

“KNOWING IS NOT THE SAME AS PRACTISING”: A QUALITATIVE STUDY OF NURSING STUDENTS’ EXPERIENCES OF A TRANSCULTURAL TRAINING PROGRAMME IN KARACHI, PAKISTAN

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ABSTRACT

Education in cultural competence is a crucial aspect of nursing training, but studying cultural difference does not always lead to culturally competent clinical practice. This study aimed to find out the experience of Bachelor of Science in Nursing (BSN) students in a four-week Transcultural Training Programme (TTP) and to elicit the barriers to transferring the learning to clinical practice in the city of Karachi, Pakistan. A qualitative descriptive design with phenomenological approach was used in four nursing colleges. Students with the highest and lowest scores in cultural competence questionnaire after training were selected using purposive extreme case sampling. Ten in-depth interviews and one focus group discussion with five students were conducted. Semi-structured expert-reviewed and piloted guides were used, audio-recordings of the sessions were made in Urdu or English, and then verbatim transcription was done. Thematic analysis was used in combination with framework analysis, with cultural knowledge, sensitivity and skill being deductive codes, and inductive codes formed from students' accounts. The analysis resulted in the following themes: increased cultural awareness, better communication, and difficulties in implementing training. The barriers reported were lack of exposure to cultural diversity, time pressure and weak institutional support. The results indicate that students might appreciate and experience benefits from trans-cultural structured learning, but that they also experience clinical realities that restrict opportunities for enactment. Therefore cultural competence education must be seen in the context of placement experiences, supervision, workload and institutional reinforcement. The findings do not give causal estimate of training effectiveness, and conclusions should be supported by direct quotations from the participants and a detailed description of the analytic process.

KEYWORDS: *Cultural Competence; Transcultural Nursing; Nursing Students; Nursing Education; Clinical Practice; Qualitative Research*

1. INTRODUCTION

In order to provide culturally responsive nursing care, it is necessary for nurses to recognize that social and cultural factors can influence health and illness, communication, and family involvement and treatment preferences. Disparities in language, beliefs, expectations or understandings about illness can impact the delivery and receipt of information and the experience of care in clinical situations. Cultural competence is then not only a component of professional knowledge but also a component of the practical skill of communicating respectfully and avoiding assumptions and adapting care for an individual patient's situation. In nursing education, this capability is often viewed as a maturing, not a static, set of facts. Conceptual work highlights the multifaceted nature of cultural competence and the importance of looking at knowledge, attitudes, skills and encounters as a whole (Campinha-Bacote, 2002; Shen, 2015; Sharifi et al., 2019). These dimensions need to be built up for the student as he or she concurrently acquires clinical reasoning, technical procedures and professional responsibilities.

Campinha-Bacote's model views cultural competence as a continuous process whereby health care practitioners attempt to function effectively in the cultural context of individuals, families and communities. The model highlights that cultural awareness, cultural knowledge, cultural skill, and cultural encounters and cultural desire are interconnected; that they are not discrete and separate; that they are not a single course that can be completed; and that competence is achieved through constant reflection and engagement (Campinha-Bacote, 2002). This is important for nursing education because it brings together personal awareness and information collection and the practical evaluation of culturally relevant needs. It also helps to prevent the notion that a student is culturally competent once he or she has learned facts about groups. Education

should instead enable reflection on one's own assumptions, allow for respectful inquiry, communication and adapt care according to each patient. A training programme based on this model can offer a structured basis, but students need to be given the opportunity to practice and build upon these capacities in clinical situations.

The duration and method of the intervention differ, and reviews suggest that transcultural education can enhance nursing students' reported cultural competence, awareness, and knowledge. Classroom instruction, case scenarios, discussion, simulation, and experiential learning and clinical exposure are all types of approaches used to develop culturally related competencies (Kääriäinen et al., 2019; Tosun, 2021; Tosun et al., 2024). Changes in attitude or scores are not indicative of consistent application in clinical settings, however. Perceived learning and observed learning are related but different outcomes, and education programmes can be assessed differently, whether it is to gain knowledge, build confidence, gain communication or be evaluated while doing their job when working with patients. Evaluation can be enriched with qualitative inquiry by studying the learner's interpretations of a programme, what they find useful and under what conditions they find it useful in practice. These narratives can be used to help understand how students can make progress while also feeling uncertain or limited in their placement experiences.

This issue has an impact on the nursing education in a big, diversified city of Karachi with people having different linguistic, religious, family and social backgrounds. A recent qualitative study was also conducted in the local context, which highlighted barriers to transcultural training, such as institutional support and communication in Karachi. (Shah et al., 2026) The present study is more specific in terms of students' experiences following a four-week program that was implemented using the model of Campinha-Bacote and utilizes post-training cultural competence scores to identify contrasting cases. It also explores not only perceived barriers, but students' accounts of awareness and communication and barriers to application of learning. The purpose of this study was to uncover the experiences of BSN students in the Transcultural Training Programme (TTP) and to discover the factors that may have impeded the transfer of the cultural competence from the classroom to the clinical environment. The question for the guidance was: What is the student's experience of the programme and what might make the difference in implementing learning in practice?

2. MATERIALS AND METHODS

This study adopted a qualitative descriptive design based on phenomenology to gain insight into the students' experiences of a Transcultural Training Programme. A qualitative descriptive approach is able to capture the perspectives of the participants whilst maintaining a close relationship with the expressed meaning (Sandelowski, 2000; Bradshaw et al., 2017). The phenomenological influence led the study to consider the experience of training and the meaning students attached to it in relation to clinical practice; the study is not pure phenomenological since the study analysis was also conducted in a structured manner. This interaction enabled the study to take into account experience as it related to the chosen dimensions of cultural competence. Interviews and a focus group were used to complement the other types of data: the individual interviews allowed for more detailed personal accounts, while the focus group gave the opportunity for both reflection and comparison of views. The design was not designed to measure causal effect of the programme, but rather to reveal learning and barriers.

This study was conducted at four nursing colleges of Karachi, Pakistan after a four week Transcultural Training Programme in the light of Campinha-Bacote's model of cultural competence. The programme offered a common ground for talking about cultural awareness, communication and clinical application. The summary does not identify the content of the curriculum, the way this is taught, the number of hours or time of interviews. These details should be included in the final copy of the programme from the original programme records as it is essential to understand students' experiences and allow replication to occur in intervention description. The dimensions of awareness, knowledge, skill, encounters and desire of the model offer a conceptual framework for training and assessment, and cultural knowledge, sensitivity and skill are the specific dimensions used in the study's deductive analysis. It is important to keep the distinction between the full model and the dimensions used for coding throughout the report to avoid giving the impression that all the components of the model were measured/coded the same.

Participants were purposively extreme cases from a sample of BSN students with high and low cultural competence scores after training. The aim of the strategy was to obtain contrasting accounts, not a representative sample statistically. Students at the extremes of the score distribution could provide insights to the nature of the experiences and perceived opportunities of contrasting post-training profiles, but score groups alone would not account for why these differences would exist. The final sample size was ten in-depth interviews and one focus group discussion with five students. The information provided for this draft does not indicate if the five people in the focus groups were also interviewed individually; hence the numbers are given by the data-collection technique used, not totaled to include fifteen unique participants. The final version should include the following information: Eligibility, recruitment process, instrument used to measure cultural competence, extreme cases, and number of unique students in the data (Table 1).

Semi-structured interview and focus group guides were used to gather data and were pre-tested and expert reviewed. The guides were designed to elicit students experiences with the training programme, their perceptions of changes in cultural awareness and communication and the conditions they faced when trying to transfer learning to clinical practice. Audio-recordings were made in Urdu or English and the transcriptions were verbatim. The use of the participants' preferred language can help ensure the full expression of meaning, and verbatim transcription can ensure that the material necessary for systematic analysis is kept. The manuscript should provide a complete and repeatable account of who did the

interviews and the focus group, the relationship of the interviewer with the participants, the location, length of time of the interviews and focus group, and whether Urdu transcripts were translated into English for analysis or publication. It should also explain how the meaning of the translated extracts was verified, as decisions made in translation may impact on the representation of culturally specific concepts and expressions.

Thematic and framework analysis were used to analyse the data. Thematic analysis uncovers patterned meaning, and the Framework Method involves organising data in a matrix and comparing cases (Braun and Clarke, 2006; Gale et al., 2013). To avoid predisposing concepts, the analysis was guided by the deductive frame, which was informed by cultural knowledge, sensitivity and skill, as well as by the inductive codes developed from the participants' accounts. The analytical process included familiarizing oneself with the transcripts, coding passages that were relevant, aggregating and grouping codes, cross-checking accounts between data sources and developing candidate themes in light of the entire data set and research question. The final themes that were reported were increased cultural awareness, communication and challenges in translating training into practice. The final submission should provide clarity about who coded the transcripts, how coding decisions were reviewed, how the framework matrix was used, and how differences in interpretation were addressed (if applicable) (Table 2). The overall analytical process is summarised in Figure 1.

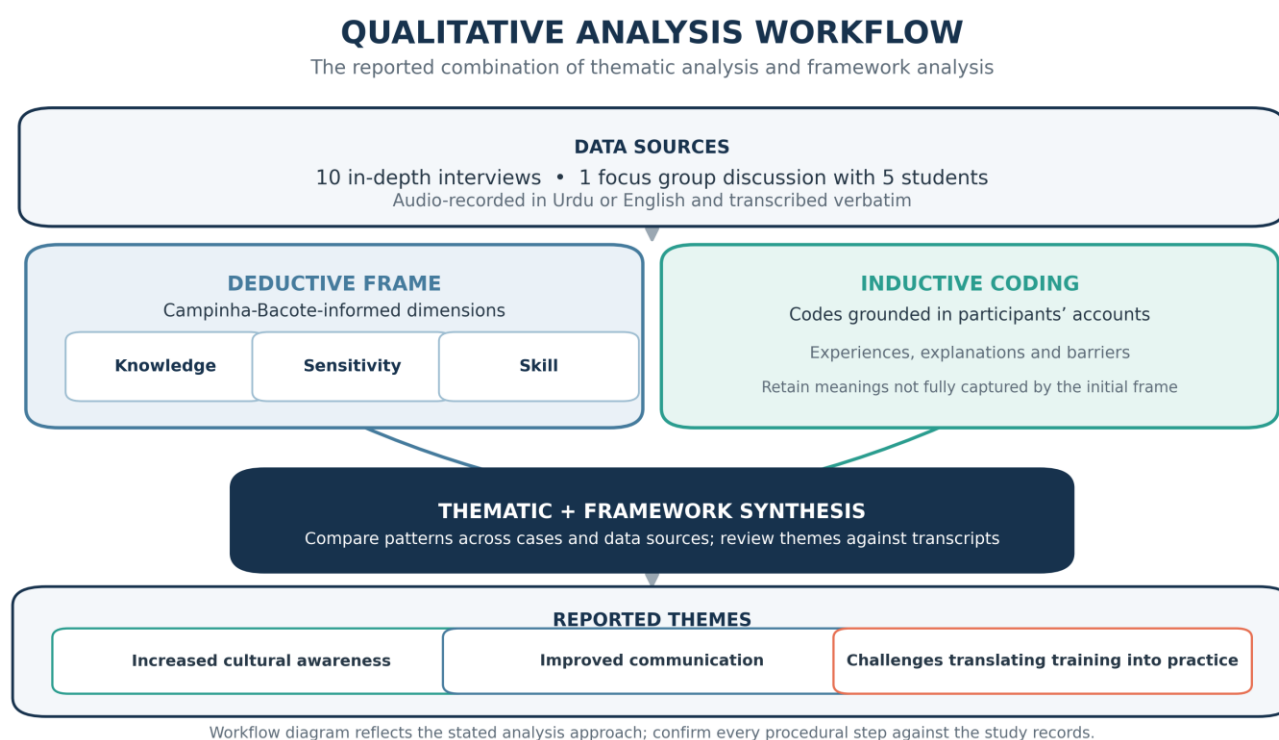


Figure 1. Qualitative analysis workflow combining deductive and inductive coding.

Note: The diagram summarises the stated combination of thematic and framework analysis. The final methods description should match the procedures documented in the study records.

Four techniques were employed to enhance methodological rigor: member checking, peer debriefing, an audit trail and reflexivity. Member checking allowed participants to reflect on or comment on interpretations, and peer de-briefing allowed participants to reflect on and/or comment on the analysis that was unfolding. A reflexivity approach was used to prompt reflection on the researcher's assumptions, professional identity and relationship to the field of nursing education, and an audit trail was used to maintain an account of analytical decisions. These practices are most convincing when they are presented in detail, rather than just enumerated; the final report should briefly explain how each of these was applied. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were used to guide reporting, which focuses on reporting the research team, study design, data collection, data analysis and findings (Tong et al., 2007). All participation was voluntary, informed consent was obtained and anonymisation of transcripts was done.

Table 1. Overview of qualitative data sources

Data source	Number reported	Purpose in the study
In-depth interviews	10 interviews	Detailed individual accounts of programme experience and clinical transfer.

Data source	Number reported	Purpose in the study
Focus group discussion	1 group; 5 students	Group discussion of shared experiences, interpretations and perceived barriers.
Data format	Audio-recorded in Urdu or English; transcribed verbatim	Preservation of participants' accounts for qualitative analysis.
Sampling	Purposive extreme-case sampling	Selection from students with the highest and lowest post-training cultural competence scores.

Note: The supplied study summary does not specify whether focus-group participants also took part in individual interviews; counts are therefore not summed to infer a unique participant total.

Table 2. Relationship between the analytical frame and reported findings

Analytical concept	Relevance to the research question	Boundary of interpretation
Cultural knowledge	Information and understanding students draw on when considering cultural context.	The summary does not identify a separate knowledge theme; do not claim a distinct outcome.
Cultural sensitivity	Attention to cultural difference and respectful engagement with patients as individuals.	Link the concept to concrete transcript evidence rather than treating it as an observed skill.
Cultural skill	Ability to seek relevant information and respond in a culturally responsive way.	Perceived communication improvement does not alone prove clinical competence.
Inductive codes	Concepts emerging from participants' accounts beyond the deductive frame.	Specific subthemes should be included only if supported by coded data.

3. RESULTS

Three broad themes were identified in the analysis: growing cultural awareness, enhanced communication and difficulties in transfer of training to practice. The first two themes are perceived areas of learning linked to involvement in the four-week programme and the third theme emphasizes those conditions that limited use outside of education. In the context of the practice-transfer theme, the barriers reported were limited exposure to cultural diversity and time pressure, and weak institutional support. All the themes indicate that students' perceptions of what learning is and their perceived opportunity to do learning is not the same. The results are reported in terms of experiences and not as direct indicators of clinical performance. Themes identified in the study summary provided for this draft do not include verbatim extracts from interviews or focus groups, but will be included in the final submission as anonymised extracts from the actual interviews or focus groups to demonstrate how interpretations are based on the data of the participants. This manuscript contains no inventions.

The first was increased awareness of the importance of cultural issues in nursing care, which was reported by the students. Awareness may be a shift from an abstract appreciation of diversity towards a more intentional focus on the impact of personal assumptions and patients' backgrounds on care encounters within a structured training programme. From the study's summary, it appears that the TTP resulted in an increase in cultural awareness for participants. This is a reported learning outcome and does not indicate that all participants resulted in the same learning or that awareness was consistently applied to interactions with patients. The sample was also split into two groups based on their post training scores, so it would be interesting to see if students in each group had similar or different descriptions of awareness. Only make comparisons where transcripts support the comparison and where there remains variation and not a narrowing down of participants to their score category.

The second theme was improved communication, which was reported by students as being supported by the TTP in understanding communication in culturally diverse care encounters. Communication is a pragmatic part of cultural competence as it affects the ability for nurses to gather pertinent information, convey care, listen respectfully to patient concerns and understand miscommunication. Studies on cultural competence training have also found that both the trainers and the participants can benefit from the training in terms of communication and an increased understanding of the patients' needs (Kaihlanen et al., 2019). The present finding should still be presented with the students' experience of improvement, however, if there are independent observations or validated pre- and post-training communication measures, then that should be included. The final manuscript should clearly explain what students intended by improved communication and give extracts of their transcript that show what they meant. It should also include any conflicting or ambiguous statements in order to capture the diversity of experiences of the participants rather than suggest a common response to training.

The lack of exposure to diversity was identified as a barrier to transfer. Learners have opportunities for experiential encounters to ask respectful questions, identify assumptions, and consider culturally relevant care. In situations of limited opportunities, students may be less likely to encounter challenges to their classroom learning in the complexity of clinical practice. Competence comes not just from exposure, but also from supervision, reflecting and talking about uncertainty. The literature on education highlights diverse approaches such as case discussion, simulation, experiential learning and clinical contact to facilitate cultural competence development (Long, 2012; Kääriäinen et al., 2019; Tosun, 2021). For this research, this barrier needs to be described in terms of the participants' own experiences of learning opportunities. In particular, the final report should not make assumptions about diversity levels being equivalent across the four colleges and/or across placements unless such a comparison has been specifically made in the data.

Time pressure was also a constraint to the application of learning. Clinician schedules and other commitments may limit patient contact time. Listening, clarification and trying to understand the way patients interpret health and care may be challenging aspects of culturally responsive communication, and these may not be able to be sustained when students think there is more emphasis on speed or task completion. The finding is relevant to the theory–practice gap as it indicates the conditions in which the knowledge is applied, and does not necessarily mean that the students have not yet learned the knowledge. However, the information provided in the summary is not specific to wards, staffing levels etc. or incidents and therefore no assertions are made here. Verbatim data should describe how participants experienced time pressure, how they felt it affected communication, and whether they differentiated between types of constraints that they were able to manage and those from the clinical system.

Weak institutional support was the third barrier. Without reinforcement of culturally responsive care in classroom instruction, supervision and institutional procedures, transfer may be problematic. Students may have conceptual support within a programme and lack clarity about how to prioritise that support when clinical demands are ambiguous or the immediate demands of the job outweigh. This is not only a personal learning challenge; it is also a challenge for educational institutions and clinical partners to provide space for reflection, feedback and culturally responsive practice. In addition to this, recent qualitative research in Karachi has also identified institutional support as a concern in transcultural nursing education (Shah et al., 2026) and, therefore, it is crucial to place the present results in the local scholarship while being careful not to confuse the samples, the context of the programmes and the areas of analysis. The final analysis should record what the participants actually experienced in their institutions and not make any assumptions about particular supervisory or management behaviours unless these are included in the interviews or focus group.

The pattern reported for the three themes is that of perceived learning with limits on application. Awareness and communication were reported to be positive experiences whereas conditions that may limit students in opportunities to apply learning were identified in the practice-transfer theme. This synthesis does not suggest that all students participated in the programme in an identical manner nor does it create a causal sequence between the three themes. Instead, it provides an explanation of the reported pattern – the value of a training programme can be influenced, perhaps in part, by opportunities for practice in the subsequent clinical setting. The extreme-case sampling strategy affords an opportunity for comparing contrasting score groups from post-training, which should be illustrated with actual transcripts and the score information. The current draft report, therefore, only includes the three broad themes and three specific barriers, which will be finalised with the full dataset. The thematic structure is summarised in Figure 3.

Table 3. Themes identified in the qualitative analysis

Theme	Reported focus	Interpretive contribution
1. Increased cultural awareness	Students reported greater awareness of cultural considerations in care.	A perceived learning outcome; not equivalent to independently demonstrated competence.
2. Improved communication	Students reported positive communication-related learning.	Connects cultural understanding with interpersonal nursing practice; detailed examples require transcript evidence.
3. Challenges in translating training into practice	Limited exposure to diversity; time pressure; weak institutional support.	Highlights clinical and organisational conditions that may constrain application of classroom learning.

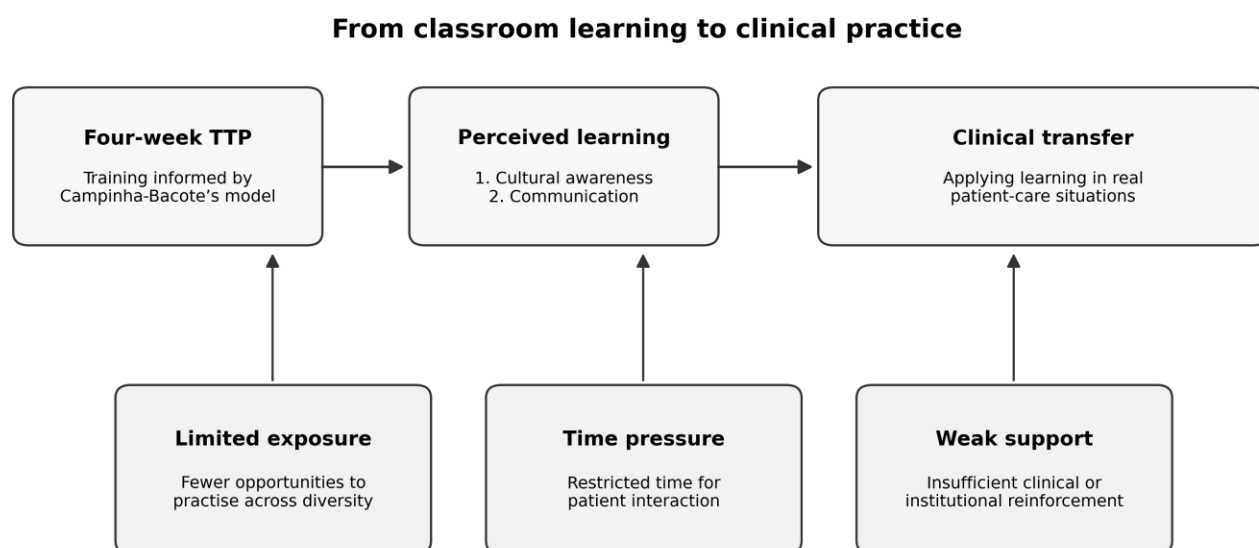


Figure 2. Proposed interpretive pathway from transcultural training to clinical application.

Note: The figure synthesises the reported themes into an interpretive model. It is not a causal model and should be revised if the final transcript-based analysis supports a different relationship among themes.

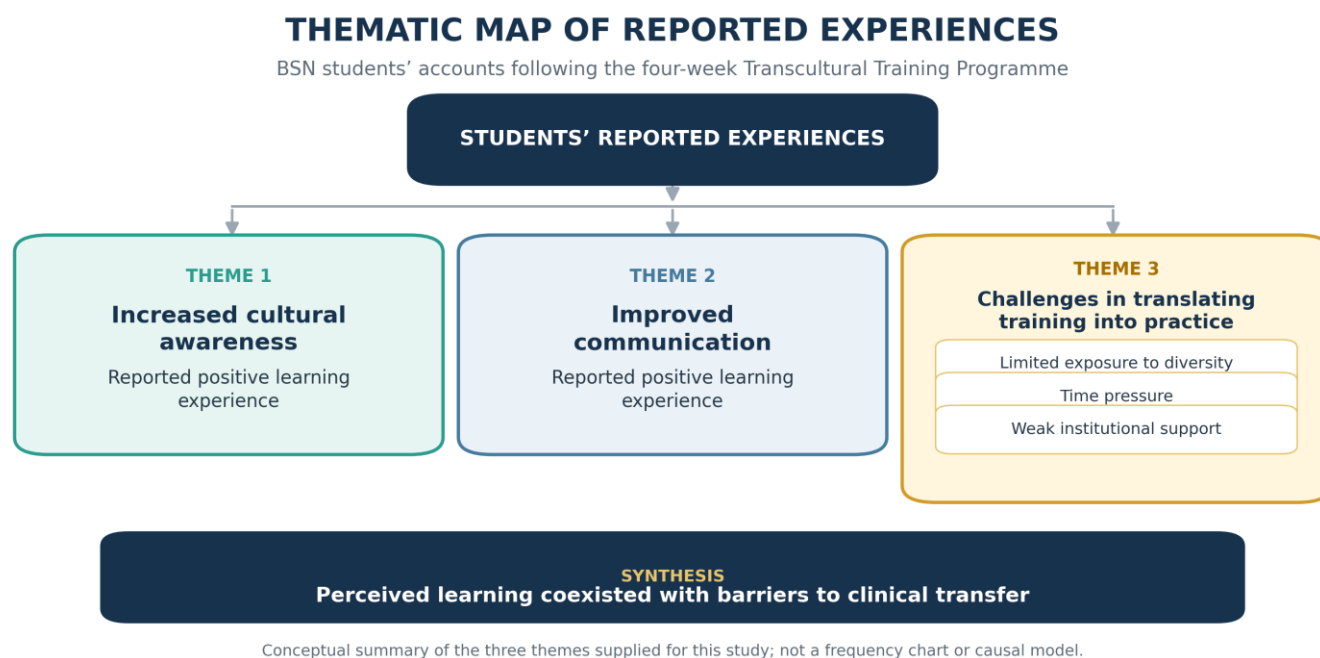


Figure 3. Thematic map of nursing students' reported experiences after the Transcultural Training Programme.

Note: This figure represents the three supplied themes and the three reported barriers. It is a conceptual summary, not a count of theme frequency or a causal model.

4. DISCUSSION

This study aimed to look into the experiences of BSN students who participated in a four week Transcultural Training Programme in four nursing colleges of Karachi and the factors that affected transfer of learning from classroom to clinical practice. Three themes were shared: cultural awareness, communication, and problems of transferring training into practice. In the third theme, barriers were identified as limited exposure to diversity and time pressure and weak institutional support. The primary contribution is the focus on connections between learning experiences and the learning

environment in which students attempt to apply the learning. The results don't prove that the programme had any impact on observed behaviour or patient outcomes. Rather, they inform about the students' learning experience and the felt limitations on applying it. It is essential to understanding the qualitative results responsibly and to planning future programme evaluations which will include consideration of the learning environment in which the programme is used.

The reported rise in awareness is corroborative of the idea that deliberate reflection on culture and care can be encouraged through structured education. Campinha-Bacote's model situates awareness as a continuous process of thinking about and reflecting on one's own cultural assumptions and background, and not merely learning about other cultures. (Campinha-Bacote, 2002) The theme can be a basis for additional development. It does not demonstrate that all participants were able to develop a consistent level of competency or that awareness is a sufficient condition for culturally responsive care. The reviews of educational interventions show differences in the design of the programmes and the methods used to capture the outcomes of the interventions, making it difficult to compare across settings (Kääriäinen et al., 2019; Tosun, 2021; Tosun et al., 2024). In the final paper, references to previous research should be tied to the experiences reported in the transcripts and include comparisons of convergence and difference. Quotations from the participants would give the needed detail to determine which forms of awareness were most salient in this context.

Communication improvement is related to interpersonal exchange in culturally responsive nursing. Clinicians should not assume cultural differences are immutable characteristics that dictate a patient's preferences; they should ask, listen and adapt to the patient. Prior literature on cultural competence highlights the link between communication and knowledge and skills, yet it also points out that there are gaps in current literature and tools (Shen, 2015; Sharifi et al., 2019). The present results indicate that students felt there was value in training related to communicating, although they did not provide evidence about the frequency of successful application of learning or the experiences of the patients. The sense of improvement must be separable from what is actually done. Future assessment might use a combination of students' reports, supervisor feedback, observed interactions, reflective logs or patient perspectives. These sources would not be used in place of qualitative inquiry, but in addition to it, to look at how changes that students describe can be seen in clinical behaviour and are meaningful to those receiving care.

One reason for the difficulty to transfer classroom learning to practice is limited exposure to cultural diversity. Formal teaching can give students opportunities for learning concepts and rehearsal but they also need to have supported encounters where they can recognise uncertainty, ask questions and consider how care can be adapted. Multiple educational approaches have been described previously, such as case-based teaching, discussion, simulations and experiential learning, but their duration is widely different as well as the content of the learning experience (Long, 2012; Kääriäinen et al., 2019; Tosun, 2021). What is not meant to be implied is that the student should be exposed to a certain class of patient or that cultural groups should be presented as homogeneous. Instead, students should be provided with educational experiences that allow students to interact with individual patients without stereotyping and to learn to find out the relevant information in a culturally respectful manner. Strong conclusions about placement design or clinical diversity require direct evidence from participants.

The theme of time pressure moves focus from student competence to conditions of practice. Common short encounters or differing clinical tasks can make it challenging to listen, clarify meaning, and explore patient preferences despite the understanding of the importance of culturally responsive communication. Teachers should reflect on the frequency with which students have the opportunity to practice what they have learned in the classroom in clinical settings. However, it would not be appropriate to attribute specific behaviours to workload or staffing levels without data providing evidence for these links. The interviews should be analysed to elucidate the ways in which students themselves related time pressure to practice and whether they reported strategies for dealing with time pressure. Educational responses can be brief communication prompts, reflections following specific encounters, and supervisor modelling of culturally responsive exchanges. Any such strategies should be made as implications that need to be evaluated, not as interventions which have been proven to be effective by this qualitative study. In addition, with clinical partners their feasibility should be discussed. The institutional-support theme implies a transfer influenced by the relation between educational and clinical systems. When curriculum messages are supported by clinical mentors, feedback and placement expectations, students might have more explicit opportunities for practice. On the other hand, if culturally responsive care is mentioned in class but not seen in clinical supervision, learners might think of culturally responsive care as a lesser priority than the task at hand. Shah et al. (2026) also mention institutional support and barriers to implementation in a recent qualitative study conducted in Karachi. The convergence suggests that organisational conditions are important in research and practice, but the present article must make its own unique contribution clear and this is done by concentrating on post-programme student experiences, extreme case sampling, and the deductive-inductive approach to analysis. Authors should also ensure that the dataset and analysis reported in this paper are independent of any previous publications or submissions and correctly report any connection to other local studies.

Campinha-Bacote's model can be helpful, but shouldn't be used to fit findings into categories. Cultural knowledge relates to knowledge about the influence of culture on health, sensitivity relates to respectful attention to differences and individual preferences, and skill relates to being able to collect relevant information and respond appropriately. Themes can be understood with the help of the model, and differentiated between perceived educational gains and conditions for application. Awareness/Communication is associated with development of cultural understanding/Interaction and reported barriers are associated with opportunity to apply knowledge and skills. However, inductive analysis still plays a vital role

since both institutional support and workload and placement exposure are contextual conditions and not attributes of learners. A balanced interpretation should thus be one that helps to explain findings through theory, not one that is a full explanation of the model. It should also recognize that cultural competence is a process and that reflective humility can be more significant than perceived competence (Tervalon and Murray-García, 1998).

Implications for nursing education are practical. Programme development should take into account how students will rehearse, receive feedback on and reflect on shared concepts throughout their clinical placements, in addition to introducing such concepts in a four week programme. Nursing colleges and clinical partners can collectively identify clinical placement opportunities, offer guidance in a structured manner, and ensure that culturally responsive communication is a component of clinical learning conversations. Shared language for faculty and clinical mentors for discussing cultural awareness, information gathering, respectful communication and uncertainty may also be beneficial. These recommendations are based on reported barriers and should be tailored to local resources and experimented with, not assumed. Evaluation would be improved by integrating students' experiences with follow-up interviews, with repeated competence assessments and, if possible, observation of practice. This approach might reveal if perceived benefits last after the programme and what kinds of supports are seen as most useful in real clinical situations by students.

There are a number of strengths and limitations that affect interpretation. The study was based on students at four Nursing Colleges and involved ten interviews, including focus group. More than one qualitative account was obtained from students of four Nursing Colleges and a combination of ten interviews, including focus group. An extreme case sampling approach based on the post training scores was also used to investigate contrasting profiles. However, purposive extreme case sampling is not used to determine the distribution of experiences among all nursing students and the findings should not be statistically generalised. The available summary does not detail the demographics of the participants, a cultural competence measurement tool, the detailed programme delivery, the length of the interviews, the overlap between interview and focus-group participants, or the full saturation decision process. Self-reported experiences can also be influenced by recall and social desirability, and interpretation by the researcher is also a key factor in qualitative analysis. These should be cleared up prior to submission.

5. CONCLUSION

The present study is qualitative and has studied the experiences of BSN students during a four week Transcultural Training Programme conducted in Karachi, Pakistan. The reported findings included enhanced cultural awareness, better communication and difficulties in the transfer of training to the clinical setting. The following three barriers were found in the theme of practice transfer: limited exposure to cultural diversity, time pressure and weak institutional support. Themes suggest that students might feel like they are getting something out of their education, but may feel they are not getting it to them when they are in a clinical situation. The study thus highlights the link between learning and its context; while concepts may be introduced in the classroom, the chances for supervised practice and for institutional reinforcement may be extended for those concepts to become part of everyday care. Qualitative study findings should be understood as contextual narratives and not evidence of causal effectiveness or objectively observed improvement, as the information gathered for this draft does not contain participant quotations.

The results suggest a connected view of transcultural education, which includes preparing the classroom, exposing students to clinical experiences, providing feedback and reflection. Future programmes should be explicit about the ways in which students can practice culturally responsive communication during placement and by supervisors in the normal clinical demands. Training, in detail, should be described in future studies, training following should be described and compared to other evidence as far as possible. The final manuscript should contain excerpts from the original interviews and focus group, should provide a clear description of coding and the framework, should include the characteristics of the participants, and should provide information that will allow the reader to understand the extreme case sampling strategy. The additions are necessary to illustrate how the three themes came from the data. The overall finding is not that training is not enough in all situations, but rather that it is the interplay of learner development and opportunities provided in the clinical learning context that determine transfer.

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