

ORIGINAL RESEARCH

Bakmaranhawuy - the broken connection. Perspectives on asking and answering questions with Yolŋu patients in healthcare contexts

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ABSTRACT:

Introduction: Questioning is a key method in general information-seeking behaviour and teaching used by the dominant culture in Australia. Within an Australian health context the fundamental diagnostic tool used by medical staff is the biomedical interview or history taking, which is based on a battery

of direct questions. Similarly, many health professionals rely on patient questions to prompt the sharing of information, or to make them aware of gaps in communication. This is problematic for many First Nations peoples, including Yolŋu (First Nations people of North-East Arnhem Land), who are culturally less inclined to use

direct questioning as it is deemed impolite within their cultural context.

Methods: Semi-structured conversational interviews using culturally congruent communication processes were conducted with participants in their preferred language. Interviews were translated, transcribed and analysed inductively using NVivo v12.

Results: A total of 30 participants were interviewed (10 health staff and 20 Yolŋu with recent experience in engaging with health services). All participating health staff believed that questioning was essential for determining how to best treat patients but many felt that questions created problems for some Yolŋu patients. They also felt that Yolŋu patients ask fewer questions related to their health issues than patients of other cultures.

Yolŋu participants conveyed overwhelmingly negative experiences with the health system and at the tertiary hospital in particular. Yolŋu participants described feelings of frustration, fear and trauma when talking of their experiences, and these feelings were often direct outcomes of poor communication with staff.

Regarding the use of questions in health care specifically, Yolŋu participants identified four key and interrelated conditions within which questioning was deemed an acceptable communication mechanism. *Dhāmanapan* (connection) was identified as an

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essential condition for effective communication between health staff and patients. This connection was established and maintained through a shared understanding of *matha* (language), *dukmarām* (Yolŋu understandings of healing) and *djuṇyuni* (Yolŋu norms of polite communication). Strategies for overcoming barriers to effective communication related to the concept of *dhuwurr* (skill) in health communication, which could increase the acceptability of health staff asking questions of Yolŋu and the confidence of Yolŋu patients in asking questions of health staff.

Conclusion: The findings from this study indicate a fundamental disconnect between the current health system and the needs of the Yolŋu patients it seeks to serve. In order for this to change, Yolŋu patients and health staff need to develop *dhuwurr* in health communication, which incorporates the four key conditions for effective communication identified in this study. To achieve this, ongoing and mandatory intercultural communication training for health staff is needed, just as mandatory training is required for hygiene and resuscitation training. Intercultural communication training must be comprehensive – reflecting the complexity involved in developing this *dhuwurr* – and sustained, for example with ongoing support from cultural communication mentors.

FULL ARTICLE:

Introduction

Aboriginal and Torres Strait Islander (hereafter referred to as First Nations) peoples make up approximately 70%¹⁻³ of the patients treated in the tertiary hospital setting in the Northern Territory (NT) and experience a much higher burden of disease⁴. Census data show that, in 2016, 60% of the First Nations population in the NT spoke a language other than English at home⁵. Effective communication is fundamental for provision of culturally safe and high quality health services⁶. However, this is particularly challenging to achieve when staff and patients do not share the same linguistic and cultural backgrounds⁶.

Ineffective communication between health staff and First Nations patients is pervasive in NT health settings^{2,3,7}. Studies have highlighted the serious consequences for patients of miscommunication, which include reduction in adherence to treatment, creation of mistrust of health services, illness and death^{2,3,7}.

Questioning is a key method in general information-seeking behaviour and teaching used by the dominant culture in Australia, where question-and-answer routines such as greetings pervade all communication⁸⁻¹⁰. However, this is culturally incongruent for many First Nations peoples, including Yolŋu (First Nations people of North-East Arnhem Land), who are culturally less inclined to use direct questioning as it is deemed impolite within their cultural context¹¹. In the legal context, research has shown that information gained from First Nations clients using direct questioning strategies is often either incorrect or incomplete: in

these situations a First Nation client will often employ either gratuitous concurrence, always answering 'yes', or complete silence to try to end an interview, and the distress it produces, as quickly as possible¹².

This study addresses an important research gap by exploring the experiences and perspectives related to the use of questions in clinical interactions with one cultural group, speakers of Yolŋu languages from East Arnhem Land. Potential strategies to overcome any identified communication barriers that questions pose are also explored.

First Nations communities in Australia are highly diverse, with varied languages, cultures and histories. Dominant culture structures, such as the health system, have often homogenised this diversity in their attempts to include First Nation communities into policy and practice¹³. The findings from this study and proposed strategies may have relevance to other First Nations contexts, but this can only be assessed by members of those cultural groups who best understand their unique needs and experiences.

Study design

This exploratory qualitative study drew on constructivist grounded theory¹⁴ in a collaborative and flexible process that was responsive to the concerns and priorities of Yolŋu. The research team included a Yolŋu researcher (RB), who coordinated the research with Yolŋu participants and ensured that the processes used were congruent with Yolŋu cultural protocols. The first author (AW, non-Indigenous to Australia) previously lived in East Arnhem and has a working

proficiency of Djambarrpuyŋu (a Yolŋu language).

Participants and setting: The study was conducted in Darwin, NT. Participants included 20 Yolŋu patients (5 men, 15 women; age range: 27–70 years), who were either permanently or temporarily residing in Darwin while receiving health treatment ($n=20$), and health staff ($n=10$) employed at a tertiary hospital. Yolŋu known to the researchers were invited to participate by the researchers through culturally congruent conversations that explained the research and gave people time to consider if they wished to be interviewed at a later date. Health staff were recruited through open advertisement and included a wide range of professions (medical officers, nurses, allied health professionals), genders, seniority levels (students through to consultants) and length of time working in the NT.

Data collection and analysis: Semi-structured conversational interviews using culturally congruent communication processes were conducted with participants in their preferred language (Djambarrpuyŋu for Yolŋu participants; English for health professionals) and audio-recorded. Interviews were conducted either individually or in groups, depending on participants' preferences, and at locations of participants' choosing. Conversations explored participants' perceptions of the use of and need for questions in the gathering of health information, ways in which questions can be a barrier to or enabler of effective communication and suggestions for overcoming identified barriers.

Interviews were translated and transcribed with the assistance of the Yolŋu researcher, who is also an accredited interpreter. Inductive analysis of interview data was conducted using NVivo v12 (QSR International, <https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home>). Codes were derived from the data to reflect the participants' perspectives rather than using a predetermined set of codes and then reviewed and categorised in an iterative process¹⁴. The process of data analysis was also informed by the experiences and interpretations of the Yolŋu and non-Indigenous researchers.

Ethics approval

Ethics approval was granted by the Top End Human Research Ethics Committee (Approval number: HREC 2019-3466).

Results

All participating health staff thought that questioning was essential for determining how to best treat patients, but many felt questions created problems for some Yolŋu patients and that their use could be reduced. They also felt that Yolŋu patients ask fewer questions related to their health issues than patients of other cultures. Many health staff also reported relying on patient questions to prompt the sharing of information, or to make them aware of gaps in communication. Yolŋu participants conveyed overwhelmingly negative experiences with the health system, and at the tertiary hospital in particular. Yolŋu participants described feelings of frustration, fear and trauma when talking of their experiences, and

these feelings were often direct outcomes of poor communication with staff. The majority of Yolŋu participants recognised the hospital was a place that could help them with their health issues but they were often reluctant to seek this treatment due to their negative experiences.

When asked about the use of questions in health specifically, Yolŋu participants explained that questioning was an appropriate communication modality as long as it was done within certain parameters. Four key and interrelated conditions within which questioning is an acceptable communication mechanism were identified. Dhāmanapan (connection) was identified as an essential condition for effective communication between health staff and patients. This connection was established and maintained through a shared understanding of matha (language), dukmaram (Yolŋu understandings of healing) and djuŋuny (Yolŋu norms of polite communication). Strategies for overcoming identified barriers to effective communication were explored. The concept of dhuwurr in health communication was identified as central to enabling barriers to be overcome.

Dhāmanapan (connection)

Making a connection at the beginning of a health interaction was identified by all Yolŋu participants as essential for them to be comfortable with questions. Without this connection, questioning was more likely to be seen as rude and harmful to the process of healing and often resulted in disengagement from treatment:

So, it is like when I met you first, because I don't know you, I need to get to know you (gumurr-kunhamirr) first before I can talk or share what I have got. (Yolŋu participant)

Establishing good rapport with First Nations patients was recognised by health staff as important for effective communication. However, their concept of rapport was not equivalent to the Yolŋu concept of dhāmanapan. The dhāmanapan described as necessary by Yolŋu is more than just rapport building and includes a desire by Yolŋu to frame their health interactions within a system from their own worldview, gurrutu. Gurrutu is the complex set of reciprocal kinship relations that organises and connects every facet of the Yolŋu world¹⁵. The purpose of gurrutu and Yolŋu rom (law) is to maintain a state of māgaya (balance and social harmony) within Yolŋu society¹⁶.

Health staff in one group interview explained that they assume a reciprocal patient–health–carer relationship:

I think it is a kind of assumed thing for the patient as well, when you come into hospital you get certain things done, like you get your obs[ervations], you get your weight done. So, at the end of the day I think they just assume we are not just asking because we have nothing else to do, but we are asking because it's an important part of the process. (Nurse participant)

However, Yolŋu participants revealed that they did not feel that this reciprocal relationship existed. This difference in perceptions was explored further through discussions about the closest

equivalent traditional relationship: Yolŋu interactions with a Marŋgitj (traditional healer). In this relationship, question-asking does not form a part of the interaction between Marŋgitj and the patient as Yolŋu participants in one group conversation explained:

They will feel it and they can feel where the heat is. And they will feel it ...

Then they can touch the right place where it is sore ...

... then they can take it out. Or they can see it, at night-time, it is something there on you ...

... no questions. (Yolŋu participants)

Yolŋu described interaction with Marŋgitj as opposite to their experience in the Balanda (non-Indigenous) health system where health staff ask a large number of repetitive, interrogation-style questions. This contrast in communication styles between their interactions with health staff and their interactions with traditional healers caused one Yolŋu participant to wonder if the Balanda doctor knew what they were doing:

And with Balanda, question, question – hey you are the doctor you should already know. (Yolŋu participant)

The reciprocal doctor–patient relationship assumed by health staff was not reflected in the accounts from Yolŋu and, as a result, health staff and Yolŋu patients were operating in bakmaranhawuy (a broken connection). Ways in which dhāmanapan could be achieved and maintained were also explored with Yolŋu participants; taking time at the beginning of consultations to gumurr-kunhamirr (get to know each other face to face) and ensuring the patient has a bāmara (companion, helper or support person) were both considered important to establish connection.

Current history-taking systems in common practice, such as the Calgary Cambridge¹⁷, rely exclusively on question-and-answer formats, with the doctor in control. Yolŋu participants suggested that, for Yolŋu patients to be comfortable with questioning, doctors should gumurr-kunhamirr rather than rush straight to medically focused questions. Previous research in other cultural contexts has also identified the importance of this process, leading to the development of different models of communication with First Nations patients, including the concept of ‘yarning’¹⁸, which focuses on a narrative style of communication.

In addition to getting to know each other, a correctly chosen bāmara, one that is appropriate under both traditional gurrutu and in their personal skills and characteristics, can help create a connection between clinician and patient by strengthening the confidence of the patient and orienting the health interaction within their cultural decision-making model:

Sometimes there is a problem, the patient and the doctor, have a clash because the doctor is trying to work out how to help and the patient feels sick. That is why the escort is important for this situation to look after this part, to ease the tension a bit. To calm the patient down, to help the doctor.

(Yolŋu participant)

The current health system supports boarders/escorts for vulnerable patients, often defined as those aged less than 18 years, first-time mothers, and frail or disabled people. However, the system is not available to all Yolŋu patients and is often poorly implemented:

The wrong one goes because of the rush. (Yolŋu participant)

Sometimes now they don’t allow escorts to come unless you are dying or very frail. Young people, even though they are not English literate ... they still won’t send an escort with them. (Yolŋu participant)

Inappropriate bāmara are often sent, which not only leaves the patient unsupported but can create family unrest:

If anything happens there is trouble for the escort but if it is from the family line, then it is alright. It’s alright to have someone from a long [extended] family relation but all the family has to agree first and then it is ok. (Yolŋu participant)

Even when appropriate bāmara accompany the patient, a lack of understanding of the strain of the position and a lack of support during long hospital stays often results in suboptimal support for the patient and a broken connection with health staff.

Once the connection has been built with Yolŋu patients, it needs to be maintained by ensuring communication allows dharanjan (understanding) and follows djuŋuny norms. Dharanjan is achieved when the information is shared meaningfully in language through matha and a shared understanding of the healing concept of dukmaram.

Matha (language)

Many Yolŋu patients speak three or more Yolŋu languages as their primary languages. The present study’s findings confirmed previous research that found health communication is most effective in the primary language of the patient with the assistance of an interpreter^{3,19}. In circumstances where this was not possible, participants emphasised that plain English must be used. Yolŋu participants noted that questions in particular can cause confusion. This challenge with questions was also observed during discussions between the researchers and participants, where the intent and meaning of questions was sometimes misunderstood during discussions, requiring further clarification.

Language was identified as the main barrier to communication with health staff, yet the potential to minimise this barrier by using professional interpreters was rarely mentioned by health staff unless this topic was raised by researchers. All participating health staff discussed ways they found to circumvent the language barrier other than using interpreters. The barriers to interpreter use included lack of availability, time pressures on clinicians and incorrect assumptions about patients’ English language skills based on social small talk. Where staff had thought of utilising an interpreter, some had asked the patient ‘if they wished for one’,

which had been declined. Some Yolŋu participants explained that, when asked if they want interpreters, they don't say 'yes' as they either feel embarrassed or misjudge the level of English that will be necessary. Once they begin to find understanding difficult it can then be too late in the conversation and they are again too embarrassed to ask:

It would make them [the patient] feel shame if you ask them. How could a doctor ever hear the true story from the patient? The doctor won't know. They can only get the true story through the interpreter. This way they can both understand. (Yolŋu participant)

A number of the Yolŋu participants and the Yolŋu researcher in this study work as interpreters at the hospital. They all felt the current system of asking a patient if they would like an interpreter and then arranging a 'meeting' was perceived as too Balanda (dominant culture) by Yolŋu and thus often declined. From their experience, when these interpreters had informally visited patients, made connections through gurrutu and explained their role, most patients had asked them to return to help them talk with their doctors: from their perspective, interpreters should be brought to consultations as the norm and not as the exception.

Dukmaram (healing)

The Yolŋu concept of dukmaram encompasses healing of mind, body and spirit. Almost all Yolŋu participants did not perceive the hospital as a place of healing, which is consistent with the findings from other research with First Nations peoples²⁰:

I get more sick in the hospital and my mind is not the same and the stress level goes up. (Yolŋu participant)

The foreign nature of the health system was one reason given for the difficulty Yolŋu experience in making a connection with their health service providers. This disconnection often begins from the very first question ('What is your name?') as health records often only list the patient's English name and not their Yolŋu name by which they are more commonly known:

When we go to visit someone we can't find them because we don't know what name they have got. We have only known them [by their Yolŋu name] for all their life but we can't find them because we don't know the name they [health service] use [their English name]. (Yolŋu participant)

The structure of the tertiary healthcare system with different levels of practitioners and different specialities, which contributes to the high burden of repetitive questions, was not widely understood by Yolŋu participants. These challenges left many of the Yolŋu participants feeling isolated, which was viewed as counterproductive for healing. For example, talking repetitively about the details of their illness was not considered to be therapeutic by Yolŋu participants:

Someone is sick and hurting and we don't want to be repeating ourselves to everyone for the same story. We come in and they ask, 'What is wrong with you?' Then the nurse

comes and checks the blood pressure and everything. Then goes and then the next person comes back and says again 'What is wrong with you?' And the person is feeling very sick and we don't want to be saying our story again and that is when we get angry patients. You should be checking the notes. (Yolŋu participant)

Yolŋu participants explained that repetitive questioning around their illness actually brings on a sense of heaviness – known as ŋoŋun. This was also observed by one of the doctors, who noted that, unlike Yolŋu patients, for non-Indigenous patients the process of repetitively discussing their health issues was therapeutic:

Whereas for a Balanda [non-Indigenous] person part of the therapy is them talking and telling me in detail their story, and how they are feeling about it and then what happened and who was there at the time. Whereas I don't think it's the same for Yolŋu. (Medical officer participant)

Upon further exploration, Yolŋu participants explained that they did talk about their problems with other Yolŋu but in the context of healing; they more commonly looked to be distracted rather than talking about their issues in detail. A conceptual idea held by many Yolŋu that talking about something can bring it into being was identified by participants as a reason for their reluctance to talk about health problems: repetitively talking about their illness or possible bad outcomes causes stress from a feeling of increasing probability of it occurring.

However, consistent with findings from previous research^{2,3} Yolŋu participants expressed a strong desire for health staff to share detailed information about their health:

We want the whole story, when we ask the questions, we want a straight answer. We want to understand what is happening. (Yolŋu participant)

Although reluctance to talk about health problems and a desire to understand the deep story about their health appear to be contradictory positions, there are culturally acceptable ways for information to be shared with Yolŋu that respond to both concerns. Achieving this requires an understanding of, and ability to adhere to, Yolŋu communication protocols, which also influence the acceptability of questions.

Djuŋuny (Yolŋu norms of polite communication)

All Yolŋu participants noted that for the connection to be maintained and questions to be an acceptable element of communication the following areas of djuŋuny needed to be addressed:

- gender separation and privacy
- non-verbal communication
- communication context/environment and timing
- cultural norms for knowledge holding and sharing

The need for privacy, in particular privacy between genders and

between those in cultural avoidance relationships, was identified as important by all Yolŋu participants. However, they felt that the hospital was not structured to allow them to maintain these boundaries, which undermined cultural safety and communication:

He should ask me privately in a small room. Not in a room with curtains. In the emergency room there are lots of beds all lined up and there are lots of Yolŋu around. They need to keep our information private so others don't hear, especially for women's or men's story. (Yolŋu participant)

These direct questions can sometimes hurt people and then the doctor doesn't get the right information, whether it's male or female, because the patient will be embarrassed for themselves because they are talking to a different sex. (Yolŋu participant)

Lack of understanding about differences in non-verbal communication was also identified by Yolŋu and health staff as contributing to communication difficulties. Consistent with findings of previous research^{22,21}, these differences included reduced eye contact and increased use of silence. Communication style and being rushed also contributed to communication difficulties:

The doctors are rushing and rough talking. It hurts my feelings. (Yolŋu participant)

The timing and set-up of communication were important to Yolŋu participants: when possible, choosing a time to talk when the patient is comfortable and not too tired, hungry, cold or in pain and communicating in a way that makes everyone feel like they are on the same level, both in words and in physical set-up of communication.

Sometimes the doctor thinks they are more important, we don't want any of that. We already know that they are the doctors. (Yolŋu participant)

The common practice of health professionals gathering in groups and talking within sight of the patients, described by Yolŋu as 'side talking', also caused significant distress for Yolŋu participants:

They side talk, over here in groups while the patient is overhearing or seeing them. It makes a patient feel, 'oh, because I am not included, what story are they hiding from me'. The patients are making up what they are talking about in their mind. It is not good for the patient, so they refuse treatment because I heard them talking in a group. What are they going to give me? It is distressing for the patient and makes them feel uncomfortable and not connected with the doctor or nurse. (Yolŋu participant)

For Yolŋu, knowledge is not seen as an objective truth, free for anyone to acquire, but rather as an owned entity (and not just by one person)²². This was confirmed through observations during this research. The Yolŋu researcher identified the special voice tones used by people when they were discussing medical

processes or stories that they felt they did not own and thus it became dhuyu (sacred and to be respected). Yolŋu participants also explained that, should a child ask them questions about something they deemed them not ready to know, they, as the knowledge holders, would not share it and the child should not continue to ask more questions. There is a cultural expectation that knowledge will be shared when the knowledge holder feels they are ready, rather than others seeking that knowledge through questioning. When considered in the context of health care, where Yolŋu feel far from being expert, it is not at all surprising that they ask few questions about their health issues.

In my mind I come to the doctor because they are there to fix me, so I didn't want to get in the way. I thought they know what they are doing, so I am lying there thinking ok just fix me. (Yolŋu participant)

A lack of understanding of cultural differences regarding sharing of knowledge can cause mistrust to grow and connection to be broken:

I think too that Caucasian people, and I am talking about doctors, or nursing staff, are more forthcoming with opinions whereas from what I understand about Aboriginal culture is that if it's not your right to speak (if you aren't the knowledge holder or decision maker) you don't speak ... And I think that causes a bit of confusion. Why didn't they [junior medical staff] just be quiet when it wasn't their right to speak? (Medical officer participant)

Potential for confusion and mistrust was also identified when exploring the commonly used 'teach back' method, which asks patients to explain back to health staff what they understand. This method was not favoured by either health staff or Yolŋu participants, who felt it could easily cause shame and disengagement for a patient rather than be a way to create shared understanding. Yolŋu explained that, for them, the health interaction needed to be a two-way process with time taken so that questions could come throughout rather than rushing through and using the throwaway 'Do you have any questions?' line at the end. To overcome such challenges, the skills of both patients and health staff in intercultural communication are important.

Dhuwurr (health communication as a skill)

Yolŋu participants explained that health communication is dhuwurr that is complex and must be learnt through support and experience over time by Yolŋu patients and health staff. Yolŋu who have gained this skill appear to have an increased level of acceptance of health practitioner questions and, importantly, they report asking questions themselves more often.

I used to be shy and I never spoke to the doctors but now I am confident. Through experience I learnt to speak up. (Yolŋu participant)

Through this study's interviews, participants gave suggestions for how this dhuwurr could be developed. Suggestions included

better access to support for communication in their primary language, appropriate support from escorts, knowledge of how the health system works, cross-cultural knowledge and increased health literacy.

All Yolŋu participants felt there needed to be universal access to interpreters. One suggestion for achieving this was through permanent integration into medical teams, preferably with first-language speakers as the first contact with incoming patients.

The use of appropriate bāmara as supports for all Yolŋu patients was also seen as essential. Current guidelines on escorts are perceived to be unclear and inconsistently enforced. In addition, there is no information detailing who is considered an appropriate escort; it is left to the patient's discretion. Yolŋu participants felt it is important that bāmara are selected in accordance with Yolŋu rom. They suggested that guidelines be created with Yolŋu that detail who an appropriate bāmara is and that systems be put in place to support these people during long hospital stays.

In order for Yolŋu to develop dhuwurr in health communication they need to understand the hospital system and how it works, the roles of different healthcare workers, common medical procedure/illness explanations and key administrative/healthcare rights (such as patient travel) in their own language. Employment of cultural brokers with Yolŋu language skills and cultural knowledge would further strengthen the connection sought by Yolŋu with the health system and would also be a valuable onsite source of mentoring and education for both Yolŋu and clinicians.

In terms of clinical questioning, suggestions from Yolŋu centred around changes that would incorporate djuŋuny norms into health interactions. Many Yolŋu participants noted that tertiary hospitals often do not provide adequate privacy, particularly in spaces such as the emergency department, where patients are often double-bunked or only have curtains separating them from the patient(s) next to them. Separate sections for men and women in the emergency department, or individual rooms with solid walls, were also suggested.

In order to incorporate other aspects of djuŋuny norms in communication contexts and processes, participants suggested the following changes in the hospital:

- access to more chairs at the bedside to enable medical teams to sit when they talk with patients
- private spaces for doctors to sit and discuss with patients away from the bedside and out of sight of other patients
- larger rooms, which allow bāmara to bunk with patients.

Yolŋu participants also identified the need for education for health staff in the following areas:

- Yolŋu naming practices to enable Yolŋu to choose the name they are commonly known by and feel most comfortable with
- the burden that continual question asking has on Yolŋu patients, and changing systems to reduce this practice
- effective use of plain English. All Yolŋu participants felt that the language, both words and concepts, used by doctors was too difficult. The 'simple, non-medicalised' English health staff are advised to use during their training does not meet the linguistic and conceptual needs of Yolŋu
- respectful practices related to gender and kinship, including the desire for same-sex clinicians where possible
- how to implement a process of gumurr-kunhamirr as a 'getting to know you' process at the beginning of communication
- Yolŋu norms of information gathering and sharing.

Employment of a cultural communication mentor was suggested as a way in which ongoing training and feedback in communication could be incorporated into the hospital, creating a reflexive training system that reflects the complexity involved in acquiring this dhuwurr²³. This would be a Yolŋu speaker with both cultural and medical knowledge who could spend time with staff during their day-to-day work, subject to patient consent. In this way, they could give real-time feedback to staff members in a true 360-degree process, empowering Yolŋu patients by increasing their level of control and engagement in health interactions.

Conclusion

This study explored the communication experiences and perspectives of both Yolŋu and health staff, particularly on the use of questions in communication between health staff and Yolŋu patients. Participants shared stories of repeated miscommunication and a lack of interpersonal connection. Questioning was found to be an appropriate communication modality as long as the connection of dhāmanapan was established with their healthcare provider. Establishing connections through the use of meaningful matha and shared understandings of the healing concept of dukmaram and djuŋuny communication norms was considered essential to achieve effective communication.

This study found that the skills known as dhuwurr in health communication can increase the level of acceptance of questions asked by health staff and can increase confidence of Yolŋu patients in asking questions of health staff. Dhuwurr in health communication can be developed through better access to interpreters to support communication in primary languages, providing appropriate bāmara to support all Yolŋu patients, education for Yolŋu about how the health system works and increasing the understanding of health staff about Yolŋu norms of polite communication and healing. For these concepts to be integrated into health communication, mandatory intercultural communication training for health staff is needed, including strategies for knowledge maintenance, similar to the requirement for ongoing hygiene and resuscitation training.

First Nations peoples in the NT experience a disproportionately high burden of disease, and effective communication is critical to the reducing this burden. The findings from this study indicate a fundamental disconnect between the current health system and the needs of the Yolŋu patients it seeks to serve. A model of health care must be created and implemented that situates Yolŋu and their concepts of health and healing at its centre if we are to overcome these issues and make and maintain the connection of

dhämanapan required to close the health gap. Culturally safe and effective communication must be the norm rather than the exception to end the cycle of trauma caused by the current broken connection that is bakmaranhawuy. This training must be comprehensive, ongoing and delivered in a reflexive manner, such as the suggested use of cultural communication mentors, that reflects the complexity involved in developing this dhuwurr.

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