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Exploring Japanese nurses' perceptions of the relevance and use of assertive communication in healthcare: A qualitative study informed by the Theory of Planned Behaviour

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ABSTRACT

Background: The hierarchical nature of healthcare environments presents a key risk factor for effective interprofessional communication. Power differentials evident in traditional healthcare cultures can make it difficult for healthcare professionals to raise concerns and be assertive when they have concerns about patient safety. This issue is of particular concern in Japan where inherent cultural and social norms discourage assertive communication.

Aim: The aim of this study was to (a) explore nurses' perceptions of the relevance and use of assertive communication in Japanese healthcare environments; and (b) identify the factors that facilitate or impede assertive communication by Japanese nurses.

Design: A belief elicitation qualitative study informed by the Theory of Planned Behaviour was conducted and reported according to the COnsolidated criteria for REporting Qualitative research.

Settings and Participants: Twenty-three practicing Japanese registered nurses were recruited by snowball sampling from October 2016 to January 2017.

Methods: Individual face-to-face semi-structured interviews were conducted and transcribed in Japanese and then translated into English. Two researchers independently conducted a directed content analysis informed by the Theory of Planned Behaviour. Participants' responses were labelled in order of frequency for behavioural beliefs about the consequences of assertive communication, sources of social pressure, and factors that facilitate or impede assertive communication in Japanese healthcare environments.

Findings: Although person-centred care and patient advocacy were core values for many of the participants, strict hierarchies, age-based seniority, and concerns about offending a colleague or causing team disharmony impeded their use of assertive communication. Novice nurses were particularly reluctant to speak up because of their perception of having limited knowledge and experience.

Conclusion: This study identified Japanese nurses' behavioural, normative, and control beliefs in relation to assertive communication. The findings will be used to inform the development of a culturally appropriate assertiveness communication training program for Japanese nurses and nursing students.

1. Introduction

A body of research has identified the relationship between communication and patient safety (Kripalani et al., 2007; Lingard et al., 2004; Lyndon et al., 2011). For example, in the United States, communication errors were identified as the root cause of 1796 sentinel events in the years 2013 to 2015, and a causative factor for delays in treatment, medication errors and incorrect procedures (The Joint Commission, 2017). A search of the Japan Council for Quality Health Care (2017) database, using the term "communication" retrieved 524 adverse events from 2010 to 2017. Communication was often mentioned as a background factor in those incidents. Although nurses are well positioned to advocate for patients and prevent communication errors (Okuyama et al., 2014; Rainer, 2015), their lack of assertiveness and hesitation to speak up is a recurring patient safety issue (Maxfield et al., 2011). It is, therefore, crucial to understand the reasons for

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nurses' reticence to use assertive communication skills.

The hierarchical nature of healthcare environments presents a key risk factor for assertive communication. The power differentials evident in traditional healthcare cultures can make it difficult for healthcare professionals to be assertive when they are concerned about patient safety. Although a range of communication tools, guidelines, and checklists have been developed, unless clinicians are confident in advocating for patients these tools are unlikely to have a significant impact on patient outcomes (Maxfield et al., 2011). Researchers have identified a number of barriers to assertive communication in healthcare including: a lack of motivation, confidence, skills, support, and control (Okuyama et al., 2014) as well as fear about how other people may respond (Attree, 2007; Suzuki et al., 2014). These issues are of particular concern in Japan where inherent cultural and social norms discourage assertive communication (Davies and Ikeno, 2002).

The concept of 'assertiveness' has only come to prominence in Japan over the last decade; although there is a growing recognition of the impact of assertive communication on patient safety. Consequently, a small number of assertiveness training programs have been conducted in Japanese healthcare settings with results indicating a positive impact on nurses' self-esteem, well-being and workplace satisfaction (Shimizu et al., 2004), and a reduction in stress and burnout (Shimizu et al., 2003; Suzuki et al., 2009b; Yamagishi et al., 2007). However, there is little evidence that these assertiveness training programs have empowered nurses to raise concerns or advocate for patients about issues related to patient safety. These results suggest that there may be a need for culturally appropriate assertiveness communication training programs that reflect the specific needs, concerns, and perspectives of Japanese nurses, and that focus specifically on patient safety.

The aim of this study was to (a) explore registered nurses' perceptions of the relevance and use of assertive communication in Japanese healthcare environments, and (b) to identify the factors that facilitate or impede assertive communication by Japanese nurses.

2. Background

For the purpose of this study, assertive communication refers to healthcare professionals being able to respectfully express their opinions and concerns regarding patient care to other members of the healthcare team, including those in positions of authority (Omura et al., 2017). Speaking up, a type of assertive communication, is a critical skill for healthcare professionals (Nacioglu, 2016; Rainer, 2015). Lack of assertiveness may lead to hesitation to speak up, resulting in vital patient information not being shared within the healthcare team. Further, unless healthcare professionals assertively articulate and escalate their concerns to appropriate members of the healthcare team, patient safety may be jeopardised, contributing to adverse incidents and patient harm (Okuyama et al., 2014).

Generally, evidence of the effectiveness of assertiveness communication training programs is limited. A recent systematic review focusing on the outcomes of interventions designed to enhance healthcare professionals' and students' assertive communication or speaking up behaviours identified only eight quantitative studies that met the inclusion criteria (Omura et al., 2017). The review concluded that face-to-face and multi-methods programs in which didactic instruction reinforced by discussions and role-play, team training, and support from leaders optimised the effectiveness of assertiveness communication training programs. However, the authors were cautious about drawing conclusions about the transferability of the results as the impact of cultural and social barriers on assertive communication is poorly understood, and few studies have been undertaken outside Western settings.

While studies suggest that assertiveness is a skill that can be improved by participating in training programs (Lin et al., 2004; Warland et al., 2014), numerous factors can influence speaking up behaviours. Healthcare professionals may be well intended and motivated, nevertheless, a fear of repercussions and concerns about how their colleagues may respond can act as a deterrent to assertiveness (Okuyama et al., 2014). Professional factors such as nurse-doctor power differentials and a limited understanding of the roles of team members can also cause nurses to be reluctant to speak up (Wilson et al., 2016; Zwarenstein and Reeves, 2002).

In Japan, assertiveness training programs were first introduced in 1993. The term 'assertiveness' which initially was considered to be a foreign concept, now appears in fundamental nursing texts and has become increasingly used and familiar to Japanese healthcare professionals (Shijiki et al., 2017). While some researchers have reported positive outcomes from assertiveness communication training in Japan (Yamagishi et al., 2007), the main emphasis appears to be on the improved well-being of healthcare professionals (Nishina and Tanigaki, 2013; Shimizu et al., 2004; Suzuki et al., 2009a), with little attention being given to patient safety. There is, therefore, a need to more fully understand Japanese nurses' perceptions of use and relevance of assertive communication. These findings could be used to inform the development of culturally appropriate assertiveness communication training programs so that ultimately nurses will be more confident in speaking up when concerned about patient safety.

3. Methods

3.1. Study Design

The Theory of Planned Behaviour (TPB) (Ajzen, 1991) underpinned this study and the COnsolidated criteria for REporting Qualitative research (COREQ) (Tong et al., 2007) was used to report the findings. The TPB has been successfully used in a wide range of healthcare studies (Casper, 2007; Hackman and Knowlden, 2014). According to the TPB, planned behaviour is preceded by a behavioural intention, which, in turn, is determined by three predictor constructs: attitudes towards the behaviour, subjective norms and perceived behavioural control. These predictor constructs are formed by belief-based indicators including: behavioural beliefs about consequences of the behaviour, normative beliefs about expectations of others, and control beliefs about facilitators or inhibitors of the behaviour (Francis et al., 2004). A graphical

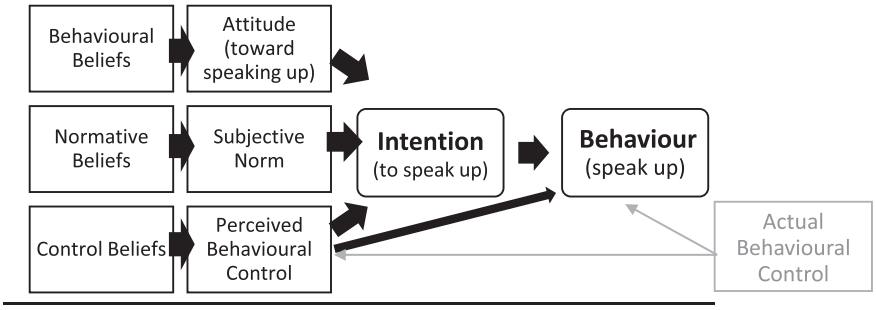

Fig. 1. The Theory of Planned Behaviour modified from Ajzen, 2006.