ESP Assertiveness and Communication Training for Japanese Nursing Students to Work in Australia

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Table of Contents

Introduction……………………………………………………………………………………1

Literature Review……………………………………………………………………...……..…..3

English Language for Medical Professionals…………………………………...…..…3

Nursing……………………………………..……………....………………...…..…4

Nursing in Japan…………………………………………………...……........5

Migration…………………………………………………….........................7

Transition Programs…………………………………………………………….…..8

Communication in Nursing………………………………………………………......…11

Importance of Communication in the Medical Field ……………………….…..12

Patient-Centered Care……………………………………………...….....…12

Empathy in Patient-Centered Care……………………...…………...…14

Patient-Centered Communication………………………………………….……15

Benefits of Patient-Centered Communication………………………….....16

Need for an Individual Approach……………………...……………..20

Assertiveness in Nursing………………………………………………………..........21

Importance of Assertiveness in the Medical Field………..……………………..22

English in Migrant Nurses Working in Australia……………………………………......23

Communicative Issues in Nursing……………………………………..………………...24

Assertiveness Issues in Nursing…………………………………………………..….……28

Assertiveness Issues in Japanese Nurses………………………………….………....29

Reasons for Assertiveness Issues in Japanese Nurses………...…………...30

English Language Issues in Migrant Nurses Working in Australia……………….……...….33

English Language Issues in Japanese Nurses……………………...……....35

Communication Training……………………………………...…………….....……..36

Assertiveness Training……………………………………………………………….……..37

English Language Training………………………………….……………………..40

Reasons for Low Language Proficiency Related to University Entrance Exams.…40

Reasons for Low Language Proficiency Related to Teacher Training and Proficiency……………………………………………………………………41

English for Specific Purposes…………………………………………………..........…42

Definition……………………………………………………………………….……44

Classification……………………………………………..…………..…………47
Historical Development……………………………………...…….…………48
Early stages……………………………………..…………………50
Register Analysis……………………………………………………….51
Rhetoric and Discourse Analysis……………………………...………..52
Skills and Strategies…………………………...…………………………..53
Learner's needs…………………………………………………………54
Learner-centered approach………………………….……………….....54
Current State……………………………………………………..…...54
Issues with Assertiveness, Communication, and English Language Training…………….54
Educational Implications…………………………………………………….…….…….56
Recommendations for an ESP course……………………………………....….….56
Creative Writing……………………………………...……………………60
Recommendations for Further Research………………………………………………...64
Conclusion………………………………………………………………………….…65
References…………………………………………………………………………..67
Appendix A…………………………………………………………………...……101
Appendix B…………………………………………………………………...…..……102
Appendix C………………………………………………………………………………103

Abstract

The extensive literature review briefly introduces nursing and nursing migration procedures and training with a focus on Japanese nurses working in Australia. The paper focuses on the three main issues Japanese nurses face when working in Australia. Nurses lack assertiveness and face difficulties when communicating with patients and colleagues working in an English-speaking country. Patient-centered communication skills, assertiveness, and English language fluency are essential for medical professionals for safe and efficient health care provision. Nurses worldwide, and especially foreign nurses working in Australia, however, exhibit insufficient assertiveness and poor patient-centered communication and English language skills. Research shows that training in assertiveness and patient-centered communication skills is generally effective, however, training often occurs post-graduation and fails to address the learner's culture and past experiences, which makes training ineffective. Researchers maintain that addressing Japanese nurses' culture in communication and assertiveness training is especially necessary. In addition, despite having received English language training since elementary school, currently nursing students in Japan lack efficient communication skills, and foreign nurses in general lack fluency. The reasons Japanese nurses face such difficulties lie with the English language education system in Japan, which does not focus on developing learners' communicative language abilities. The paper suggests Japanese nursing students preparing to work in Australia would benefit from an English for Specific Purposes (ESP) course which addresses all three issues related to English language abilities, communication, and assertiveness at once, since a review of the literature showed the three skills are interconnected. The course should also address the nurses' culture and should be conducted during the nurse's undergraduate study. After introducing the nature and historical development of ESP, a suggestion is made that aside from role-play and modeling activities and discussions which have proven to be

effective in Patient-centered communication and assertiveness training, all three issues described above can be addressed through creative writing.

ESP Assertiveness and Communication Training for Japanese Nursing Students to Work in Australia

Introduction

Globalization has led to travel for pleasure and business to become more widespread worldwide. With globalization, the English language has also spread as a lingua franca, most often used by individuals who studied English as a second or a foreign language, as opposed to native speakers (Crystal, 2012). Learning English is especially important for individuals who work with travelers on a daily basis, such as hotel receptionists or tour guides, and for individuals who travel abroad to practice a certain profession. English language proficiency can allow individuals to communicate freely even in countries where English is not an official language. However, English is especially important to be taught to workers who intend to migrate to a country where English is spoken by the majority of the population, especially when an individual's profession requires frequent communication with the local population. Professions related to healthcare provision in particular have historically been associated with mobility, and currently nursing migration is considered as both the cause and the solution for the global shortage of trained healthcare professionals. Nurses tend to migrate in search of better wages and working conditions, with English-speaking countries such as New Zealand, the United Kingdom, Canada, the United States, and Australia being some of the most desirable destinations. These developed countries view foreign nurses as a means to deal with the demographic issue of aging patients and medical professionals. According to Buchan and Sochalski (2004), in 2002 more than half of the newly registered nurses in the United Kingdom were born and trained outside of the country, and Kingma (2018) states that foreign-trained nurses represent a quarter of all registered nurses in Canada, the United States and Australia. The foreign-trained nurses can be viewed as not only highly-skilled medical professionals

or immigrants, but in many cases, foreign nurses are also learners of English as a second or a foreign language, who now work in an English-speaking country.

In Australia in particular foreign nurses play an essential role in adequate healthcare provision. Research shows that foreign nurses represent a quarter of the country's entire healthcare workforce (Ohr, Parker, Jeong, & Joyce, 2009). The demand for Overseas Qualified Nurses (OQN) in Australia presents an opportunity for foreign nurses to pursue a career abroad, but when transitioning from one language and cultural context to another, nurses face numerous challenges. Japanese nurses in particular who aim to work in Australia face three main challenges, mainly communication skills, assertiveness, and English language proficiency. Language proficiency can be defined as the degree to which an individual can use and comprehend a language (Richards & Schmidt, 2013). Emmons and Alberti, two of the leading researchers in the field of assertiveness training, define assertiveness as a way of communication through which someone can confidently express feelings and ideas in a respectful matter (2008) and the Australian Department of Health describes assertiveness as behavior midway between passive and aggressive (Assertive communication, n.d.). Communication skills include knowledge on and ability to utilize grammatical, strategic, and sociolinguistic competencies properly and appropriately (Richards & Schmidt, 2013).

The literature on the topic shows that despite having undergone training, the foreign nurses' lack of assertiveness, communication, and English language skills can negatively affect patients and has, in some cases, led to casualties. Thus, research into the nature of the three skills, the training nursing students undergo, and reasons why such training can be unsuccessful, is important for preventing medical errors and adverse health effects. The current paper includes a literature review on assertiveness, communication, and English language skills in foreign nurses and issues related to the training in the three skills. Then, educational implications are discussed and an ESP course for

Japanese nurses preparing to work in Australia is proposed. Finally, the author makes recommendations for further research.

Literature Review

The current literature review aims to first briefly outline English language learning by nurses. Then, the nursing profession and migration processes in Australia are presented in order to provide background information on the various responsibilities nurses undertake worldwide, and the requirements and training involved in foreign nurses' entrance to the Australian workforce. Then, the importance of communication, assertiveness, and English language skills are discussed, as well as the problematic realization of the three skills among foreign nurses and Japanese nurses in particular in Australia. Finally, the means through which nurses are trained in those skills are presented. The author of the current literature review will then present an overview of the literature related to English for Specific Purposes (ESP) courses, specifically related to definition, classification, and historical development. Finally, findings related to reasons why training in communication, assertiveness, and English language skills in nurses may be unsuccessful are synthesized.

English Language for Medical Professionals

The English language is widely considered worldwide to be a lingua franca. English is considered necessary for successful communication not only for travelers and hospitality workers, but for scientists and university students as well (Barker, 2012; Burmistrova, Nukeshtayeva, & Kaktayev, 2017). Scientists and students engage in English language study in order to access valuable and contemporary information often only available in English and to be able to cooperate with colleagues worldwide. Globalization and the accompanying spread of the English language affects medical students and professionals as well. English language proficiency allows clinicians to access information related to current medical trends, cooperate with medical professionals within and

outside the borders of the country the clinicians operate in (Burmistrova, Nukeshtayeva, & Kaktayev, 2017), and is necessary for communications with patients and hospital staff, regardless of differences in language and culture (Burmistrova, Nukeshtayeva, & Kaktayev, 2017; Fumie, 2002). The ease of travel brings foreign patients to hospitals worldwide and English is often the common language between the patient and the medical professional. Medical specialists such as doctors and nurses also travel to various countries in order to practice the medical profession and often need to learn English, as countries such as the USA, the UK, Canada, and Australia, where the majority of the population speaks English, employ a significant number of foreign-born medical professionals. Nursing especially is associated with mobility, so the need for nurses and nursing students to learn English is considerable.

Nursing

Access to quality medical care has been considered a basic human right since the publication of the 1946 World Health Organization (WHO) Constitution (World Health Organization, 2017). Currently, hospitals and clinics are the main centers of public health care provision and employ numerous different healthcare specialists. Doctors and surgeons are the first to come to mind, but the backbone of every medical facility are nurses (Birks, 2020). The nursing profession is highly valued around the world, as nursing care is an essential component of quality medical service. Nurses and midwives are often the only health care providers in the community, and the value and importance of the nurses and midwives' work inspired the World Health Assembly to designate the year of 2020 as the Year of the Nurse and the Midwife (World Health Organization, 2020a).

Half of all medical professionals worldwide are represented by 28 million nurses (World Health Organization, 2020b). Half of all healthcare professionals in the United States and Australia are nurses (Ohr, Parker, Jeong, & Joyce, 2009), which shows just how significant the nurses' role is in healthcare provision. Nurses are mainly responsible for administering medicine, monitoring and

documenting patients' condition, and informing and educating patients and the patients' families (Anonymous, 2019). Nurses act as mediators between the experiences of the patient and the doctor's proposal for a resolution, and spend more time with patients than doctors do (Coven, 2012). Coven added that nurses also connect with hospital visitors on a deeper emotional level and on a more frequent physical level than doctors do. Thus, nurses' responsibilities lie not only with providing physical care for the patients, but nurses also act as patient advocates and as medical professionals who educate and console the sick, injured, and terminally ill. For nurses to properly transfer information between all parties involved in a patient's treatment and condition, nurses require effective communication skills and high levels of assertiveness. The specific responsibilities nurses may have in terms of providing medical care and communicating with other healthcare professionals, patients, and families, however, may differ from country to country and nurses who migrate to work abroad face difficulties with acting assertively and communicating successfully in a foreign language. As the most preferred countries by migrant nurses include the USA, the UK, Canada, and Australia, foreign nurses often need to be trained not only in assertiveness and communication, but need to also be taught English.

Nursing in Japan. Nurses play a major role in the Japanese healthcare system as well. The number of registered nurses and assistant nurses in Japan in 2018 was a little over 1 500 000 ("Total Number of Registered Nurses", 2019) and in order to practice the medical profession, nurses in Japan need to graduate from high school and complete three years of basic nursing education. Midwives and public health nurses need to complete at least one additional year of study due to the increase of responsibilities and necessary levels of expertise when caring for and educating the public or providing postpartum care (Nursing in Japan, n.d.). Generally, Japanese nurses are responsible for reporting on changes in a patient's condition, observing the course of an illness and a patient's treatment, caring for patients, and providing support inside patients' home, which is especially necessary due to the growing population of elderly citizens in the country (Kajita, Hattori, &

Maruyama, 1998). However, nurses' practical and communicative responsibilities in Japan slightly differ from what is expected of nurses in other parts of the world.

The cultural nature of Japanese nursing practice, and by extension nursing education in Japan, has been researched by Tsujimura et al. (2016), who interviewed foreign-born nurses working in Japan about the nurses' perception of what sets nursing in Japan apart from nursing in the interviewees' home countries. In terms of nursing practice, the participants shared that Japanese nurses had more responsibilities compared to nurses in the US, Thailand, Korea, and Sweden. Nurses in Japan are taught and expected to measure vital signs, provide bed baths, toileting, and post-mortem care. Another difference between the US and Japan in particular, is that in a Japanese medical environment nurses encourage patients themselves to manage medication intake, while medication distribution is exclusively a nurse's responsibility in the US. At the same time, nurses in Japan are not expected to make personal judgments if any change in the amount or type of medication should occur and instead need to receive permission from a doctor first before implementing any changes in a patient's treatment, while nurses in the US have more freedom to make personal judgments.

Participants in Tsujimura et al.'s (2016) research also shared the existence of differences in the manner Japanese nurses communicated with patients and other health care providers in the workplace. A common sentiment was that in Japanese medical settings nurses were expected to sense and anticipate the patient's needs, without expecting patients to explicitly share said needs. When conversing with doctors and other nurses, non-verbal communication was also prevalent, a characteristic of Japanese culture described by Hisama (2001) and Omura, Stone, and Levett-Jones (2018a, 2018b). Korean participants were also surprised by the familiarity Japanese nurses treated elderly patients with, calling them by nicknames and speaking casually. Thus, the literature shows the presence of differences in nursing practice around the world, which may lead to difficulties for nurses, patients, and hospital staff when the nursing medical professionals migrate to work abroad.

Nurses may be taught communication strategies and protocols for clinical settings with a focus on dealing with hospital staff and patients who are most likely to reside in the nurse‘s country of training. When migrating, however, special attention needs to be paid to assertiveness, communication, and in the case of Japanese nurses migrating to Australia, English language training, as there are differences in practices and expectations of nurses in different countries.

Migration. Migration is a common phenomenon in the nursing profession, as currently numerous countries in the world are experiencing a significant lack of trained nursing professionals. According to a report by the World Health Organization (2020b), the world is in need of 6 million more nurses. Understaffing in hospitals is a global issue (Ohr, Parker, Jeong, & Joyce, 2009) with social, ethical, economic, and health implications (Kingma, 2018). Countries such as the Philippines and Ghana, for example, face an increasing shortage of nurses, as the medical professionals leaving the two countries in a year outnumber the nurses completing training (Buchan & Sochalski, 2004). The shortage of nurses forces hospitals to refuse treatment due to lack of staff, and has led to reported cases in Australia of patients being forced to stay in corridors for up to two days before being admitted, and calls for ambulance diversion are not uncommon in teaching hospitals (Kingma, 2018). To combat the issue with insufficient hospital staff, governments and hospitals have turned to hiring healthcare professionals from abroad.

Nursing has historically been accepted as an occupation that allows individuals to travel to different cities and countries to practice medicine. One in every 8 nurses employed currently were born or trained in a country different than the one the nurse is currently employed in (World Health Organization, 2020b). Currently, nurses most often leave South Africa, the Philippines, Zimbabwe, Nigeria, and India (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004), and world leaders in foreign nurse employment are Canada, the United Kingdom, the United States, and Australia. In 2009, foreign-educated (also foreign or foreign-born) nurses working in Australia were almost 18% of all registered nurses in the country (Australian Institute of Health and Welfare, 2009). In 2018,

however, the percentage of foreign nurses in all of the aforementioned countries, including Australia, rose to about 25% (Kingma, 2018), resulting in an even bigger diversification of Australia's medical workforce than the arrival of an unprecedented number of foreign-born nurses between 1996 and 2000 (Hawthorne, 2001). The high number of foreign nurses migrating to these countries raises the questions of the nurses' compatibility and adaptation to a new national healthcare system, language, culture, and nursing practices (Xu & He, 2012). To ease the adaptation process, some of these countries require foreign nurses to participate in transition or orientation programs before the medical professionals are allowed to work.

Transition Programs. The need for support for foreign nurses stepping into a new environment of practice has been widely recognized (Deegan & Simkin, 2010; Garling, 2008; New South Wales, 2012; Ohr, Holm, & Brazil, 2016; Sherman & Eggenberger, 2008; Zizzo & Xu 2009). The support comes in the forms of transition, orientation, or acculturation programs which, despite having different names in different countries, usually include introductions to each country's health care system, assessment of the nurses' clinical practical skills, as well as language and communication training (Allan, 2010; Boylston & Burnett, 2010; Davis, 2003; Ohr, Holm, & Brazil, 2016; Robinson, 2009; Ryan, 2003; Sherman & Eggenberger, 2008; Timilsina, Xiao, & Belan, 2014; Zizzo & Xu, 2009). The current literature review focuses on migration of Japanese nurses to Australia.

To receive permission to practice in Australia, foreign nurses need to meet several criteria regarding the nurses' education, experience, and language abilities, including participation in an orientation course. To work in Australia, nurses need to meet a certain set of criteria. Nurses must have graduated from an institution that provides proof of qualifications that are relevant to the position the nurse is applying for, and the qualifications need be to a large extent equivalent or based on analogous competencies to a qualification approved by Australia (NMBA, 2019). Most commonly the successful applicants include nurses who have graduated with a nursing diploma and top-up

degree in order to reach a bachelor's level of qualifications, or an associate degree in nursing (Emigrate to Australia as a Diploma Nurse, 2019). For Japanese nurses, a bachelor's degree in nursing is sufficient.

In terms of language abilities, unlike foreign nurses born in English-speaking countries such as New Zealand, Ireland, and the UK for instance, nurses for whom English is not the first language face an additional requirement in the form of mandatory testing of the nurses' English language skills (Hawthorne, 2001; Nursing and Midwifery Board of Australia (NMBA), 2019). While nurses whose first language is English need to only provide proof of spending a certain amount of years in an education facility where the medium of education was English, nurses who studied English as a second language need to pass a proficiency test (NMBA, 2019). These tests and the required minimum scores include the IELTS test with a minimum score of 7, as well as a minimum score of 7 on each separate component (speaking, listening, reading, and writing); the Occupational English Test with a minimum score of B in each component (speaking, listening, reading, and writing), the Pearson Language Test, Academic version, with a minimum score of 65 and a minimum score of 65 on each separate component (speaking, listening, reading, and writing), and the TOEFL iBT test with a minimum score of 94 and a score no lower than 23 for speaking, 24 for listening, 24 for reading, and 27 for writing. The requirement to pass a test with a specific minimal score is set in order for the nurses to demonstrate the necessary language skills to communicate effectively with patients and other medical staff (NMBA, 2019).

Until January 2020, Australia required OQNs to participate in transition programs in order for them to be registered and thus allowed to work in the country (Xu & He, 2012). The purpose of those privately-owned transition programs was to help educate OQNs about the health system in Australia and to verify that upon completion of the program nurses were competent to meet the Australian healthcare standards (ANMC, 2009). As of January 2020, however, the NMBA, which is in charge of accreditation of midwifery and nursing education, imposed a new, more efficient system

of assessment of OQNs, while still maintaining the set standards. The new system does not rely on multiple private transition programs and instead allows foreign-born nurses to follow a simpler set of steps in order to receive permission to work in the country. These standards aim to ensure public safety and maintain professional norms, and the steps require future OQNs to first provide identity verification, present proof that the nurse meets Australian requirements related to nursing education (described above), and are proficient in English at a certain level. In addition, nurses should have either completed 450 hours of practice in a clinical setting or can demonstrate abilities related to nursing care during a practical assessment in a program approved by the NMBA (NMBA, 2019; Xu & He, 2012).

The registration process for OQNs currently requires nurses to undergo Outcome-Based Assessment, which replaces the previously mandatory transition programs. Nurses first have to pass a computer-based multiple-choice exam. Upon successful completion of the exam, nurses are assessed on performance in a clinical setting, with the goal being to determine whether foreign nurses can demonstrate the skills, knowledge, and competence of Australian nurses in possession of a graduate degree. The third step before a successful registration is a mandatory orientation course, which includes three components. The first is an online segment aiming to introduce Australia and the country's healthcare system. The second component's purpose is to educate OQNs about Australian culture, and the final step of the orientation program is provided by the nurse's new employer, the contents of which follows guidelines provided by NMBA (NMBA, 2019). These guidelines may be equivalent to the ones provided for the transition programs, which include instruction related to medical documentation, supervision, leadership, and communication (Entry Programs for Internationally Qualified Registered Nurses, 2014). The exact standards for communication training provided by the NMBA are unknown, but some training in communication skills is required. In addition, assertiveness training, perhaps to address the leadership skills training, also seems to be included in some training programs for foreign nurses. However, the literature shows nurses, both

native to Australia and foreign-born, still show insufficient communication and assertiveness skills, despite those skills being part of some nurse-training courses and despite the proven importance of communication and assertiveness for quality health care provision.

Communication in Nursing

Communication is defined as "the exchange of information, thoughts and feelings among people using speech or other means" (Kourkouta & Papathanasiou, 2014, p.65). Sibiya (2018) adds that "the purpose of communication is to inquire, inform, persuade, entertain, request and investigate" (p. 20). Through communication, individuals can inform and influence others, and thus prompting a response to the message. Communication is widely considered to be an essential component of the nursing profession (Fakhr-Movahedi, Salsali, Negarandeh, & Rahnavard, 2011), as nursing requires not only theoretical and practical medical knowledge, but for successful completion of the nursing duties, nurses need to take part in dialogues with patients and families, and other healthcare professionals (Kourkouta & Papathanasiou, 2014).

Importance of communication in the medical field. An essential skill for medical staff is the ability to conduct patient-clinician communication effectively (Australian Commission on Safety and Quality in Health Care, 2016). Quality communication skills ensure the protection of both the medical professional and the patient, as these skills ensure the nursing responsibilities are executed consistently and accurately (Kourkouta & Papathanasiou, 2014). Nurses' responsibilities in relation to communication include listening to and addressing worries and inquiries from patients and the patients' families. In addition, nurses are responsible for transmitting messages to and from doctors about the nature of the patient's illness and possible and prescribed treatments, as well as discussing the condition of a patient with other medical professionals (Papagiannis, 2010). The nature of these communicative interactions can have a significant effect on patients' health and treatment outcomes (Sibiya, 2018). Communication between a patient and a medical specialist can have a significant

impact on both the patient's treatment inside the medical facility and outside, after the patient has been discharged (Australian Commission on Safety and Quality in Health Care, 2015; Weingart et al., 2011), and even small talk between nurses and patients has been discovered to be important by Macdonald (2016), who maintains that quality small talk leads to better outcomes for patients and also aids in reducing stress and anxiety level in patients and the patients' families. In order for a communicative act to have a positive effect on the listener in a medical setting, however, nurses need to follow specific guidelines.

Patient-centered care. For centuries, patient consultation interactions were dominated by the physician and patients rarely had an active role in the diagnostic and treatment process. Patient-centered care, however, allows patients to be active participants in the diagnostic and treatment processes (Epstein & Richards, 2011). A medical-setting communication style that is favored by numerous experts in the field is the patient-centered communication style, which is an integral component of patient-centered care (Berwick, 2009). Patient-centered care is promoted in medical education all over the world (Zandbelt, Smets, Oort, Godfried, & Haes, 2007) and The Institute of Medicine puts patient-centered treatment as one of six components of high-quality medical care (2001). The development of patient-centered care was rooted in the belief that patients are living beings deserving of respect, and the desire to treat patients on the patient‘s own terms (Epstein & Richard, 2011). Researchers and medical professionals who strongly support the practice of evidence-based medicine, or medical practices ruled by what current research deems to be the most suitable or effective, maintain that treatments based on the individual values and preferences of a patient are necessary for favorable clinical and affective outcomes (Guyatt, Montori, Deveraux, Schunemann, & Bhandari, 2011).

The focus in medicine has shifted from disease treatment to patient care, and the patients are now expected to play a bigger role in the diagnostic and treatment process. Patients and doctors are now viewed as partners, who share responsibility for the patients' physical and mental wellbeing

(Bensing, Verhaak, van Dulmen, & Visser, 2000). Bensing, Verhaak, van Dulmen, and Visser (2000) also maintain that one reason for the shift in responsibilities lies in the view that patients should be considered to be experts in the patient's own experiences and symptoms and thus medical professionals need to rely on the patient's story and account of the illness in order to better understand an individuals' reasons for visiting a medical facility. In 2010, the *Australian Safety and Quality Framework for Health Care* framework was endorsed by the Australian Health Ministry. The framework proposed three main dimensions necessary for quality and safe healthcare provision in the country, and patient-centered care is one of those dimensions. The framework proposes strategies and guidelines for the implementation of healthcare which takes into deep considerations the values, needs, and preferences of consumers and patients (Australian Commission on Safety and Quality in Health Care, 2011).

The Institute of Medicine characterizes patient-centered care as not only dependent on the healthcare system as a whole but on an individual medical practitioner's behavior and attitude (Committee on Quality of Health Care in America, 2001). Epstein and Street (2011) caution, however, that failure on a practitioner's side to understand the characteristics of patient-centered care may lead to unconvincing and trivial results. For example, the authors maintain that the desire to please a patient is not based on patient-centered practice. Medical professionals may suppose that the most reliable source of information about whether a certain interaction is patient-centered or not are the patients themselves. However, in some cases what patients want (such as a specific drug, test, or treatment) may not correlate with what the patient actually needs and the most optimal treatment for a patient may leave the ill or injured individual disappointed. Patient-centered care, if properly understood and practiced, does not come into a contradiction with proper medical care. Thus, successful implementation of patient-centered care may be difficult and training in patient-centered practices needs to address possible misunderstanding of the nature of patient-centered care. Another caution was expressed by the Australian Commission on Safety and Quality in Health Care (2011),

which questions whether procedures and guidelines aimed at improving patient-centered care which were developed and implemented in countries such as the US and the UK can be readily transferred to the Australian context, due to differences in the countries' healthcare systems. Thus, the commission proposes that patient-centered care needs to be specific for the Australian health care system and patient demographic in order for patients to benefit from patient-centered practices.

Empathy in patient-centered care. An important component of patient-centered care is empathy, the "capacity to understand and relate to the patient's illness experience and emotions" (Hashim, 2007, p. 32). Empathy is a process that allows individuals to better comprehend and react to the emotional state on another individual, which in turn improves compassionate behavior (Decety, Yang, & Chen, 2010; Harris, 2009; Neumann et al., 2009). Empathy is highly valued in the medical profession and empathetic communication skills are related with better health outcomes for patients (Hojat, Louis, Markham, Wender, & Rabinowitz, 2011; Kaptchuk et al., 2008; Kelly et al, 2009; Marci & Ress, 2005), increased patient satisfaction (Hickson et al., 2002), and patients are more likely to adhere to the prescribed treatment (Halpern, 2010).

Showing empathy is also an essential aspect of effective patient-clinician communication (Stewart, 2001), as empathetic behavior and communication aids the delivery of quality healthcare, improves the building of trust, and allows medical professionals to treat patients in a more humane manner. Empathetic communication leads to better satisfaction in patients (Australian Commission on Safety and Quality in Health Care, 2016) and can also aid in reducing patients anxiety (Bellet & Maloney, 1991; Wanzer, Booth-Butterfield, & Gruber, 2004), improving compliance (Beckman & Frankel, 1984), and doctor-patient relationships (Butler & Keller, 2001; Neuwirth, 1997; Spiro, 1992, Suchman, Markasis, Beckman, & Frankel, 1997). Positive effects of empathetic communication on medical professionals are decreased burnout and improvement in physical health (Krasner et al., 2009), fewer claims of malpractice (Hickson et al., 2002), and physicians tend to make fewer medical

errors (Brennan, Leape, & Laird, 1991). Empathy is essential for nurses who engage in patient-centered care and is an indispensable part of patient-centered communication.

Patient-centered communication. One of the major practices with significant value in medical care related to patient-centered care is patient-centered communication. Patient-centered communication has been defined as both a *trait*, meaning a style of medical practice, according to McWhinney (1995), and as a *state,* meaning the exhibition of certain behaviors during an interaction (Roter et a., 1997). Epstein, Franks, and Shields (2005) define patient-centered communication as a moral philosophy that builds on the established biomedical approach to treatment by acknowledging and addressing the social context of treatment. Addressing the context of treatment occurs through inquiry into the patient's concerns, ideas, feelings, expectations, needs, and perspectives (Epstein & Street, 2007), and by helping the patients become more informed on the illness and more involved in the decision-making process (McWhinney, 1995; Mead & Bower, 2002). Patient-centered communication began to be frequently incorporated in medical settings after the year 2001, when the Institute of Medicine proclaimed medical care needed to be oriented toward the patient's values (Committee on Quality of Health Care in America, 2001).

Patient-centered communication involves medical personnel engaging in various practices. For instance, patient-centered communication requires nurses to refrain from interrupting (Marvel, Epstein, Flowers, & Beckman, 1999), encourages nurses and clinicians to ask open-ended questions, to elicit all required information from the patients, confirm what has been heard, and encourage the patients to share all that concerns them (Heritage, Robinson, Elliott, Beckett, & Wilkes, 2007). In addition, successful clinician-patient communicative interactions, according to King and Hoppe (2013), need to include repetition, the medical professional needs to use language easily understood by the patient – uncomplicated, specific, and with minimal medical jargon, and the clinician needs to check if the patient or the patient's family have understood correctly. Additional aspects of patient-centered communication include the medical professionals speaking clearly and empathetically,

actively listening to the patients, and engaging in proper introductions with the patients (Wanzer, Booth-Butterfield, & Gruber, 2004). Wanzer, Booth-Butterfield, and Gruber (2004) maintain that empathy, listening skills, appropriate and timely introductions and other communicative aspects related to patient-centered care are an especially important part of a nurse's role, as nurses are often the first to be involved in patient interactions and consultations. Research shows patient-centered communication can have numerous positive effects for patients, clinicians, and medical facilities alike.

Benefits of patient-centered communication. Patient-centered communication can have numerous positive effects on an affective and physical level. Researchers maintain that even the affective positive effects on a patient – the patient feeling heard, respected, informed, and engaged, are a sufficient reason for medical professionals to opt for a more patient-centered communication style, as patients will feel less anxious about the diagnostic and treatment process (Arora, Weaver, Clayman, Oakley-Girvan, & Potosky, 2009). One positive effect of patient-centered communication is indeed reduced levels of anxiety and uncertainty in patients. A communicative patient-centered act as simple as a greeting can be beneficial. Patients tend to come into contact with numerous medical personnel in clinics and hospitals, so, according to Heery (2000), a patients' initial anxiety related to uncertainty about the diagnosis and the cost and nature of possible treatments can be significantly reduced if all medical personnel who patients come in contact with introduce themselves and explains the role the medical personnel plays in the patient‘s treatment. In addition, according to the Australian Commission on Safety and Quality in Health Care (2016), some steps doctors and nurses can take to make the patients feel more comfortable and safe and to help build trusting patient-clinician relationships is to clearly explain the time a certain treatment or procedure is going to take, and to engage in a two-way exchange of information. Clarity in patient-centered communication is also considered to be important in reducing uncertainty and alleviating patient anxiety (Wanzer, Booth-Butterfield, & Gruber, 2004). Chesebro and McCroskey (2001) compare doctor-patient

communication to the interactions in a classroom. The two authors maintain that when instructors express themselves clearly, students are less anxious and more motivated. Similarly, clear and direct communication in a medical setting can reduce misunderstandings and patient anxiety, and reduce uncertainty about the diagnostic and treatment process (Kreps & Thornton, 1992).

Other affective benefits from patient-centered communication for patients include increased patient satisfaction (King & Hoppe, 2013; Kinmoth, Woodcock, Griffin, Spiegal, & Campbell, 1998; Kinnersley, Stott, Peters, & Harvey, 1999; Rosenburg, Lussier, & Beaudoin, 1997; Williams, Weinman, & Dale, 1998) in patients who had previously shared feelings of worry when communicating with physicians (Zandbelt, Smets, Oort, Godfried, & de Haes, 2007) at the end of the doctor visit and during subsequent treatment (Beckman & Frankel, 1984). More specifically, clinician behaviors related to patient satisfaction are categorized as task-oriented, which include active listening and provision of detailed information, and affective behaviors, which require the medical professional to exhibit empathy, and addressing the main concerns of the patient (Rowland-Morin & Carroll, 1990; Tallman et al., 2007). Eye contact, which is an important part of proper patient-centered communicative interactions, is also related to higher patient satisfaction (Roter, Frankel, Hall, & Sluyter, 2006). Mead and Bower (2002) also observe increased feelings of shared responsibility for and trust in the prescribed treatment.

Patient-centered communication skills have been associated with improved health outcomes in patients (Kaplan, Greenfield, & Ware, 1989, Maisiak, Austin, West, & Heck, 1996; Rao, Weinberger, & Kroenke, 2000; Rosenburg, Lussier, & Beaudoin, 1997; Stewart, 1995), including lower blood pressure levels, decreased frequency of headaches, improvement in symptoms of depression, and decreased distress in patients (Clever et al., 2006; Epstein, 2000; Fallowfield, Hall, Maguire, & Baum, 1990; Headache Study Group, 1986; Kaplan, Greenfield, & Ware, 1989; Kinmonth, Woodcock, Spiegal, & Campbell, 1998; Levinson, Lesser, & Epstein, 2010; Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001; McCormack et al., 2011; Mead & Bower, 2002; Ong, Haes,

Hoos, & Lammes, 1995; Orth et al., 1987; Rao, Anderson, Inui, & Frankel, 2007; Riccardi & Kurtz, 1983; Starfield et al., 1981; Stewart, 1995; Stewart, et al., 2000). Kreps and Thornton (1992) added that careful listening is also an important part of patient-centered communication and can lead to a reduced number of mistakes which can have a negative effect on a patient's health. Patient-centered communication has also been associated with better adherence to prescribed treatment (Rosenburg, Lussier, & Beaudoin, 1997; Safran et al, 1998), more effective prescription, and a higher rate of correct diagnosis (Griffin, et al., 2004). Information about a patient‘s understanding of the root of the illness, an important part of patient-centered communication, may also contribute to the final diagnosis (Hashim, 2017). Another benefit is observed by Epstein, Franks, and Fields (2005), who found a correlation between a reduction in diagnostic testing and patient-centered communication. Stewart et al. (2000) also observed that patient-centered communication on behalf of medical professionals leads to reduced diagnostic tests, an observation supported by (Barsky, 1981), and improved physical comfort in patients. In addition, patients who participated in patient-centered communication tend to be more compliant with the doctors' suggestions and advice (Clark & Becker, 1998; Falvo & Tippy, 1988). Patient-centered communication has also been associated with improved control of chronic disease (Mead & Bower, 2002; Stewart, et al., 1999; Kaplan, Greenfield, & Ware, 1989; Michie, Miles, & Weinman, 2003).

When clinicians fail to provide patients with the opportunity to share expectations of the treatment, the patient's symptoms may persist (Jackson, Kroenke, & Chamberlin, 1999; Kravitz, Callahan, Azari, Antonius, & Lewis, 1997; Kravitz, Cope, Bhrany, & Leake, 1994). Clinicians who tend to encourage the patients to speak, check for understanding of the doctor or nurses' explanations, and ask the patients for the patient's feelings and opinions have a lower number of malpractice claims (Hickson et al., 1994; Tamblyn et al., 2007). Aside from the numerous affective and medical benefits of patient-centered communication, patients themselves have expressed a preference for patient-centered communication. (Bendapudi, Berry, Frey, Parish, & Rayburn, 2006;

Little et al., 2001). However, clinicians, administrators, and clinical communication educators need to consider the context and individual preferences of each patient before engaging in patient-centered communication.

Need for an individual approach. Research shows patient-centered communication needs to match each patient's preference and particular context. A patient's willingness to engage in patient-centered communication can be influenced by numerous factors and medical professionals need to verify the patient's needs and preferences. Some patients prefer to take an active role in the diagnostic and treatment process, while other patients may prefer to take on a passive role (Australian Commission on Safety and Quality in Health Care, 2016). A patient's cultural background and past experiences can influence the preferred communication style (Morse, Clark, Haynes, & Noji, 2015). Swenson, Buell, Zettler, White, Ruston, and Lo (2004), for example, conducted a study to determine the preferred clinician-patient communication style amongst US citizens. The researchers discovered that patients over the age of 65 preferred a more direct approach, which confirms findings by Benbassat, Pilpel, and Tidhar, (1998), Krupat et al., (2000), McKinstry (2000), Parker et al. (2001), and Krupat, Bell, Kravitz, Thom, and Azari (2001).

The characteristics and behaviors associated with patient-centered communication are various and are closely related to the context of practice (Mcwhinney, 1995; Roter et al., 1997). Studies suggest that close-ended questions and direct speech on behalf of the clinicians lead to more accurate disclosure of information from patients when the subject of the conversation is more sensitive (for example, HIV prevention) (Floyd, Lang, Beine, & McCord, 1999; Gmel & Lokosha, 2000; Ivis, Bondy, & Adlaf, 1997). In addition, Cassell, Leon, and Kaufman (2001) maintain that while detailed sharing of information is a characteristic of patient-centered behavior that fosters a close doctor-patient relationship and eases decision making, in situations when a patient's condition severely deteriorates doctors may cease patient-centered communication. The reason for the doctor's

switch to a more direct communication style, according to Cassell, Leon, and Kaufman, is related to the higher likelihood that the patient will have a more favorable response.

Another issue related to the strict and constant following of behaviors considered to be typical or desirable in patient-centered communication was discussed by Odgen et al. (2002) and is related to trust between a patient and a physician. While the building and maintaining of a relationship based on trust between a patient and a medical professional is an integral part of successful patient-centered communication, in some cases the medical care provider's desire to be truthful and maintain the patient's trust may have a negative effect on the patients' overall medical experience. Odgen et al. maintain that if a physician shares with that patient that there are uncertainties regarding to the patient's condition or treatment, the patient may lose trust in the doctor. The question remains whether in such cases when the doctor was completely honest with the patient and provided all information available, the interaction was truly patient-centered when the trust between the two parties was broken. Thus, Epsein, Frank, and Fiscella (2005) maintain that the fundamental characteristics of patient-centered communication are not the specific behaviors of physicians need to follow, but a medical professional's ability to exhibit patient-centered behaviors in a flexible and responsible manner, depending on the context. Communication skills in clinicians and patient-centered communication are important for effective medical care and improving a patient's affective and physical state. Aside from communication skills, however, assertiveness is also an important trait for nurses.

Assertiveness in Nursing

As illustrated above, some of the nurses' responsibilities include the nurses acting as educators and patient advocates, two skills which require high levels of assertiveness. Alberti (1992) defines assertive behavior as an expression of the speaker's feelings and thoughts without denying the listener's rights. Alberti and Emmons similarly define assertiveness as an individual‘s genuine

expression of one‘s desires, needs, thoughts, and feelings, without detriment to other individuals' rights (Alberti & Emmons, 2008). Burnard (1992) adds that the ability to express one's needs and desires in a calm and clear manner is another characteristic of assertive behavior, and puts assertiveness in contrast with aggressive practices and behavior, such as arguing and shouting. Overall, assertive behavior and communication involve the speaker to confidently, calmly, and clearly express the speaker's feelings, thoughts, ideas, etc., in a manner that does not humiliate, undermine, or offend the listener.

Importance of assertiveness in the medical field. Assertiveness is a valuable characteristic in medical professionals, as medical professionals need to share, in a respectful manner, thoughts and worries regarding the condition, preferences, and care a patient is receiving. Assertive communication in a clinical setting includes nurses expressing concerns and thoughts about a patient's condition, or other issues related to the patient's care to other healthcare professionals, regardless of authority levels (McVanel & Morris, 2010; Omura, Maguire, Levett-Jones, & Stone, 2017). The expression of such concerns and opinions is usually aimed at other healthcare professionals, even those of higher status (Omura, Stone, Maguire, & Levett-Jones, 2018), but nurses may also need to exhibit assertive behavior in front of patients when giving instructions and directions, for example.

Assertive communication leads to numerous benefits in all areas of medical care. For instance, assertiveness is considered to be a style of interaction that is instrumental in strengthening prosperous relationships between nurses, patients, and other healthcare professionals (Mahmoud, Al-Kaladeh, & Abed Elrahman, 2013), as well as increasing job satisfaction (Yshinaga et al., 2018). Yoshinaga et al. also stress the importance of assertive communication in nursing in particular, as the researchers maintain assertiveness helps reduce the nurses' stress, and improves team dynamics and quality nursing care. In addition, Boone, King, Wahl, and Suh (2008) maintain that successful team

relationships are built on cooperation and assertiveness, and O'Mara (1995) states that lack of assertiveness in nurses can lead to unsuccessful interactions with patients.

Assertive communication is important not only for improving and maintaining successful professional relationships between medical staff and patients at a clinic or hospital, but also for improving patient care and safety (Deltsidou, 2009). Assertive communication is especially important for nurses, as opposed to doctors or other healthcare professionals, as assertiveness prevents medical errors and reduces the occurrences of risk situations. Nurses especially are to be encouraged to exhibit assertive behavior because nurses are in the position to observe early hints of issues and conditions which may have an effect on a patient's health (Manning, 2006; McVanel & Morris, 2010). Nurses worldwide need to exhibit assertive behavior in order to improve patient safety, but migrant nurses, especially nurses who migrate to Australia where the most widely spoken language is English, also need sufficient language proficiency.

English in Migrant Nurses Working in Australia

As expressed previously, a quarter of nurses in Australia were born or trained outside the country and for many of the foreign nurses, English is a foreign language. Nurses need to reach a certain language proficiency level approved by the NMBA. The minimum score of the IELTS test is 7, a score which educational institutions worldwide accept to be sufficient for students to successfully participate in courses (IELTS Academic, 2020). An individual who has a score of 7 on the IELTS exam is believed to be able to comprehend complex language overall, but some misunderstandings, inaccuracies, and inappropriate expressions may be present in language production (IELTS, 2020). Similarly, a minimum score of 94 on the TOEFL iBT test, which is more popular among Japanese language learners than IELTS, would mean an individual can use the language independently, but some lack of precision and nuance are present (EF SET, 2020). Foreign nurses in Australia are thus expected to be able to function independently in various situations, but

some misunderstandings and occasional difficulties are to be also expected. Japanese nursing students in particular are required to study English (Fumie, 2002), and the need for Japanese nurses to study English is increasing due to the growing number of foreign residents in the country. By reaching the minimal score required by the NMBA, foreign nurses should be able to successfully function in English in Australian medical settings.

Communicative Issues in Nursing

The sections above described the importance of effective communication and patient-centered communication skills for clinicians and nurses in particular. Despite communication being an integral part of the nursing profession (Audean, 1984), nurses seem to lack sufficient communication skills (Crotty, 1985, Faulkner & Maguire, 1994; Gott, 1982; O'Mara, 1995), which can have negative effects on both medical practitioners and patients. Nurses not properly trained in communication, for instance, may experience difficulties in separating the nurses' personal and professional lives (Panagopoulou & Benos, 2004). The issue related to proper communication skills is especially prevalent for foreign nurses due to differences in education, cultural and language backgrounds, and practical and communicative experience, which lead to difficulties when beginning work in a foreign country (Chun, Birks, & Mills, 2018; Li, Nie, & Li, 2014). The two main communicative settings clinicians and nurses face issues in are when communicating with patients and with other medical personnel.

While patient-centered communication is preferred by the majority of patients (Krupat, Bell, Kravitz, Thom, & Azari, 2001; Swenson et al., 2004), medical professionals tend to have a direct, biomedical approach to communication (Roter et al., 2004). Patients may consider insufficient sharing of information, lack of coordination in care, and lack of emotional support from doctors as serious of an issue as more traditional harmful medical errors (Mazor et al., 2012). Studies have also found a correlation between poor communication skills in medical professionals and negative

medical outcomes. For instance, research shows that doctors with a high number of malpractice claims have two times more complaints related to the doctor's communication skills, as opposed to doctors with a low number of malpractice claims (Hickson et al., 1994; Tamblyn et al., 2007). As recently as 2009, a major portion of the complaints made to commissioners dealing with health issues in Australia were related to the healthcare providers' manner and attitude towards the patients (Australian Commission on Safety and Quality in Health Care, 2009). Vincent, Young, and Philips (1994) maintain that such complaints mean that a physician or a nurses' failure to acknowledge and address a patients' emotional needs can be just as important as a failure to provide physical treatment. Medical professionals also often fail to establish an emotional connection with patients, an important characteristic of patient-centered care, by not recognizing the struggles patients are facing, and rarely approaching patients and the patients' families with empathy (Morris, 1998; Konner, 1993).

Patients often feel distress when visiting hospitals and clinics (Berkatis, Roter, & Putnam, 1991) and such distress and feelings of anxiety may be caused by a physician or nurse‘s lack of patient-centered communicative behavior. Researchers have found that physicians tend to overlook important aspects of patient-centered communication, such as providing detailed information to the patients, or giving the patients the opportunity to express themselves, for example. Such cases are described by Favlo and Tippy (1988), who found that half of the medical professionals the two authors observed did not provide the patients with information about the expected duration of the treatment, and almost 40% did not explain in detail to the patients what the prescribed amount of medication is. Beckman and Frankel (1984) also present similar findings, maintaining that physicians tended to interrupt the patients, without giving the patients an opportunity for self-expression and clarification.

Some medical errors are strictly related to training and practice. Lack of practice in drawing a patient‘s blood, for instance, can lead to mistakes during such medical procedures. Another major

responsibility for nurses, however, is related to communication, and quality and safe patient care can be achieved not only through effective communication between healthcare professionals and patients, but between also between clinicians themselves (Garling, 2008; Iedema, Piper, & Mandis, 2015; Nagpal et al., 2012). These vital interactions involve informing concerned parties about a patient's condition, medical history, and medication side effects, prescribed treatment, preferences, etc. Medical errors, which can often lead to distress, negative health outcomes, and inappropriateness of care provided to a patient (Jorm, White, & Kaneen, 2009; Thomas, Schultz, Hannaford, & Runicman, 2013), can often be attributed to communication errors (The Joint Commission, 2016), especially during handover, when the care for a patient is transferred from one medical expert to another (Australian Commission on Safety and Quality in Health Care, 2016). Such communication may be complicated due to common interruptions, time constraints brought about by emergency situations, and the wide variety of clinical settings in which communication is conducted (Johnson et al., 2017; Manias, Gertz, Williams, McGuiness, & Dooley, 2016). Eggins and Slade (2013) and Manias, et al. (2016), for instance, observed that interruptions during interactions between medical professionals can lead to disruptions of patient care, medical errors, and in some cases even fatal incidents. Aside from interruptions, other factors can also inhibit effective clinician communication, including hierarchical relationships within a clinic or hospital, differences in cultural backgrounds, unfamiliarity between members of a team, and differences in experience and education (O'Daniel & Rosenstein, 2008).

Miscommunication in particular is a major cause of medical errors (Benjamin, 2003). These errors include unnecessary hospital readmissions, delays or failure to provide treatment, the administration of incorrect medication, and requests for unnecessary tests and lead to a waste of resources and time, harm, and even death in patients (Jorm, White, & Kaneen, 2009). In 2008, for instance, poor communication between a nurse and a doctor lead to the death of a man in Australia (Jorm, White, & Kaneen, 2009). In Japan, miscommunication was determined to be the cause of 524

medical errors between the years of 2010 and 2017 (Japan Council of Quality Health Care, 2017). Such medical errors often remain undisclosed (O'Connor et al., 2010; Roehr, 2012), despite a key for future prevention of such errors being open communication, as understanding the cause of errors is crucial (Loewenbruck, Wach, Muller, Youngner, & Burant, 2016). Open communication, however, is often prevented by communication habits which value silence and hierarchical relationships within hospitals.

Poor individual communication skills unrelated to set hospital protocols or context also play a role in communication outcomes (Loewenbruck, Wach, Muller, Youngner, & Burant, 2016) and are often related to a doctor or nurses' cultural background (Kreuter & Mclure, 2004). Japanese nurses are no exception, as the nurses' culture is reflected in medical practice in Australia (Kishi, 2010). Behaviors influenced by cultural factors may, unfortunately, lead to the colleagues of foreign nurses to view the OQNs as incompetent (Deegan & Simkin, 2010; Gerrish & Griffiths, 2004; Holmes & Major, 2003; Phillip, Manis, & Woodward-Kron, 2015; Takeno, 2010). Thus, the literature shows that communication skills and patient-centered communication are favored and proven to have multiple benefits both for the patients and for the clinicians themselves. Research also shows, however, that nurses, including foreign-born nurses, lack sufficient communication skills, which leads to harm being inflicted on patients. Japanese nurses are no exception, as communication errors are prevalent in both the Japanese medical context and for Japanese nurses working in Australia. Unfortunately, lack of proper communication skills is not the only issue for nurses worldwide, as research shows that a lack of assertive behavior also leads to medical errors.

Assertiveness Issues in Nursing

As discussed previously, assertiveness is essential for medical professionals and failure to act or communicate assertively can lead to a deterioration of a patient's condition. For instance, an unfortunate case was recorded in Australia in which a lack of assertive behavior on behalf of medical

personnel led to the death of an infant (Warland, McKellar, & Diaz, 2014). Another case has been recorded in the United States, where a toddler passed away after a nurse, perhaps driven by exhaustion, turned off the alarms by the boy's bed. Although the primary cause can be attributed to a history of false alarms and overwork, Boynton, an instructor of communication in healthcare settings and a nurse consultant, maintains that had the nurse been more assertive in sharing concerns related to the equipment or feelings of overwork, the death of the child could have been avoided (Boynton, 2015). Other cases of medical errors caused by lack of assertiveness have been recorded in Denmark, where almost 25% of all communication errors were due to a medical professional's hesitance to speak up on behalf of a patient (Rabol et al., 2011). Foreign-born nurses working in Australia in particular express difficulty in communicating assertively (Tregunno, Peters, Campbell, & Gordon, 2009) which does not allow them to question or express workplace-related concerns, as is required by the guidelines for Australian professional practice (Holmes & Major, 2003; NMBA, 2016).

Lack of assertive behavior is a phenomenon common to nurses worldwide, the reasons for which have been widely discussed in the literature. Some researchers consider nursing to be a discipline subject to oppression (Farell, 2001) due to the majority of nurses being female, who have been traditionally encouraged to be complaisant assistants to doctors (Poroch & McIntosh, 1995; Slater, 1990) However, Farell adds that male nurses, who as of 2020 represent 10 percent of the nursing force worldwide (World Health Organization, 2020b) also feel discouraged to show assertiveness (2001). Healthcare professionals are reluctant to communicate freely and exhibit assertive behaviors due to the strict hierarchical nature of the relationships between healthcare professionals (Burnard, 1992; Gluyas, 2015; World Health Organization, 2012). Poorch and McIntosh (1995) add obstacles to assertive behavior such as a lack of self-esteem, concern with how the nurses will be perceived by others, more specifically fear of peer pressure and rejection from other medical staff, and a lack of understanding of what the nurses' professional and personal rights are. Even in cases with concerns for the safety and wellbeing of a patient, healthcare workers in the

lower hierarchical levels feel reluctant to voice any concerns (Green, Oeppen, Smith, & Brennan, 2017). Japanese nurses are no exception in terms of reluctance to exhibit assertive behavior.

Assertiveness issues in Japanese nurses. Research shows that medical professionals worldwide, including nurses, exhibit lack of assertive behavior, and nurses in Japan are no exception. The literature shows that Japanese nurses are not assertive (Kanade, 2018; Nakamura et al., 2017; Shimizu, Kubota, Mishima, & Nagata, 2004; Shimizu, Mizoue, Kubota, Mishima, & Nagata, 2003; Yoshinaga et al., 2018). Even in cases with concern about the safety of a patient, nurses in Japan are reluctant to act assertively in order to avoid challenging the listener (Omura, Stone, & Levett-Jones, 2018a). To further examine the issue with the Japanese nurses' reluctance to communicate assertively, Omura, Stone, Maguire, and Levett-Jones (2018) conducted a study aiming to determine Japanese nurses' opinions of and experiences with assertiveness. The results determined the Japanese nurses were aware of the advantages assertive communication can have, especially concerning the care and safety of the patients. The nurses shared concerns that lack of assertiveness can lead to feelings of worry, stress, and regret (Omura, Stone, Maguire, & Levett-Jones, 2018; Rainer, 2015; Suzuki et al., 2006). However, the 23 participants in the 2018 study also shared a belief that assertiveness can lead to arguments and can ultimately lead to deterioration in hospital staff relationships (Omura, Stone, Maguire, & Levett-Jones, 2018).

The real-life experiences of the nurses, however, were divided. While half of the participants shared experiences of feeling supported when speaking up in relation to a patient-safety issue, the other half expressed speaking up had led to the nurses feeling pressured and discouraged by senior hospital staff (Omura, Stone, Maguire, & Levett-Jones, 2018a). Novice nurses also experienced difficulty in speaking up due to fear of becoming a subject of bullying (Omura, Stone, Maguire, & Levett-Jones, 2018b). Although Japanese nurses express a wish to communicate more assertively to maintain patient safety, (Okutama et al., 2014; Omura, Stone, Maguire, & Levett-Jones, 2018; Schwappach & Gehring, 2014), obstacles seem to be lack of confidence, strategies, and assistance

(Okuyama, Wagner, & Bijen, 2014). Other reasons Japanese nurses may not be assertive can be traced to the country's deeply rooted socio-cultural norms, described in more detail below.

Reasons for assertiveness issues in Japanese nurses. Assertiveness in Japanese nurses has been attributed mainly to sociocultural factors. Japan is considered to have developed cultural values quite distinct from, and at times difficult to comprehend by, the rest of the world due to the country's isolation until the 1850s (De Mente, 2004). One such cultural feature of communication in Japan is the fact that non-verbal communication is highly valued, as listeners are often expected to extrapolate meaning from ambiguous and indirect messages (Goekler, 2010). The ambiguity of Japanese communication may be difficult to grasp by individuals more accustomed to more direct and blunt communication (Omura, Stone, & Levett-Jones, 2018a) and comes in opposition to the direct nature of assertive behavior. In a study published in 2018, Omura, Stone, and Levett-Jones (2018a) interviewed Japanese nurses regarding the nurses' perception of barriers to assertive behavior and discovered that the two main cultural factors which impede assertiveness are collectivism and strict hierarchical structures in the workplace.

Japan's society is considered to be highly collectivist (Cheng, Cheung, Chio, & Chan, 2013) as individuals are expected to conform to group norms (Abe & Henly, 2010). Group members may feel reluctant to speak up or openly state an opinion in an attempt to preserve the groups' harmony (Konishi, Yahiro, Ono, & Nakajima, 2007; Turale, Ito, & Nakao, 2008). The Japanese, influenced by collectivist social and cultural norms, tend to avoid conflict, and strive to protect and maintain group harmony. The needs of the group are considered more important than those of an individual (Goekler, 2010) and individual group members are expected to mimic the behavior of other group members (Rutledge, 2011), otherwise risking being viewed as selfish (Bramble, 2008; Naotsuka, 1996). These communicative characteristics are in contrast with assertive behavior (De Mente, 2004; Harumi, 2011), which requires speakers to clearly state personal feelings and opinions. In the Japanese context, asserting one's opinion may lead to offense being taken, or disruption of the team's

harmony, according to the nurses interviewed. Some nurses in the study shared that lack of confidence that the listener would agree has stopped them from expressing an opinion in the past. In addition, one of the participants in the study shared that had there been a role-model of assertive behavior, the nurse would have been more willing to speak up. These cultural norms affect nursing practice and education in Japan, despite influences from the West (Turale, Ito, & Nakao, 2008), and can impede nurses from speaking up on behalf of a patient in front of other medical staff, especially if the listener is in a position of power over the speaker.

Another aspect of collectivism that seems to stand in the way of assertive behavior is the nurses' reluctance to openly talk with members outside of the nurse's own group (such as a group of nurses from the same cohort, or who work in the same ward, or under the same supervisor). Outsiders, such as doctors, are considered difficult to communicate openly with. Nurses share that not knowing details about another person, such as personality traits or background, for example, inhibit open and assertive communication. Another communication aspect related to collectivism illustrated by Omura, Stone, and Levett-Jones (2018a) is the speaker's desire to prepare for speaking up in group meetings in advance by first speaking with future listeners individually. One nurse shared an experience of speaking with a doctor prior to a meeting, accompanied by a senior nurse. Before the meeting with the doctor, the nurse had already discussed the topic with other nurses and had had a preparatory meeting with the senior nurse. The need to thoroughly prepare before speaking up may have a negative effect on a patient's wellbeing in emergency situations.

The second cultural factor which inhibits nurses in Japan from asserting themselves in the workplace is hierarchy (Omura, Stone, & Levett-Jones, 2018a; Omura, Stone, & Levett-Jones, 2018b), as workers generally are expected to pay respect to those in senior positions (Green et al., 2017; Taylor Slingsby, Yamada, & Akabayashi, 2006; Tokuda, Walsh, & Stone, 2016). In Japanese hospitals, doctors are at the top of the hierarchical ladder (Tsuno, Kawakami, Inoue, & Abe, 2010) and legally the care of a patient is to be under a doctor's supervision (Brandi & Naito, 2006). Thus,

nurses tend to refrain from exhibiting assertive behavior and the interactions between doctors and nurses tend to be one-sided (Annzai, Douglas, & Bonner, 2014; Taylor Slingsby et al., 2006). Nurses in Japan are reluctant to show assertiveness not only in front of doctors, but to senior nurses as well, and Suzuki, Kanoya, Katsuki and Sato (2006) discovered that senior nurses perceive novice nurses' assertive behavior as hostile in cases when less experienced nurses behave assertively. Thus, nurses and less senior doctors tend to accept the opinions of those in authority without question (Davies & Ikeno, 2002; Singhal & Nagao, 19993). In addition, the concept of shame is a major part of Japanese society (Benedict, 1946), which leads to healthcare professionals being reluctant to admit to mistakes to colleagues in fear of being humiliated, and less experienced nurses tend to not ask questions or request clarification in order not to be considered incompetent (Omura, Stone, & Levett-Jones, 2018).

Position on the hierarchical ladder in Japan, however, does not depend only on whether an individual is employed as a doctor or a nurse, but also on seniority and gender (Green et al., 2017). While numerous countries and institutions prioritize positional hierarchy, in Japan a major factor that determines an individual's hierarchical position is the individual's age (Almost, 2006). The most respected members of a team in Japan are the oldest ones, both in terms of actual age and in terms of years served at a certain position (Davies & Ikeno, 2002). While the younger generations seem to be less concerned with the issue of seniority, conflicts may occur between medical staff from different generations (De Mente, 2011). In 2018, 255 thousand of physicians registered in Japan were male and 72 thousand were female ("Total number registered physicians", 2019), meaning Japanese nurses were more likely to work under male doctors, making assertiveness even more difficult for nurses.

While interviewing Japanese nurses on the nurses' perception of assertiveness in the workplace, Omura, Stone, and Levett Jones (2018b) stated that nurses working in Japanese hospitals shared that due to the vertical relationship between nurses and doctors, communication was difficult. In addition, some participants shared that hierarchy between the doctors themselves needed to be

taken into consideration, as nurses were scolded by senior doctors if the nurses report directly to the highest-ranking doctor, instead of the lowest ranking one. Less experienced nurses were also less likely to speak up against a more senior nurses' request, even if the less experienced nurse disagreed with the request.

English Language Issues for Migrant Nurses

For many nurses who migrate to Australia, including Japanese nurses, English is a foreign language, and insufficient language proficiency can lead to issues and medical errors. The adaptation process of moving into a new working environment is especially challenging for nurses whose native language is not English, and failure to adapt to a new working environment presents a risk for the quality of the medical treatments and the safety of the patients (Davis & Nichols, 2002; Edwards & Davis, 2006; Hearnden, 2007; Shen et al., 2012; Takeno, 2010; Tregunno, Peters, Campbell, & Gordon, 2009; Xu, 2007; Xu, Gutierrez, & Kim, 2008). For foreign-born nurses working in Australia, Philip, Woodward-Kron, and Manias (2019) stress that language barriers are a factor that may negatively affect communication between medical professionals. Nurses who migrate to Australia face intercultural communication challenges, meaning communication between individuals from diverse language and cultural backgrounds (Roberts, 2008), when the nurses' native language is not English (Newton, Pillay, & Higginbottom, 2012; Xiao, Willis, & Jeffers, 2014). The issue is especially prevalent in Australia, where a quarter of the nurses were born or trained outside the country (Kingma, 2018). The language barriers for foreign nurses may include unfamiliar abbreviations in medical documents, accents, and unknown slang used by the nurses and doctors who come from various language and cultural backgrounds (Deegan & Simkin, 2010). Lack of fluency and communicative competency in English can be especially detrimental to successful communication and collaboration in medical settings (Lum, Bradley, Dowedoff, Kerekes, & Valeo, 2015; Magnusdottir, 2005; Xu & Davidhizar, 2004), and can often cause misunderstandings and

tension between colleagues (Jose, 2011; Ma, Quinn Griffin, Capitulo, & Fitzpatrick, 2010). In addition, OQNs may experience difficulties in initiating and maintaining a conversation due to insufficient vocabulary and lack of confidence (Lum et al., 2015; Philip, Manias, & Woodward-Kron, 2015).

Philip, Woodward-Kron, and Manias (2019) conducted a research on the workplace communication practices of foreign-born nurses working in Australia. The research participants were born and trained in India, the Philippines, and Nigeria. The research showed the OQNs' responses during conversations with other medical professionals were significantly shorter than the nurses who were born and trained in English-speaking countries, which required additional inquiries and clarifications, often at the expense of valuable time. On the other hand, when receiving information from other clinicians, OQNs often refrained from asking additional questions or requesting clarifications, either due to lack of confidence, or insufficient language abilities. Foreign nurses also tended to favor the use of close-ended questions.

Philip, Woodward-Kron, and Manias' research, similarly to Harris's 2009 research, showed significant variation in the nurses' communicative competence, despite all foreign-born nurses having passed language proficiency tests, which shows passing an English proficiency test is not a guarantee that a nurse can effectively communicate in English in medical settings. Despite Philip, Woodward-Kron, and Manias' research focusing on OQNs English language abilities, the authors also discovered a difference in the participants' levels of assertiveness. These differences, according to the researchers, may be attributed to past working experiences in English-speaking countries, which means Japanese nurses who have just graduated from university may not have the necessary experience to be neither fluent in English, nor assertive.

English language issues in Japanese nurses. Despite English language education being mandatory in nursing schools in Japan, the curriculum fails to meet the students' overall language needs, especially in terms of communication skills (Fumie, 2002). Fumie determined that over 95%

of nursing students find English necessary, regardless of whether a nursing student plans to work in Japan or abroad. According to Fumie, nursing students also maintain that speaking is the most important of the four English language skills to master. However, the majority of students are not confident in the students' language abilities and more than half of the participating nursing students in Fumie's research shared that the nurses are not confident enough to speak with patients in English. Fumie's research shows that Japanese students' poor English language abilities persist in tertiary education, despite the nurses having, often unsuccessfully, studied English since primary school.

With the rapid globalization of the economy, English language education in Japan has become a priority for the Ministry of Education, Culture, Sports, Science, and Technology (MEXT) (MEXT, 2015). Despite the efforts of the Ministry to employ practices and regulations aiming to develop the Japanese students' English language abilities, Japanese students' TOEFL scores are some of the lowest in Asia. Japan ranked 25th out of 30 Asian countries on the general TOEFL scores and was ranked last on speaking ability (Aoki, 2016). MEXT confirmed this tendency in a paper, according to which the weakest English language skills were related to speaking and writing among third-year upper secondary students in the country (2015), despite communication skills being the most important for Japanese students (Hosoki, 2011). Japanese nurses may face difficulty in reaching the required minimal score required by the NMBA and communicating fluently with patients and colleagues overseas.

Communication Training

Previous sections discussed the importance of proper communication in medical settings and difficulties medical professionals face in communicative clinical situations. Communication skills are considered necessary for the medical professionals to be prosperous when working in the medical field (Wikstrom & Sviden, 2011), but communication skills may be difficult for healthcare professionals to master (Sibiya, 2018). In order for physicians to engage in a less authoritative and

more patient-centered role, future medical professionals need to be trained to be more informative, empathetic, and mindful. Epstein and Richard (2011) maintain that such training will allow medical professionals to foster trusting and collaborative relationships and will engage with the patients with more empathy and solidarity. Doctors and nurses can be taught patient-centered communication skills (Baerheim et al., 2007; Fallowfield, Jenkins, Farewell, & Solis-Trapala, 2003; Levinson, Lesser, & Epstein, 2010; Lewin, Skea, Entwistle, Zwarenstein, & Dick, 200; Smith et al., 1998; Smith, Marshall, & Cohen-Cole, 1994; Yedidia, et al., 2003) and communication skills are taught as part of the curriculum of nursing programs in Australia, and the Australian Nursing and Midwifery Council (ANMC) considers communication training to be necessary for foreign nurses who wish to work in the country (ANMC, 2009).

Communication skills can be developed through modeling and practice in pairs or groups. Audean (2011), for example, shares that interpersonal communication skills can be improved through role-play and role modeling activities (1984), and Wilkstrom and Syden also discuss the widespread use of role-play activities, videos, and reflection for improving communication skills. After a review of the literature, King and Hoppe (2013) discovered the optimal functions of communication in medical settings (Appendix A), which educators can use when preparing materials and setting goals and objectives for a communicative course for medical professionals. Unfortunately, the communication-related issues described above show that nurses in both Japan and Australia need to be better trained in communication strategies to ensure the health and safety of the patients under the nurses' care. However, in order for nurses to be educated in patient-centered and intercultural communication, the nurses' cultural backgrounds and biases need to be taken into consideration in communicative training courses (Kreuter & Mclure, 2004; Tsujimura et al., 2016). Not only communicative training, but assertiveness training for nurses who intend to work abroad are also not entirely effective.

Assertiveness Training

Assertiveness is considered a vital skill for nurses to master (Kanade, 2018) and studies recommend assertiveness training to become a part of nursing education (Clinical Education & Training Institute, 2011; Thomas et al., 2007), especially in the early stages of the nurses' career, as the nurses themselves observe a lack of skills necessary for speaking up (Omura, Stone, Maguire, Levett-Jones, 2018). Training in assertiveness, for example, is part of the curriculum of some nursing schools in the United Kingdom and Ireland, but as of 2003 assertiveness training was not standardized and the hours spent on assertive communication training may vary (McGabe & Timmins, 2003). In Ireland during the whole course of nursing education, 6 hours of the 30 hours of communication training are dedicated to assertiveness (McGabe & Timmins, 2003). The two authors maintain training in assertiveness at the undergraduate level leads to improved skills in assertive practices in nurses when dealing with situations of oppression and patient communication (2003).

Assertiveness training in nurses worldwide has proven to be successful in positively influencing nurse’s self-reported levels of assertiveness. Training also leads to an improvement in the nurses’ self-esteem and reduction of feelings of stress and depression in the workplace (Shimizu, Kubota, Mishima, & Nagata, 2004; Shimizu, Mizoue, Kubota, Mishima, & Nagata, 2003). Kilkus (1993) conducted a study on nurses’ assertiveness using Rathus Assertiveness Schedule (RAS) and discovered that assertiveness levels were not influenced by clinical settings, gender, years of experience, or age. What did determine differences in assertiveness, however, was an experience with training in assertiveness in the past, as well as higher levels of education, with such nurses showing significantly higher levels of assertive behavior. Kilkus’ findings were supported by Freeman and Adams (1999), who conducted a similar study. According to another study by Poroch and McIntosh (1995), however, nurses in Ireland exhibited low assertiveness levels despite a third of them having received training in assertiveness. According to Poroch and McIntosh, the low

assertiveness levels are proof that training alone may not be sufficient and continuous support and incentives are also necessary in order to allow nurses to feel comfortable when speaking up.

The literature on the subject also shows that assertiveness in an individual can be improved through reflection, practice, role-play activities, and discussions on the topic (Burnard, 1992; Gijbels, 1993; Lin et. al., 2004; McGabe & Timmins, 2003; Warland, McKellar, & Diaz, 2014). One example of an assertiveness training seminar for nurses was described by McGabe and Timmins (2003). Lesson goals for the seminar included aiming for the students to understand the importance of exhibiting assertive behavior when making requests, notice the importance of non-verbal aspects of communication when being assertive, and understand situations when being assertive is appropriate. Some examples include maintaining proper eye contact, having a relaxed stance, smiling appropriately, and speaking bluntly and clearly. The seminar began with an exploration of the definition of assertiveness through group discussions, with an emphasis placed on the fact that assertiveness is not a personality trait, but a way of behaving which can be learned. Characteristics of non-verbal assertive communication were also discussed and demonstrated and nurses participating in the training also reflected on possible reasons an individual may wish, or may not be able to, exhibit assertive behavior. These reasons include stress, lack of self-confidence, or lack of role-models. In addition, through reflection, the trainees explored situations in which assertive behavior is desired or necessary, as well as benefits of assertiveness in the workplace.

Two assertiveness training courses for Japanese nurses have proven to be successful. One such two-month course included eight sessions during which nurses engaged in role-playing, brainstorming, and group discussions (Kanade, 2018). By the end of the course, the researcher claimed the participants had improved communication skills and self-esteem. Another course that lasted two days and included two 90-minute sessions in total resulted in long-term improvement in assertiveness among Japanese nurses (Nakamura et al., 2017). While self-reported improvement in assertiveness is a favorable outcome from both of the assertiveness training courses described above,

Nakamura et al. warn that whether the improved self-reported assertiveness can be related to enhancement in patient safety is not yet clear (Nakamura et al., 2017). Nevertheless, studies maintain that assertive communication is an important skill to be taught to nurses (Engin & Cam, 2006; Kanade, 2018; Meng, & Sullivan, 2011; Okuyama, Wagner, & Bijnen, 2014; Omura, Stone, Maguire, & Levett-Jones, 2018; Shimizu, Kubota, Mishima, & Nagata, 2004), especially since lack of assertiveness seems to be an issue for nurses in both Japan and Australia. Although often successful, researchers maintain that assertiveness training for Japanese nurses needs to be accommodated to the country's cultural norms, as relying on a method of training from a different culture without consideration of possible conflict of values may lead to the training being less effective (Davis, 1999; Hisima, 2001; Okuyama, Wagner, and Bijen, 2014).

English Language Training

English is a mandatory subject in Japanese nursing schools (Fumie, 2002), however, as seen in previous sections, nursing student's language abilities, especially in terms of communication, are insufficient. Weak communicative abilities and poor language proficiency in Japanese youth, in general, have pushed political figures, educators, and business representatives to call for change and improvement of the English language education curriculum (Butler, 2007), beginning with the youngest learners. Thus, the English language activity classes, causal classes for children of grades five and six which aim to encourage students to listen and speak English and which were optional in 2002, were made mandatory in 2011 (Mizuho, 2006). These classes are held once a week for 45 minutes as part of a curriculum aiming to develop intercultural understanding (McKenzie, 2010). The hours of vocabulary teaching were also increased (MEXT, 2008; Tahira, 2012). The lack of proficiency improvement, however, has pushed the ministry to propose further changes (Taihara, 2012). Thus, in 2020 the English language activity classes became a mandatory subject for fifth and sixth graders, which almost doubles the annual classroom hours spent on the language from 35 to 70

(MEXT, 2014; Mizuho, 2006). The English activity classes have become a mandatory part of the curriculum for students of grades three and four. These changes were implemented with the aim to improve the communicative abilities of Japanese students, but may not be enough as the lack of time allocated for practice is not the only issue.

Reasons for low language proficiency related to university entrance exams. Despite the Ministry of Education‘s efforts described above, two main factors still impede the communicative language proficiency development of Japanese students. First, language educators in Japan have been mainly focusing on reading, grammar, and translation skills (Hosoki, 2011). Language teachers realize the importance of the development of communicative abilities, however, instructors seem to prioritize grammar and reading-related activities in the classroom, believing these skills will be the most useful for students when taking the English language university entrance exams (Gorsuch, 2001; Hiramatsu, 2005). To address the issue, in 2006 a listening task became part of the Unified University Entrance Exam (Nishino & Watanabe, 2008). In addition, The National Center for University Entrance Examinations decided to accept students' scores on tests such as the Cambridge English Exams, TOEFL, IELTS, and other private English proficiency tests that include a speaking component (The National Center for University Entrance Examinations, 2017). These changes may encourage teachers in Japan to spend more time on communication activities, but another issue may halt drastic changes to students' proficiency.

Reasons for low language proficiency related to teacher training and proficiency. Not only students but English language instructors in Japan also demonstrate language proficiency that is lower than the prescribed guidelines proposed by MEXT (MEXT, 2015; Butler, 2004). A study conducted by Butler shows that more than 85% of teachers in Japan are not convinced the educators' language proficiency meets the criteria of a score of 550 on the TOEFL test, a goal set by the ministry (Butler, 2004). Another study conducted in 2006 confirms that less than half of the English language instructors meet this criterion (Nishino & Watanabe, 2008). The number of teachers

qualified to teach English is even lower for instructors of elementary school students, where a survey conducted by the ministry determined that 95% of the instructors were not licensed to teach English (as cited in Aoki, 2016). Butler warns that insufficient knowledge of the material can negatively influence the students' success (Butler, 2004).

Teacher training on English Language teaching methodology also poses an issue to effective instruction. A reason why teachers may not be entirely comfortable with teaching in a more communicative manner is that most instructors have been taught English through the grammar-translation method, making activities related to grammar and translation more convenient to conduct (Reesor, 2003). Language instructors seem to be insufficiently trained for communicative language teaching, especially after the rapid implementations of the changes in the curriculum described above (Wilkinson, 2015). In 2014 the Japanese government took the initiative to provide training for 1,000 English language instructors, who by 2018 would, in turn, be able to provide support for fellow teachers. 1,000 trainees, however, are considered insufficient since by 2020 Japan will need approximately 145,000 trained English teachers (Aoki, 2016). Thus, with insufficient teacher training and focus on communication in the language classroom, Japanese students exhibit low overall English language proficiency and the lowest speaking ability among 30 Asian countries. Still, Japanese nurses can achieve the desired score on specific NMBA approved language proficiency tests, but, as the research by Philip, Woodward-Kron, and Manias (2019) showed, additional practice and fluency development are necessary for successful communication in clinical settings. One way particular language skills, such as clinical or assertive communication skills and fluency, for example, can be addressed, is through an ESP course, which allows students with particular language-related needs to be taught language which will be necessary for the learner‘s career.

English for Specific Purposes

The following section will briefly discuss the nature of ESP and the historic development which lead to ESP’s current form. Often with constraints related to time and money, language instructors have to make well-thought-out and justified decisions related to the content presented in class. The teacher might opt not to focus on survival English when teaching teenagers in an EFL context, for instance, and will present the students with material closely related to the student‘s language goals, age, and interests. Even a General English (GE) syllabus takes into consideration the specific context of instruction. No matter the context, all language instructors and course designers must analyze the students’ needs. With ESP courses, however, the needs of the students might be narrower than the needs of students enrolled in GE classes (Holme, 1996). The line that separates GE and ESP courses may be blurred at times, as low proficiency students might require a great deal of GE education even in an ESP course (Barnard & Zemach, 2003). A clear difference between GE and ESP courses is related to the goals of course. GE courses usually focus on internal, linguistic goals aiming to develop reading competence or oral fluency, for example. ESP courses, on the other hand, deal with external goals linked with real-life use of the language outside of the classroom (Cook, 2002).

The main characteristics of ESP courses are the focus on practical language use, rather than memorization of vocabulary words and grammatical structures. The narrow focus of ESP education determines the position of ESP as a distinct part of English language education with “its own approaches to curriculum development, materials design, pedagogy, testing and research“ (Nunan, 2004 p.7). Enrolling students in an ESP as opposed to General English course has numerous advantages, according to Strevens (1988). These include increased motivation in students, class content focused on the needs of the learners, and thus more relevant, more time-efficient, and is more cost-effective. The content of an ESP course is often related to the communicative needs determined by the educational or occupational situation of the students (Dudley-Evans & St John, 1998), which

in turn makes the learning experience more meaningful, especially in cases with adult learners (Howatt & Widdowson, 2004). These needs may call for courses that focus on business English, English for hotel receptionists, English for Engineering students, and English for nurses, for example. A course designer may further narrow down the focus of an ESP course by relating the goals and objectives to the communicative needs of students about to work in a specific country, or even company. The communicative needs for nurses in one area may be different from the needs of nurses working in a different area based on patient demographics. For instance, depending on whether the nurses are employees in a city or a rural area, nurses in Australia may need different training in communication, as a higher number of indigenous people live in Australia's rural areas, which leads to a larger cultural and linguistic gap between the medical professionals and the patients (Amery, 2017). Such specific needs demonstrate the importance of ESP course development. Defining ESP is not that simple, however, and has been a subject of discussion.

Definition. The issue with defining ESP has been a subject of discussion for multiple researchers, and currently, four major definitions are used in the literature. The first major definition, built on previous works (Dudley-Evans & John, 2008), was proposed by Hutchinson and Waters in 1987, whose view of ESP is that educators are not required to use specialized materials or employ methodologies much different than those used in ELT. In other words, the two authors consider ESP to be an approach to language teaching, rather than a particular product. Hutchinson and Waters maintain that the root of ESP lies with the motive to study English. The reason or reasons to study a foreign language are closely related to the learning context, the learners themselves, and the language the students are required to master. This view puts the students' needs at the center of ESP. The need to study a foreign language, meaning the point which establishes the specific aspects of a language to be taught varies, and some examples include purposes related to work, or participation in a postgraduate course in a country with English-medium education, for instance.

Hutchinson and Waters do not limit themselves with describing some basic characteristics of what ESP is, but also choose to examine the issue with what ESP is not. The two authors propose three main points. The first is that ESP cannot be summarized as a way of teaching specialized varieties of the English language, as the language taught is not different from the “general” language. ESP rather deals with helping students navigate certain academic and occupational situations through the medium of English. The differences between the situations may lie in how typical to a certain context specialized vocabulary or grammatical forms are. Secondly, ESP does not only deal with teaching certain grammar and vocabulary, as the grammar and vocabulary typical for a certain context do not exist in a vacuum. Hutchinson and Waters make a point on the need for a distinction between the way speakers use language and the vast range of underlying skills and knowledge which allow them to do so. Finally, ESP does not require a specific methodology, which the authors define as teaching based on principles of efficient learning. Regardless of the content, the learning process is the same for students of General, Academic, and Occupational English, and thus does not require the instructor to teach through a specific methodology or to make use of specific materials.

Another definition of ESP was proposed by Strevens (1988), who divides the characteristics of ESP into two categories: absolute and variable. Two of the four absolute characteristics include the necessity for ESP courses and materials to meet the learners’ needs and that class content needs to be related to particular disciplines and occupations The remaining two absolute characteristics proposed by Strevens are that ESP course preparation involves analysis of discourse, which will be discussed in more detail below, and finally, ESP requires the language taught to be appropriate for the target occupation or discipline in terms of semantics, discourse, syntax, etc. The two variable characteristics Strevens proposes are that ESP may include the teaching of a restricted range of language skills, for example only reading or speaking, and that ESP may require a distinctive methodology.

Finally, in 1991 Robinson proposed a definition of ESP, in which again a major role was determined to be the learners' needs and, similarly to Strevens, she proposed two main criteria and several secondary characteristics. The two main criteria she discussed are the need for ESP courses to be directed by specific goals and that these goals need to be derived from an analysis of the students' needs. Some characteristics proposed by Robinson include that ESP courses are generally designed for adults with backgrounds in similar occupations and that the courses are usually limited in terms of time.

Some differences between two of the definitions are evident, as Hutchinson and Waters maintain that ESP does not require specialized methodology, while Strevens states that this may not always be the case. The issue with whether ESP is a unique approach to language teaching is also examined by in detail by Dudley-Evans and John (2008) in the authors' own definition of ESP. Dudley-Evans and John maintain, as Strevens does, that teachers of ESP courses often need to make use of methodologies different from the ones employed in general English language courses, especially when the course content is linked to a specific occupation (Dudley-Evans & St John, 2008). Dudley-Evans and St John view methodology as the way students and teachers interact with each other, which in ESP classes dealing with more specific content leads to the hierarchy between the students and the teacher being leveled. In such cases, language teachers are viewed as consultants of language, rather than teachers, and the instructors work alongside the students who may be more knowledgeable on the topic.

Dudley-Evans and John (2008) state that the definitions presented above may not be entirely correct. The researchers also maintain that s weakness of Strevens' and Robinson's definitions are the latter's focus on the content of ESP courses and homogeneity of the students. Both of these characteristics may lead to the false impression that ESP courses always focus on a specific subject content, while in some cases an ESP course may focus on language skills common to multiple disciplines in academia, for instance. Dudley-Evans and John, mirrored by Widdowson (1983)

maintain that instead of teaching skills specifically related to certain content, ESL educators may opt to present concepts and teach problem-solving skills common for a wider range of disciplines.

Dudley-Evans and John propose a definition of ESP, categorizing the characteristics into absolute and variable. The three absolute characteristics of ESP include the necessity of ESP to meet specific student needs, the fact the ESP employs activities and methodologies present in the discipline with which the discipline is associated with, and that these activities are carried out through appropriate genres and language skills. The variable characteristics are: ESP is most commonly designed for adult learners with intermediate or advanced command in English, can use methodologies different than those most commonly encountered in the teaching of general English, and finally, may be closely connected to certain disciplines.

The main contradiction in the definitions presented above is the researcher's view of teaching methodologies and whether or not these methodologies are unique in ESP. Strevens and Dudley-Evans and John claim that the student-teacher relationship may affect the teaching methodology, while Hutchinson and Waters maintain that no special materials or practices are necessary. Age and differences in levels of expertise in a particular subject matter may exist in all teaching situations, not only in ESP courses, but that does not necessitate drastic differences in teaching practices or student-teacher interaction protocols. Students' past experiences, interests, and needs should be taken into account in all language courses (Augusto-Navarro, 2015; Larouz & Kerouad, 2016), not only in ESP teaching situations, as a teacher may make adjustments in practices and ways of interaction on GE courses as well. The reasons and situations a learner may use the language may differ, but the language learning process is the same for both GE and ESP situations (Larouz & Kerouad, 2016).

A generalized definition of ESP based on the ones described above will include absolute and variable characteristics. The two absolute characteristics are: ESP is rooted on the learner's needs to learn a language, and the materials and content need to be based on an analysis of the target situation the learners are expected to use the language in. Variable characteristics include the possibility the

students to be taught a limited range of language skills, and students are usually adults or students in the tertiary stage of education. In addition, most often ESP courses deal with either language closely associated with specific academic or occupation fields, or the teaching of language skills and strategies common to a variety of specialist fields.

Classification. This section briefly illustrates the relationship between ESP and the rest of ELT. Hutchinson and Waters (1987) use the image of a tree (Appendix B) to illustrate the position of ESP in English language teaching (ELT). The roots of ELT are labeled as *learning* and *communication,* which the authors view as the basis of all *language teaching*, which in turn the authors visualize as the trunk of the tree of ELT. English language teaching is divided into three branches. One branch is teaching English as a Mother Tongue, which is divided into other branches that Hutchinson and Waters do not illustrate nor describe in detail. The other two branches are English as a Foreign Language (EFL), which is taught in countries where English is not spoken by the majority of the population, and English as a Second Language (ESL), which is taught in countries where English is widely used by the population. Hutchinson and Waters then divide ELT into ESP and GE. According to the authors, ESP is separate from GE, which is defined as English usually taught at or below secondary education, mainly to pass English proficiency exams. ESP, in turn, splits into EAP (English for Academic Purposes) and EOP (English for Occupational Purposes) (Dudley-Evans & John, 2008; Hutchinson & Waters, 1987), depending on whether the learners need the skills taught in the ESP course for academic purposes, or work. The three categories EAP and EOP fit into are English for Social Sciences, English for Business and Economics, and English for Science and Technology (EST) (Hutchinson & Waters, 1987).

Historical development. ***Early stages.*** The historical development of ESP cannot be considered a planned movement with clear distinctions between one phase and the next. In the Middle Ages, the use of French died out in England, which meant French became a language monolingual speakers of English had to purposefully learn. A popular method of language, especially

Latin, learning and teaching was through printed dialogues students had to learn by heart. One of the earliest examples of English language teaching material originates in 1415, in which a sample dialogue related to trade was used to provide learners with examples of different types of goods usually found in markets (Howatt & Widdowson, 2004). Such printed dialogues aimed at English travelers to France and merchants looking to expand the merchants'
business abroad were widely distributed, which shows that teaching English for learners with specific needs began long before the term ESP was used. Examples are provided by Howatt (1984), who maintains that business English was taught to refugees to England in the 16th century. The teaching of commercial English, according to Howatt, continued to develop into the 19th century when textbooks on business letter writing and commercial English were published.

Before the Second World War, knowledge of a second language was considered a sign of well-rounded education (Hutchinson & Waters, 1987). Latin language study was common in educated individuals, and attention was focused mainly on the teaching of children. However, some materials were still produced for adult learners with more specific needs, such as bilingual medical textbooks and dictionaries of technical and scientific terms (Howatt & Widdowson, 2004), and materials on French and English for travelers and merchants (Howatt & Widdowson, 2004).

After WWII, English began to emerge as a new international language of technology and commerce. The international expansion of economic, scientific, and technical activity in the 1950s and 1960s (Dudley-Evans & St John, 1998) created the demand for a common language. Because of the economic power held by the USA and some oil-rich countries and the increase of international students in Australia, the UK, and the USA meant more and more individuals were learning English. In the post-war world knowing English was not simply a sign of prestige, but was an important part of successful commercial and technological relationships between countries (Hutchinson & Waters, 1987). Learners now turned English not for prestige, but with a specific purpose – to read manuals, to sell products, to gain access to recent developments in various fields only available in English.

Another aspect of ESP development in the late 60s was the increased attention to the learner's needs and the learner's attitudes towards learning (Rodgers, 1969). The differences in needs and interests would influence the students' motivation and learning outcomes. Researchers theorized that providing students with materials from the students' specialist field would increase motivation and learning outcomes.

***Register analysis*.** The number of adult learners rose in the 60s and the demand for language teaching that meets the student's specific needs was in high demand (Howatt and Widdowson, 2004). During the 60s ESP began to be developed as a discipline under various influences, the first among which was register analysis, or the analysis of grammar in scientific texts. (Dudley-Evans & John, 1998). Scientific, medical, engineering, and other similar texts underwent linguistic analysis, the result of which were used for the development of syllabi and teaching materials (Howatt & Widdowson, 2004). The true beginning of ESP as a discipline, according to Swales (1988), was Barber's 1962 work on the grammatical features of scientific texts. The most widespread view of the time was that to teach language that meets the specific needs of a student, an analysis of the linguistic characteristics of target scientific or occupational fields was necessary (Dudley-Evans & St John, 1998). In the 1960s when the view that written and spoken language varies depending on the context became more popular and language educators and researchers started to view the difference between, say, medical and commercial English as more important (Hutchinson & Waters, 1987).

The work in that time was focused on the creation of dictionaries of technical and scientific terms. More specifically, language educators and researchers worked on differentiating between semi-technical (terms such as analyze, substance, and device) and specialized technical terms. During that period, the relationship between the content instructor and the language teacher also became a subject of discussion (Howatt & Widdiwson, 2004). Strevens, Ewer, and Swales (Howatt & Widdowson, 2004), dedicated time and effort in the late 1960s and early 70s to register analysis and determined that the only features which made the English used in scientific texts different from the

English used in other fields were the more frequent appearances of passive voice, nominal compounds, conditionals, and the present simple tense. These grammatical features are of course present in general English as well but are favored by authors of scientific texts. Syllabi which aim to teach scientific English focused on these features, as the learners were more likely to encounter and use them, thus making the learning more meaningful and relevant (Howatt & Widdowson, 2004). Barber and other researchers interested in register analysis focused on the types of grammatical patterns often used in scientific texts, but failed to explain as to why these patterns were favored over others. In addition, the analysis was focused on the sentence level and did not deal with the way sentences connected into paragraphs and texts (Dudley-Evans & St John, 1998). An interesting development in ESP is that currently, ESP course design relies on a modern version of Bramble's register analysis, in which an analysis of written and spoken discourse is performed through concordance programs (Dudley-Evans & St John, 1998).

***Rhetoric and discourse analysis*.** The next phase of development of ESP is characterized by analysis of discourse as opposed to register, when the idea of relating language form to language use was first introduced. While Barber is considered the pioneer of register analysis, discourse analysis was first proposed and developed by Selinker and Trimble in 1973. The two researchers discuss the process a writer goes through when writing a text and the way a writer organizes a scientific piece of writing. Selinker and Trimble determined four levels of organization. The first level includes the goals of the discourse and the next level includes the overall rhetorical functions which lead to the development of the texts' goals. The third level of organization includes the specific functions which comprise the general ones, and finally, Selinker and Trimble discuss the techniques that deal with the relationships with the functions from the 3rd level.

The development of discourse analysis was led by Allen and Widdowson, who in 1974 stated that difficulties faced by students do not stem from lack of understanding of English grammar, but from unawareness of English use, which can be addressed through an understanding of the

sentences' role in the performance of communicative acts (Howatt & Widdowson, 2004). Howatt and Widdowson also share that at the time researchers set out to determine the organizational patterns of texts and the features that signaled the patterns, which became the basis of ESP syllabi. In these ESP courses, students were mainly supposed to focus on recognizing textual patterns through diagramming exercises.

Aside from the development of discourse analysis, the late 60s and early 70s were characterized by the use of materials and teaching which mainly dealt with written language. The product approach was also prominent, as students were required to learn set phrases and learned through copying models (Dudley-Evans & John, 1998). The greatest expansion of research into specific varieties of English was in the 1970s, when researchers published numerous works on the nature of scientific and technical English. So much attention was paid to the characteristics of English used in the scientific fields that, according to Hutchinson and Waters, English for Science and Technology (EST) and ESP were used almost interchangeably (1987).

Skills and strategies. The next stage of ESP development dealt with research not into language itself, but into the thought processes tied to language use – the strategies and skills students employ when dealing with the language. The beginning of the 1970s was a time when universities began to establish language centers and institutes to assist international students with the students' academic English language skills. Also, courses focusing on strategies were set up in situations in countries where English was not an official or widespread language and where students had to rely on specialist materials in English. Certain types of materials developed in and for these language centers or institutes managed to enter the wider market, due to the dealing with broader academic, or so-called study and skill-related content (Howatt & Widdowson, 2004). These skills dealt with issues related to comprehension of lectures, taking notes during class, writing essays, and employing a range of reading strategies, such as scanning and skimming. The focus was set on interpretive strategies, not on surface language forms. Guessing a word's meaning from context, making use of

cognates, and relying on the visual layout of the text to determine the text's type are some examples of strategies taught under the understanding that reading strategies are universal and not necessarily subject and language-specific (Chitravelu, 1980).

Learners' needs. After register and discourse analysis, the third phase of ESP development came in the late 1970 and early 80s, which put the students' needs in the center of ESP course design. During this stage, the existing knowledge on ESP was set on a more scientific basis. Procedures were developed which aimed to assist language instructors and researchers in relating the language analysis to the students' needs. Learners were enrolled in an ESP course with the expectations the course would enable them to function successfully in a specific target situation, and naturally, researchers turned to analyzing the linguistic features of the target situation, which formed ESP courses' syllabi. The term *target situation* analysis was proposed by Chambers (1980) to describe this process.

Parallel to the spread of popularity of teaching strategies to students, and performing analysis of the target situations the students were expected to perform in, after the 1980s students in ESP classes were required to engage more actively with the material provided and were encouraged to perform a variety of tasks. These tasks included requiring the students to draw arrows between matching pairs, determine whether statements were true or false, and to arrange sentences into a correct order. Such tasks aimed to simulate real-life communicative situations by encouraging students to discover the main features of text organization by working in pairs or groups (Howatt & Widdowson, 2004). The focus in ESP classes switched from written to spoken interactions, when students were encouraged to practice functions such as agreeing and disagreeing, greetings, and making arrangements through role-plays, similar to the functions nurses were expected to produce in real life.

Learner-centered approach. The final stage of the development of ESP, proposed by Dudley-Evans and John (1998) is the implementation of an approach centered on the learners. The

focus shifts from what the students can do with the language to how students learn a foreign language. Researchers stress that knowledge on grammar, vocabulary, and text structure does not equal the ability to successfully produce language. Differences in learners are taken into account and are addressed through the encouragement of pair and group work (Dudley-Evans & St John, 1998).

Current state. The development of ESP did not occur simultaneously in all parts of the world and some stages of the development can be found to be predominant in different institutions around the world. As mentioned above, Barber's register analysis has returned in popularity due to the spread of computer technology which allows language instructors and researchers to easily perform corpora analysis on a wide variety of spoken and written discourse. Genre analysis is also a common tool used by current ESP language instructors and includes an analysis of the structure and common functions of discourse in specific communities (Swales, 1990). Language features the students are required to learn (real content) are presented through carrier content, often authentic samples of text. Courses catered to medical students and workers currently are especially valuable, since these courses allow learners to practice the highly valuable profession of health care provision worldwide safely and efficiently.

Issues with Assertiveness, Communication, and English Language Training

Previous sections described the importance of proper communication, assertiveness, and English language skills for foreign nurses working in Australia in improving relationships among medical professionals, patient satisfaction, and, most importantly, patient safety. Despite the proven importance of those skills, research shows nurses still have difficulties in communicating effectively in English with colleagues and patients, and behaving assertively, despite, as seen in the sections above, having received some training in those areas. Researchers maintain that two possible reasons why training may have been unsuccessful are because training often does not match the learner's

culture and because training needs to begin in the future nurses' undergraduate programs, instead of after graduation.

For instance, Hussin (2002) described an English for nurses language module in an Australian university, part of a two-year program for foreign-trained nurses who have already completed two years of nursing school in the nurses' home countries. The language module meets the criteria of communicative skills necessary for nurses in Australia set by the Australian Nursing Council's (ANC) and includes a one-week assertiveness training. Educators, however, have noticed that the biggest issue after the course was related to the student's lack of assertiveness and knowledge on how to speak up in clinical situations. Instructors maintain that the ineffectiveness of the assertiveness training is related to the nursing student's cultural differences, which were not addressed individually during training.

Researchers have stressed that the nature and outcomes of routine communicative medical interactions may be heavily influenced by the nurses' country of origin, as the nature of nurse-patient and nurse-health professional communication is rooted in the nurses' culture (Kreuter & Mclure, 2004). Culture and training strongly influence a nurse's levels of assertiveness and communication style when interacting with patients, two factors that, in turn, can strongly influence patient outcomes. Foreign nurses do undergo training in communication in Australia, but the nurses' individual and cultural backgrounds are not addressed separately. This is problematic because while Japanese nurses tend not to exhibit assertive behavior, nurses in Korea, for example, a country very close to Japan geographically, are significantly more assertive when communicating with patients, doctors, and fellow nurses (Tsujimura et al., 2016). Differences in assertiveness levels and communication styles, as well as the cultural reasons such differences exist, need to be addressed in communication and assertiveness training.

In addition, researchers maintain training should begin during nurses' undergraduate education, as training in programs post-graduation are not very effective. Wanzer, Booth-Butterfield,

and Gruber (2004), for example, maintain that medical personnel needs to be trained in patient-centered communication during the future doctors' and nurses undergraduate or graduate studies and should involve role-play activities. In terms of language education, nurses who migrate to Australia have different language training needs depending on the nurses' past experiences and cultural backgrounds (Chun, Birks, & Mills, 2018; Harris, 2009; Philip, Woodward-Kron, & Manias, 2019), and thus researchers maintain that language and communicative training should begin in nursing school (Philip, Woodward-Kron, & Manias, 2019).

Japanese nurses who intend to work abroad need to be involved in medical communication, assertiveness, and communicative language training while in nursing school. Such training needs to address the nurses' past experiences and cultural background. However, another possible reason why training in these three skills may be unsuccessful is because medical communication, assertiveness, and English language communication tend to be taught separately, despite evidence that the three skills are interconnected. For instance, issues in executing communicative functions characteristic of patient-centered communication are often blamed on insufficient language proficiency. Philip, Woodward-Kron, and Manias (2019) expressed that OQNs in Australia favored close-ended questions and often refrained from asking additional questions or asking for clarifications, either due to lack of confidence, or insufficient language abilities. Lack of confidence, on the other hand, is often addressed as a barrier to assertive behavior. In addition, when researching communication issues in foreign nurses in Australia, Philip, Woodward-Kron, and Manias (2019), and Harris (2009) noticed lack of assertiveness in nurses in a section focusing on the foreign nurses' English language proficiency. Other researchers also found a correlation between a nurses' lack of confidence and poor language abilities and the nurses' difficulties when initiating and maintaining conversations in clinical settings (Lum et al., 2015; Philip, Manias, & Woodward-Kron, 2015).

Connections between patient-centered communication and assertiveness in nurses can also be found in the literature. For example, Heery (2000) maintains that patients and the patients' families

are more likely to feel relaxed and at ease around medical personnel if the patients and the medical personnel discover a presence of common interests. Unfamiliarity between members of a team also impedes successful communication between clinicians (O'Daniel & Rosenstein, 2008), and is a barrier for Japanese nurses to communicate and act assertively (Omura, Stone, & Levett-Jones; 2018a). In addition, common traits between patient-centered and assertive communication include clear and direct communication (Kreps & Thornton, 1992). Culture which favors silence and hierarchy inhibit both open communication and assertiveness (Morris, 1998; Konner, 1993), and Kreps and Thornton (1992) stated that clear and assertive communication is part of patient-centered communication. English language proficiency, patient-centered communication skills, and assertiveness have not been addressed together in the literature, despite occasionally being mentioned in papers dedicated to one of the three topics.

In sum, Japanese nursing students' need to be trained in English, communication, and assertiveness. The nursing students' culture needs to be taken into consideration, as research shows training in open communication and assertiveness is closely related to the learner's culture and failure to address the learner's cultural background leads to ineffectiveness of the training. Another factor that may render training in assertiveness and communication without regard to the nurses' culture ineffective are differences in the expectations of care nurses should provide after graduation from nursing school in the nursing students' home countries. Researchers also recommend training in English, communication, and assertiveness to be carried out during the nurses' undergraduate studies, as opposed to after graduation or before employment in Australia. Finally, assertiveness, communication, and English language skills are connected and should be taught together. Japanese nurses preparing to work in Australia would benefit from an English for Specific Purposes (ESP) course which addresses the learner's cultural, communicative, assertiveness, and language needs at the same time, and such a course needs to be part of nurses' undergraduate education.

Educational Implications

Assertiveness, patient-centered communication, and English language skills are necessary for nurses worldwide, especially those working in a foreign, English-speaking country. Although further analysis may be necessary to determine the extent to which the three skills are problematic in nurses working in countries such as the US, the UK, Canada, and New Zealand, foreign nurses who intend to work in those countries may still benefit from training in assertiveness, patient-centered communication, and English. Research suggests that not only Japanese nurses, but nurses from India and the Philippines who work in Australia also struggle with assertiveness, communication, and English language communication, so further training is necessary in order to improve patient safety. In addition, the globalization and increase of international travelers leads to an increase in the number of cases of foreign patients in hospitals, which necessitates medical professionals to be trained in assertiveness, patient-centered communication, and English, regardless of the clinician's intention to work abroad. The current literature review, however, focused specifically on the learning needs of Japanese nursing students who intend to work in Australia and clearly showed the need for additional training in the three skills.

Recommendations for an ESP Course

The literature shows the existence of significant gaps in Japanese nurses' education in relation to assertiveness, communication, and English language training. Despite training in communication and English being mandatory in nursing school and courses provided by overseas employers, issues persist. Assertiveness training may also be included in training in Australia, but does not address Japanese nurses' culture. In addition, all three skills are treated and taught separately, despite them being connected, and insufficient skills in either English, patient-centered communication, or assertiveness will negatively affect the other two skills and can ultimately lead to a deterioration in clinicians' workplace relationships, patient's mental condition, and even patients'

health. The three skills need to be taught with consideration of the nurses' cultural background and expected country of employment, training needs to begin early in the nursing student's undergraduate education, and the three skills need to be taught together. Tasks and activities which research shows to be effective in improving assertiveness and communication skills include role-playing and modeling activities, discussions, and reflection and need to be included in an ESP course for Japanese nursing students preparing to work in Australia. In addition, for Japanese nurses preparing to work in Australia some training in intercultural communication is also necessary, as a quarter of all nurses working in the country were born or trained abroad.

Educators need to conduct a more detailed needs analysis before developing an ESP course. In order to analyze individual nursing students' levels of assertiveness before training as part of the needs analysis and after training in order to determine the success of the training, educators can use The Rathus Assertiveness Schedule (RAS). RAS is a self-report, 30-item questionnaire which employs a six-point Likert scale (Rathus, 1973). RAS has been used as a research instrument multiple times as a means to assess the assertiveness levels of individuals, including with Japanese nurses (Omura, Levett-Jones & Stone, 2019; Yoshinaga et al., 2018). Researchers may also use a short version of McCormick's Simple RAS (SRAS-SF) (McCormick, 1984), developed and tested by Jenerette and Dixon (2010) (Appendix C). McCormick's SRAS includes the same number of items as Rathus's original questionnaire, but with less complex "language, format, and scoring" (Jenerette & Dixon, 2010, p. 316). Jenerette and Dixon shortened SRAS through a regression method which required an analysis of the independent variables to determine those variables' contribution. SRAS-SF has 19 items with a decreased response burden, while still maintaining reliability. The results of SARS-SF vary from 19 to 114, the higher number corresponding to a higher level of assertiveness in the respondent.

Usually, needs analysis involves an analysis of the target situation and the communicative acts carried out in the target situation. For example, educators and researchers may visit a few

Australian hospitals and record the communicative acts carried out by nurses when interacting with doctors, patients, and other nurses. However, since research shows issues in the execution of patient-centered and open communication, as well as assertive communication in nurses in Australia, educators should also take into consideration analyzing best practices in patient-centered communication, synthesized by King and Hoppe (2013) (Appendix A) and include them in the curriculum. As for the practical side of training nurses, training in the skills described above need to be based on best practices recorded by researchers, which in the current situation require nurses to participate in role-play and modeling activities, discussions, and reflections. Oral practice is essential for developing fluency and communicative abilities and strategies, but Japanese nurses' communicative, assertiveness, and English language skills can be improved through creative writing, which combines successful training activities and necessary skills described by the literature.

Creative writing. Issues in Japanese nurses related to English language proficiency, poor communication skills and lack of assertiveness can all be addressed through creative writing. Creative, as opposed to technical or academic writing, is a form of self-expressive writing that allows the writer to articulate feelings, thoughts, experiences, and opinions. Forms of creative writing include poetry, personal essays or reflections, memoirs, fiction, etc. Creative writing, especially the reflection and narrative genres, can be used in the classroom to develop skills discussed in the previous sections, namely the English language proficiency, assertiveness, and communication skills. Medical students in some universities take part in creative writing courses or workshops, from which learners and the medical studnets' future patients benefit in various ways (Calman, 2001; Charon, 1993; Charon, 2001; Hurwitz, 2000; Lemay, Encadela, Sanders, & Reisman, 2017; Neumann et al., 2011; Thomas, 2004; Wilkinson (2004; Wikstrom & Sviden, 2011).

Wilkinson (2004) stresses the importance of individuals who study to become medical professionals to reflect on the learning process. Written reflection and discussions on the students' own experiences are a key part of Wilkinson's creative writing workshop for third-year medical

residents. The mandatory writing workshop is held for three hours and is met by positive reactions from students. Students are not encouraged to strive to write “well”, but to focus on expressing in writing past experiences and thoughts related to the medical profession. Wilkinson maintains that through written reflections and subsequent discussions, future medical professionals benefit in two ways – the creative writing process can be emotionally cathartic for the writers, and the completed works can serve as a learning opportunity for the students. Some prompts Wilkinson uses in the creative writing workshop include topics related to students being in situations in which the future medical professionals did not know how to proceed in a certain situation, or to describe a relatable patient, for instance. An added benefit of creative writing other researchers share is the development of observation skills, which are essential for medical professionals. Wilkstrom and Sviden (2011) maintain that written or oral reflection is a necessary part of observation skills development in medical students, which is important as understanding what a patient is going through is essential and can improve the collaborative relationship between the healthcare professional and the patient.

Two genres that can aid nurses in improving communicative and assertiveness skills development are narrative and reflection. Healthcare professionals need to deal with not only the physical symptoms of an injury or illness but need to also consider the patient’s experience and Charon (2001) warns that failure to listen to the patient’s narrative might lead to medical professionals prolonging the patient’s treatment, or offering an incorrect diagnosis. According to Charon (1993), narrative competence, meaning an individual’s ability to assimilate and interpret a story, is necessary in medicine, as medical practitioners are allowed to exercise the medical profession with empathy, credibility, and reflection, all necessary for patient-centered care and communication. In addition, narrative in medicine, influenced by the concept of patient-centered care, assists medical professionals in improving patient care in general, as well as work relationships (Charon, 2001).

Narrative writing also allows medical professionals to recognize the trouble of others (Lemay, Encadela, Sanders, & Reisman, 2017). By writing with a focus on narrative and description, medical practitioners are later able to take down the patient‘s information in a detailed story format, which later helps clinicians gather necessary medical information in an organized fashion. Sharing information with patients by using precise and descriptive language greatly eases communication between the two parties and nurses who have participated in a creative writing course were able to transfer these vital skills to a medical setting.

Both narrative and reflection are closely integrated into the development of assertiveness and communication skills. Through reflection, writers seem to develop skills that aid in interpreting the patient‘s narrative (Charon, 2001), which in turn helps nurses and doctors understand the lived experiences of patients on a deeper level (Lemay, Encadela, Sanders, & Reisman, 2017). This is crucial for nurses who have to listen to the patient‘s recollections of past events such as activities leading up to an injury, description of the patients' family‘s medical history, and symptom development. The exchange between patients and medical professionals takes a narrative form, which makes a clear understanding of the narrative a major aspect of medical communication (Calman, 2001; Hurwitz, 2000). Reflection in the form of personal essays is an integral component of both creative writing courses and the assertiveness training courses presented above. In addition, by reflecting on past experiences and personal thoughts and opinions students are taking a step into developing assertiveness skills.

Reflective writing can also result in improved patient-centered communication skills. As mentioned previously, empathy development is a necessary part of successful patient-centered care and communication and reflective writing has proven to develop empathy in medical students with long-lasting effects (Charon, 2001; Lemay, Encadela, Sanders, & Reisman, 2017; Neumann et al., 2011; Thomas, 2004). Empathy is also closely related to assertiveness, which involves speakers firmly and confidently expressing thoughts and feelings while showing respect and understanding to

the listener (Alberti & Emmons, 2008; Assertive Communication, n.d.). Thus, narrative and reflection can help nursing students develop skills related to assertiveness and communication.

As for English language skills development, for successful language acquisition, students need both input and output in the target language. Input comes in the forms of listening and reading, while language output is either oral or written. Language students need plenty of opportunities to produce language while focusing on meaning, and one way to accomplish this is through writing (Nation, 2008). Nation maintains that learners of English need to be allowed to write in a wide variety of genres, as these genres require different language features and are part of different writing conventions (2008). In addition, issues related to communicating in English can also be addressed through creative writing, as development in writing skills leads to improvement in speaking skills (Rausch, 2015). Through reflections (descriptions of thoughts and feelings related to experiences), and narrative and description, nursing students can improve skills necessary for both language proficiency development, but also for the successful work as healthcare professionals in terms of improved assertiveness and communication skills.

Recommendations for Further Research

The review of the literature revealed some gaps and further research is necessary on some of the issues described above. First, from the year 2020, foreign nurses are required to undergo training by the nurses' employer in Australia (NMBA, 2019). The nature of such training and the training's effectiveness in improving the foreign nurses' communication, assertiveness, and English language skills needs to be researched. Information about the content and effectiveness of the training will determine whether training from the employer needs to be improved and reveal which skills need to be included in the nursing student's university curriculum.

Second, the relationship between assertiveness training and improvement in patient safety needs to be explored. Although research shows that training in assertiveness leads to improved self-

reported levels of assertiveness (Lin et. al., 2004; McGabe & Timmins, 2003; Warland, McKellar, & Diaz, 2014), further research needs to be conducted to determine whether training in assertiveness at the university or post-graduation level leads to an actual increase in assertiveness in clinical settings. Such information will allow educators to improve or revise assertiveness training if needed.

An additional issue that may inform nursing students' educators when conducting needs analysis is the number of Japanese nurses who migrate abroad, as well as the preferred countries for migration and the reasons Japanese nurses migrate to practice medicine abroad. Such information will allow educators in Japan to determine the focus of ESP courses that includes training on assertiveness, communication, and English language skills, depending on the countries and reasons Japanese nurses prefer to migrate to. As discussed in the literature review, expectations in terms of nurses' clinical and communicative responsibilities differ across countries (Tsujimura et al., 2016). Information on the preferred countries for Japanese nurses to migrate to, for example, will inform educators on the particular communication skills nurses need to be taught.

Finally, research into the effectiveness of creative writing in improving assertiveness, patient-centered communication, and English language skills in nursing students is also recommended. Nursing students can be enrolled in a creative writing course that focuses on narrative, description, and reflection, as these three genres of writing are related to improvement in medical students' empathy, communication, assertiveness, and English language skills. Research should focus on whether creative writing leads to an improvement in patient-centered communication, English language, and assertiveness skills. The results of such research would be beneficial for medical student educators worldwide in determining whether ESP instructors should include creative writing in assertiveness, communication, and English language training.

Conclusion

The current paper briefly introduced nursing and nursing, migration procedures, and training, with a focus on Japanese nurses working in Australia. The paper focused on the three main issues Japanese nurses face when working in Australia. Nurses lack assertiveness and face difficulties when communicating with patients and colleagues working in an English-speaking country. Patient-centered communication skills, assertiveness, and English language fluency are essential for medical professionals for safe and efficient health care provision. Nurses worldwide, and especially foreign nurses working in Australia, however, exhibit insufficient assertiveness and poor patient-centered communication and English language skills. Research shows that training in assertiveness and patient-centered communication skills is generally effective, however, training often occurs post-graduation and fails to address the learner's culture and past experiences, which renders training ineffective. Researchers maintain that addressing Japanese nurses' culture in communication and assertiveness training is especially necessary. In addition, despite having received English language training since elementary school, currently nursing students in Japan lack efficient communication skills, and foreign nurses in general lack fluency. The reasons Japanese nurses face such difficulties lie with the English language education system in Japan, which does not focus on developing learners' communicative language abilities. The paper suggested that Japanese nursing students preparing to work in Australia would benefit from an ESP course which addresses all three issues related to English language abilities, communication, and assertiveness at once, since a review of the literature showed the three skills are interconnected. The course should also address the nurses' culture and should be conducted during the nurse's undergraduate study. After introducing the nature and historical development of ESP, a suggestion was made that aside from role-play and modeling activities and discussions which have proven to be effective in patient-centered communication and assertiveness training, all three issues described above can also be addressed through creative writing.

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Appendix A

Best Practice for Communication in Medical Encounters

(King & Hoppe, 2013)

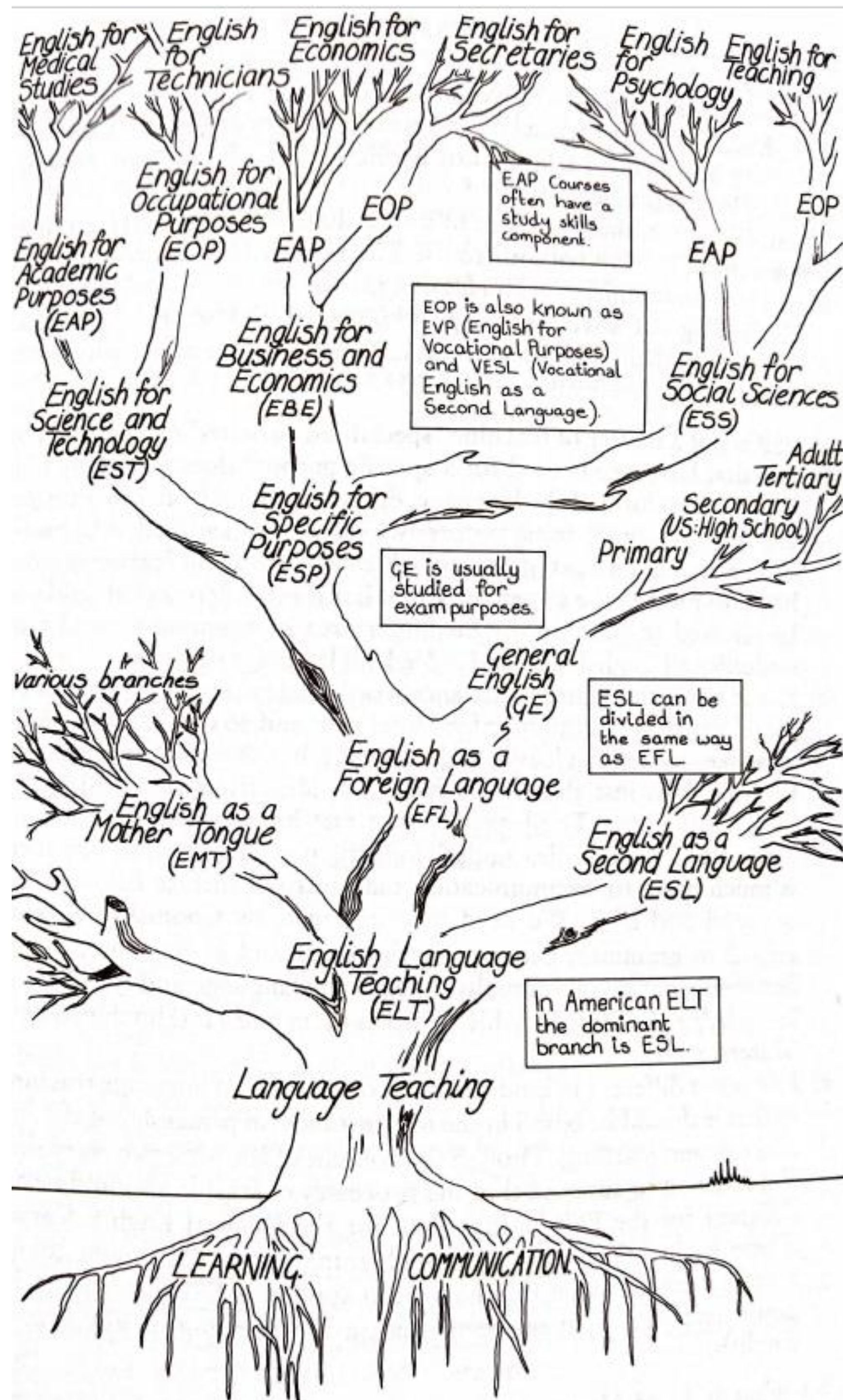
Functions of the Medical Interview	Roles and Responsibilities of the Physician	Skills
Fostering the relationship	• Build rapport and connect • Appear open and honest • Discuss mutual roles and responsibilities • Respect patient statements, privacy, autonomy • Engage in partnership building • Express caring and commitment • Acknowledge and express sorrow for mistakes	• Greet patient appropriately • Maintain eye contact • Listen actively • Use appropriate language • Encourage patient participation • Show interest in the patient as a person
Gathering Information	• Attempt to understand the patient's needs for the encounter • Elicit full description of major reason for visit from biological and psychosocial perspectives	• Ask open-ended questions • Allow patient to complete responses • Listen actively • Elicit patient's full set of concerns • Elicit patient's perspective on the problem/illness • Explore full effect of the illness • Clarify and summarize information • Inquire about additional concerns
Providing Information	• Seek to understand patient's informational needs • Share information • Overcome barriers to patient understanding (language, health literacy, hearing, numeracy) • Facilitate understanding • Provide information resources and help patient evaluate and use them	• Explain nature of problem and approach to diagnosis, treatment • Give uncomplicated explanations and instructions • Avoid jargon and complexity • Encourage questions and check understanding • Emphasize key messages
Decision making	• Prepare patient for deliberation and enable decision making • Outline collaborative action plan	• Encourage patient to participate in decision making • Outline choices • Explore patient's preferences and understanding • Reach agreement

		• Identify and enlist resources and support • Discuss follow-up and plan for unexpected outcomes
Enabling disease- and treatment-related behavior	• Assess patient's interest in and capacity for self-management • Provide advice (information needs, coping skills, strategies for success) • Agree on next steps • Assist patient to optimize autonomy and self-management of his or her problem • Arrange for needed support • Advocate for, and assist patient with, health system	• Assess patient's readiness to change health behaviors • Elicit patient's goals, ideas, and decisions
Responding to emotions	• Facilitate patient expression of emotional consequences of illness	• Acknowledge and explore emotions • Express empathy, sympathy, and reassurance • Provide help in dealing with emotions • Assess psychological distress

Source: King, A., & Hoppe, R. B. (2013). "Best practice" for patient-centered communication: A narrative review. *Journal of Graduate Medical Education*, *5*(3), 385-393.

Appendix B

ELT Presented as a Tree



Note. Hutchinson, T., & Waters, A. (2008). *English for specific purposes: A learning-centered approach.* Cambridge, UK: Cambridge University Press.

Appendix C

Simple Rathus Assertiveness Schedule – Short Form

(McCormick, 1984)

Directions: Indicate how well each item describes you by using this code:

6 - very much like me

5 - rather like me

4 - slightly like me

3 - slightly unlike me

2 - rather unlike me

1 - very much unlike me

- ______Most people stand up for themselves more than I do.
- ______At times I have not made or gone on dates because of my shyness.
- ______When I am eating out and the food I am served is not cooked the way I like it, I complain to the person serving it.
- ______If a person serving in a store has gone to a lot of trouble to show me something which I do not really like, I have a hard time saying "No."
- ______There are times when I look for a good strong argument.
- ______I try as hard in life to get ahead as most people like me do.
- ______To be honest, people often get the better of me.
- ______I do not like making phone calls to businesses or companies.
- ______I feel silly if I return things I don't like to the store that I bought them from.
- ______If a close relative that I like was upsetting me, I would hide my feelings rather than say that I was upset.
- ______I have sometimes not asked questions for the fear of sounding stupid.

- ______During an argument, I am sometimes afraid that I will get so upset that I will shake all over.
- ______If a famous person were talking in a crowd and I thought he/she was wrong, I would get up and say what I thought.
- ______If someone has been telling false and bad stories about me, I see him or her as soon as possible to "have a talk" about it.
- ______I often have a hard time saying "No."
- ______I complain about poor service when I am eating out or in other places.
- ______When someone says I have done very well, I sometimes just don't know what to say.
- ______If a couple near me in the theater were talking rather loudly, I would ask them to be quiet or to go somewhere else and talk.
- ______I am quick to say what I think.

Source: McCormick, I. A. (1984). A simple version of the Rathus Assertiveness Schedule. *Behavioral Assessment,* 7, 95-99.