants [14], as well as difficulties in PC organization and coordination [18]. Although these studies examined different populations and settings, they underscore the relevance of structural and service-related factors. Participants' experiences further suggest that multidisciplinary and interorganizational collaboration could help develop care plans tailored to individual circumstances.

The accounts concerning patients who wished to return to their countries of origin at the end of life highlighted the interaction among personal preferences, family relationships, funeral expectations, clinical conditions, and organizational coordination. The situations reported by P3, P4, and P10 illustrate the importance of discussing patients' preferred place of death while evaluating the clinical safety and practical feasibility of travel. Recent research has identified clinical, logistical, and administrative challenges associated with end-of-life repatriation [37]. A retrospective study of bereaved caregivers' perspectives also emphasized the importance of respecting patients' wishes, although its findings concerned a small and specific patient population [38]. These accounts suggest that repatriation decisions require individualized assessment, timely communication, and coordination among professionals, families, and relevant services. They should, however, be understood as specific clinical experiences rather than evidence of the frequency of repatriation in PC.

Although the study was not designed to compare professional groups, socioeconomic difficulties and end-of-life repatriation were particularly emphasized in social workers' accounts, potentially reflecting their responsibilities in supporting patients and families and coordinating access to resources. No clear profession-specific patterns were identified across the remaining themes. Given the small and uneven distribution of participants across disciplines, these observations should be interpreted cautiously and do not support systematic comparisons between professional groups.

One participant perceived community-based PC as offering greater flexibility than hospital-based care in accommodating individual preferences. However, this observation represents an individual professional perspective and does not establish differences between care settings. Given the small sample and the absence of a systematic comparison between hospital-based and community-based teams, further research is needed to explore whether organizational context influences the provision of culturally responsive PC.

Patient autonomy emerged as another relevant consideration, particularly in relation to advance care decisions, family expectations, religious beliefs, and disclosure of clinical information. Participants emphasized the importance of ensuring that patients understand the consequences of their decisions while respecting choices that may differ from professionals' preferences. Their experiences also highlighted the need to clarify each patient's wishes regarding family involvement in decision-making and access to information. Decisions informed by religious beliefs or supported by family members should not automatically be interpreted as limitations to autonomy. Recent qualitative research has discussed relational

autonomy and culturally sensitive communication in advance care planning, recognizing individual variation in preferences for family involvement [39]. Research involving migrant populations has likewise identified the complex influence of families on communication and decision-making [10]. These findings support approaches that promote informed decision-making while respecting patients' values and remaining attentive to professionals' own assumptions [17].

The third theme explored professionals' perceptions of how individual beliefs, values, and cultural practices may shape experiences of suffering and end-of-life care. Participants described different expressions of suffering and recognized that familiar practices may provide comfort during advanced illness. These accounts reinforce the importance of understanding suffering in the context of each patient's personal, social, and cultural circumstances rather than focusing exclusively on physical symptoms [5,7]. Participants also recalled situations in which family preferences concerning the disclosure of clinical information affected communication and, in their view, could contribute to patient distress. Such experiences underline the need to ascertain patients' own preferences regarding information sharing and family involvement, without assuming that individuals from the same cultural group experience or express illness and suffering in similar ways.

Participants also described preferences concerning food, hygiene, physical contact, the gender of caregivers, and spiritual support in relation to personal beliefs, values, and everyday habits. Professionals reported attempts to accommodate these preferences but sometimes encountered difficulties identifying individual needs or accessing the necessary resources. A recent systematic review highlighted the relevance of professional education, communication, and organizational factors in end-of-life spiritual care [11]. Participants also emphasized the need for sensitivity to preferences regarding care of the body after death, funeral practices, and mourning rituals, noting that accommodating these practices could require negotiation with existing institutional procedures. These findings are consistent with an integrative review emphasizing both established religious rituals and individual practices in PC [40]. Rather than treating cultural or religious affiliation as a reliable predictor of preferences, care planning should seek to understand what matters to each patient and family.

Across the three overarching themes, the findings can be interpreted through Campinha-Bacote's multidimensional model, which conceptualizes CC as an ongoing process involving five interrelated constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire [20]. Participants' reported willingness to learn and adapt care aligns with cultural desire, while their recognition of unfamiliar practices and reflection on personal assumptions relate to cultural awareness. Their accounts of professional training, experiential learning, and knowledge limitations are relevant to cultural knowledge, whereas their interactions with patients and families from diverse cultural backgrounds illustrate opportunities for cultural encounters. Reported efforts to explore individual preferences, adjust communication, and accommodate specific care needs may also be understood in relation to cultural skill, although these accounts do not establish that such skills were consistently or effectively demonstrated in clinical practice.

Importantly, the relationship between these findings and the model is interpretive rather than confirmatory. Although the researchers were familiar with Campinha-Bacote's framework, its constructs were not used as predefined coding categories, and the initial analysis was primarily inductive within a topic-focused interview framework. The model therefore provides a conceptual perspective through which the findings can be understood, rather than a structure against which participants' competence was assessed. Furthermore, the language, socioeconomic, and organizational barriers reported by participants highlight the influence of contextual factors that cannot be adequately addressed through individ-

ual professional competence alone. Accordingly, the study does not determine whether participants were culturally competent, but offers insights into how they perceived cultural diversity, negotiated individual preferences, and responded to related challenges in PC practice.

The findings have implications for professional education, healthcare organization, and future research. Integrating CC into initial and continuing education in PC, providing opportunities for multidisciplinary reflection, improving access to qualified interpreters, promoting appropriate communication resources, and strengthening collaboration with community and religious organizations may support more culturally responsive practice. Greater flexibility in institutional procedures could also help accommodate individual preferences concerning communication, autonomy, family participation, spirituality, and end-of-life rituals. However, these approaches were not evaluated as interventions in the present study, and their effectiveness in improving patient outcomes, communication, satisfaction, or cultural competence cannot be inferred from the findings. They should therefore be regarded as potential strategies arising from participants' experiences rather than as interventions with demonstrated effectiveness. Their implementation would also require organizational commitment and should not depend exclusively on individual professionals' efforts [23,24].

In Portugal, further research is needed to examine the feasibility, acceptability, and outcomes of such approaches and to understand how PC services can meet the needs of an increasingly culturally diverse population equitably and ethically while maintaining person-centered care.

Taken together, the findings address the study aim. Participants described professional learning, openness, reflective practice, and efforts to adapt care, illustrating their perceived approaches to developing and applying CC in clinical practice. Their accounts also highlighted linguistic, sociocultural, socioeconomic, and organizational barriers, alongside complex situations involving family participation, patient autonomy, and end-of-life preferences. These experiences illustrate the interplay between individual professional responses and the wider conditions of care, contributing context-specific insights into culturally responsive PC in Portugal. However, the potential strategies identified require further evaluation before conclusions can be drawn about their effectiveness.

Study Limitations

Several limitations should be acknowledged when interpreting the findings of this study. The research involved a convenience sample of ten PC professionals from different regions of Portugal, which may limit the transferability of the findings to other professional groups and care settings. Although the multidisciplinary composition of the sample provided insights from different professional backgrounds, the small sample size and uneven representation across disciplines did not allow systematic comparisons between professional groups. Similarly, while participants worked in both hospital- and community-based settings, the study was not designed to systematically examine differences between these care environments. Recruitment difficulties also constrained the inclusion of additional participants, potentially limiting the diversity of professional experiences captured.

No formal assessment of data saturation was undertaken. Therefore, the observation that the final interviews did not introduce new overarching thematic dimensions should not be interpreted as evidence that the dataset was exhaustive. Additional interviews, particularly within underrepresented professional groups, might have yielded further experiences or thematic dimensions.

Additional methodological limitations should be considered. All interviews were conducted by a single researcher via Zoom and were relatively short, which may have lim-

ited opportunities for more detailed exploration of participants' experiences. Convenience and snowball recruitment may also have favored professionals with a particular interest in culturally responsive care. Furthermore, the interview questions addressing CC and professional preparedness may have encouraged socially desirable responses. Although transcripts were returned to participants for verification and no corrections were requested, the final themes were not submitted to participants for validation. The translation of selected quotations from Portuguese into English may also have introduced subtle changes in meaning, despite the research team's review of the translations against the original transcripts. Finally, no spiritual care professionals participated, limiting the range of disciplinary perspectives represented.

The findings were based on professionals' retrospective accounts rather than direct observation of clinical practice or formal assessment of their CC. Furthermore, the absence of patients' and families' perspectives limits understanding of how culturally responsive care was experienced by those receiving it. Certain situations, including patient repatriation, were reported by only a small number of participants. Although the accounts of P3, P4, and P10 concerned separate clinical cases, P10 described a patient's wish to return without confirming that the journey took place. These experiences should be interpreted as illustrative examples rather than evidence of representative patterns. Additionally, the study did not evaluate the effectiveness of the visual communication materials under development or the interorganizational collaboration described by participants.

Future research involving larger and more diverse samples of professionals, with more balanced representation across disciplines, could provide a broader understanding of culturally responsive PC and enable the exploration of potential differences in experiences and approaches among professional groups. Including the perspectives of patients and families would also contribute to a more comprehensive understanding of culturally responsive care. Furthermore, studies evaluating educational interventions, communication resources, and organizational approaches could help identify effective strategies for strengthening culturally responsive PC in the Portuguese context.

5. Conclusions

This study provides insights into how PC professionals in Portugal perceive and respond to cultural diversity in clinical practice. Participants emphasized the perceived importance of considering patients' and families' individual beliefs, values, habits, and preferences in care delivery, and described a willingness to learn and adapt their practices accordingly. However, their accounts also revealed challenges related to limited training in CC, language barriers, socioeconomic and institutional constraints, and the complex interplay of cultural beliefs, patient autonomy, and family involvement in end-of-life decision-making.

The findings suggest that culturally responsive PC requires more than cultural knowledge or individual professional motivation. It also involves reflective practice, effective communication, respect for patients' individual preferences, multidisciplinary and interorganizational collaboration, and organizational commitment. This interpretation is consistent with Campinha-Bacote's model [20], which conceptualizes CC as an ongoing, multidimensional process involving cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Recognizing individual differences, rather than making assumptions based on cultural or religious affiliation, remains central to protecting patients' autonomy and dignity.

These findings offer a preliminary, context-specific account of professionals' experiences rather than evidence of the effectiveness of proposed responses. Future studies involving patients and families could clarify how culturally responsive palliative care is experienced by those receiving care and inform the evaluation of practical improvements.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/healthcare14234013/s1, Supplementary Material S1, English translation of the semi-structured interview guide; Supplementary Material S2, Participant contributions to each subtheme—research-team-validated retrospective matrix.

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Informed Consent Statement: Written informed consent was obtained from all participants prior to the interviews, including consent for the scientific publication of pseudonymized interview quotations.

Data Availability Statement: The interview transcripts are not publicly available or available upon request due to confidentiality and privacy considerations, including the potential risk of indirect identification. In accordance with the informed consent obtained, access to the transcripts is restricted to the research team. Pseudonymized excerpts supporting the findings are included in the manuscript.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

PC	Palliative Care
CC	Cultural Competence

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