Cultural factors influencing Japanese nurses' assertive communication: Part 2. hierarchy and power

Abstract

Hierarchy and power characterize healthcare relationships around the world, constituting a barrier to assertive communication and a risk to patient safety. This issue is more problematic and complex in countries such as Japan, where deep-seated cultural values related to hierarchy and power persist. This paper is the second of two that present the findings from a study exploring Japanese nurses' views and experiences of how cultural values impact assertive communication for healthcare professionals.

We conducted semi-structured interviews with 23 registered nurses, following which data were analyzed using directed content analysis. Two overarching themes emerged from the analysis: hierarchy/power and collectivism. In this paper we focus on cultural values related to hierarchy and power, including differences in professional status, gender imbalance, seniority/generation gap, bullying, and humility/modesty.

The findings from our research provide meaningful insights into how Japanese cultural values influence and constrain nurses' communication and speaking up behaviors and can be used to inform educational programs design to teach assertiveness skills.

Keywords: assertive communication, culture, hierarchy, Japan, nurse, power

INTRODUCTION

The strongly hierarchical nature of healthcare is one of the major barriers to open communication and assertiveness between healthcare professionals (World Health Organization, 2012; Gluyas, 2015). Hierarchy and power differentials make it difficult for those who are at the 'bottom of the ladder' to speak up, even when they are concerned about risks to patient safety (Green, Oeppen, Smith, & Brennan, 2017). This issue is of particular relevance in countries like Japan, where a culture of respect to seniors, male dominance, and strong professional courtesy is firmly entrenched in the fabric of society, as well as in healthcare cultures (Taylor Slingsby, Yamada, & Akabayashi, 2006; Tokuda, Walsh, & Stone, 2016). However, there is a limited understanding of how culture impacts communication behaviors and ultimately patient safety (Walton, 2006).

This paper is the second of two that profile the findings from a study exploring Japanese nurses' views and experiences of how cultural values impact communication between healthcare professionals. The focus of this paper is the cultural values of hierarchy and power; the influence of collectivism on nurses' assertive communication is the subject of the previous paper (Omura, Stone, & Levett-Jones, 2018). The definition of assertive communication in this paper refers to nurses being able to respectfully express their opinions and concerns regarding patient care to other healthcare professionals including those in authority (Omura, Maguire, Levett-Jones, & Stone, 2017).

BACKGROUND

Nurses are considered to be knowledge workers in an independent discipline, rather than subservient to medicine (The Sentinel Watch, 2015). Despite efforts to flatten the hierarchical gradient between healthcare professionals, power differentials and deeply-ingrained patterns of respect in countries like Japan remain strong (The Sentinel Watch, 2015). These disparities due to hierarchy and status influence nurses' willingness to speak up when they have concerns about patient safety (Green et al., 2017).

The Chrysanthemum and the Sword ", one of the most influential texts on Japanese cultural norms, stated that "any attempt to understand the Japanese must begin with

their version of what it means to take one's proper station (Benedict, 1946, p.43). The author then described what she believed to be fundamental Japanese attitudes - an extreme awareness of hierarchy, respect, virtue, and duty; and "prescriptive rules of conduct and form that discourage differences" (Henshall, 1999: xix, 177). Even today, behaviors that acknowledge order and hierarchy are ingrained in Japanese people, and those with high status and lower status act in accordance with this convention.

Healthcare is complex and dynamic (Rouse, 2008), and within intradisciplinary and interdisciplinary professional relationships there are status differences (Green et al., 2017). In Japan, hierarchical structure is prominent (Tsuno, Kawakami, Knoue, & Abe, 2010), and the status of doctors is considerably higher than any other healthcare professionals'. Although the narrative in Japan is about team-based medicine, all patient care is legally required to be under the direction of doctors (Brandi & Naito, 2006). For this reason, communication can be unidirectional and problematic (Taylor Slingsby et al., 2006). Consequently, it is difficult for nurses to be assertive and speak up to doctors (Anzai, Douglas, & Bonner, 2014).

Position within the healthcare hierarchy also depends on gender and seniority (Green et al., 2017). The Japanese healthcare workplace is highly gendered; 80% of physicians are male (Japan Ministry of Health, Labour and Welfare, 2014) and 94% nurses female (Japanese Nursing Association, 2015). Japan has a significant gender gap for professional and technical workers, despite progress in reducing this gap in tertiary education enrolment and women's representation among legislators, senior officials, and managers, and in improving wage equality for similar work (World Economic Forum, 2016). International studies of conformity suggest that women are more likely to conform than men and more likely to attempt to accommodate than assert themselves (Bond & Smith, 1996). This dynamic can further detract from the willingness of Japanese nurses to communicate assertively.

Japanese people put significant emphasis on seniority. Unlike many other countries where positional hierarchy is unrelated to age (Almost, 2006), in Japan the oldest and longest-serving staff members tend to be the most senior and are afforded a great deal of respect with their opinions deferred to (Davies & Ikeno, 2002). However, the younger generation of healthcare staff tend to be less respectful of seniority (De Mente,

2011); this generation gap can negatively impact relationships between nurses from different generations. Additionally, in workplaces where generational differences exist, unstated assumptions, perspectives, and expectations can cause conflict (Almost, 2006).

Strict hierarchy in Japan also influences the cultural value of humility. The well-known proverb, “a rice plant’s ears grow ripe and hang low,” illustrates the expectation that virtuous people will humble themselves rather than being proud (Davies & Ikeno, 2002). Negotiations of any sort are avoided or offered indirectly and with great subtlety (Country watch, 2017). Although people from many Western countries tend to treat authority figures with a degree of scepticism, the Japanese defer to and do not question those in positions of authority (Davies & Ikeno, 2002; Singhal & Nagano, 1993).

Japan is also said to have a culture of shame (Haji) (Benedict, 1946), and because of this people often hesitate to clarify things they do not understand to avoid being humiliated. Senior healthcare professionals might also be reluctant to admit to mistakes because of fear of being shamed. Japanese people carefully consider whether they should ask questions, as it is said that those who say the least are considered the most credible. This is exemplified by the Japanese proverb “he who speaks has no knowledge and he who has knowledge does not speak” (Samovar & Porter, 2003). The culture of shame affects the confidence of less experienced staff to challenge power and hierarchy. Consequently, this contributes to bullying by those in positions of power (Brown, 2013). In Japan, workplace bullying is directly linked to hierarchy and is termed “power harassment” (Hsiao, 2015).

STUDY AIM

The aim of this paper was to profile the findings from a study that explored how cultural values influence Japanese nurses’ assertive communication behaviors and attitudes.

METHODS

Design

Face-to-face, semi-structured interviews were undertaken using open-ended and probing questions.

Ethical considerations

Ethical approval was sought and obtained from the University of Newcastle, Australia (H-2016-0092) and Yamaguchi University, Japan (368). Participation was voluntary, informed consent was ensured and confidentiality was maintained.

Data collection

Snowball sampling was used to recruit Japanese registered nurses. Interviews were conducted at a venue of the participant's choosing, generally at their workplaces or university.

Data analysis

Recorded interviews were transcribed, translated and analyzed by a native Japanese speaker, who also had sociolinguistic competence in English (Squires, 2008). Translation was confirmed by another bilingual language expert who is competent in both languages. Two researchers (MO, TES) independently undertook a directed content analysis with deductive category application (Hsieh & Shannon, 2005) using the recognized cultural codes in Japan (Davies & Ikeno, 2002; De Mente, 2011). We reported how each cultural factor influenced nurses' assertive communication through participants' words. An audit trail was provided by means of a reflective journal.

FINDINGS

Demographics

Twenty-three Japanese registered nurses (9 males and 14 females), aged between 21 to 60 years, and representing a variety of specialities, participated in interviews. They had between 1 and 21 years of nursing experience, including five who had held management positions.

Themes

Two distinct themes emerged over the categorized cultural factors that described the influence of cultural value on nurse's assertive communication behaviors. The themes were named: collectivism and hierarchy/power differentials. The latter theme was

represented by five categories: differences in professional status, gender imbalance, seniority/generation gap, bullying and humility/modesty.

1. Differences in professional status

Hierarchy is one of the most powerful inhibiting factors of assertive communication as participant 3 put it so precisely:

> *Hierarchy is a factor that makes us hesitate to speak up. [P3]*

There are several kinds of hierarchical issues based on professional status and seniority within the same profession. The majority of participants perceived differences in professional status to be an impediment to communicating assertively with doctors:

> *Doctors and nurses are still in a vertical relationship. I hear that a veteran nurse gives advice to a new intern in a university hospital, but I have the impression that it does not happen here most of the time. [P14]*

> *Even when talking to a doctor about something, I think that the nurse's position and the doctor's position are different…there is a thing (training) such as 'customer service' to use honorific words. [P18]*

> *I also appreciated what I was taught about the organization. For example, there is also a hierarchical relationship among doctors, this doctor is the senior doctor, and that doctor is the junior doctor, so the report first goes to the doctor with lower position…there were times when the most senior doctor said: "Why is a lower nurse reporting to me? Don't tell me such a thing". [P20]*

Some participants explained that this was because of how doctors are revered and considered to be the leaders of the Japanese healthcare system by both patients and nurses:

> *Patients feel that the doctor is at the top of the Japanese healthcare world, and this flow still remains even among nurses. It cannot be entirely equal. This makes it hard to say something while there is a hierarchical relationship. [P1]*

2. Seniority (senpai-kohai) / generation gap

The word 'senpai' (senior) nurse was frequently mentioned by younger participants, and they described how deeply this seniority-based hierarchy has been entrenched in Japanese society including the health workplace:

There may also be a seniority-based hierarchical relationship like the positions of the senior (senpai) and mine…I have grown up in a hierarchical relationship, in which seniors (senpai) are the first no matter what we do. If that is unique to Japan, it certainly may have influenced assertive [communication]. [P20]

We really learned the potential errors that must not repeated by watching and listening to our seniors …what a senior person told us was really like a class. [P1]

Some mentioned that it was so hard to speak up against senior nurses to the point of accepting their requests regardless of whether they are correct:

It is difficult to contradict what senior nurses say, so I accept everything they say even if I do not agree. [P3]

Older participants also spoke about perceived generational differences:

Nowadays, some among the "aunties" do not reprove or do not talk too strictly to the young newcomers. For example, many are of opinion that the nursing unit manager and assistant manager should get angrier with mistakes… it would be better to be stricter...but young ones lose their motivation and quit when bullied. [P6]

3. Gender imbalance

Gender imbalance was perceived by the participants to be another factor influencing assertive communication in Japan. Female participants, who had a traditional view of gender roles, were accustomed to treating men with the respect that they believed was due to them, and they felt that this also affected the way they spoke to male healthcare professionals:

Predominance of men over women [makes speaking up difficult]. [P5]

I am also an old-fashioned woman, I guess I treat men with due respect. Young people are not like that. They (both men and women) do the child rearing and work together. [P13]

4. Bullying (ijime)

Some participants candidly described experiences of being bullied, especially when they were the 'new face'; this made it impossible for them to communicate assertively:

People who I am not really good at talking to in hospitals are people who attack, people who attack me. Because there was also "new face" bullying, I surely draw a line (do not associate closely) with those who attack me. [P10]

Some participants described their observations that bullying affected the communication of not only bullied individual but also other team members:

When I was bullied, I could not say anything because of ceremonious politeness (being dreadfully afraid). I think that it is also the same with people around me who are watching it. I think that it will be impossible for them to say, "Now, now." I think that people around me find themselves not being able to say anything. [P23]

If the person in the higher post does it, no one can express their opinions, and it is hard for me to express my opinion, too. [P4]

5. Humility / Modesty

A number of participants described how the Japanese hierarchical society and cultural virtues of humility and modesty made speaking up almost impossible. They felt that expressing one's own opinion denies another person's opinion:

When I talked with the team where doctors and allied health professionals expressed their respective opinions…I found it difficult to speak up because I thought that I would have denied their opinions by expressing mine… in Japan, there is probably a mindset or culture that states that expressing your own opinion denies other's…therefore, I think it is hard to readily express my own opinion. I think that there is also the culture that accepting is beautiful, that is to accept the opinion of other party and make the best of it even if it is wrong. [P4]

Because of these deep-rooted values the participants believed that assertiveness was discouraged:

It's, how can I say this, a modest attitude, everyone, including me, does not want to overly self-assert themselves. [P16]

I think the [Japanese] value…to 'lower yourself one step' (humble yourself) prevents us from being assertive. [P10]

We can be somewhat reserved, or how should I put it? I think that it is nice to be considerate, but if we are too modest, we might feel that we cannot speak right now because they are too busy, or there are times when we cannot say anything even though we remain a bit worried and troubled about it. So, I think that it is a bit difficult to speak assertively there. [P9]

DISCUSSION

Japan's hierarchy has been a fundamental part of how they perceive ones' relation with others (Benedict, 1945). People communicate according to ones' position in this ladder and conservative healthcare is no exception. It is extremely difficult for novice nurses to speak up against this rigid order. The first step in empowering nurses to overcome barriers to assertiveness in healthcare is to understand why it remains so challenging. We identified how specific cultural attributes, values, and behaviours related to hierarchy and power differentials affect assertive communication in Japanese healthcare settings. Differences in professional status, gender imbalance, seniority/generation gap, bullying, and humility/modesty were then described and illustrated using the participants' words.

Differences in professional status

A number of the participants described the challenges of working in an environment where vertical relationships dominated and how this undermined their confidence in speaking to doctors. This finding is supported by a number of studies that emphasize how nurses' subservience to doctors damages effective teamwork and impacts patient safety (Green et al., 2017; Otsubo, Shimada, Morinaga, & Misawa, 2003; Tsujimura et al., 2016). Conversely, research by Brandi and Naito (2006 p.62) outlined how female nurse managers valued nursing empowerment and believed that there is a need to "raise the ability of the nurses to debate with the doctors in an equal footing".

Educational programs have been offered as an important strategy for improving communication and relationship between doctors and nurses (Nadzam, 2009; Rabøl, McPhail, Østergaard, Andersen, & Mogensen, 2012). This assertion is supported by a systematic review of assertiveness communication training programs, which concluded that the provision of support from organizational leaders was a critical success factor for these types of programs (Omura et al., 2017). This type of endorsement from those in authority emphasizes the shared commitment to improve patient safety and legitimize nurses' attempts to be assertive. Although the change of professional status at organizational and social levels might take time, an effective educational intervention to improve nurses' assertiveness could be an important step in the right direction to reduce communication difficulties.

Seniority (Senpai-Kohai) / Generation gap

The opinions of more senior nurses were highly valued by the less experienced participants in this study. It often prevented them from speaking up even if they strongly disagreed with the decisions that had been made. This finding is in accordance with previous research (Ohtsubo et al., 2003). This perspective is underpinned by the strict 'senpai-kohai' (senior-junior) relationships embedded in all educational experiences and sporting activities. For example, even when the age difference is as little as one year, senpai (senior) is allowed to "put on airs" with kohai (juniors) and kohai "are given the cold shoulder" unless they obey senpai (Davis & ikeno, 2002, p187). Senpai-Kohai relationships continue to be reinforced in workplaces including conservative healthcare settings. It is interesting to note that some of the participants felt that the importance of senpai-kohai relationships was beginning to wane, but that this was causing tensions between nurses from different generations. Other commentators have identified that while senior nurses still want to be respected and obeyed because of their years of experience, an emerging younger generation of nurses want to be paid more attention (Tolbize, 2008), and expect senior nurses' to be more generous with the provision of positive feedback and support (Anzai et al., 2014).

Gender imbalance

Female participants, including mature nurses, expressed difficulty in speaking up to male healthcare professionals. Gender imbalance is a long-standing issue that creates tensions between healthcare professionals (Hall, 2005). Unlike Western countries that tend to be more individualistic, Japan's collectivist culture negatively influences assertive behaviours, particularly by women (Cho, 2014). Added to this, the fact that Japanese women often feel subservient to men makes healthcare environments vulnerable to workplace conflict (Northam, 2009).

Bullying (ijime)

The prevalence of bullying in Japanese healthcare settings is estimated to be 7.5 - 9.7%, with verbal violence as high as 32.2 - 32.9% (Japanese Nurses Association, 2004), resulting in stress, anxiety, depression, and low job satisfaction (Northam, 2009). The perpetrators of bullying are often nurses in management positions (13.8-16.3%). Although open communication and information sharing were frequently

reported as important countermeasures to bullying (Japanese Nurses Association, 2004), Japanese cultural expectations prohibit nurses from “honestly and candidly expressing themselves, as they are required to suppress their individuality in most professional and public situations” (De Mente, 2011, p.26).

Humility/modesty

The Japanese cultural value of lowering oneself to be one step below others presents an impediment to assertive communication. The participants in this study believed that assertiveness is directly opposed to humility and modesty - virtues that are highly regarded in Japanese society. Added to this is the highly-attuned awareness of how one’s actions affect group dynamics, and the playing down of personal achievements to maintain humility (Rutledge, 2011). As the well-known Japanese proverb goes, “The nail that sticks out gets hammered down”; therefore, it was not surprising that many of the participants felt it was very difficult to speak up. Previous studies provide further insights into this challenge, with examples of senior nurses viewing novice nurses’ assertive communication as inappropriately aggressive, leading to tensions in the workplace (Suzuki et al., 2006). From the perspective of the study participants, these cultural norms present a major barrier to assertive communication, especially to senior staff. These views might be similar to other countries where Confucianism exists (Davies & Ikeno, 2002).

Implications for research and practice

Due to an entrenched hierarchy and the virtues of humility and modesty, direct expressions of assertiveness might not be well accepted or adopted in Japanese healthcare settings. Educational interventions designed to increase nurses’ assertiveness must take into consideration the cultural complexities of power relationships and the potential impact on patient safety.

Limitations

Participants in this study were recruited from two prefectures, away from Japanese capital cities where people may be more assertive. Whilst Japan has a relatively homogeneous culture, it is likely that country areas might be more conservative and hierarchy and tradition seen as more important. Undoubtedly, nurses’ perceptions will be influenced by the cultures of institutions and units in which they are working.

CONCLUSION

This paper explored nurses' perceptions of cultural attributes and values that impact on their assertive communication in their daily practice. These values included differences in professional status, gender imbalance, seniority/generation gap, bullying, and humility/modesty. These findings may be useful for researchers and policymakers with an interest in the impact of endeavouring to reduce hierarchy as well as those planning to teach assertiveness skills in South East Asian countries where educational and healthcare systems are markedly hierarchical.

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AUTHOR CONTRIBUTIONS

Study design: M.O., T.E.S., and T.L-J.
Data collection: M.O. and T.E.S.
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