

Understanding the ways in which health visitors manage anxiety in cross-cultural work: a qualitative study

Fiona Cuthill

Department of Pharmacy, Health and Wellbeing, University of Sunderland, Sunderland, UK

Aim: This paper is a report of part of a study that explored the ways in which health visitors manage uncertainty and anxiety when working with clients across cultures.

Background: Internationally health care professionals are required to deliver a high standard of culturally appropriate care to increasingly diverse communities and yet problems persist. Research evidence informing cultural ‘competence’ is focused largely around student experience and consequently little is known about the day-to-day experiences of health professionals in diverse community settings. Anxiety and uncertainty are increasingly recognised as important emotions experienced by a variety of health care professionals when working across cultures and yet the ways in which anxiety and uncertainty is managed in practice is less well understood.

Design: Grounded theory methodology was used and 21 semi-structured interviews were conducted with participating health visitors in the North East of England between May 2008 and September 2009. All participants described themselves as white.

Findings: This study identified three different positions adopted by the health visitors to manage uncertainty and anxiety in their work across cultures. Identified as, ‘Fixing a culture’, ‘Reworking the equality agenda’ and ‘Asserting the professional self’, these strategies identify the ways in which health visitors try to manage the uncertainty and anxiety they feel when working in diverse communities. All of these strategies attempt in different ways to negate cultural difference and to render culture as static and known. **Conclusion:** Given that health professionals report anxiety and uncertainty when working across diverse community settings, identification of the strategies used by health visitors to manage that anxiety is important for both policy and practice. New strategies need to be developed to help health professionals to manage uncertainty and anxiety in ways that promote both cultural safe care and health equity.

Key words: anxiety; cultural competence; ethnicity; health inequalities; health visitors; primary health care

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Introduction

In recent years, the international health care literature has witnessed the rapid development of cross-cultural care as a field of enquiry

(Leininger, 1988; Papadopoulos, 2006; Omeri, 2008; Purnell *et al.*, 2011; Taylor *et al.*, 2011). As the joint pressures of globalisation and migration increasingly bring people from different cultures together in local communities, the ways in which health professionals work within these diverse and changing communities have recently come under increased political and scholarly scrutiny.

Correspondence to: Dr Fiona Cuthill, PhD, University of Sunderland, Sunderland, UK. Email: fiona.cuthill@sunderland.ac.uk

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Professional bodies internationally require that care is culturally appropriate (Association of American Medical Colleges, 2005; General Medical Council, 2007; International Council of Nurses, 2007; Nursing and Midwifery Council, 2007) and national legislation in the United Kingdom, along with many countries globally, enshrines the principles of equality of provision and the acknowledgement of diversity [Race Relations (Amendment) Act, 2000; Equality Act, 2010]. Nonetheless, a growing body of literature recognises that problems persist. A substantial body of international research in the United States, Canada, Australia, New Zealand and the United Kingdom has uncovered poor communication, difficulty with interpretation services and a lack of trust as impacting negatively on cross-cultural care (Gerrish, 2001; Cioffi, 2003; Diver *et al.*, 2003; Curtis, 2004; Gerrish *et al.*, 2004; Drennan and Joseph, 2005; While *et al.*, 2005; Richardson *et al.*, 2006; Jirwe *et al.*, 2009; Walker *et al.*, 2009; Barron *et al.*, 2010; Williams and Sternthal, 2010). In addition, the work of health professionals within community settings is recognised as presenting different opportunities and challenges to hospital settings, as staff working within community settings hold a unique role, in that their work is as 'invited guests' into the homes of their clients and is largely invisible (Swearingen, 2008). Van Ryn and Fu (2003) have also drawn attention to the ways in which the experiences of nurses working within cross-community settings remain under researched.

Over the last three decades, a plethora of cultural 'competency' programmes have flourished across the industrialised world in an attempt to address these issues (for a literature review, see Williamson and Harrison, 2010), and yet, despite the intense level of activity directed towards cultural education, there has been limited success in measuring culturally 'competent' practice in health care practice. There is no consensus as to what constitutes cultural 'competency' (Nokes *et al.*, 2005; Park *et al.*, 2005; Ladson *et al.*, 2006), nor is there evidence that cultural education improves health outcomes for the client (Beach *et al.*, 2005). The limited amount of research into the evaluation of the effectiveness of teaching interventions in cultural education, in both the United States (Jeffreys, 2005) and the United Kingdom (Dogra and Karnik, 2003), has become a cause for concern.

The majority of cross-cultural programmes within health care take a culturalist approach, focusing their attention on the acquisition by the health professional of cultural knowledge, skills and sensitivity (Betancourt, 2003; Papadopoulos, 2006). What is surprising is that, although issues of 'race', culture and ethnicity are imbued with emotion (Ahmed, 2004), very little attention has been paid to emotional (dis)engagement in cross-cultural work. A number of educational programmes point towards addressing issues of self confidence and self efficacy (Jeffreys, 2005) but very few acknowledge or address the emotional aspects of cross-cultural care.

Increasingly, uncertainty and anxiety are being recognised as important emotions experienced by health professionals when working in diverse community settings (Penrod, 2007; Jirwe *et al.*, 2009; Cuthill, 2011). In the United Kingdom, Kai *et al.* (2007) found that health care professionals across a wide range of settings experience uncertainty and anxiety when working across cultures. GP registrars in Ireland reported considerable professional uncertainty when working in ethnically diverse contexts (Pieper and MacFarlane, 2011) and Peckover and Childlaw (2007) carried out a small piece of qualitative research exploring the experiences of district nurses in Scotland and found similar reports of uncertainty and anxiety. Nonetheless, the majority of research in cross-cultural work is carried out with nursing or medical students (Weissman *et al.*, 2005; Dogra *et al.*, 2007) and few studies explore the experiences of practicing health care professionals in their day-to-day work.

Scholarly research has uncovered several different ways in which nurses manage uncertainty and anxiety in different health care contexts. Over two decades ago, Pam Smith found that student nurses dealt with anxiety by using techniques of 'distancing', 'seen it all before' and 'labelling of the difficult patient' (Smith, 1992: 131) and Bolton (2001) first described the 'Professional Face' of nursing, where nurses were found to be 'caring but distant' (p. 90). Nurses have been shown to detach themselves from situations according to specific patient circumstances (Henderson, 2001; Law and Rostill-Brookes, 2009) and to protect themselves to cope with emotional stress (Mackintosh, 2007). Nonetheless, the specific strategies exhibited by health visitors to cope with fear, anxiety and

uncertainty in cross-cultural work remain largely under researched.

This paper is a report of part of a qualitative study carried out in primary health care and community settings in England, to investigate the ways in which health visitors manage anxiety when working in diverse communities. It presents the findings of the part of the study that uncovers the ways in which health visitors sought to manage uncertainty in cross-cultural work.

Health visitors were chosen as a focus for this study because they are a group of health care professionals who work in a variety of community settings and across diverse and changing neighbourhoods. In the United Kingdom, the term 'health visitor' refers to a specialist Registered Nurse who works primarily in the community to support families, protect children and promote health. The role is recognised in different countries by various terms, such as Public Health Nurses (United States) or Child Health Nurses (New Zealand). Although the role and scope of health visiting services are currently under review in the United Kingdom [Hoskins, 2009; Department of Health, 2011], health visitors remain at the forefront of child and family health care and surveillance.

Method

Design

An interpretivist grounded theory methodology was used (Charmaz, 2006), as it seeks to investigate the views of the research participants from the ground level upwards. The inductive nature of the grounded theory methodology ensured that the methodology was appropriate to investigate the views and perspectives of practising health visitors in their day-to-day work (Charmaz, 2006; Corbin and Strauss, 2008).

Sampling and recruitment

Twenty-one health visitors were interviewed to explore their views and perspectives on working with clients who they perceived as being from another culture. Although all health visitors in the region were invited to take part in this study, the health visitors who agreed to participate were female and described themselves as white.

Nineteen of the research participants described themselves as British, one participant described herself as half-German and one described herself as half-Swedish. This is reflective of the demography of this region, where 96% of the population describe themselves as white [North East Public Health Observatory (NEPHO), 2008].

Sampling only included health visitors who had been qualified and working in the community for a minimum of a year or more. The length of time the participants had worked as health visitors varied from 1 year to 35+ years. All of the health visitors were generalist health visitors ($n = 21$), although three of the participants described the majority of their clients as coming from Black Minority Ethnic groups. All of the communities within which the health visitors worked were identified as containing a variety of different cultural groups within them. The health visitors were located within a range of different locations but, broadly, three health visitors described their work locality as being in the suburbs of cities, 12 were practicing within inner city areas and six health visitors worked in small towns in the North East of England.

In accordance with grounded theory, theoretical sampling should have been employed following the initial purposeful sample (the first two interviews) according to the theoretical development of the emerging data (Corbin and Strauss, 2008). Although attempts were made to theoretically sample, unfortunately this was not possible in this study as sampling was controlled by the rigour of the NHS Ethics Committee requirements. Ethical protocols ensured that a request was sent to the Director of Nursing Services at the relevant Primary Care Trusts, and they then cascaded the approved letter of invitation down to their staff to invite participation in the study. No direct request was permitted to be sent to individual health visitors and the sample was therefore a purposeful sample of volunteer health visitors.

Data collection and analysis

The study was conducted in five primary care trusts in the North East of England between May 2008 and September 2009. All of the interviews were conducted in English. Interviews were recorded using a semi-structured interview schedule as an initial guide, but as the research process

progressed, the interview questions were directed by the emerging theoretical codes. To elicit the nurse's perspective, initial open-ended questions began with a question asking, 'Can you tell me about your experiences of working as a health visitor with people who are from other cultures?' and then two questions asking, 'What have you found are the best things about working with people who are from other cultures?' and conversely, 'What have you found are the most difficult things about working with people who are from other cultures?'. When emotional aspects of cross-cultural work began to emerge as a selective code, additional questions were asked, such as 'How did you feel when working with this client group?'. It was left to the participant to define for themselves what they understood by the term 'other cultures'. All names were changed to preserve the anonymity of the research participants and interviews were recorded, transcribed in full and then analysed.

Glaser and Strauss (1967) emphasised the uniqueness of grounded theory data collection. The central premise of grounded theory data collection is not to amass huge amounts of data for later analysis but to analyse it against the current data and then adapt it to the new data generated. In this way, the interview data was analysed using open, axial and selective codes and, using constant comparison of the data, these codes moved from descriptive categories to the final emerging conceptual categories. Initially, a wide variety of open codes were generated, for example 'losing confidence', 'positioning self', 'standing on uncertain ground', 'equality versus equity', 'things hidden in culture', 'when to probe... when to accept?' and 'scared to offend'. These open codes began to make visible the participants' accounts of working across cultures. As data analysis progressed, these open codes were compared and contrasted with the emerging codes from each subsequent interview and axial codes began to be developed from interview 8 onwards. Axial codes grouped the experiences of health visitors into categories such as the 'emotional self', 'all equal... all the same', 'promoting equality over equity', 'culture as "other"' and 'positioning self'. Concurrent coding and comparison of the axial codes continued until selective codes were generated. Within the category of 'managing anxiety', the final categories of 'Fixing a culture',

'Reworking an equality agenda' and 'Asserting the professional self' emerged. Memo writing and an audit trail of all the coding and data analysis decisions were made throughout the analysis and were used to confirm the findings of the study.

Findings

Health visitors use three different strategies to manage anxiety when working with cultural difference; named as, 'Fixing a culture', 'Reworking the equality agenda' and 'Asserting the professional self'. Each of these strategies helps to stabilise the uncertainties of culture that cause anxiety in cross-cultural work and yet have the potential to perpetuate disengagement across cultures. The quotes below give a clear representation of the data gathered and the expressed views of the health visitors interviewed.

Fixing a culture

The majority of health visitors ($n = 19$) used language when talking about 'race', culture and ethnicity¹ that grouped their clients into specific cultural groups and several of the health visitor accounts demonstrated a stereotyping of cultural groups:

Within the Bangladeshi community, because their culture does not believe in that [depression] anyway, so we wouldn't use, em, that form. They don't believe in depression [sic] (Rebecca).

I also find the Chinese families quite difficult. You know, you tell them about cot death but they just keep swaddling their children and laying them on their tummies and you just sort of think, well, what can you do? [sic] (Ruth).

In addition, the majority of health visitors wanted to gain more knowledge about different cultural groups and felt that increased knowledge would increase their cultural 'competency'.

¹ 'Race' is used within parenthesis to denote the difficulty of naming a concept that does not exist (as a biological marker), although it is acknowledged that racism does exist in the lived experience of many people. 'Race', culture and ethnicity are recognised as having different meanings at different times (Gunaratnam, 2003), but in this paper they are used interchangeably.

However, a few health visitors found that they were pleasantly surprised by cultural differences and the stereotypical views they held were challenged by the clients they met. Leah was surprised by things about some of her clients and this challenged her pre-conceived ideas:

You think, god, there are some good things to pick up and some of their attitudes to health are excellent and they don't miss appointments or anything like that, they value health care, they value immunisations and they value their child getting weighed and advice and all that. Yeah, and they really value it more than, sort of like, people here just take it for granted [sic] (Leah).

What was particularly interesting was that several of the health visitors recognised that through experience, and contrary to their expectations, cultures changed over time. Annette noted that:

Cultures evolve and you think, 'is that still accurate years later?' [sic].

Health visitors who described themselves as having moved away from a previously held 'fixed' view of culture, to recognising culture as changing and fluid expressed feelings of uncertainty and of 'losing confidence'. This is starkly articulated by Jane:

Well, it's funny, because sometimes I think I was, kind of arrogant going into these families and thinking I could provide a service...I don't know if arrogant is the word, but something like thinking how did I ever consider I could do this and now I feel far less confident...I just don't know Fiona, it [culture] is just so overwhelming, it is just too vast [sic].

Nonetheless, the majority of health visitors described culture as static and divided their clients into two distinctive groups, either 'Westernised' or 'non-Westernised'. 'Westernised' was associated with similarity and 'non-Westernised' was associated with difference and increased anxiety.

I found that the very Westernised adhere to the weaning but I find some other people, they would just do it the way they would do back in India really I suppose, or in Bangladesh, so they would just adhere to

what they would do and that is really doing what their mothers say [sic] (Leah).

Reworking an equality agenda

This study found that the majority of health visitors were confused about the rhetoric of 'equality and diversity' in health care discourses and re-worked the equality agenda to minimise difference in two different ways; namely, as either conceptualising equality as 'all equal...all the same' or by 'promoting equality over equity'.

In many of the narratives of the health visitors, a theme emerged, which was conceptualised as 'all equal...all the same'. In order to manage the anxiety and uncertainty created by different cultural practices, particularly in relation to child rearing, the majority of health visitors minimised (or completely negated) cultural difference and focused on aspects of child rearing that was similar to their own cultural norms and values. When asked to talk about the things Cathy liked about working across cultures, she said;

What do I like? Well, obviously it gives you a better variety to the job and it gives you a better understanding of different cultures but also they are really just the same as us. It is not so much [pause], that I have enjoyed working with people who are different, it is that I have enjoyed learning that they are not that different really [sic].

Many of the health visitors struggled to know whether it was acceptable to give more resources to certain clients or not, especially if they required more time or additional visits. In 'prioritising equality over equity' they focused on equality of time allocation, rather than equity and social justice. Stephanie described struggling with the normal practice of offering new mothers two home visits and yet recognised that some of her clients might need to have more than two visits;

Black Minority Ethnic clients really do appreciate a home visit and so we do it more but then we are sort of [pause], em, constrained, em, we are only supposed to offer a couple of visits but our team leader is very good and she just says 'go as often as you need to', which is what you do but sometimes people say to you, 'you know, you should just do your two visits' [sic].

Primary Health Care Research & Development 2014; 15: 375–385

Conversely, Annette emphasised the universality of the health visitor service to her clients and, in doing so, prioritised equality of service over equity issues;

I think it was very important to make it known that this was normal, we weren't picking on you...we are not saying we have singled you out, this is a universal service here to support you [sic] (Annette).

Several health visitors were also afraid that they might be accused of giving a lower level of service to clients from Black Minority Ethnic groups and so developed strategies to ensure this could not happen;

I often take a crib sheet, it is awful really but I don't want to miss anything and not give the level of service that I give to everyone else and I feel that they are entitled to that and I feel that it would be wrong of me to miss something out, so I just do that, then I know I have given this mum one hundred percent [sic] (Jane).

Asserting the professional self

The third way that the health visitors tried to reduce anxiety when working with cultural difference was to assert their professional self. One of the ways they did this was to introduce themselves as qualified nurses. When asked how she introduced herself to clients, Cathy said:

I, I start by telling them that we are qualified nurses, that is the first thing that I start by telling them, that we are qualified nurses, and I usually go on to describe the difference between us and midwives [sic].

For the majority of health visitors, an important aspect of 'asserting the professional self' was to gain knowledge of other cultural groups. To be professional is bound up with competence and knowledge, and the majority of health visitors wanted to gain a detailed and certain knowledge of the cultural 'other'. There was a strong feeling that knowing about the cultural 'other' would help to reduce anxiety in practice.

My biggest fear would be finding out I had to move to an area with a high BME (Black Minority Ethnic) group in a short space

Primary Health Care Research & Development 2014; **15**: 375–385

of time. I wouldn't like to have to do it suddenly. I would need time to prepare and find out about that group of people [sic] (Mary).

When asked how she would design cultural education programmes Kate was desperate for an educational package to help her to understand each cultural group.

I would get someone to talk about Asian cultures, Egyptian cultures, we have someone who is with us from Iraq, just the little things really, just someone to say what to do...Nothing has helped really because it is like more insight into the culture I feel that I need. We have done enough about equality and diversity but it is more about specific cultures and I think you are worried that you are offensive [sic] (Kate).

Some of the health visitors were reluctant to ask questions in relation to culture, because asking would reveal a level of ignorance they felt was not acceptable for a health visitor.

Sometimes you think you don't want to ask questions in case they think you are being ignorant [sic] (Leah).

Closely linked to a desire for more cultural knowledge, the majority of health visitors used the rhetoric of 'research-based evidence' to assert their professional knowledge. In any disagreement over child rearing practices, organisational norms of 'research-based evidence' were used to silence the discussion.

If it was a new mum, they [the extended family] want this new mum to do what they did and it is hard for us to get our advice and our information across because they just want to give their part and they just want to steer them in their direction rather than listening to research based evidence that we are giving to them [sic] (Lisa).

Discussion

Anxiety and uncertainty are increasingly recognised as shaping professional practice in cross-cultural contexts. Nonetheless, this study has uncovered three specific strategies used by health visitors in professional practice to manage that

uncertainty and anxiety, namely: 'Fixing a culture', 'Reworking an equality agenda' and 'Asserting the professional self'. In particular, these results gesture towards a desire by health visitors to try to gain more knowledge of the cultural 'other' as a way to reduce uncertainty and anxiety. The health visitors therefore wanted to stabilise culture and fix it into something that could be known. They also negated cultural difference by focusing on equality and 'sameness' at the expense of important cultural differences and, finally, 'research-based evidence' was used as a source of certain knowledge to silence different cultural child rearing practices.

In examining the accounts of the lived experiences of health visitors in their day-to-day work, this study suggests that the concepts of 'race', culture and ethnicity, as historically defined within health care discourses, need to be expanded to include a more dynamic, fluid and changing view of culture. Several of the health visitors found that when they encountered the complexity of culture in practice, the result was increased anxiety and disengagement. Although researchers in the social sciences have been exploring and developing the concept of cultural fluidity for the last two decades (Gilroy, 1993; Bhaba, 1994; Hall, 2000; Bauman, 2005), there remains a tendency for medicine to pathologise cultures and to associate cultural 'traits' with disease processes (Ahmad and Bradby, 2007). Recent research by Vanderberg (2010), examining the relationships between culture, health and nursing practice, found that nurses continue to support a view of culture that is fixed and demonstrate a limited engagement in the complexity of culture. Professional-client interaction and knowing the client have a long and important tradition in primary health care and the results of this study suggest that in trying to know the client, and to cope with the uncertainty of culture, the health visitors tried to squeeze cultures into defined categories and risked stereotyping and prejudice. In recent years, several nursing scholars have challenged this static conceptualisation of culture within health care practice (Culley, 2006; Lynam *et al.*, 2006). Drawing on sociological, critical and philosophical insights, these scholars have alerted us to the dangers of fixing culture in time and place and, as a consequence, urge health care practitioners to engage with the socio-political complexity of culture (Anderson, 2000).

Although the danger of racial stereotyping has been widely recognised as culturally unsafe practice in a number of different international contexts (Steen *et al.*, 2005; Milner, 2007; Williams and Mohammed, 2009), there remains a strong desire by health professionals to understand the cultural 'other'. The majority of health visitors in this study expressed a desire to acquire more knowledge about different cultural groups. These findings support the results of a recent study with GPs in Ireland, which found that GPs wanted factual knowledge of the cultural 'other', as they felt this would help reduce the uncertainty and anxiety they felt in cross-cultural work (Pieper and MacFarlane, 2011). Several studies with medical and nursing students have similarly indicated that uncertainty and feelings of discomfort with cultural issues have fuelled a drive for cultural knowledge in educational contexts (Dogra *et al.*, 2007). While Fadiman's disturbing account of the failures of health care staff in a small US town to understand the cultural needs of a refugee family from Laos warns us of the disastrous outcomes of cultural ignorance in health care (Fadiman, 1998), a fixed and static knowledge of the cultural 'other' can also lead to inappropriate care, prejudice and racism (Bowler, 1993; van Ryn and Burke, 2000; Gustafson, 2005).

Little is known about the ways health professionals work with issues of equity in everyday practice. The results of this study contribute to closing that gap in knowledge by uncovering the two different ways that health visitors managed equity in practice, first, by negating difference and treating everyone as the same and, second, by focusing on equality of provision, rather than issues of equity and social justice. Findings by researchers in the United Kingdom (Vydelingum, 2005) and South Australia (Grant and Luxford, 2008) similarly highlight a tendency for white nurses to treat all minority ethnic clients as the same. The results of this study concur with research in the United Kingdom (Forbes, 2002; Aranda, 2005; Cowley *et al.*, 2009), which also found that community nurses in the United Kingdom draw on principles of equality in their day-to-day work and, in doing so, injustices were ignored and discriminatory practice was perpetuated.

Although discourses of individualised care have dominated nursing theory and practice for several

decades (Reed, 1992, Suhonen *et al.*, 2007; Finfeld-Connett, 2008), the last 10 years have witnessed a welcome broadening of theoretical perspectives in health care which interrogate the ways in which structural inequalities in society impact health outcomes (Sistrom and Hale, 2006; Marmot Review, 2010). A substantial body of research evidence also now suggests that inequalities linked to ethnicity exist (Nazroo *et al.*, 2007) and that people from minority ethnic groups suffer discrimination (Bhopal, 2001) and have poorer access to health care services (Davey-Smith, 2000). Lynam and Cowley (2007) have made an important contribution to this body of work, by exploring the multiple and complex ways in which marginalisation effects health. In addition, researchers in the United States, Canada, Australia and the United Kingdom (Bhopal, 2001; Nairn *et al.*, 2004) are increasingly exploring the ways in which racism can have a detrimental effect on health. Internationally, a growing body of research asserts the need for nursing, and community nursing in particular, to engage more directly with issues of equity and social justice (Cohen and Reutter, 2006; Lynam and Cowley, 2007). Nonetheless, the health visitors in this study affirmed the principles of equality over those of equity. Several of the health visitors, however, understood that their clients needed more time, resources or interventions to compensate for certain disadvantage but they felt unsure as to how they could reconcile these with current discourses of equality and diversity. Getzlaf and Osborne (2010) urge health care leaders and professionals in the United States to develop a critical perspective to understand equity and social justice to better improve care for a diversity of clients.

In 'asserting the professional self', the health visitors drew on Westernised discourses of research-based evidence to silence difference. While research-based evidence has undoubtedly made an important contribution to health care practice and policy, it remains rooted in the culture of Westernised scientific medicine (Kleinman and Benson, 2006) and does not adequately account for cross-cultural aspects of care. Standardisation of medical practice has happened at the expense of cultural considerations (Ming-Cheng and Stacey, 2008) and while doctors have struggled to reconcile evidence-based medicine and clinical uncertainty

(Langley *et al.*, 1998; Timmermans and Angell, 2001; Griffiths *et al.*, 2005), this has not been explored in relation to cultural uncertainty.

Study limitations

This study involved the analysis of health visitors' narratives about their experiences working across cultures but did not include direct observation of practice itself. On reflection, observation might have allowed different perspectives on emotion to be uncovered. Furthermore, there were no male or non-white health visitors who volunteered to be involved in this study and their narratives might have told a different story of cross-cultural engagement. This study does not claim that the experience of the health visitors interviewed is a universal experience, and acknowledges that the health visitors involved in this study volunteered to take part in the study because they were interested in cross-cultural care and wanted to improve their practice. It can be assumed that health visitors holding racist and discriminatory views may not have come forward to be interviewed.

Conclusion and implications for practice

In conclusion, the results of this study uncover the ways in which health visitors manage anxiety in cross-cultural work. In trying to fix and stabilise the complexity of culture, the health visitors stereotyped cultures and negated important cultural differences. This was also done by asserting the primacy of research-based evidence and silencing dialogue on culturally diverse child rearing practices. In addition, by treating everyone as equal and the same, important cultural differences could have been missed, which had the potential to contribute to inappropriate care and to perpetuate health inequalities.

The implications of this study are that the concepts of 'race', culture and ethnicity need to be expanded beyond fixed cultural categories in health care and the complexity of culture acknowledged. Health care policy needs to balance knowledge of the cultural 'other' with an understanding of the fluid, changing and dynamic nature of culture. Health care practitioners should recognise that the strategies they use to manage anxiety across cultures have the potential to not only contribute to

culturally unsafe care but also to perpetuate inequalities in health. Finally, new strategies need to be developed to help health professionals to manage uncertainty and anxiety in ways that promote cultural safety and equity.

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