

# ‘Yarn with me’: applying clinical yarning to improve clinician–patient communication in Aboriginal health care

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**Abstract.** Although successful communication is at the heart of the clinical consultation, communication between Aboriginal patients and practitioners such as doctors, nurses and allied health professionals, continues to be problematic and is arguably the biggest barrier to the delivery of successful health care to Aboriginal people. This paper presents an overarching framework for practitioners to help them reorientate their communication with Aboriginal patients using ‘clinical yarning’. Clinical yarning is a patient-centred approach that marries Aboriginal cultural communication preferences with biomedical understandings of health and disease. Clinical yarning consists of three interrelated areas: the social yarn, in which the practitioner aims to find common ground and develop the interpersonal relationship; the diagnostic yarn, in which the practitioner facilitates the patient’s health story while interpreting it through a biomedical or scientific lens; and the management yarn, that employs stories and metaphors as tools for patients to help them understand a health issue so a collaborative management approach can be adopted. There is cultural and research evidence that supports this approach. Clinical yarning has the potential to improve outcomes for patients and practitioners.

**Additional keywords:** communication barriers, culture, doctor–patient communication, education, Indigenous, patient-centred care.

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## Background

Although interpersonal communication between practitioners, such as doctors, nurses and allied health professionals, and patients is the foundation upon which quality patient care is built, it is arguably the biggest barrier for Aboriginal people when they seek health care (Cass *et al.* 2002; Shahid *et al.* 2009). Communication barriers between practitioners and Aboriginal patients include language issues, an absence of communication, and the use of medical jargon (Box 1). These issues undermine constructive practitioner–patient relationships and result in Aboriginal patients feeling alienated, being non-compliant with treatments and disengaging from health care. Evidence demonstrates that Aboriginal patients want to be informed about health and disease, however information is frequently lacking, inadequate, or presented in ways that are incongruent with Aboriginal peoples’ beliefs and life experiences (Anderson *et al.* 2008). Communication issues are further heightened when Aboriginal people feel alienated by unfamiliar health care settings, their families are not involved in communication processes, and when there are prejudicial attitudes of healthcare staff (Shahid *et al.* 2009; Artuso *et al.* 2013). Furthermore, a history of negative health care experiences results in mistrust

and suspicion by Aboriginal people of health practitioners and what they say (Shahid *et al.* 2009).

Numerous recommendations for communication in Aboriginal health care exist (e.g. Aboriginal and Torres Strait Islander Cultural Capability Team 2014) however a simple overarching framework to guide practitioners is lacking. Here, we present a patient-centred framework for communication between practitioners and Aboriginal patients. We argue that reframing communication in the consultation as a ‘clinical yarn’ has the potential for better outcomes for Aboriginal patients and practitioners. We discuss the cultural origins of clinical yarning, describe the framework and its three interrelated elements (social, diagnostic and management), provide examples of clinical yarning and highlight potential obstacles to its use. The framework was based on the collective experiences of authors as practitioners, educators and researchers in Aboriginal health care, and evolved after a number of yarns between the authors about patient–practitioner communication. In particular clinical yarning is informed by the cultural knowledge and experiences of authors C. Green and D. Bessarab as Aboriginal people and community members, and their personal and family experiences of health care.

**What is known about the topic?**

- Improving communication between Aboriginal patients and practitioners is a priority. Numerous recommendations exist however there is no overarching framework to guide practitioners' communication in clinical consultations with Aboriginal patients.

**What does this paper add?**

- Clinical yarning is a simple, person-centred framework for practitioners to reorient their communication with Aboriginal patients. It consists of social, diagnostic and management elements. Cultural and research evidence suggests it can improve outcomes.

**Yarning as an approach to communication**

For Aboriginal people 'yarning' is a culturally appropriate way to connect, exchange information and share stories between two or more people socially or more formally (Bessarab and Ng'andu 2010). Yarning is a way to talk about things that are important. Information is embedded within the story or yarn being told, with the onus on the listener or receiver of the yarn to hear and make meaning of the information being imparted. It is a conversational and informal way of sharing news or imparting information.

Recently there has been an emergence of yarning-based approaches to communication as a culturally appropriate method in Aboriginal health research and in counselling and other therapies.

Bessarab and Ng'andu (2010) first described 'research yarning' as a method in Indigenous health research. Research yarning is used to elicit qualitative information from Aboriginal participants in a relaxed conversational style (Bessarab and Ng'andu 2010), in which the relationship is paramount, and that 'prioritises Indigenous ways of communicating, in that it is culturally prescribed, cooperative, and respectful' (Walker *et al.* 2014, p. 1216). In research yarning 'a topic is introduced in a deliberately open manner, and the yarning participants can then take that topic and respond as they see fit, rather than feeling that they are being interviewed or formally questioned' (Fletcher *et al.* 2011, p. 93). Yarning approaches have been used in health care, largely for therapy or counselling and psychosocial support of Aboriginal clients (Towney 2005; Vicary and Bishop 2005; Bacon 2013).

Lin *et al.* (2014) reported that Aboriginal patients prefer yarning styles of communication, involving a two-way dialogue and careful listening, shared treatment decision-making, clinicians taking an interest in the patient as a whole, having sufficient time, and sharing information of a non-clinical nature. Additionally, evidence suggests that yarning approaches result in a more critical and accurate portrayal of Aboriginal people's perspectives than a closed style of questioning (Tidemann *et al.* 1996). Therefore if practitioners can incorporate yarning into their communication there is the potential to improve care.

**Clinical yarning**

Clinical yarning is used in clinical consultations with patients to build rapport and trust. It is a conversational, relaxed, open-ended style of communication that privileges storytelling as a vehicle to understand a patient's health issue within the context of their life, and as a way to communicate health information. It marries a cultural base – a consultation style that is culturally congruent with Aboriginal ways of communicating – to traditional biomedical knowledge. Clinical yarning has three interrelated areas: the social yarn, diagnostic yarn and management yarn (Bessarab and Ng'andu 2010; Fig. 1).

*Social yarn*

A clinical yarn consultation typically begins with the social yarn, although this can occur at any stage during the interaction. For Aboriginal people the social yarn is an important precursor to other conversation and functions to establish connection and relatedness (Bessarab and Ng'andu 2010). For practitioners the social yarn is about finding common ground and might include sports, family, the weather, seasonal factors (e.g. relating to bush foods) or how Aboriginal people relate to local country. For example, coastal communities may place high cultural value on the ocean and so fishing may be a topic for a social yarn. The patient's age and gender may also provide some conversation cues. Social yarning is easier for practitioners with effective interpersonal skills who are able to connect with someone about their cultural or personal interests. It is a means for a practitioner to find out more about the local Aboriginal culture from their patient and demonstrates that they are interested in the person.

Culturally aware practitioners with knowledge of local Aboriginal culture may find it easier to develop a conceptual 'map' of what is relevant to Aboriginal people in the region in which they are working, or have pre-existing awareness of the patient's kinship relationships within the community. Establishing connection to a place (country) or to family members of their patients may assist practitioners to initiate the social yarn. It may be useful for clinicians to share information about themselves or their experiences (Box 2). Practitioners must also be aware of non-verbal communication including their body language (Shahid *et al.* 2009), for example by adopting an open posture that is attentive and non-confrontational.

Although the primary purpose of the social yarn is to establish trust and a relationship with the patient, the social yarn also allows the practitioner to understand a health issue within the context of the patient's life story. Importantly the social yarn sets the tone for the consultation by being patient-led, valuing the patient as expert and making it clear that the practitioner is interested in the person as a whole and values their story and life knowledge. Power is thereby shared between practitioner and patient.

*Diagnostic yarn*

To determine a diagnosis, practitioners traditionally elicit information from the patient through a structured series of questions, a style that could be construed as confrontational and impolite by Aboriginal people (Trudgen 2000; Cass *et al.* 2002).

**Box 1. Barriers to interpersonal communication between health practitioners and Aboriginal patients**

- Practitioner-centred communication style (e.g. question and answer; Cass *et al.* 2002)
- Medical jargon use (Artuso *et al.* 2013; Lin *et al.* 2014)
- Incongruities between Aboriginal and Western or biomedical perspectives of health (Artuso *et al.* 2013)
- Lack or absence of communication (Anderson *et al.* 2008; Lin *et al.* 2014)
- Information not evidence-based or not plausible based on the patient’s previous experience (Lin *et al.* 2014)
- Mistrust of health care services (Shahid *et al.* 2009)
- Language issues or lack of use of interpreters (Cass *et al.* 2002)
- Perceived racism (Artuso *et al.* 2013)



**Fig. 1.** Key elements of clinical yarning.

In contrast during a diagnostic yarn the health practitioner directs conversation towards a descriptive telling of the patient’s story in relation to their health. A diagnostic yarn is open-ended, flowing and story-based, like a comfortable conversation. Techniques include open-ended questioning and non-judgemental listening. Allowing conversational silences is recommended and allows the patient time to think and consider their story (Trudgen 2000; Shahid *et al.* 2009; Box 2). Although patient-led, the diagnostic yarn is a two-way dialogue. It can be thought of as a balancing act, where the practitioner allows the yarn and patient’s health story to unfold while simultaneously interpreting the conversation through a biomedical lens of health

and disease and directing the yarn towards the information needed to understand and diagnose a patient’s condition.

*Management yarn*

Patient participation in health care increases when patients are more knowledgeable about their health condition (Hill 2011). A collaborative management yarn involves the practitioner getting to know what the patient understands about their health concern and an honest discussion with the patient, and their family if they are present, about their condition, followed by an agreed upon management plan. Areas related to health that the patient

### Box 2. Examples of yarning in the clinical consultation

#### A. Social yarn (example from practice)

Clinician: Come in Mrs L. Now, I was reading in your notes that you moved down here from Clearwater Bay. Seems everyone I speak to from there just loves it up there.

Mrs L: Yes! I love it at home. I miss it living down here.

Clinician: They say the fishing is pretty good up there?

Mrs L: Yes, fishing and squidding off the jetty. We take the grannies squidding, they love it. We all go back whenever anyone comes back for a visit, big mob of us meet up there. We were just up there 2 weeks ago. All my brothers and sisters and the grannies together.

Clinician: I've never been up there. We've been meaning to go up for a visit for years. My kids would love that.

Mrs L: It's great for the kids, you should go! I miss it, can't wait for the next trip. In fact I think all my problems started after I left there 4 or 5 years ago.

Clinician: Oh, can you tell me about that? [Moves onto clinical yarn]

#### B. Clinical yarn (example from a student education program)

During a cross-cultural communication workshop facilitated by author C. Green, a medical student was interviewing Mr F about his health. Mr F was an Aboriginal elder and participated in the program as a 'community teacher', he had multiple long-term health conditions (diabetes, cardiovascular disease, previous cerebrovascular accident).

Initially the student adopted a biomedical interviewing style and asked Mr F 'Do you drink alcohol?' To which Mr F replied, 'No, not much. No, just a few with my mate.'

Facilitated by C. Green, this was introduced to the student as an entry point for a yarn. The student began a clinical yarn exploring further with Mr F the social context when he saw his friend, 'Tell us a bit more about when you have a drink with your mate.'

Mr F yarned about how he would visit his friend, sit down in his back garden and socialise, which was an important way for him to de-stress. Here they would have a few drinks. As the clinical yarn evolved Mr F disclosed how when he sat with his friend they would each drink a bottle of wine or more as they caught up. The clinical yarn, which was in the context of managing his long-term health conditions, gave Mr F the option to disclose more information without fear of being judged. After this disclosure Mr F reflected on how the amount he was drinking was not good for his health. This led on to a management yarn about the effects of alcohol on his diabetes.

#### C. Management yarn

##### i. Example from Trudgen (2000), p. 133

So I told him about scabies. Drawing pictures as I went, I showed him the life cycle of the parasite. I started with what he already knew. 'How do turtles lay their eggs?' I asked.

'In a hole the turtle has made in the sand, a big mob all at one time.'

'And how does a bird lay its eggs?'

'One a day until there's a handful or two.'

I then told him that one scabies female has lots and lots of eggs, which it lays in a hole it burrows under a person's skin, two or three each day. It takes the young scabies a few days to hatch and come out of the burrows – maybe 3 to 5 days. I explained that the 'medicine' cream was a poison to these scabies, but it might not kill off all the eggs that are down the burrows in the skin.

As soon as I had said this, the old man responded. 'I can see it now. I have to wait for the eggs to hatch before I put the next lot of cream on.'

##### ii. Example from clinical practice (explanation of a heart attack) (T. Dowling, pers. comm., 29 December 2015)

The heart has three major blood supplies. The main blood supply down the front of the heart is like the freeway; in the hospital we call it the LAD [left anterior descending coronary artery].

The cars driving along the freeway are like the blood flowing to your heart.

Imagine 5 o'clock on the freeway: the lanes are congested but the cars are moving slowly. No one is broken down. Everyone gets home but there are delays and frustration. This is like the blood flow in your heart when you have chest pain or angina. The blood flow slows but there is no damage to the heart muscle.

Now imagine 1 o'clock in the afternoon and a semitrailer drops its load across all lanes of the freeway. The freeway is blocked. It doesn't matter who's on the freeway, no cars are going anywhere. This is what happens when you have a clot that is blocking the blood vessels to your heart. The blood is not going to get through. This is what we call a heart attack and results in muscle damage.

#### D. Closing a yarn (example from practice)

Doctor: Thanks for coming in today Mrs D. It was good to talk about what you can do to look after your diabetes. Better get the kids onto their skateboards!

Mrs D: Yeah, I didn't think about taking the kids downtown on their skateboards and going for a walk. I'll come along to the exercise program in here you were talking about as well when the kids are at school.

Doctor: That sounds great. Can you come again in 2 weeks so we can talk about how you're going then?

Mrs D: Yeah that would be good.

does not understand or where there are misperceptions are clarified, medical information is translated into clear, meaningful terms and free of jargon.

Stories and metaphors are an important method used to explain health information in a way that relates to the patient's life experience (see Box 2). Diagrams, sketches, anatomical models

of the body, printed information or culturally appropriate audio-visual resources can be used to reinforce verbal information. The management yarn is individual and patient-led and so practitioners must be flexible and have the ability to adapt their communication style according to the patient's knowledge, health literacy, language, life experiences and preferred learning style. The management yarn encourages patient understanding and ownership by using a motivational style that considers the patient's life context, goals and values (Rubak *et al.* 2005). Health information is presented in a manner that is sensitive to a patient's needs, but is also honest, clear and to the point (Lin *et al.* 2014). In general lecturing to the patient is to be avoided, however practitioners must employ their judgement if they feel the patient prefers a direct, 'no-nonsense' explanation. A good outcome of a management yarn is an agreed upon plan that is meaningful to practitioner and patient.

### Clinical yarning and patient-centred communication

Like other patient-centred communication frameworks (Kurtz 2002) clinical yarning emphasises a strong therapeutic alliance between practitioner and patient, it takes a holistic perspective, and aims to understand a health condition from the patient's worldview. A unique aspect of clinical yarning is the emphasis on the social yarn as a means to establish a relationship, build trust, and to begin to understand a patient's story. The social yarn demonstrates to the patient that the practitioner is interested in them and assists both to know and understand where the other is coming from.

Clinical yarning and other patient-centred communication frameworks encourage exploration of a patient's problem via their narrative or story (Silverman *et al.* 2005). Attentive listening by practitioners to the patient's story improves the quality of care by encouraging empathy, engendering greater emotional engagement and allowing a more thorough understanding of illness within the patient's context (Greenhalgh 1999). In clinical yarning, stories and metaphors are also used by practitioners as a tool to explain health information. This approach aligns with Aboriginal cultural traditions in which storying is the way in which information is exchanged (Nakata 2010).

Metaphors can be used to explain health information in a way that is meaningful and the patient is more likely to recall details, for example when health information is likened to something within someone's life experience (Box 2). This is consistent with evidence that stories and metaphors can be successfully used to improve health knowledge and behaviours in a variety of situations, including chronic diseases, hypertension, and chronic pain (Hunter *et al.* 2007; Houston *et al.* 2011; Gallagher *et al.* 2013). It is theorised that metaphors improve understanding because they elicit an emotional response, thus activating areas of the cerebral cortex also associated with memory, learning and imaginative functions (Gallagher *et al.* 2013).

### Challenges to clinical yarning

Time constraints during medical consultations are a potential barrier to clinical yarning and must be balanced against the quality of the information that is not elicited using a traditional consultation style. Evidence suggests that the consultation time requirements are initially higher when practitioners are learning

new patient-centred communication skills but reduce once they are proficient (Kurtz 2002). Gaining proficiency in clinical yarning may require training that includes knowledge and a theoretical rationale, skills practice, and reflection and feedback processes (Dwamena *et al.* 2012), similar to techniques we have used previously in student education (see Box 2). A yarning style of consultation takes less time once a relationship has developed (e.g. following a social yarn) or when the practitioner and patient are familiar to each other. Hence clinical yarning is facilitated more readily when there is continuity of care.

Knowing when a clinical yarn has gone 'off track' and having the confidence to bring it back on track, especially when a yarn that seems tangential may lead circuitously to important health information, are important skills. Practitioners need to recognise when a yarn is off-track and intervene and close a yarn sensitively. Closing a yarn and a consultation is more validating for patients when the practitioner shows interest in them as a person, reemphasises parts of their story that are important to their health, including their management plan, and making it clear that continuing the yarn and a relationship with them is important (Kurtz 2002; Box 2).

Working with Aboriginal interpreters or liaison officers can help to overcome language and cultural barriers between practitioners and Aboriginal patients (Cass *et al.* 2002). Ensuring practitioners and interpreters are familiar and comfortable with clinical yarning is integral to the process. This may involve the interpreter and practitioner working together to help the patient understand what is being said and enable them to ask questions of the practitioner through the interpreter. In situations where an interpreter or a liaison officer is not available, yarning with family members who could be present if the patient gives consent may also be helpful. We also recommend that the practitioner confirm with the patient that they understand what is being said, especially if they suspect that the communication is not going so well. Acknowledging one's own personal language limitations to the patient and giving the patient permission, via a clinical yarning approach, to say when they do not understand what is being said may also empower the patient to be involved in their health consultation.

### Summary

Communication between Aboriginal patients and health practitioners can be improved by reframing clinical consultations as a clinical yarn. Clinical yarning has social, diagnostic and management elements. This approach has the potential to improve relationships and outcomes for Aboriginal patients and practitioners.

### Conflicts of interest

The authors declare that they have no conflicts of interest.

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