

# The aboriginal community experience of the Virtual Rural Generalist Service in Western New South Wales: A yarning study



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## Abstract

**Purpose** The Virtual Rural Generalist Service (VRGS) is an innovative hybrid medical model providing 24/7 medical support to rural public hospitals in Western New South Wales (NSW) where local doctors need additional support or where there is no local doctor available. A key component of the evaluation was to understand the impact of VRGS on access to healthcare for Aboriginal people<sup>1</sup> living in rural NSW and their experiences and views of virtual care provided by VRGS.

**Methods** Nine Aboriginal health workers from five VRGS sites were recruited and trained as Aboriginal community researchers (ACRs). The ACRs led the qualitative part of the Aboriginal community experiences component, including conducting all yarns, participating in the interpretation of findings, and formulating recommendations for ongoing service improvement.

**Main findings** Virtual healthcare delivered by VRGS was acceptable to some Aboriginal people but not others. VRGS improved access to a doctor afterhours or when a patient could not get an appointment. The connection and engagement with the VRGS doctor varied and many of the participants would have liked to

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<sup>1</sup>Aboriginal and Torres Strait Islander people are respectfully referred to throughout this article as Aboriginal in accord with NSW Health Policy (NSW Health 2005).





have had someone they trust with them during a VRGS consultation, to help them communicate with the doctor and explain things after the consultation. Education, Adequacy of care, Trust and rapport, and Communication were four important themes for informing continuing engagement and improved provision of care with VRGS for Aboriginal people living in rural NSW.

**Principal conclusions** There is clear variability in the experience of VRGS for Aboriginal patients and their carers across rural sites. While there is more work to do, the VRGS model can provide quality, culturally acceptable, remote healthcare when a doctor is not available locally.

**Keywords:** Virtual healthcare; Rural generalist; Yarning; Aboriginal community researchers; Evaluation

## Highlights

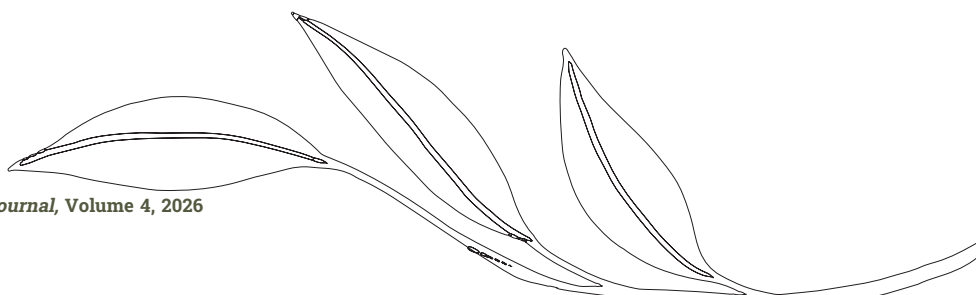
- Community-specific factors and local community dynamics play an important role in how a service, such as the Virtual Rural Generalist Service (VRGS), is viewed and experienced by the community.
- Experiences vary, but virtual care services like VRGS can be acceptable within the Aboriginal community and can work as an equal service to in-person care for the provision of healthcare in rural areas.
- It was important for Aboriginal patients and carers to share their experiences so that local health services are not lost but get better for community.
- Word of mouth is a vital promotion strategy because 'one bad experience filters through', but so does trust with a good experience.

## Introduction

The Virtual Rural Generalist Service (VRGS) is an innovative hybrid medical model providing 24/7 medical support to rural public hospitals where local doctors need additional support or where there is no local doctor available (Nott et al. 2024). This care is primarily virtual, but the service model incorporates an 'in-person' component with VRGS doctors visiting the communities they virtually serve and covering shifts at the hospital. Where care is virtual, VRGS doctors interact with patients and their families in an emergency department or inpatient ward via a purpose-designed mobile telehealth cart that allows two-way audio-visual communication. The VRGS also conducts daily virtual ward rounds, family meetings and case conferencing. The VRGS is an initiative of the Western New South Wales (NSW) Local Health District

(WNSWLHD), a large and primarily rural and remote health district, to improve health service access and outcomes in the context of rural workforce shortages. The VRGS has supported 31 rural and remote NSW health sites across the WNSWLHD since February 2020 and has expanded to serve Southern NSW Local Health District since 2023.

An evaluation of the VRGS was funded through a grant by the NSW Health Office for Health and Medical Research to investigate the impact and influence of the VRGS on healthcare and workforce for rural communities in the context of COVID-19 and in addressing the challenges of rural and remote health workforce (NSW Health 2024). A key component of the evaluation was to understand the impact of the VRGS on access to healthcare for Aboriginal people





living in rural NSW and their experiences and views of VRGS. This was important for several reasons. Aboriginal people make up 14.5% of the WNSWLHD population, compared with 4.2% across NSW ([NSW Health 2023; 2018](#)). Aboriginal people in WNSWLHD generally suffer a greater burden of chronic diseases and lower life expectancy than non-Aboriginal residents ([Australian Government Department of Health and Ageing and Primary Health Network 2022](#)). Historical discriminatory practices, government policies and marginalisation associated with colonisation mean that there can be significant barriers or reluctance for some Aboriginal people to access mainstream health services and healthcare ([Wilson et al. 2020](#)). Finally, a recent scoping review of telehealth use by Indigenous populations found that 60% of reviewed studies specifically mentioned Indigenous involvement in the development of a health service or the research process ([Moecke et al. 2024](#)). Improving this rate is essential to improve the cultural safety, accessibility and outcomes of health services for Aboriginal people.

The Aboriginal community experiences component of the VRGS evaluation employed a mixed methods approach to explore the experiences of patients and carers; the analysis of linked service administrative and quality of care data was published separately ([Luscombe et al. 2024](#)). This part of the project was strongly supported by the WNSWLHD Directorate of Aboriginal Health and Wellbeing.

This article reports the findings of the yarning and qualitative analyses against these three aims:

1. To understand the experiences of Aboriginal patients (and their carers) who have accessed care from VRGS;
2. To understand if VRGS improved access to and quality of healthcare for vulnerable populations, including those who identify as Aboriginal; and
3. To understand the perspectives of Aboriginal patients (and their carers) relating to the appropriateness and cultural safety of care from VRGS.

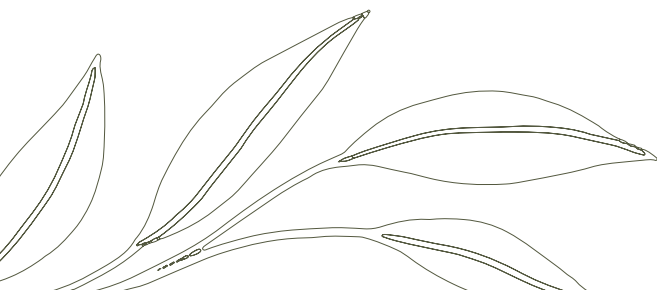
## Methods

### Setting

WNSWLHD includes the lands of 10 Aboriginal nations and Aboriginal people make up a significantly higher proportion of the WNSWLHD population than the state or national average ([NSW Health 2023; 2018](#)). The 31 WNSWLHD sites supported by the VRGS are small community hospitals and multipurpose services that provide emergency care, acute and subacute inpatient management and, in some cases, residential aged care.

An Aboriginal reference group was established to provide cultural advice and guidance for the design, implementation, interpretation and dissemination of the Aboriginal community experiences project. Nine Aboriginal health workers (including authors AC, DK, EK-W and S-AM) from five VRGS sites were recruited via expression of interest and trained as Aboriginal community researchers (ACRs) through a unique experiential research training program ([Thompson et al. 2026](#)). Three of the five communities are classified as remote (MMM6), the other two are small rural towns (MMM5) according to the Modified Monash Model (MMM), which measures remoteness and population size on a scale from major city (MMM1) to very remote (MMM7) ([Australian Government 2025](#)).

The ACRs were uniquely placed as respected members of the local communities who have local





cultural and community knowledge. They were also local Aboriginal health workers from either WNSWLHD or a local Aboriginal medical service, with professional skills and knowledge (they were the right people with the right skills), which supported authentic and culturally safe research while working in partnership with the VRGS evaluation team (Abbott et al. 2015; Kelly et al. 2012; Thompson et al. 2026). The ACRs led the qualitative part of the Aboriginal community experiences component, including conducting all yarns, participating in the interpretation, and formulating recommendations for ongoing service improvement.

### **Yarns: participant recruitment**

The ACRs used health service records and word of mouth to identify adults (18+ years) in their community who identified as Aboriginal and had seen a doctor via the VRGS at least once. VRGS interactions within two months were preferred, but any VRGS interaction was eligible, as long as the person could remember the experience. Eligible community members were provided information about the project. For those who agreed, a time and location for yarning was arranged.

### **Yarns: data collection**

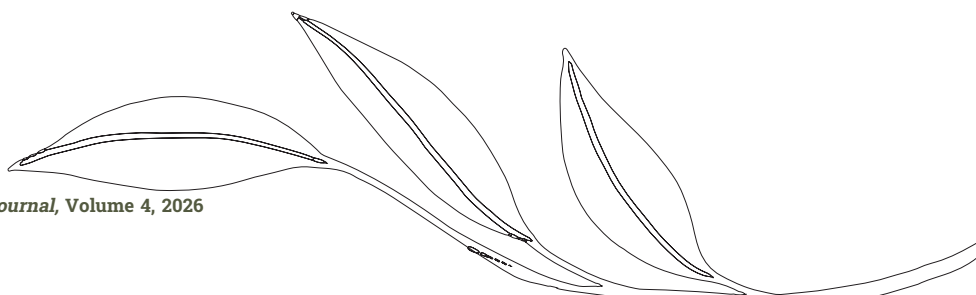
Yarns were conducted between 16 October and 3 November 2023. A two-stage verbal consent process was used, and yarning took place in accordance with the preferences of the participants: face-to-face, by phone, individually, in a group, at their home, in a public place (e.g. park) or at the local health service. Yarning began by reading an introductory script (Appendix A), then participants were allowed to control the direction and content of the yarn, consistent with the Blak Impact Yarning Tool (National Centre of Indigenous Excellence et al. 2020) and established principles of the yarning methodology in research (Barlo et al. 2021). The ACRs

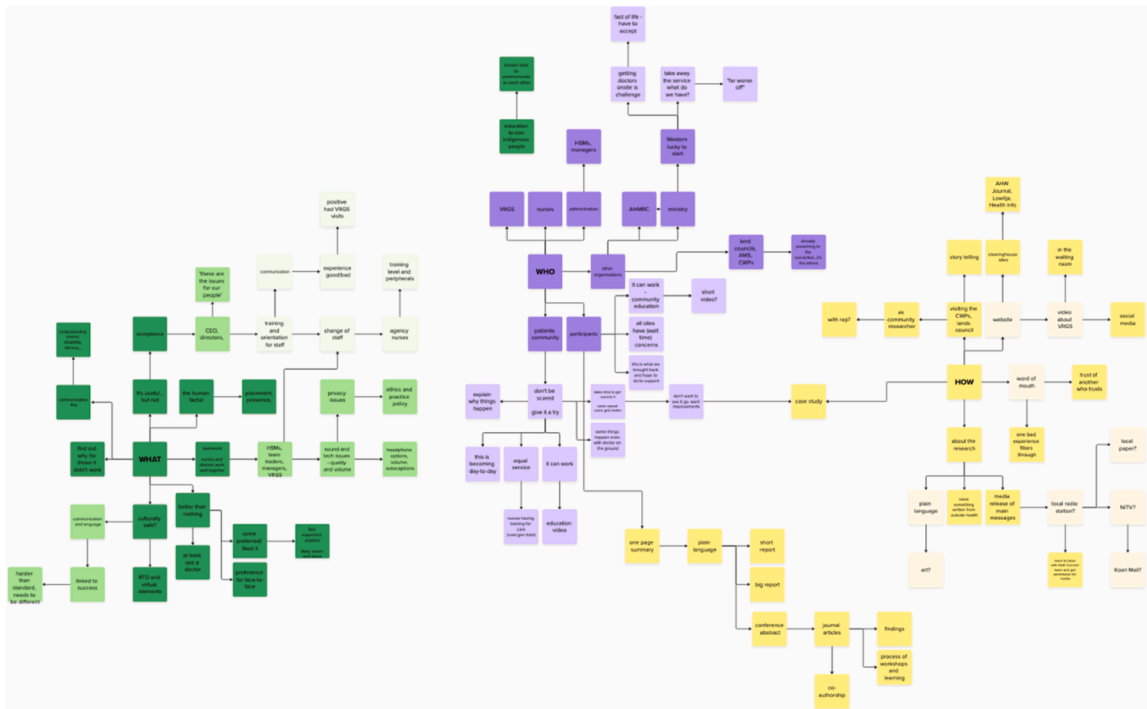
also had a list of possible prompts, if needed, to assist participants to tell their story (Appendix A). A community leader or Elder at each site could be employed as a ‘cultural safety officer’, to provide cultural support to the ACRs and participants. Use of this provision was at the discretion of the ACRs, based on their assessment of the needs and dynamics in their local community. None of the ACRs engaged a cultural safety officer.

Each yarn was audio-recorded and assigned a unique code. Each participant’s age, gender and geographical site of the yarn was recorded. No other participant-identifying information was recorded, and no individual characteristics or identifiers are attached to exemplar quotes, as per the agreement to maintain confidentiality. After yarning, a \$30 grocery gift voucher was given as compensation for each participant’s time and acknowledgement of the knowledge shared.

### **Yarns: sense-making**

The sense-making process was led by the ACRs and two members of the Aboriginal reference group with members of the VRGS evaluation team through two workshops in which the content of the yarns was reviewed, discussed and compared in terms of the three aims. All ideas were shared and confirmed by the group. Four concepts were identified in the final workshop that address the three aims and promoted ongoing service development for improved care with VRGS. The ACRs and VRGS evaluation team members went on to explore what needed to be shared, with whom, and how to share that information to improve virtual care and the experiences for Aboriginal patients and communities; this was recorded using the Mural online collaboration tool (Figure 1) (LUMA Institute 2023). The sense-making workshops supported exploration of the data and creating useful meaning together, as well as determining





**Figure 1:** Data analysis and sense-making; identifying What, Who, and How to improve virtual care and experiences of Aboriginal patients and communities. Screenshot of the Mural workings, *What – shades of green, Who – shades of purple, How – shades of yellow*, 20 November, 2023.

what needed to be shared, with whom and how to share that information to improve the experiences of virtual care for Aboriginal patients and communities.

The VRGS evaluation protocol was approved by the Greater Western Human Research Ethics Committee (GWHREC) (Project No. 2021/ETH01379 and 2021/ETH01355). Ethics approval was also obtained from the Aboriginal Health and Medical Research Council (AH&MRC) Human Research Ethics Committee (HREC) on 8 February, 2023 (#2010/22).

**Results**

Thirty-four people yarned with ACRs about their experience of the VRGS as a patient and/or carer. Two individual yarns were excluded because these

participants were reflecting on interactions with another virtual medical service, not VRGS. Most participants were female (75%) and the median age was 47 years (range 23 to 78). Seventeen yarns were with individuals and the remaining 15 participants yarned in small groups (Table).

**Aim 1: Patient/carer experience**

Healthcare delivered by the VRGS was acceptable to some but not others. For some, seeing a VRGS doctor was better than seeing a doctor in person because it was thorough, accurate and informative. Others said they would avoid going to hospital if they thought they would see a VRGS doctor (a ‘doctor on the screen’). Some reported long wait times to see a VRGS doctor, while others reported that it was ‘quick’.



One impediment was the quality of virtual transmission. Interruptions in the video connection and/or poor vision or sound quality affected communication and reduced confidence in the quality of care the VRGS doctor was able to provide.

Experience also varied by site, with participants from some sites more satisfied with the service. This satisfaction seemed to reflect their overall level of trust in the local health service. Those with positive comments about the care from local nursing and health staff expressed positive views about the VRGS, and vice versa.

### **Aim 2: Access to and quality of healthcare**

The VRGS improved access to a doctor when the hour was late or when they could not get an appointment. One parent of young children said: 'It's good to be able to just find out what's going on when it's late or something.' Another person said it was better than waiting for an appointment with the local doctors 'which takes forever with the local doctors around here'.

Among those who felt they received poor quality care, there was a lack of confidence that the VRGS doctor could examine them properly over a screen, and a view that the doctor on the screen was not 'a real doctor'. These people felt that the doctor could not fully understand the problem without a direct physical examination: 'You just feel there's no point of going up there because they can't physically observe you.' Another person said they would have had more confidence in the examination if the VRGS doctor had directed the local nurse to perform the examination, but this did not happen.

One participant said that some VRGS doctors were able to examine them adequately in the virtual format

using photographs as well as the video, but other doctors did not seem to use these tools. No one mentioned the use of the specialist equipment available at rural sites to assist virtual examinations, such as otoscopes. When one participant was asked about this, they were unaware that this equipment was available.

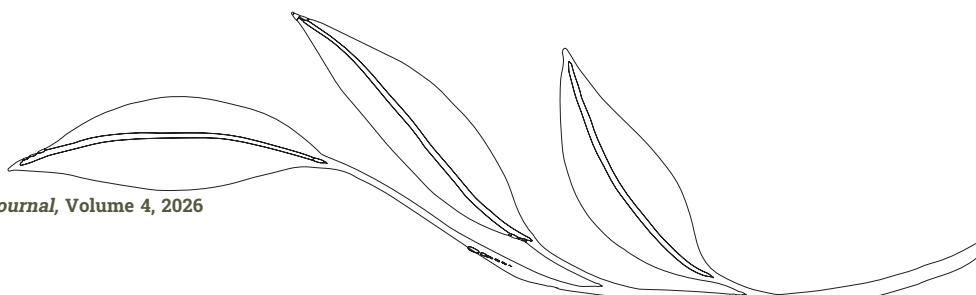
### **Aim 3: Appropriateness and cultural safety**

The connection and engagement with the VRGS doctor varied. Patients' VRGS experiences were informed by the individual doctor, their skill, manner and the effectiveness of their communication. Individual doctors were variously described as: being good at explaining things, being caring and concerned, and being thorough ('more thorough than the local doctors') to having an accent difficult to understand, being rushed and cursory ('wanted to get through their day quicker') and being 'rude'.

Many of the participants would have liked to have had someone they trust with them during a VRGS consultation, to help them communicate with the doctor and explain things after the consultation: 'cause some lot of Aboriginal people are too frightened to say anything, you know?'. This person could be a local nurse or an Aboriginal health worker. Although having a local nurse present with the patient for the VRGS consultation is part of the model of care, participants reported that the nurse was not always present because they were busy providing care to other local patients.

## **Discussion**

Many Aboriginal people accept the need for virtual services, like VRGS, to support health services and the provision of healthcare in rural areas (Fien et al. 2022; Caffery et al. 2018; Woodall et al. 2025; Mathew et al. 2023). There was a range of experiences shared with





Variable	Number
<b>People who yarned</b>	34
Excluded	2
Total participants	32
<b>Gender</b>	
Female	24
Male	8
<b>Interactions with VRGS as patient or carer*</b>	
Patient	23
Carer	6
Both	3
<b>Site of yarn</b>	
MMM5	
Molong	5
Narromine	8
MMM6	
Condobolin	5
Coonamble	8
Walgett	6
<b>Yarning format</b>	
Face-to-face	28
Telephone	4
<b>Yarn group size</b>	
Individual	17
2–3 people	6
4–5 people	9

MMM, Modified Monash Model, a rurality scale from major city (MMM1) to very remote (MMM7). Sum of interactions does not equal total number of participants, one person can have multiple interactions.

**Table: Characteristics of participants and the yarns led by Aboriginal community researchers exploring Aboriginal experience of the Virtual Rural Generalist Service (VRGS)**

the ACRs and keenness from the ACRs during the sense-making process to disseminate these findings for the improvement of care. Education, Adequacy of care, Trust and rapport, and Communication were four themes identified as important for informing continuing engagement and improved provision of care with the VRGS, each theme addressing matters of 'who', 'what' and 'how', identified during the sense-making process.

**Education** was a thread throughout the sense-making and sharing of the findings. It begins from a place of awareness on the side of the service about history and

local context, and on the side of the community about health service availability and adequacy (Saurman 2016). The greatest service is useless if people do not know about it or how to use it. The education needed, as identified by the ACRs, sat in line with education needs expressed for other virtual services; this included training in the exact use and application of technical equipment, physical examinations and cultural safety (Alotaibi et al. 2025; Woodall et al. 2025).

**Adequacy of care** included providing clarity about how virtual care works while also ensuring technological quality along with considered placement or use of the equipment and virtual tools, such as respecting privacy and managing volume settings (Kobeissi and Hickey 2023). Adequate telecommunications and equipment are necessary to minimise connection interruptions and maximise video and audio quality. While Aboriginal members of the community were willing to receive virtual care, ensuring patients' privacy while using the VRGS was a common consideration. Simple ideas from the ACRs to maximise privacy aligned with evidence for considering appropriate volume settings, the physical location of devices or equipment that could assist with privacy, such as the use of headphones, auto-captioning or external speakers to improve audio quality and allowing for a lower volume setting (Kobeissi and Hickey 2023; Caffery et al. 2017). There was also a clear component about the hands-on side of care and the importance of training local staff to use the available virtual tools and assist the doctor with remote examinations (Galvin et al. 2024).

The findings from this study echo international evidence that, while telehealth improves access for Indigenous populations, **Trust and rapport** remain



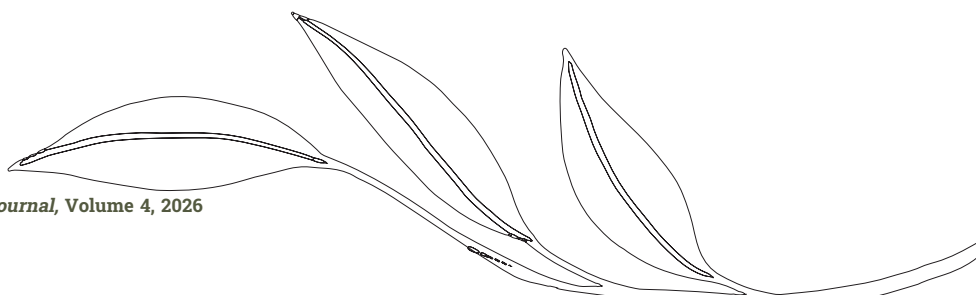


critical determinants of acceptability and effectiveness (Moecke et al. 2024). The findings highlighted the importance of contextual and cultural knowledge for cultural safety and trust (Fitzpatrick et al. 2023; Caffery et al. 2017; Caffery et al. 2018; Woodall et al. 2025; Terrill et al. 2025). This was identified by the ACRs in three arenas: the importance of the VRGS and local health staff understanding local historical experience for Aboriginal people regarding healthcare and services; engagement with the practitioner and the value of having the VRGS doctors visit the sites and meet the people in the community; and the application of this knowledge to better support care, particularly after hours. The ability to establish trust and rapport using virtual communication and interpersonal skills by VRGS clinicians is particularly important because Aboriginal peoples are more likely to have experiences of trauma related to healthcare settings. How healthcare is provided and how it is experienced are important aspects when delivering care for Aboriginal consumers (Australian Institute of Health and Welfare 2023; Caffery et al. 2018). This study reinforces the evidence that virtual models are most effective when combined with in-person engagement and a pre-existing doctor-patient relationship to build trust and rapport (Saurman et al. 2015; Woodall et al. 2025). VRGS clinicians physically visiting sites they serve virtually allows for contextual knowledge and understanding that engenders trust within the community. The presence of Aboriginal health workers also improves cultural safety and reduces self-discharge from hospital (Shaw 2016; Terrill et al. 2025). An implication is that models of virtual care, like VRGS, should embed structured roles for Aboriginal health workers and ensure resourcing for their presence during consultations. This is consistent with national strategies for culturally

safe care (Australian Institute of Health and Welfare 2023).

When virtual care is the only option, the responsibility surrounding **Communication** sits firmly with the VRGS and local staff. It is the health providers who are responsible for navigating language and accent barriers and providing thoroughness in examination and explanation while minimising preconception or judgement (Mathew et al. 2023; Caffery et al. 2018; Terrill et al. 2025). It is also important to ensure that Aboriginal patients are able to receive any necessary follow-up care from their preferred provider (e.g. local Aboriginal Medical Service). This demands good communication between multiple providers, including the provision of clear and timely discharge summaries. Communication necessarily goes beyond the virtual moment, with evidence demonstrating the impact of clear communication between providers for continuing care and improved outcomes (Becker et al. 2021; Sheehan et al. 2021).

Even though some have perceived that virtual care is not appropriate, the concerns outlined in a Parliamentary review align with the findings of the VRGS Aboriginal community experience, and while evidence is scant, there is an opportunity to do more (NSW Parliament 2022). The broader VRGS evaluation showed that VRGS does not differ in quality of care to in-person care and people's perceptions of VRGS become more positive with more experience of it (Thompson et al. 2024; Luscombe et al. 2024). The Aboriginal community experience project showed that Aboriginal people considered the VRGS to be 'better than nothing' because at least people were able to see a doctor when they needed one. As in other studies, sound, technology and privacy issues challenged engagement and use, but an early actionable recommendation for VRGS was to explore





the use of headphones to improve hearing, communication and elements of privacy (Terrill et al. 2025). Those who preferred face-to-face care needed to feel that they were supported and understood when getting care virtually. The human factor, allowing personalised care while acknowledging 'the issues for our people', was necessary for acceptability.

Next steps include a plan for the ACRs to share and discuss these findings with health service staff. The health service staff – VRGS doctors, local nurses and administration – were considered the first line responsible for improving the community's understanding of virtual care; that it can work and can be an equal service to in-person care. It was recognised that it was equally important for patients and carers to share their experiences so that the service is not lost but gets better. Word of mouth was deemed a vital promotion strategy because 'one bad experience filters through' but so does trust with a good experience. Promotional videos shared on social media or in hospital waiting rooms were another proposed strategy that may help improve Aboriginal communities' engagement with the VRGS. These findings have the potential to improve delivery of virtual care and the experiences of Aboriginal patients and communities. Future research should examine whether repeated exposure to virtual care improves perceptions of care and whether these improvements translate into measurable health outcomes (Thompson et al. 2024).

### Strengths and limitations

This evaluation yarned with Aboriginal patients and carers from five of the 31 sites in WNSWLHD with the VRGS. The evaluation demonstrated that community-specific factors and local community dynamics play an important role in how a service,

such as the VRGS, is viewed and experienced by the community. While community members valued being part of the yarns and there are transferable findings, the voices of Aboriginal patients and carers from only five communities were heard and each community is unique. There is a responsibility for VRGS to consider local needs to improve access and use.

There was limited exploration and prompting of participants' responses in the yarning process. This was partly intentional, allowing participants to direct the yarning, consistent with culturally appropriate research methods. It may also be partly due to limited applied research experience of the ACRs or opportunity for additional training and support (National Centre of Indigenous Excellence et al. 2020; Bessarab and Ng'andu 2010). Nevertheless, the opportunity and reality of learning while 'on the job' through the yarning and workshopping was considered important and valuable by the ACRs.

### Conclusion

This is an important contribution to the literature because there is a paucity of evidence related to the cultural safety of hybrid virtual services. Services like the VRGS, as with all health services, need to be culturally responsive and consider the sociocultural context of the communities they serve. There is clear variability in the experience of Aboriginal patients and their carers across rural sites. Addressing Education, Adequacy of care, Trust and rapport, and Communication can improve the experience, access and considerations of safety for Aboriginal patients, their carers and rural communities. While there is more work to do, this study demonstrates that the VRGS can provide acceptable remote healthcare when a doctor is not available locally.





## Author contributions

A. Thompson: methodology, formal analysis, writing – review and editing, visualisation, supervision, project administration. A. Carroll: formal analysis, investigation, writing – review and editing. D. Kenna: formal analysis, investigation, writing – review and editing. E. Kennedy-Williams: formal analysis, investigation, writing – review and editing. S-A. Merritt: formal analysis, investigation, writing – review and editing. J. Skinner: conceptualisation, methodology, writing – review and editing. G. M. Luscombe: conceptualisation, methodology, formal analysis, writing – review and editing, supervision, funding acquisition. E. Saurman: conceptualisation, methodology, formal analysis, writing – original draft, writing – review and editing, visualisation, supervision.

## Declaration of interests

Georgina Luscombe reports that financial support was provided by NSW Health Office for Health and Medical Research (COVID-19 grant). If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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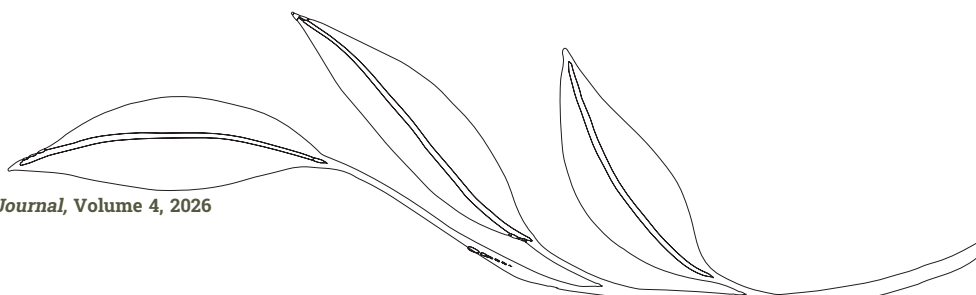
evaluation was funded through a grant from the NSW Health Office for Health and Medical Research, with co-Chief Investigators, Andrew Wilson and Shannon Nott. The project was supported by the Western NSW Local Health District (WNSWLHD) Directorate of Aboriginal Health and Wellbeing, and by the Coonamble Aboriginal Health Service. There were informal agreements between the partners involved, the research institutions and Indigenous governing organisation. The team acknowledge and thank all who participated in a yarn with our ACRs and the members of the Aboriginal reference group who contributed during the sense-making workshop, including Urayne Warraweena (Burranbinja).

## Supplementary material

Supplementary material associated with this article can be found in the online version at [10.1016/j.fnhli.2026.100118](https://doi.org/10.1016/j.fnhli.2026.100118).

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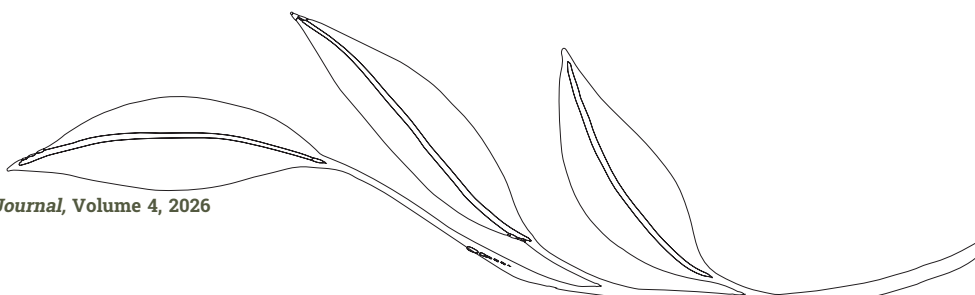


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## Appendix A

Yarning script and prompts for the Aboriginal community experiences component of the VRGS evaluation.

### *Introductory script:*

**INTRO:** Today we will be yarning about a service called the Virtual Rural Generalist Service, or VRGS. The VRGS is a video doctor service used in small hospitals and health facilities in western NSW. The video doctor service supports local doctors and can be used to fill gaps when no doctor is available.

Whether you join us in a yarning circle or a one-on-one yarn, we want to hear about your experience with the VRGS. You are welcome to say whatever you like and whatever you would like to offer will be treated as a gift of your knowledge and experience. We recognise that yarning about health can be difficult, and you can leave at any time you want to. Support from a

community cultural safety officer is also available if needed. You will also have an option for a one-on-one yarn after this yarning circle if you wish.

### *Optional prompts:*

- How many times have you seen VRGS? In ED or as an admitted patient or both?
  - > Suggest focusing on the most recent VRGS consultation they remember
- What was it that you did/didn't like?
- Have some of your experiences with VRGS been better/worse than others? Why?
- Has your view about virtual care changed since you first experienced it?
- How did you feel the VRGS doctor worked with local staff – as a team?
- If you hadn't seen a doctor on the screen, what would have been the alternative for you?
- Is there anything you can think of that would make it a better experience for you?

