Motivations, barriers and enablers for the sexual assault medical workforce in NSW, Australia

Research Report
November 2023

Acknowledgement of Country

We acknowledge the people of the many traditional countries and language groups of New South Wales. We acknowledge the wisdom of Elders past and present, and pay respects to all Aboriginal communities of today.

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Declarations

Funding

This research was funded by NSW Ministry of Health.

Conflicts of Interest

Natalie Edmiston is employed as the medical lead for Northern NSW Sexual Assault Services and as an on-call specialist VMO for Northern NSW Sexual Assault Services. She is a member of PARVAN Medical and Forensic Advisory Group, in her role as medical lead for Northern NSW Sexual Assault Services.

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The remaining investigators and researchers, Jane Ussher, Rosalie Power, Sam Sperring, Samantha Ryan, Azhaan Haq and Tatum Faber have no conflicts of interest to declare.

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Dr Jane Shapiro is acknowledged for assisting in preparing the Ethics application for this research.

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Ellie Freedman is a sexual health specialist working as the Manager of the Medical Forensic Portfolio at NSW Education Centre Against Violence, and also works as an on-call specialist VMO sexual assault examiner. Ellie Freedman worked with Natalie Edmiston and Kathryn Evans to help develop the research protocols, discuss the research findings and recommendations. She was primarily responsible for dissemination of recruitment information and liaison with the research team about participants. Her experiences as a medical and forensic examiner and her role supporting doctors and nurses state-wide who work as medical and forensic examiners informed her approach to the research.

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Executive Summary

Background

This report describes the outcomes of a research study that sought to understand the motivations and barriers for the sexual assault medical workforce in NSW, Australia. NSW Health is the main provider of sexual assault services in NSW, with services delivered in every Local Health District (LHD). NSW Health Sexual Assault Services (SASs) provide a range of evidence-based, trauma-informed and trauma-specific services including counselling, case coordination, advocacy, outreach, support in navigating the criminal justice system, medical treatment, and medical and forensic examinations. Doctors and nurses work alongside SAS counsellors to provide integrated psychosocial, medical and forensic crisis responses across the districts. Increased demand for expert medical and forensic services for people experiencing sexual assault requires a significant expansion of the workforce of examiners. Despite consistent interest from doctors and nurses in entering the workforce, transition to practice and long-term retention remain challenging. In order to understand the workforce dynamics, a team of medical professionals and researchers associated with Western Sydney University undertook a qualitative study of the motivations of people who work, have worked or have sought to work as sexual assault examiners in NSW. The objective of this study was to inform mechanisms to both encourage and retain employees, and in doing so, improve the ability to deliver services to people who have experienced sexual violence.

Methodology

The study population represented 31 doctors or sexual assault nurse examiners (SANEs) currently working in the NSW SAS workforce, those that had left the SAS workforce within last three years and those that had undertaken training to work in SAS in last three years but were not working in this capacity. We sampled metropolitan, rural and regional examiners, and also specifically sampled SANEs. We sought representation from a broad geographic area within NSW, and people with a variety of employment arrangements. The data collection utilised semi-structured individual interviews with participants and analysed these using thematic analysis.

Key Themes from Findings

1. The responsibility burden of a highly motivated workforce

The sexual assault medical workforce is highly motivated. They feel a sense of responsibility to patients, to other examiners, and are committed to continuing to provide a valuable service. For many, this responsibility burden is perceived as held by individuals rather than the organisation and can cause conflict with individual's own needs. Many of the participants revealed being under considerable pressure related to current workforce shortages with the balance of motivation to external factors and emotional demands approaching a tipping point whereby demands outweigh motivation. Participants spoke of a desire for flexible solutions that would enable their ongoing workforce participation.

2. On call: experiences of isolation and invasion

Being on-call can lead to experiences of isolation and invasion into home and personal life and these contribute to on-call being the most problematic aspect of current workplace structures, particularly for those who had limited daytime roles. Working predominantly on-call impacted the ability of examiners to use desired coping strategies, which included peer support and compartmentalisation. When the main work was crisis responses out of hours, examiners were reluctant to make contact with medical leads at the time and did not have other times with peers for support, leaving them feeling isolated. Being on-call brought the work into people's homes and personal lives, challenging compartmentalisation as a strategy to manage trauma exposures.

3. Workforce diversity

The workforce is diverse with differing motivations and barriers. Profession, background, gender, and age are quite varied creating a highly diverse workforce. Both doctors and nurses conduct the same medical and forensic examinations. As this is considered the primary role requirement, payment disparities between professions seems inequitable. In general, examiners from women's health or sexual health backgrounds described having an expert skill set related specifically to sexual assault, whereas those with emergency department experience were more comfortable with a potential broader scope of work. We noted younger examiners expressed a need for income and professional security and less responsibility burden expressed by male examiners.

Recommendations

1. NSW Health should increase medical and forensic examiners daytime staffing

Daytime staffing is urgently required in all LHDs, and this should be for a substantial proportion of the week, to allow genuine participation. Research participants described limited daytime roles impacting on service delivery, support and training opportunities and career pathways. Daytime staffing could be with nurses, doctors, or ideally, a mixture of both. Increased daytime staffing would benefit individual staff, both those in permanent daytime roles and those working predominantly on-call and enable LHDs to meet the expectations of NSW Health *Responding to Sexual Assault (adult and child) Policy and Procedures.*

Important considerations in increasing daytime staffing are:

- Ensuring medical lead support is available to all nurses, either within the LHD or via other mechanisms.
- Clear responsibilities and lines of management within the broader Violence, Abuse and Neglect (VAN) service.
- Access to appropriate nursing senior support for SANEs.
- Peer networking opportunities and teamwork with the VAN service as a whole.
- Service leads to facilitate increased communication with Ministry of Health, and within and between LHDs.
- A shift in responsibility to respond to sexual assault from individual on-call doctors and nurses to the VAN service as an organisation.

2. NSW Health should reduce demands and increase support for on-call examiners

Research participants almost universally described on-call as problematic and impacting workforce participation, so there needs to be mechanisms to reduce the demands of being on-call, and also provide more support for primarily on-call roles. The following are recommended as potential mechanisms.

- Increased daytime staffing, reducing the reliance on on-call staff, as examinations can be conducted in rostered hours. Additionally, daytime roles increase confidence with on-call work.
- Consideration of allowance for delayed responses, for both sexual assault examinations in the early hours of the morning and for after hours domestic violence presentations.
- A 24-hr advice line, similar to Child Abuse & Sexual Assault Clinical Advice Line (CASACAL) for adult examiners. It would provide remote supervision, expert advice and support, particularly useful for rural examiners and for new SANEs.
- Enhanced supervision to allow debriefing and processing of on-call experiences, particularly for predominantly on-call staff.
- Appropriate remuneration particularly for predominantly on-call roles, noting the missed income earning opportunities resulting from being on-call.

3. NSW Health should support a flexible approach to scope of practice to retain examiners

Research participants demonstrated high intrinsic motivation but this makes them vulnerable to distress if personal and organisational expectations exceed resources. Additional pressures on a short-staffed workforce, and organisational change risks losing examiners for whom SAS is a secondary role. To minimise this, consultation and flexibility such as the following are recommended:

- Allowing medical and forensic examiners to provide a limited range of services based on availability and expertise. Some SANEs are interested in patient care, including recording of forensic information and collection of evidence, but not preparing medico-legal reports or going to court. Such a role may be appropriate for SANEs solely working on-call and new SANEs in training.
- Requests for expert certificates and subpoenas managed as a responsibility of the service, not just the examining doctor. Where examiners are on leave or otherwise unable to produce an expert certificate and attend court, the potential for a non-examining expert to produce the expert certificate and attend court should be considered.
- Continuing flexible approaches to rostering and on-call expectations, as highly appreciated by participants. Approaches include reduced on-call hours and periods of leave from on-call responsibilities.
- Ensuring consultation and resourcing for potential expanded roles, such as examinations for people experiencing domestic violence.
- Transparency of expectations regarding potential changes to scope of practice.

4. NSW Health should review current pay and conditions

Fair payment is important both for equity and for visibility of the workforce. Research participants noted payment disparities between doctors and nurses, between doctors employed in differing capacities and between nurses employed in different positions, as well as disparities in renumeration for medico-legal tasks. It is crucial that large payment disparities are reduced, particularly where the expectations of the examiner are equivalent. Advisory group members provided input into the following potential solutions.

- Review of nursing payments. Standardisation of role descriptions to allow equivalent positions to be graded consistently across the state would reduce disparities.
- Pathways for experienced nurses to be regraded to clinical nurse consultant level or other senior levels, with clearly articulated responsibilities, would make a career path visible for nurses.
- Addressing on-call arrangements for medical and forensic examiners employed as staff specialists. Conducting examinations and filling roster gaps were considered an excessive expectation of staff specialists on-call and separate arrangements for allocation and remuneration are needed.
- Appropriate remuneration for expert certificate writing and court attendance is required, whether this be paid time or a reasonable payment.

5. NSW Health and ECAV should review approaches to recruitment and training

Increasing the medical and forensic workforce may require new approaches to recruiting and training examiners alongside opportunities for existing examiners to maintain and increase their knowledge and skills. Whilst satisfaction with existing training was high among participants, limits on developing expertise and unpaid time spent on training were noted. The following are recommended:

- Consideration should be given to changing recruitment strategies via increased visibility within medical education and recruiting more broadly, including men.
- Emergency nurses may have skills and interests more in line with potential future domestic violence work, notwithstanding the likely need to upskill in genital examinations.
- Development of a professional body for medical and forensic examiners or alignment with a larger professional body, such as Emergency Medicine.
- Paid training opportunities are required as there is a strong preference for face-to-face opportunities which require examiners to take time out of other work plus travel costs for regional examiners.
- Consider expanding opportunities for ongoing training, including doctors wishing to gain further expertise.
- Consider reviewing the approach to medico-legal training within Education Centre Against Violence Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault.
- Increasing activities and visibility of the SANE network.

Glossary

Barriers – personal or organisational factors that made it difficult to commence or continue in the sexual assault examiner workforce.

Burnout – characterised by a sense of frustration, emotional exhaustion, depersonalisation, reduced sense of control and personal accomplishment, burnout is known to be a reason people may leave the workforce.

Caseload – the number of sexual assault examinations conducted in a particular time period.

Clinical Nurse Consultant (CNC) – is an experienced registered nurse who contributes across the domains of clinical service and consultancy; clinical leadership; research; education; and clinical service planning and management.

Clinical Nurse Specialist (CNS) – is a registered nurse who applies a high level of clinical nursing knowledge, experience and skills in providing complex nursing care directed towards a specific area of practice, such as sexual assault.

Compassion Fatigue – the physical, emotional, and psychological impact of helping others, often through experiences of stress or trauma.

Compassion Satisfaction – the pleasure derived from helping others, often found to correlate positively with resilience; that is, the ability to cope, learn and grow from difficult experiences.

Domestic Violence (DV) – a complex pattern of behaviours that may include, in addition to physical acts of violence, sexual abuse and emotional abuse.

Education Centre Against Violence (ECAV) – ECAV is NSW Health's state-wide unit responsible for workforce development in the specialist areas of prevention and response to violence, abuse and neglect, including sexual assault.

Enablers – factors that support and facilitate participation in work. They overcome barriers to participation or make it easier, despite the challenges.

Expert Certificate – also known as Expert Witness Certificate, is a medico-legal report that records the medical and forensic examination and the examiner's expert opinion in a format acceptable as evidence in court.

Expert Witness – an expert witness is a person who has specialised knowledge based on their training, study or experience. Unlike other witnesses, a witness with such specialised knowledge may express an opinion on matters within their particular area of expertise.

External factors (Herzberg) – also referred to as hygiene factors, which do not motivate employees but can minimise dissatisfaction, if handled properly. These include policies, supervision, salary, interpersonal relations and working conditions.

Forensic – referring to activities such as the collection of history of the assault, physical injury documentation, and biological evidence collection to assist with a criminal investigation. In NSW these activities are usually part of a medical and forensic examination.

Intrinsic motivation (Herzberg) – work motivation stemming from internal factors such as achievement, recognition, responsibility, and work that is challenging or interesting.

Local Health District (LHD) – NSW Health has a total of 15 Local Health Districts: eight in metropolitan areas and seven in rural and regional NSW.

Medical and forensic examiner (MFE) – specifically trained doctors and nurses who provide combined medical and forensic or medical only examinations to people who have experienced sexual violence, abuse and neglect. Within NSW, the majority of MFEs work within a sexual assault service to provide examinations to people who have experienced sexual assault (See Sexual Assault Examiners). However, some also provide examinations to people experiencing domestic violence.

Medical Lead – a doctor employed to provide the overall coordination and quality assurance of the medical and forensic components of the LHD's response to sexual assault. Sometimes referred to as Medical Director.

Medico-legal – referring to the activities conducted to support the prosecution of sexual assault criminal matters as part of medical and forensic responses to a person who has experienced sexual assault. Providing medico-legal reports and attendance at court as an expert witness are the primary activities conducted.

Moot court – a simulated court. The process of "mooting" involves arguing points of law before a simulated court during training.

Motivations – things that motivate someone to start or stay in the work.

Organisational factors – structural factors contributing to a worker's experience, e.g., within the LHD, NSW Health, or management.

Patient – a person receiving medical care. The term 'patient' is used when referring to a person accessing medical and forensic responses, and therefore someone who has experienced sexual assault or domestic violence. The terms victim or survivor are used when connected to the literature or within quotes.

Psychosocial – the influence of social factors on an individual's mind or behaviour, and the interrelation of behavioural and social factors.

Secondary traumatic stress (STS) – the natural consequent behaviours and emotions that result from knowing about a traumatising event experienced by another and the stress resulting from helping, or wanting to help, a traumatised or suffering person.

Sexual Assault – when a person is forced, coerced or tricked into sexual acts against their will or without their consent, or if a child or young person is exposed to sexual activities. This can include both sexual assault as defined in the NSW Crimes Act 1900, and other sexual offences.

Sexual Assault Examiner – in this report we primarily use the term sexual assault examiner to refer to medical and forensic examiners working within a sexual assault service. This is to avoid conflation with other roles associated with the broader term, MFE. For all intents and purposes, the participants of the study are sexual assault examiners. Sexual assault examiners may be doctors or nurses (see SANEs).

Sexual Assault Nurse Examiner (SANE) – a nurse, registered with a board and who has completed additional education and training to provide comprehensive health care to people who have experienced sexual assault.

Sexual Assault Services (SAS) – services for people experiencing sexual assault, delivered by LHDs. Every LHD has a Sexual Assault Service that operates 24 hours a day, seven days a week.

Social Worker – social workers give support, counselling and information to patients and their families. Within sexual assault services, social workers are also referred to as counsellors, and provide the initial response to patients.

Staff Specialist – a Staff Specialist is a Specialist doctor employed within an LHD.

Violence, abuse and neglect (VAN) – Violence, abuse and neglect is a term used by NSW Health as an umbrella term to describe three primary types of interpersonal violence that are widespread in NSW and across Australia:

- all forms of child abuse and neglect
- sexual assault
- domestic and family violence.

Vicarious Resilience – the positive impact on and personal growth of people resulting from exposure to others' resilience, particularly in the face of trauma.

Vicarious Trauma – a negative reaction to trauma exposure, which includes a range of psychosocial symptoms that responders may experience through their intervention with those who are experiencing or have experienced trauma.

Visiting Medical Officer (VMO) – is a medical practitioner appointed under a service contract to provide services as a visiting practitioner for monetary remuneration or on behalf of the public health organisation concerned. Both specialist doctors and general practitioners can be VMOs.

Introduction

This report describes the outcomes of a research study that examined the experiences of people who currently or previously have worked as medical and forensic examiners in New South Wales (NSW), Australia. The study aimed to understand the motivations, barriers, and enablers for people to work as medical and forensic examiners in NSW Health Sexual Assault Services (SAS). It explored all stages of work engagement, from recruitment to commencing work, remaining at work, and because people who leave the workforce may be an important source of information about the problems within it, leaving the workforce. The study makes recommendations to improve the number of examiners in the workforce, the retention of trained examiners, and as a result, improve the experiences of those accessing the service.

Background

What are NSW Health Sexual Assault Services and who works in them?

NSW Health has a network of specialist SASs delivered by Local Health Districts (LHDs) and speciality health networks. SASs provide services to clients or patients and their families and significant others, professionals and communities.

The key elements of the SAS model are:

1. **crisis response**
2. **medical and forensic service**
3. **ongoing counselling and other therapeutic interventions**
4. **systems advocacy**
5. **court preparation and support**
6. **professional consultation and training**
7. **community engagement, education and prevention.**

NSW Health SAS provide integrated psychosocial, medical and forensic crisis responses to people who have experienced sexual assault.

There are three key elements of a SAS crisis response:

1. **coordinating the overall care commencing with an initial assessment**
2. **providing crisis counselling, information, support, advocacy and referral**
3. **providing medical and forensic services.**

An integrated crisis response is where a SAS counsellor and a medical and forensic examiner work in partnership to address the immediate psychosocial, emotional, and medical and forensic needs of person who has been sexually assaulted. The key focus of this intervention is the health, safety and wellbeing of the person who has been sexually assaulted.

NSW Health *Responding to Sexual Assault (adult and child) Policy and Procedures* (NSW Health, 2020), requires each LHD to have at least one Level 4, 24/7 integrated psychosocial, medical and forensic SAS which provides responses to adults and children. Other SASs operate with varying combinations of other elements of the SAS Model as outlined in Section 12 of the SAS policy. Services are organised across 15 LHDs. These districts manage public hospitals and health facilities and provide a range of health care services to defined geographical areas across the state (NSW Health, 2020). As per the *Responding to Sexual Assault (adult and child) Policy and Procedures* (NSW Health, 2020), a SAS counsellor will commence a crisis response, ideally within an hour of an individual who has experienced a recent sexual assault (within the past seven days), presenting to a NSW Health facility. The crisis response by the counsellor includes co-ordinating a medical response if required and a forensic response if the individual wishes. Medical and forensic services are delivered in partnership with the SAS counsellor and should commence within two hours of a request. In addition to providing medical care to an individual, a forensic response will involve evidence collection and preparing medico-legal documents for criminal justice processes (NSW Health, 2020). A crisis psychosocial only response is also provided by NSW Health SAS counsellors for a range of presentations. SAS provide services to adults and children, however service models vary across the state. In 2019, the NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework (NSW Health, 2019) was released which included an objective to ensure that coordinated, integrated and comprehensive psychosocial, medical and forensic services are provided to people who have experienced sexual assault (adult and child) or domestic and family violence. One method of integration could include SASs expanding their scope to include other aspects of Violence, Abuse and Neglect (VAN) such as domestic violence medical and forensic examinations.

The SAS medical and forensic workforce includes both medical officers and nurses, who may be employed for rostered hours, as on-call examiners, or a mixture of both. Medical officers are employed either as Visiting Medical Officers (GP or Specialist), Career Medical Officers, or Staff Specialists, noting that as sexual assault response is not a specialty, these doctors are trained in related clinical specialties. Nurses are employed in a range of gradings and classifications and once qualified are referred to as Sexual Assault Nurse Examiners (SANEs). Whilst LHDs are responsible for credentialing examiners, medical officers have no specific training requirements, whereas the minimum requirements for SANEs are more prescriptive. These include three years relevant clinical experience and a requirement to undertake a Graduate Certificate, such as the Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault offered through the NSW Health Education Centre Against Violence (ECAV) (NSW Health, 2020). Doctors may be credentialed to provide examinations for adults, children or both, whereas SANEs can only provide services to people 14 years and up. The workforce providing examinations for children under 14 years of age includes paediatricians and credentialed doctors with limited overlap with the workforce providing examinations for adults and children and young people 14 years and over. This research has not included examiners providing services to children under 14 years of age exclusively, as the workforce issues and employment arrangements have unique features and were considered outside of scope.

What gaps is this research addressing?

In addition to timeliness, best practice for medical and forensic responses is to deliver these close to the residence of the person who has experienced sexual assault. Prompt local availability of a response is trauma-informed, and avoids unnecessary delays for forensic collection, transportation challenges, and increased cost. Across NSW the demand for SAS varies, but sexual assault occurs in all LHDs and at all times of the day. A 24-hour response requires a suitably large workforce to maintain prompt availability both across time periods and geographic locations. However, in many areas of NSW, SASs have difficulty maintaining adequate staffing to provide this response, particularly the medical and forensic care delivered by doctors and nurses (personal communication) (Edmiston, 2022). The reasons behind inadequate staffing levels are poorly represented in the literature as few Australian studies address these issues.

Existing research indicates that the SAS workforce experience numerous challenges in the work they do. These challenges – outlined in the proceeding sections of this report – have the potential to greatly impact staff wellbeing and retention. Although preliminary research has begun to explore the barriers to workforce participation in SAS much of this has focused on counselling staff (Choi, 2011; Choi, 2017; Ghahramanlou & Brodbeck, 2000; Iliffe & Steed, 2000; Ullman & Townsend, 2007). Further research is needed to better understand the specific needs and experiences of medical and forensic examiners. Despite challenges, many doctors and nurses remain highly motivated to participate in the work, with annual large intakes into ECAV's Graduate Certificate. Informed by Herzberg's motivation – hygiene theory (Herzberg et al., 1993), which says that work satisfaction is a balance between intrinsic motivation and external factors, we sought to understand the motivations, barriers and enablers to participation in the workforce. The objective of this study was to inform mechanisms to both encourage and retain employees, and in doing so, improve the ability to deliver services to people who have experienced sexual violence.

Why is this important?

The effective provision of SAS is critical as sexual violence, including sexual assault, is a serious public health and human rights issue with long-term personal, social, health and economic costs to individuals, families and communities (NSW Health, 2019; World Health Organisation, 2014), one which is only worsening (Nathanson et al., 2016). In Australia, one in five women and one in 16 men have experienced sexual violence since the age of 15, which often occurs in the context of relationships or family (ABS, 2023).

As this is the first study devoted to understanding the motivations and barriers for the sexual assault medical workforce in NSW, Australia, it will provide the evidence to inform policies to improve workforce participation numbers. The following section of this report examines the background evidence which informed the development of the study. We then outline the methodology of the research study conducted, and the findings of the research.

EMOTIONAL ASPECTS OF SAS

A notable feature of the sexual assault workforce is domestic violence and sexual assault advocate's sustained devotion to the mission of ending violence and supporting survivors (Bemiller & Williams, 2011; Wood et al., 2017). There are both positive and negative emotional outcomes associated with this mission, and numerous challenges impacting staff wellbeing and retention (Crivatu et al., 2023). Professionals who specialise in working with sexual violence can experience a range of negative psychological outcomes associated with exposure to trauma, including elevated levels of stress, compassion fatigue (Townsend & Campbell, 2009), and vicarious trauma (Tabor, 2011), often meeting clinically diagnosable levels of post-traumatic stress disorder (PTSD) (Baird & Jenkins, 2003; Brady et al., 1999; Choi, 2011). Burnout, characterised by a sense of frustration, emotional exhaustion, depersonalisation, reduced sense of control and personal accomplishment (Cocker & Joss, 2016; Maier, 2011; Townsend & Campbell, 2009; Valent, 2002) is known to be a reason that nurses not working in sexual assault leave their jobs, and even the nursing profession (Moloney et al., 2018). While the emotional impacts of working in SAS are well documented, we know relatively little about the way workers are supported and support those around them in this workforce.

Studies have shown that age may play a protective role amongst sexual assault staff, irrespective of time spent in the role; hence it has been suggested supervisors and administrators could work with younger staff to identify coping strategies that can help mitigate workplace stress (Voth Schrag et al., 2022). This aligns with the work of Brady et al.'s (2019) study on the effect of secondary traumatic stress on the relationships of forensic interviewers, including those with friends, family, and their respective children. This study pointed to the critical importance of organisational practices in reducing workplace stress in sexual assault. It also echoes another study (Substance et al., 2014), wherein it was found that training supervisors in trauma-informed supervision and equipping them to identify workers at high risk of exposure to traumatic material is critical to addressing occupational stress. Peer or group model approaches to supervision were seen to promote collaboration and mutuality among workers – both key principles in a trauma-informed organisational approach (Baird & Kracen, 2006; Crivatu et al., 2023; Substance et al., 2014). For domestic violence social workers, an Australian study found frequent individual supervision is associated with lower intention to leave work (Cortis et al., 2021). Supervision is recognised as integral in social work but less well recognised for nurses and even less so for doctors.

External social support such as family and friends is highly important, demonstrating the significance of outside social support for workers, as shown in a study of chief medical investigators in cases of child sexual assault (Brady, 2017). Paradoxically, as a consequence of vicarious trauma, medical and forensic examiners are at a heightened risk of emotional unavailability to family (Ellis & Knight, 2018). Workplaces should ensure time for coping strategies, such as time with family, peer support, supervision, and hobbies (Baird & Kracen, 2006; Bouchard et al., 2022; Crivatu et al., 2023; Wachter et al., 2020). However, poor staffing makes this difficult to achieve.

The capacity to mediate the negative impacts associated with sexual assault work is influenced by organisational satisfaction (Brady et al., 2019), the presence of training, supervision and guidance, workloads and caseload characteristics, individual characteristics, and examiners' own coping and self-care mechanisms (Baird & Kracen, 2006; Crivatu et al., 2023). Positive impacts associated with support include emotional empowerment, improved relationships, compassion satisfaction, and post-traumatic growth (Crivatu et al., 2023).

EMPATHY AND THE FEMINISED HEALTH WORKFORCE

While health workforce composition has become increasingly feminised, little research has been conducted to explore the experiences of health workers through a gender lens (Witter et al., 2017). Despite the feminised growth of the health workforce, women still tend to be over-represented in the lower tiers (Gupta et al., 2003), are under-represented in leadership roles (World Health Organization, 2008), over-represented in unskilled and unpaid work (George, 2007), and earn less than men (Gupta et al., 2003). By considering the gendered nature of sexual assault work, this study will shed light on the ways in which gender structures women's involvement in, and experience of, sexual assault work. This includes an understanding of the relationship between gender and empathy. Lobb (Lobb, 2013) has drawn attention to the ways in which stereotypical accounts of empathy, as intrinsically feminine, have gradually reinforced empathy's unjust distribution via gender. What Lobb refers to as "empathism" – the cultural investment in and ontological claim that women "do empathy" better – will provide a useful framework for understanding women's experiences of responsibility burden (and their consequent burnout) in SAS. A consideration of empathism in relation to labour distribution in SAS will assist in questioning the "complex structures of affect and power in social space" – including the space of health – to reconceive its effects on women as "an issue of distributive justice" (Lobb, 2013, p.429).

ORGANISATIONAL CONTEXT

Social workers in sexual assault have identified neo-liberal organisational aspects as barriers to effective practice (Hendrix et al., 2021); for example, the neoliberal values of individualism and neoliberal responsibility which emphasise, "revenue generation, accountability and micro-management, and competition, privileging market processes over human or social processes—its constant chant is 'do more with less'" (Hendrix et al., 2021, p.164). Here, self-care is the responsibility of the individual and not the organisation, framing burnout as a personal failure (Hendrix et al., 2021). Inadequate organisational resources, unmanageable caseloads and burnout have been identified by sexual assault advocates as interfering with delivery of quality services (Kulkarni et al., 2012). To address this, it has been suggested that neoliberalism be "made visible". Specifically, as researchers we are encouraged to be systematically critical of "individual problems" that do not attend to social, economic and organisational contexts (Hendrix et al., 2021). Organisational interventions that seek to protect workers and take responsibility for policies and practices that seek to relieve stress can therefore promote a healthy workforce (Kulkarni et al., 2013; Wachter et al., 2020). To date, there is no research on the impacts of neoliberal organisational factors on doctors and nurses working as medical and forensic examiners.

In terms of organisational risk factors, high caseloads and poor pay, staffing issues, lack of supervision and training availability, and increased bureaucracy in the workforce have been shown to increase rates of emotional fatigue and burnout amongst sexual assault and domestic violence advocates (Frey et al., 2017; Ullman, 2010).

OTHER CHALLENGES

Apart from the complex and challenging nature of the work itself, data from a national survey of Australia's domestic, family violence and sexual assault sector indicated that this population also faced insecure funding and low remuneration (Cortis et al., 2021). Feeling fairly paid has been associated with lower intention to leave SANE work and with feeling valued for the work (Strunk & Strunk, 2012). Although more research is needed to understand SANE's turnover intent, existing research suggests that adequate pay and opportunities for professional development may enhance feelings of empowerment, and in turn, decrease turnover intention (Strunk & Strunk, 2012). Conversely, Swiss, German and Austrian Forensic doctors have reported work satisfaction but consider the lack of career opportunities and career support to be the main reason for low staff numbers (Gauthier et al., 2013).

Provision of evidence and expert opinion in court is required for a minority of cases but can be delayed months or even years from the time of the initial medical and forensic response. The medico-legal aspects of sexual assault work may be challenging to staff. Family court and supporting domestic violence survivors has been viewed negatively by general practitioners (GPs), and role conflict between the disciplines of nursing and forensic medicine are potentially problematic (Downing & Mackin, 2012; Kuruppu et al., 2023). Court may therefore serve as a disincentive to work in SAS; a greater understanding of this barrier and how it may be addressed is required.

Under NSW Health policy, every district must have a minimum of one 24/7 integrated psychosocial, medical and forensic service (NSW Health, 2020). For the most part, LHD staff these services after business hours via on-call. Working predominantly on-call without substantial daytime hours has significant negative consequences because it impedes examiner's ability to interact with peers and utilise other coping strategies such as regular sleep and time with family (Geiger-Brown et al., 2011). SANEs in United States face challenges of on-call systems and scheduling as well as high levels of stress and anxiety due to sleep deprivation and a lack of confidence in, and familiarity with, the SANE role (Geiger-Brown et al., 2011; Gonnering, 2015). In addition to feelings of inflexibility over work-life balance, sleep problems due to being on-call have shown to increase the likelihood of errors, delay reaction time and impair judgement (Geiger-Brown et al., 2011).

CONCERNS SPECIFIC TO SANES

As this is a new and emerging area of research there is a shortage of literature on SANEs in Australia. International literature was used, the majority emerging from a United States context, as will be the primary focus here – followed by Australia and the United Kingdom.

United States

There is a longstanding recognition of the important role that skilled SANEs can play in the medical needs, safety and long-term emotional consequences of individuals who have experienced sexual assault (Green et al., 2021). Due to the issue of a global nurse shortage, there is a growing demand for nurses across all areas of healthcare (Drennan & Ross, 2019). Maintaining a SANE workforce is a key challenge when "the average length of stay in [the US SANE] field of nursing is 12 to 18 months after successful completion of orientation" (Green et al., 2021, p.644). While financial incentives play an important role in attracting nurses, peer support and a good working environment are also highly valued (Drennan & Ross, 2019). A systematic review in 2017 indicated managerial style and supervisory support to be the organisational factors that hold most weight in regard to nurse turnover (Halter et al., 2017). The business solution proposed by Green et al (2021) was to employ SANE/emergency department (ED) nurses who work in ED half of the time and SANE work half of the time but could, however, attend cases from either position (Green et al., 2021). In better supporting nurses, this strategy "reduce[d] burnout related to secondary or vicarious trauma, foster[ed] sustainable staff, increase[ed] the quality of care, and reduce[d] legal and regulatory risks to patients" (Green et al., 2021, p.652). That said, working in both ED and as a SANE has been associated with higher burnout and lower staff retention (Zelman et al., 2022).

Of the studies in the United States of SANEs, burn out, moral distress, vicarious trauma, interpersonal conflict with other staff, high staff turnover, job dissatisfaction, and areas of work-life fit are named as reasons for nurses leaving their jobs (Baird & Kracen, 2006; Karakachian & Colbert, 2019; Wood et al., 2019). Maier's (2011) qualitative study on SANEs' experiences of vicarious trauma and burnout as a result of treating sexual assault victims, noted that of 39 SANEs interviewed, 67% disclosed experiences of vicarious trauma, concerns over victims after they had left, and burnout. They all, however, expressed using strategies to cope after difficult cases, including talking with family members, debriefing with colleagues individually and at meetings, and engaging in relaxing activities. Peer support therefore appears vital in mitigating the negative emotional impacts associated with SANE work (Maier, 2011). Hospitals and other organisations employing SANEs should provide a support system with resources in place to mitigate these effects (Baird & Kracen, 2006).

There is a potential for role conflict (Van Sell et al., 1981) between the disciplines of nursing and forensic science, which may occur when an individual must perform multiple different roles in a single capacity. SANEs are at risk of role conflict as they prioritise patient support and advocacy (Downing & Mackin, 2012), yet must also "collect evidence in an objective and scientific manner" (Langness et al., 2022, p.89). Nurses may additionally experience moral distress because of this value/job conflict and this is associated with burnout (Karakachian & Colbert, 2019). Having a sexual assault advocate present at examinations, such as a counsellor, may help to mitigate some of this role conflict and increase work satisfaction (Downing & Mackin, 2012).

Anxiety and low confidence in SANE skills are two key barriers to SANE nursing – particularly in rural areas (Logan et al., 2007). Maintaining proficiency through training and professional development opportunities is therefore crucial in overcoming these barriers and increasing workplace participation.

Australia

Despite there being an estimated 335,000 staff employed in first responder roles, there has been limited research on the wellbeing of Australia's first responder populations, particularly SANEs (Moseley & Beckley, 2019). These studies tend to focus on "first responders" as a broad category including emergency services such as police officers, firefighters, ambulance officers and paramedics but rarely SANEs specifically (Frazer et al., 2022; Gray & Collie, 2017).

A Western Australia study (Jancey et al., 2011, p.250) explored health professionals' perceptions of sexual assault management practices, where health professionals referred to "medical doctors, nurses, social workers and counsellors". The study highlighted some issues identified in the US context such as staff shortages and burn out due to the high demands placed on SANES and counsellors, in addition to a range of other factors including: limited services and resources for sexual assault management in regional areas, a variation in delivery of sexual assault services provided in metropolitan and regional areas of WA, staff shortages, and a lack of follow up of cases presenting with sexual assault. A study on staff retention in Australia's domestic and family violence and sexual assault workforces noted that frequent individual supervision in social workers was associated with lower intention to leave work, and yet one in eight practitioners lacked access to regular supervision (Cortis et al., 2021). Other barriers to workforce retention included insecure funding, poor remuneration, workforce ageing, burnout, lack of role clarity, and inadequate access to professional development (Cortis et al., 2021; Wendt et al., 2020).

United Kingdom

Similarly to the research described above, studies emerging from the UK also indicate that forensic nurses experience higher levels of burnout throughout their careers due to exposure to stressors unusual for the general nursing population (Ewers et al., 2002). A rapid evidence assessment wherein the majority of studies were conducted in the UK indicated that SANEs there also experienced a lack of support, limited access to training, resources, peer support and supervision, while managing high workloads. Distress levels and coping ability were associated with individual factors such as resilience, specialist knowledge levels, beliefs, time spent on self-care and coping strategies, and individual personality type (Crivatu et al., 2023).

In light of these findings it is necessary to address both personal and organisational factors in alleviating turnover intention among SANEs, and within the workforce more generally, which has been a focus of this study.

RURAL AND REGIONAL WORK

Cosgrave (2020) utilises a "whole of person model" to demonstrate how workplace, organisation, role, career opportunities, community, and connection to place all have implications on staff retention in rural health. Healthcare workers' considerations of rural work are heavily influenced by their overall familiarity and interest in rural work and lifestyle, as a commitment to work rurally is also a commitment to live rurally (Cosgrave et al., 2019). Those from rural backgrounds, and those who had positive experiences in rural employment and recreation, are more likely to consider working rurally than their urban counterparts (Cosgrave et al., 2019; Guilfoyle et al., 2022). Having a pre-existing support or social network in a rural community, or having a partner, family or friends moving rural attracts workers as well (Cosgrave et al., 2019; Slagle, 2010). Focus groups with rural disability sector workers found slow recruitment processes and in-concrete or short-term contracts to be particularly off-putting for prospective employees (Lincoln et al., 2014). The limited availability of SAS practitioners in rural areas and difficulties in their recruitment and retention is proven to be a significant barrier to sexual assault reporting (Wales & Barbour, 2012; Wood, 2008) and the provision of optimal care.

Another critical barrier to recruitment is the need for specialised training, which can preclude interested nurses or doctors from entering the field. This is amplified for prospective workers who live rurally and need to travel to reach training facilities, as well as those with limited funding who struggle to meet the costs of the necessary training and study materials (Gonnering, 2015; Treat et al., 2022). The majority of SAS training in NSW is conducted by ECAV, which, depending on the course, may include in-person modules or training days, which are only conducted in Sydney (NSW Health Education Centre Against Violence).

Study aims

The aims of this study were to provide a detailed understanding of the motivations, barriers and enablers to participation in the NSW medical and forensic workforce through interviews with those currently employed in, attempting to enter, or who have recently left the workforce. This study informs the work of NSW Health Prevention and Response to Violence Abuse and Neglect (PARVAN) and ECAV to design training and workplace support for medical and forensic examiners, so that remediable barriers to both recruitment and retention can be addressed.

Methodology

Researchers from WSU were engaged by the NSW Ministry of Health to conduct independent research about the motivators, barriers, and enablers for participating in sexual assault medical workforce in NSW. This qualitative research project included metropolitan, rural, and regional services and both doctors and SANEs. Qualitative research has been shown to provide evidence to understand the motivation and reasons people act. This approach is holistic in nature and aims to preserve the complexities in human behaviour (Strong, 1992). The data collection utilised semi-structured individual interviews using an interview guide. The schedule was developed by members of the training body ECAV, a clinical lead of a regional SAS, and a SANE. Representatives from PARVAN were consulted and provided input into the schedule. A summary report of this study's findings has been provided to the Research Advisory Group, and some were also shared at PARVAN advisory meetings and ECAV updates. Publication in a peer review journal and presentations at conferences are anticipated.

STUDY POPULATION

The study population represented both doctors or SANEs (n=31), including those currently working in the NSW SAS workforce, those who had left the SAS workforce within last three years and those who had undertaken training to work in SAS in last three years but were not working in this capacity. We sampled metropolitan, rural and regional examiners, and also specifically sampled SANEs. We excluded sexual assault examiners who exclusively provided sexual assault examinations to children under 14 years of age. We sought representation from a broad geographic area within NSW, and people with a variety of employment arrangements. These criteria were obtained from the interviews and allowed the research officer and ECAV to purposively sample to ensure broad representation. All participants were required to provide informed consent for participation in the study and to be aged 18 years or above. [See Tables 1 and 2 for participant demographics].

RECRUITMENT

Participants were recruited via email by ECAV. The email invitation included a participant information sheet, a consent form, and the criteria for the study. In the process of arranging interviews, the interviewer contacted participants and obtained key demographics to inform the interview. Snowballing was also utilised, whereby participants were invited to share information about the study with peers.

When the pace of recruitment slowed, a second mailout was undertaken. Selective sampling was also used, which involved direct contact with SAS employees by a member of the research team.

INTERVIEWS

The interviews were audio-recorded and transcribed using videoconferencing software (Zoom and Microsoft Teams). Before commencing, the interviewer was trained on qualitative interview techniques, and on the clinical and workforce issues prevalent in SAS. Pilot interviews were conducted to ensure the interview schedule was effective. Participants were asked a range of open-ended questions pertaining to their experience working in sexual assault, its associated rewards and challenges, and ways the service might be improved.

DATA ANALYSIS AND THEORETICAL FRAMEWORK

Thematic analysis of the data was conducted using NVivo as a data analysis tool. The research team familiarised themselves with the data and then transcripts were coded following an initial reading of the transcript, as recommended (Bazeley, 2013; Clarke & Braun, 2014). Transcripts were then re-read line-by-line, in close detail, to capture relevant concepts or 'codes' coming from the data. Known as semantic codes, these first order codes were mostly descriptive and reflected the semantic content of the data (Braun & Clarke, 2006). A preliminary codebook was then developed and trialled by the research team. Researchers then met to discuss the initial coding and refined the codebook.

Analysis utilised existing theory on workforce issues, in particular Herzberg's two factor theory and resilience. Herzberg's motivation – hygiene theory has been influential in understandings of workplace motivation (Herzberg et al., 1993). Although Herzberg first described this theory in 1959 it remains relevant today and is still referenced in much job-related research. Herzberg postulated that work motivation comes from within the worker and is affected by external factors, which he labelled hygiene factors. Without the external (hygiene) factors such as policies, supervision, and working relationships, the work is not possible. But having these factors does not guarantee a rewarding job in the absence of motivators to work. Intrinsic factors such as achievement, recognition, responsibility, and work that is challenging or interesting are motivators for work. Herzberg et al (1993) postulated that most job satisfaction arises from intrinsic factors and dissatisfaction is derived from external factors. This study has adapted Herzberg's external factors to include emotional demands wherein motivation to work then involves achieving a balance between intrinsic motivation, and external hygiene factors – plus emotional demands. This theoretical framework structured the study's analysis of the motivations, barriers, and enablers for sexual assault medical workforce.

An inductive thematic analysis (TA) approach was also employed. Here, themes were guided directly from the data rather than derived from existing theory (Braun & Clarke, 2006). This is a suitable approach given the paucity of research to inform analysis – particularly in the Australian context. Whilst there are several ways to conduct TA, the current study employed the method set out by Braun and Clarke (Braun & Clarke, 2006). In this context, TA is used as an analytical tool to identify and describe meaningful patterns across data (Braun & Clarke, 2022). TA searches data for implicit and explicit themes related to the research questions and these themes become the categories of analysis (Fereday & Muir-Cochrane, 2006). Braun and Clarke (Braun & Clarke, 2006, 2022) assert that TA is a valuable tool in qualitative analysis as it is flexible and compatible with a range of different epistemologies.

ADVISORY GROUP

NSW Ministry of Health disseminated a request for expression of interest to participate in an Advisory Group to service managers and medical leads in March 2023.

The Advisory group was formed from service managers and medical and nursing examiners (noted on page 2) to cover the majority of the geographic areas within NSW, and to include those working in supervisory and management roles. In addition, a representative from Ministry of Health workforce was recruited. Meetings with the group were held on 27th April and 27th June 2023. Additional meetings were held with individual Advisory Group members Fernando Pisani, Jen Chapman, Michelle Alexander, and Batoul El-Husseini to provide supplementary information, as well as to receive feedback on the final draft of this report. The terms of reference were to provide expertise and specialised knowledge to the Research Group in relation to one or more of the following:

- Human resourcing including recruitment, contractual arrangements, and performance appraisals.
- Workforce challenges in relation to specific localities across NSW.
- Sexual Assault Nursing concerns including remuneration, supervision and rostering.

ETHICAL CONSIDERATIONS

The study received ethics approval from Western Sydney Local Health District Human Research Ethics Committee (ref. no. 2022/ETH01945). It was a low-risk project. The potential risks were: inconvenience to participants who were giving up time to speak with an interviewer; there was also a chance that reflecting on unpleasant aspects of work, or reasons for having left work may have caused distress to participants. The interviewer was trained to sensitively ask questions in relation to these experiences, and had access to the principal investigator if a participant became distressed. Access to counselling was also available.

In addition, there was the potential for the interviewer to be adversely impacted by the traumatic content of some of the responses. There was support and counselling available for the interviewer by the supervisor and external support from Fullstop Australia counselling if needed.

Confidentiality and data security were also important ethical considerations. Written and verbal consent to participate in the study was obtained from all participants and to maintain participant anonymity, data was treated as confidential, de-identified, and securely stored. Audio recordings were destroyed by deleting any copies from computers and/or servers, once transcription had occurred. The transcripts had any identifiable information removed and were stored on a password protected Western Sydney University OneDrive.

Findings

Participant demographics

We recruited a total of 31 participants (Table 1) and reflective of NSW SAS medical and forensic workforce, the majority were female (27/31, 87%). Age ranged from 32 to 74 years (median 54 years) and years in the workforce ranged from 0 to 23 years (median 7 years). We were able to recruit across both metropolitan and regional/rural locations as well as a substantial number of people who were not currently employed as examiners (10/31, 32%).

Table 1 Participant demographics

	N	%
Healthcare professional type		
Nurse	8	26
Doctor	23	74
Gender		
Male	4	13
Female	27	87
Age		
<60	20	65
60+	11	35
By Regionality		
Metropolitan	18	58
Regional/Rural	13	42
Employment status		
Employed	21	68
Not employed	10	32
Roster arrangements (in last position if no longer employed)		
On-call only	21	68
Daytime hours with on-call	8	26
Daytime hours with no on-call	1	3
N/A	1	3
Years in workforce (range)	0 to 23	

Each participant is identified by a pseudonym and key demographic features (Table 2). Due to the small number of sexual assault examiners, further demographic details are not able to be provided.

Table 2 Pseudonyms and key demographic features

Pseudonym	Gender	Participant type	Regionality	Employment status
Alicia	Female	Doctor	Metropolitan	Employed
Alyce	Female	Doctor	Regional/Rural	Employed
Anika	Female	Doctor	Regional/Rural	Employed
Anita	Female	Nurse	Metropolitan	Not employed
Barbara	Female	Doctor	Regional/Rural	Not employed
Bill	Male	Doctor	Metropolitan	Employed
Caroline	Female	Doctor	Regional/Rural	Employed
Christina	Female	Nurse	Regional/Rural	Employed
Courtney	Female	Doctor	Regional/Rural	Employed
David	Male	Doctor	Regional/Rural	Employed
Elaine	Female	Doctor	Regional/Rural	Not employed
Eliza	Female	Doctor	Metropolitan	Not employed
Frances	Female	Doctor	Metropolitan	Employed
Greer	Female	Nurse	Regional/Rural	Employed
Harriet	Female	Doctor	Metropolitan	Employed
Hera	Female	Doctor	Metropolitan	Not employed
Jane	Female	Nurse	Regional/Rural	Employed
Jenny	Female	Doctor	Metropolitan	Employed
Julia	Female	Nurse	Metropolitan	Not employed
Kath	Female	Doctor	Metropolitan	Employed
Kim	Female	Doctor	Metropolitan	Employed
Lori	Female	Nurse	Metropolitan	Employed
Lucy	Female	Doctor	Regional/Rural	Not employed
Matthew	Male	Doctor	Metropolitan	Employed
Romy	Female	Doctor	Metropolitan	Employed
Rufus	Male	Doctor	Regional/Rural	Employed
Ruth	Female	Nurse	Metropolitan	Employed
Sarah	Female	Nurse	Regional/Rural	Not employed
Siobhan	Female	Doctor	Metropolitan	Not employed
Yasmin	Female	Doctor	Metropolitan	Not employed
Zoe	Female	Doctor	Metropolitan	Employed

Key themes

THE RESPONSIBILITY BURDEN OF A HIGHLY MOTIVATED WORKFORCE

The sexual assault medical workforce is highly motivated. They feel a sense of responsibility to patients, to other examiners, and are committed to continuing to provide a valuable service. For many, this responsibility burden is perceived as held by individuals rather than the organisation and can cause conflict with individual's own needs.

As expected, the workforce demonstrated high levels of intrinsic motivation to the work. Recruitment into the workforce often targeted people likely to have intrinsic motivation and once examiners were involved in the work, they felt responsibility to continue. There were numerous external factors and emotional demands that made the work problematic. Despite this, many examiners were reluctant to leave work because of a feeling of responsibility.

Many of the participants revealed being under considerable pressure with the balance of motivation to external factors and emotional demands approaching a tipping point whereby demands outweigh motivation.

Problematic factors for participants included processes for employment and maintenance of employment within LHDs, payment issues, processes related to being an expert witness and the work/life balance of on-call work. Attempting to maintain balance was problematic when there were workforce shortages, as perceived to already exist and as feared to worsen with retirement of older examiners.

Whilst the emotional demands of work were often offset by compassion satisfaction, they were seen as something that required management. Management involved talking to peers and social workers, exercise, and family time, but also avoiding exposures that they considered too traumatic, such as seeing children and people experiencing domestic violence.

Additional demands on individuals and the workforce as a whole risks tipping the balance for many people. As the sexual assault work is rarely a primary role, it is the work that people will stop if they are in a situation where they wish to reduce their workload or change work arrangements to improve their income.

> ***"I can't be that person so it means that gap has to be filled by someone else and in a way, I feel guilty. I feel guilty that somebody else – we're already strapped, we're already short staffed and I feel guilt that if I can't make it to my normal allocated shift, someone else has to fill the gap. Everyone's got a life and I think if we could build up the workforce so we can spread the shifts across more evenly that would be fantastic … You do feel bad."***
> **(Kim, F, Dr, Metropolitan)**

This responsibility is gendered with the experience both described by women and attributed as a responsibility *belonging* to women.

> ***"But I guess, you know, as a woman with an understanding of women's health and sexual health, it's a really essential service. And people who've experienced sexual assault need to have access to services that are informed and supportive of their needs. So I guess I've always seen it as a bit of a service role."***
> **(Courtney, F, Dr, Regional/Rural)**

There is also a perceived moral responsibility to right a wrong that is occurring in society. Examiners spoke about increasing violence and sexual assaults in their communities.

> ***"I think things have changed a lot over the last four years and I'm very concerned by the increase in violence that we're seeing now. I know sexual assault is always a violent act but there is a lot of physical violence in some of the presentations we're having where previously that was not as significant. Some of it I think relates to a greater acceptability of violence in sex that people think is normal and actually it's not and often young women – the biggest age group is that 15 to 30 sort of age group, the primary presenting age group, and a lot of presentations are people in their late teens, early 20s. There's an enormous intake of alcohol, which is a problem. I think as a society we're going to have to address this issue of accepting violence. And even just accepting the violence of people."***
> **(Harriet, F, Dr, Metropolitan)**

The multi-faceted motivation and responsibility burden can become a source of conflict with one's own needs and values. By recruiting women with a high intrinsic motivation towards justice for women, there is potential exploitation of women and the expectation of women to be empathetic and serve others. This potential exploitation can be constructed as women's empathy being co-opted by a neo-liberal and anti-feminist organisational structure that places responsibility burden on the individual rather than the organisation. A few examiners highlighted feeling that the demands of the work, alongside workforce structures perceived as neo-liberal left them feeling unappreciated. One examiner explicitly described their workforce arrangements as "anti-feminist". For others, their own feminist values were strongly aligned with their participation in the workforce.

When examiners noted lack of recognition and value of the work by their LHDs, they implied that the LHDs did not also demonstrate these feminist values. This experience is echoed in the justice system, where court attendance is not appropriately remunerated and there is the concern that it is rare that a perpetrator is convicted.

> ***"I just wish I could then say to them and we'll get the bastard in court, but I know that's very unlikely to happen and I feel really bad about that but I think the better we do the job the more likely we are to get perpetrators. And you know, the better the evidence we present and the more pressure we put courts to get rid of some of their entrenched biases, the better things will be. So you know, it's very, very slow glacial change, but it is changing."***
> **(Courtney, F, Dr, Regional/Rural)**

ON-CALL: EXPERIENCES OF ISOLATION AND INVASION

Being on-call can lead to experiences of isolation and invasion into home and personal life and these contribute to on-call being the most problematic aspect of current workplace structures.

All of the workforce had experiences of being on-call, either in paid or unpaid capacities. For some, they only worked on-call, whilst some had a small amount of rostered daytime hours. A small amount of rostered hours was often seen as little benefit as it did not allow sufficient time to make connections with local co-workers and with workers in other LHDs. Attendance at training or forums was restricted due to limited daytime hours and the visibility of the workforce was not increased. Very few had a substantial daytime rostered role.

Working only and almost exclusively on-call meant examiners felt isolated. They described feeling isolated when attending call-outs in the early hours of the morning, and reluctant to contact medical leads or peers for support because of not wanting to disturb their sleep. They also feel isolated from their peers because of not seeing them regularly. A desired coping strategy for dealing with the challenges of work was to spend time with and talk to peers; however, not having daytime hours meant people might go months without seeing a co-worker.

Hence, working predominantly on-call impacted the ability of examiners to use coping strategies to deal with the emotional or trauma elements of the work. Although examiners did not often speak explicitly about the impact of working with trauma, it was obvious that they were using coping strategies to deal with this. One of these that was mentioned is compartmentalisation or forgetting about the work when not at work. Being on-call brings the work into people's homes and personal lives and impedes the ability to leave work at work.

> ***"Feels invasive. This work is invasive because it asks so much. And if you don't have good practise at, you know, locking away things you don't really wanna address, like then I imagine it would be, like, emotionally invasive. But I would say it really does get in the way of your family life and your personal time."***
> **(Ruth, F, Nurse, Metropolitan)**

Self-care activities are also impeded by being on-call. Examiners identified time with family as an important coping strategy for the unpleasant aspects of work. They also mentioned time for pleasant life activities such as exercising and cooking, and on-call work had an impact on both this work-life balance and family time.

> ***"I don't know why I did it, lots of things like, I would walk out of family gatherings, I would walk out of birthday parties and school concerts and stuff because there was nobody else and I felt like I had to. Even though it wasn't a roster, and I wasn't being paid to be on-call."***
> **(Lucy, F, Dr, Regional/Rural)**

The other problems with on-call were loss of income and fatigue. Most examiners described being on-call as detrimental to their income earning potential, as it meant time that they did not work in another role.

WORKFORCE DIVERSITY

The workforce is diverse with differing motivations and barriers. Profession, background, gender and age are quite varied creating a highly diverse workforce.

We spoke with both doctors and nurses employed as forensic examiners. The workforce is unusual in having the same work being done by different professions. Doctors rarely reflected on their position as doctors within the workforce whereas nurses often discussed the work in the context of their profession. This is likely reflective of the fact that the majority of the workforce are doctors and that the workforce structures for doctors are more well established. Nurses are aware of the payment discrepancy between themselves and some doctors, particularly those receiving the payment determination. Nurses are generally paid less and expected to do more training, yet there are not concessions in relation to the work that the different professions are expected to perform. It is noted that there are additional requirements for medical lead or directors of SASs, but the majority of doctors with whom we spoke were not in these roles.

The background of examiners, generally being from either emergency departments or from women's health fields, impacted on the expressed motivations and barriers, to a similar degree as the profession. In general people from emergency backgrounds enjoyed the opportunity to spend uninterrupted time providing care to a patient. They are generally comfortable with the inclusion of domestic violence as part of their work.

Examiners from women's health or sexual health backgrounds were less comfortable with domestic violence. They were often particularly motivated by using an expert skill set that they felt related to sexual assault, in particular.

> ***"So, I'm an expert in domestic violence. So that was part of a section I've delved into, so I started with my research project. As part of your emergency training, you have to do a research project, so I did a research project on domestic violence"***
> **(Alicia, F, Dr, Metropolitan)**

Given the differing professions and backgrounds of examiners, it is noteworthy that the role of medical and forensic examiner is not a unifying identity. There is no continuing professional development framework for forensic sexual assault and no professional pathway. As sexual assault examinations were rarely a primary role, examiners tended to identify with their primary role, for example, as a women's health nurse, rather than as an examiner.

The workforce includes a number of older individuals who are planning to retire in the next few years. Older doctors frequently spoke of working in medicine broadly as being a career where one expects to be on-call and to be of service to the community. Medicine is considered a "calling" and the challenges of sexual assault examiner work were not considered as particularly different from the challenges of being a doctor. Some older doctors and nurses also considered medical and forensic examiner work to be a good semi-retirement career. They were not particularly worried about the ability to generate a regular income but enjoyed the opportunity to continue to work and be able to contribute to the workforce. Their main concerns were sleep disturbance, which was mentioned as more challenging with age. For some retirement would be able to be deferred if on-call overnight could be limited.

"The worst thing – I'm not very good at getting up in the middle of the night. As I get older, I just don't want to do that anymore. I mean, I don't want to do it the day before I have to go work in the clinic, for example. So, I've managed to negotiate, you know, I'll be on-call but I can't be on-call in the middle of the night. I'll be on-call to 10pm. And then not again until sort of five o'clock in the morning. Just don't call me in the night, and they've been very good about that. Because they need examiners, they've been quite flexible"
(Courtney, F, Dr, Regional/Rural)

For younger doctors and for most nurses, being a medical and forensic examiner is a "job", albeit one to which they have considerable responsibilities and to which they feel intrinsically motivated. This likely reflects broader changes within the medical profession and also socio-economic conditions currently.

Younger people were more concerned about the loss of income related to being on-call or attending court proceedings. (see Payment). They were concerned about job security and the potential impact of vicarious trauma and how this might affect future earning ability. People in permanent daytime roles were the most satisfied as the need for the work to be a "job" was satisfied both financially and for how they viewed themselves as a professional. This satisfaction was also demonstrated by an ED doctor who considered her forensic work as part of her emergency specialty.

We spoke to a few male examiners. They had similar motivations but seemed not to express the same levels of responsibility and distress related to the work.

"The work does take an emotional toll. You wouldn't be human if it didn't. And everyone always feels terrible for the individuals concerned and what they've gone through, but I don't necessarily think that I'm being impacted, so much to say like I have vicarious trauma or whatever, that hasn't been a big thing for me so far."
(Matthew, M, Dr, Metropolitan)

Detailed findings

MOTIVATIONS

Entering the workforce

The interview schedule began with questions about entering the workforce, so motivations for entering the workforce are well described. Many people began work as an examiner because someone personally reached out to them and suggested the work. The person reaching out to them was often seen as inspirational, for their passion for the work and their values.

Examiners identified with the person reaching out to them, or with the work via both values and skill set. The values that motivated people were described as social justice, gender equality/feminism and anti-violence. Examiners described having a baseline skill set and relevant experience that would allow them to do the job well. This was often highlighted to them by the person reaching out to them. The ability to apply expertise in this area to help someone vulnerable and (ideally) support a conviction of a perpetrator was viewed as highly motivating.

People also expressed motivations in relation to a sense of duty, as a person working in women's health. These motivations were again often instigated by a person reaching out to them, or by incidental knowledge of the demand for examiners. Some people expressed an interest in developing skills and expertise and were motivated to develop expertise, in particular if this could be done without cost to themselves.

Staying in the workforce

Once working as an examiner, people describe satisfaction at being able to make a bad experience better and support someone at a vulnerable time. This was almost universally described and was a strong motivator for ongoing participation in the workforce. They also enjoyed having a few hours with a person and being able to provide a service that was comprehensive, compassionate, and not rushed. They enjoyed working with the counsellors in a multidisciplinary team. Some examiners were hesitant to use "enjoyment" in regard to the work, given the nature of the work involves someone suffering, but there was satisfaction (described in the literature as compassion satisfaction) that came from being able to relieve suffering. A related motivation was described relating to feeling that the sexual assault service and people presenting for examinations needed them – "It's nice to be needed".

> ***"But you know there's more than just joy and work, and probably the least joyful part of my work is the sexual assault service. But it's fulfilling and rewarding in its own way."***
> **(Kath, F, Dr, Metropolitan)**

Being needed was positively motivating for some, but for several, the fact that they were needed meant they were motivated by a sense of duty. Several people mentioned being motivated to stay in the workforce otherwise the staff shortages would become so problematic that the service would fail. Examiners described pressure to take on more on-call shifts despite wanting to do less.

> ***"I had been very hopeful that we would recruit somebody else and that I could share the workload and yeah, I don't know what my go to is. I think the thing that keeps me is that, you know, these nursing staff have put in the effort to train and are very motivated about the role. Well, this is not the only thing, but it's certainly part of it. If I was to walk away, because there's something very appealing about that in terms of my life, that would let other people down. I realise that not a great motivation for staying in a role and I really like the work, but I would like to do less."***
> **(Caroline, F, Dr, Regional/Rural)**

Ongoing development of expertise related to forensic and medico-legal processes was motivating for some. Seeing that expertise contribute to a conviction motivated some people to participate and to continue to develop their skills and expertise. Although examiners acknowledged convictions only occurred in a minority of cases, many remained committed to doing their best to enable possible convictions. They also described positive changes within the courts and felt that the presentation of quality evidence was able to contribute to some broader system improvements.

In general, people are highly motivated in regard to the work. They demonstrate commitment to training and describe adjusting their other work and family obligations in order to ensure they are available for the work. The high motivation is reflected in the rapid response to the recruitment emails and the length and depth of many of the interviews. People had clearly thought about the interviews and what they wanted to share.

BARRIERS AND ENABLERS

Organisational

Barriers were described in relation to organisations not having an appropriate position for staff. In particular, lack of permanent daytime positions was a significant barrier for nurses. The need to be on-call overnight and the resulting fatigue was a significant barrier for many people and was often mentioned as a reason for thinking about leaving work. Daytime hours also made it easier for people to maintain skills and confidence for the work they might do after hours.

> ***"I think it's really useful to have daytime hours available to people, even if that's just, you know, one day a week or half a day a week so they feel like they're more a part of the team and they're doing other work that makes them feel, feel confident ... And that means that the service runs better as well, if you've got adequate daytime support."***
> **(Romy, F, Dr, Metropolitan)**

Organisations that were able to respond flexibly to people's personal situations facilitated people staying in a position where they may otherwise have left. Flexible responses included being able to participate during limited hours, or being able to take periods of extended leave and then re-enter the workforce. Being able to respond flexibly to cases in terms of timing was also supportive in removing pressure to keep the whole shift entirely free of commitments. Similarly, management that demonstrated support for staff by negotiating appropriate payment and on-call allowances made people committed to their service and encouraged ongoing employment. Not having a voice regarding one's work was problematic for some people. Medical leads were seen as useful in ensuring that examiners had a voice within the organisation. NSW Health Sexual Assault policy requires all districts to appoint a designated medical director or lead with responsibility for the overall coordination and quality assurance of the medical and forensic component of the district's response to sexual assault, but it was apparent these may not be present in all LHDs.

> ***"So having a medical lead would guarantee that doctors had a voice and that they had felt they had ongoing support and training. And that person would also be able to focus on recruitment and working with other stakeholders to break down some of those barriers, I think."***
> **(Courtney, F, Dr, Regional/Rural)**

General hospital employment procedures were seen as time-consuming and cumbersome, particularly if people were only working on-call and not frequently attending the hospital. Lack of access to appropriate examination rooms, resources such as the morning after pill and out-of-date materials were described. Time-consuming administration processes took up participants' time and were described as frustrating.

Participants described being "dumped" with running a service without support or being harassed to work extra shifts. Sexual assault medical services were described by some as a "sinking ship" and that individuals were being left with the responsibility of keeping the service afloat, without organisational support.

Training

ECAV training was almost universally highly regarded and appreciated for the fact that it was free, skill-based and accessible. Opportunities to grow skill and continue learning were enablers for ongoing participation.

Increased availability of on-line training was useful in improving accessibility, particularly for regional and rural examiners, but meant reduced face-to-face interactions which were highly desired. Payment to participate in face-to-face training was highly appreciated where present and considered to facilitate maintaining skills and motivation to continue working.

Personal mentors were strong enablers for people entering the workforce. Having someone available for support 24/7 was highly valued. Many people described having this available from a medical lead but being reluctant to wake that person and a 24-hour advice line was recommended.

A few doctors felt that they would like more of a pathway into a specialty or a more rigorous approach to their ongoing education. It was noted that a lot of the learning happens "on the job".

> ***"There is no set way that you can become a forensic examiner … I think it retains people who have interest … I think looking back now, I wish that I had more forensic photography skills, I had better expert certificate writing skills. But I've managed to gain it … The question is whether you need to have all of that before you become a forensic examiner or it's one of those things where you just, you know, learn on the job and just keep getting better … I started off from more being an expert on injury interpretation, to now being a more holistic forensic examiner, so a good counsellor, a good, you know, kind of, psychological first aid provider."***
> **(Alicia, F, Dr, Metropolitan)**

Moot court and medico-legal training was described by some as distressing whereas others found it to be "a really good exercise to understand what the law is looking for as opposed to what medicine is looking for." In terms of recommendations related to training, it was suggested that information around supporting vulnerable populations ("people who are cognitively impaired or drug impaired") be included in training, as well as psychological first aid. Other suggestions included the provision of scholarships/paid access to training for SANEs, and the availability of extra training and support for those re-entering the workforce.

Teamwork

Examiners enjoyed working as part of a multi-disciplinary team. They valued the social workers involvement in care but also the support provided by the social worker to themselves. This was described in terms of having a brief chat after the person went home. Working closely with counsellors was described as rewarding, particularly the opportunity to debrief "emotionally taxing" presentations. However, other participants described counsellors as more "removed" from their service, but with opportunities for crossover during peer review meetings.

For much of the workforce, who primarily participated on-call, there was a lack of collegiality in the workforce and feeling isolated in the work. This was primarily due to not being a salaried part of the team with opportunities to "chew the fat" with colleagues.

> ***"It really was just a crisis intervention. I felt like I was to come in at two o'clock in the morning and do a SANE in the casual capacity, but never really feeling like part of the team, because I was never there during the day. So, one day a month was not enough to even go to meetings or catch up with my colleagues, and being casual, I started to feel after six years there was no opportunity for me that, you know, there was no understanding of any vicarious trauma that I might be suffering, or anything like that. I had my sick leave entitlement. You know, it's a cumulative effect."***
> **(Sarah, F, Nurse, Regional/Rural)**

Payment

Payment structures varied widely. Disparities and perceptions of inadequate remuneration led participants to feel unappreciated. Some staff specialists are working as medical and forensic examiners on-call, with limited or no daytime hours in sexual assault, and have no arrangements for remuneration for attending examinations. NSW Health Staff Specialist Award includes "reasonable on-call" within the staff specialist payment, however some staff specialists were employed within other departments to which they had on-call responsibilities or were employed minimal daytime hours so therefore received minimal payment.

There were strong sentiments that the payment and conditions should be equivalent to other specialised practitioners, whether that be a specialist doctor or nurse. For doctors employed as staff specialists, this meant having conditions similar to other specialist practitioners, who were presumed to have more ability or willingness to negotiate conditions of employment. For nurses, this meant being employed as a clinical nurse specialist or higher grade. Participation as an examiner often meant foregone earnings in another capacity so that there was an economic cost for participating. On-call examiners were not able to work elsewhere at that time, and often had to ensure the following day was free of paid employment in case they did not sleep overnight. However, the unpredictable nature of presentations meant that they may not attend examinations while on-call and only be paid a small on-call allowance. Some participants indicated they may have to leave the sexual assault examiner workforce to be able to earn more money in another capacity, primarily by having access to regular hours.

Most VMOs, both GP and specialist, considered the remuneration appropriate for examinations, but still noted the unpaid time spent preparing for and attending court.

> ***"There are other opportunities that I could, there are places that I could work. It's like I said to you, it's a strange situation with money like I'm a single person, so I need to earn an income, you know, like, I basically kind of spend a 36-hour week like organising my life for a very small amount of money if I'm not called in."***
> **(Frances, F, Dr, Metropolitan)**

> ***"I'm passionate about it, you know, but if you want to attract, more people, we can't expect all of them to be as passionate as I am, so then, how do you make it attractive? And you make it attractive by ensuring that you get mostly the right people. Secondly, that you fund their training. And thirdly that you pay them what they're worth. This is really important work, I mean, I can earn more as an emergency physician working in virtual health or, you know, in a private ED, but I don't because I know that I'm happier working in this space. But for people who are not as passionate, you want to retain them. So you retain them by giving them incentives to stay. And those are the three main incentives, I think."***
> **(Alicia, F, Dr, Metropolitan)**

Career

Working in sexual assault is not seen as a career. It is generally seen as a secondary role. Increasing professionalism of the work is considered to be positive, but it comes with a cost such as increased workload yet little personal benefit in terms of improved work conditions or career opportunities. Professionalism has not yet led to a pathway for recognition of sexual assault examiners as specialist doctors. For both doctors and nurses, the focus of on-call, meant a lack of permanent daytime positions.

Sexual assault work is not understood by other members of the health workforce and there is a perception that it is undesirable work.

> ***"Oh, one of the interesting things I find is that whenever I tell other people in medicine what sort of work I do, you get a really weird reaction from them, so it's like, you know, you're doing some really horrible job. So, you tell people that, even if I get a dentist, or you know, another health professional, if you say you work in sexual assault, their immediate reaction is sort of one of, you know, oh, I don't know how you could do that work, it must be so terrible. So, it's a lack of understanding from other health professionals about what the work really entails."***
> **(Romy, F, Dr, Metropolitan)**

COURT

Unpredictability around court attendance was described as frustrating because participants found it difficult to plan holidays and work around their employment. Poor remuneration for attending court and writing expert certificates was described. For some, they felt supported in writing expert certificates by supervisors and training, whereas others feared making mistakes which would affect court outcomes.

For same examiners, predominantly nurses, the expert certificate writing process and attending court was sufficiently problematic that it meant they were considering leaving or had left the role. The combination of high expectations of perfection, unpredictability of attendance, and lack of support meant that the medico-legal processes were highly anxiety provoking.

"But I did find, and this is probably the main reason I've had to stop working, at least for the moment, in sexual assault medicine, is just because you have no control whatsoever over when they ask you to come to court. They're often really vague about, you know, if the case starts on a certain day, they're really vague about which day you'll be needed, if at all. So it just became too disruptive from that point of view."
(Hera, F, Dr, Metropolitan)

Not getting feedback on court outcomes was disappointing for some and was interpreted as another indication of not being valued, along with the lack of remuneration.

"Then when you go to court, you know, they pay you nothing compared. They don't even pay you one hour's worth of what the attorney gets paid, right? And what does that show, you know, because we are the advocate for the victim...You know, so it basically shows that the system disproportionately rewards the perpetrator's team. And completely ignores the victim's team. And the same applies to the victim. It's just a bias against them, so that you know, people shouldn't be surprised sexual assault is so rampant. And so is domestic violence."
(Alicia, F, Dr, Metropolitan)

EMOTIONAL ASPECTS

Many people spoke of compassion satisfaction, or a feeling of satisfaction in being able to provide care for people at a vulnerable time. They described vicarious resilience in being able to witness a woman present for an examination in order to obtain justice.

> ***"I can't say I have experienced a great deal of trauma from it because I feel that the patients are very brave to come forward. They're the ones who've been traumatised. I feel for them. I'm horrified for them, but I do feel at least I'm doing something to help them. So yes, it's shocking, but I do feel that by doing something to help them, that can sort of mitigate the shocking things I hear."***
> **(Barbara, F, Dr, Regional/Rural)**

Few people directly spoke of an effect of trauma from the nature of the work on themselves, yet it was alluded to indirectly such as by saying – "it is not for everyone." Many people noted the effect of the trauma on the individual, but actively worked to avoid vicarious trauma. This was considered a useful strategy but may have impeded the ability for examiners to acknowledge or share their own experiences of trauma related to work.

> ***"I probably feel about it the same way as some other people do, which is, I really, I think, people's trauma belongs to them, and I know I don't take it on. And that's not my job, to take on their trauma."***
> **(Eliza, F, Dr, Metropolitan)**

It was noted that doctors may tend to downplay the impacts of trauma on themselves. One doctor alluded to the fact that the potential stressors of the work were hidden from them before they commenced the work.

> ***"I think the trauma has an impact and I suspect as a doctor, I think I probably downplay that. We all play down just how much we can be affected by a patient's story, by patient experiences."***
> **(David, M, Dr, Regional/Rural)**

Those that did articulate direct effects on themselves often presented it in relation to their responsibility to the client.

> ***"But absolutely, there's been tears and reflection and fear, following the – mostly questioning my own practice and my own – and concern for the clients, in the days and the weeks later there is absolutely an emotional response."***
> **(Christina, F, Nurse, Regional/Rural)**

Several people describe actions that a person working as a medical and forensic examiner should take to look after themselves such as exercising. Formal supervision was rarely used to deal with the nature of the work, but talking with counsellors or peers was frequently used.

Some people discussed anxiety in relation to the "double whammy" of responsibilities to the patient and to the courts. Fear and anxiety around attending court was common, associated with fear of questioning, making mistakes and negative experiences with lawyers. Some participants described leaving the job due to these fears. Others felt traumatised by court in hearing client cases and being questioned, with descriptions of inappropriate questions being asked of them. Distress around perpetrators not being convicted in court was also reported.

> ***"Well it's a double whammy, right. In medicine you can have an obligations to the patient; if you screw up the patient gets hurt but on top of this, you screw up and a court case goes awry. So there's a double weight of responsibility that your standards are always impeccable. There's just no room for error in forensic medicine."***
> **(Lucy, F, Dr, Regional/Rural)**

Some people mentioned the effect of the nature of the work on their family. This included the effect caused by the examiner/parent being absent both physically because of needing to attend an examination, or emotionally absent because of being on-call and perhaps thinking about work. People mentioned a change in world view caused by the work, in that they had a heightened level of anxiety about sexual assault happening for female family members. Finally, a few mothers noted that their young adult daughters were experiencing anxiety related to the mother's work.

One woman described fear of working in sexual assault and perceived this as related to a general fear of rape. This fear dissipated as she became older and facilitated her ability to enter the workforce. Others acknowledged that their emotional responses were at times heightened because of their own experience of sexual assault, or the experiences of people that were close to them.

Although some described self-care as important due to the nature of the role, it was reported as something they would like to organise rather than something they were actively engaging in or encouraged to engage in, such as free counselling sessions booked through the service. Others maintained hobbies, prioritised family time and debriefed with colleagues, family, and friends as self-care. Participants engaged in therapeutic modalities such as positive psychology, mindfulness, meditation, exercise, and massage. Dissociation, disengagement, and compartmentalising was also described. For others, feeling helpful to the patients was a central motivation to continue the work. Some had no particular forms of self-care and managed their emotions on their own.

ON-CALL AND WORK-LIFE BALANCE

Despite recognising the many challenges associated with being on-call, such as sleep deprivation, fatigue, feeling "bullied" and emotional distress, participants described a sense of duty and obligation to be available – of "being on-call for love".

Being on-call is tiring. Even if people weren't called, they often described not being able to sleep or relax when they are on-call. Being on-call meant people weren't able to work in another role so it often meant a financial loss for the individual on-call. This was described by both doctors and nurses. Staff specialists with minimal daytime hours or employed in another department, felt the contribution of their award payment towards on-call was not proportionate to the demands of an examination. The lack of dedicated payment for on-call or for examinations done while on-call, compared to VMOs, meant they were probably the most dissatisfied. That they continue to provide a service reflects the high degree of motivation to make sure someone is available to see patients. Nurses noted the limitations of the payment for being on-call within their award, and higher on-call payments provided by some LHDs were very appreciated.

People mentioned feeling guilty for not being on-call more when shifts were then not covered. After hours was described as unsustainable for staff. Examiners thought patients would get a better service if the examiner wasn't tired; in addition, after hours call outs meant that patients were often also very tired, and sometimes disgruntled. Having paid daytime work in addition to being on-call was described as helping the service "run better" with adequate daytime support, and practitioners able to maintain their skills and confidence.

"I think the having to be on-call, it was the deal breaker for me, you know, like I just, I don't sleep when I'm on-call anymore. I know that I have trouble sleeping regardless but I think it's just because of the, my body clocks out. Yeah, so I'm much happier now in the job that I don't have to do on-call. I feel bad for the others, I think that they are doing too much. There's only a handful of staff who can cover the roster 24/7 all the time."
(Lori, F, Nurse, Metropolitan)

Being on-call was described as interfering with some participant's home lives including missing family events. Regarding paid versus unpaid on-call, there were few people who had experienced both models, but one respondent who had experienced both much preferred paid on-call.

"Because we're not paid to be on-call it kind of felt like you were always on-call. So unless I was doing something that would absolutely exclude me from attending like drinking, or out of town, I suppose it always felt like it was potentially gonna happen. And I know I did leave a couple of – two family events which I didn't feel like it at the time, I felt like I was doing the right thing. Upon reflection, while I did good work, and I did help somebody, I still chose work over my family. So, you know, and I had a choice because I wasn't on paid on-call."
(Christina, F, Nurse, Regional/Rural)

The majority of participants struggled to maintain a healthy work-life balance. Often this was to do with the impacts of after hours on-call work, which interfered with family and social engagements. Making plans outside of on-call work was difficult and at times a strain on family relationships. As staff shortages increased, participants work-life balance decreased as they felt a duty to be on-call. In retrospect, one participant described choosing work over her family as "propping up a dysfunctional system". Having older children and being in the service for a longer period was described as beneficial to work-life balance, as well as maintaining confidence in one's skills. Some participants were resigned to the unpredictable nature of the work, commenting "that goes with the job", and "we signed up for this." For one doctor this meant deliberately and strategically integrating his work and life.

EXPANDED VAN SERVICES

Interviews included questions on potential expansion of the role of examiners. Some examiners had already provided medical and forensic responses to people experiencing domestic violence, but the majority did not. Participants felt that if SAS were broadened to include domestic violence, expertise would need to change. For example, medical and forensic examiners would need to be trained and well versed in forensic photography. Concerns were also expressed regarding funding, given "that domestic violence and sexual assault are crimes that are remaining just as high if not increasing". Some participants viewed SAS and domestic violence services as necessarily intersecting, whereas others thought domestic violence should be restricted to the ED. The capacity of crisis support approach to include domestic violence – the definition of which can be "four shades of grey" – was questioned, particularly as this would broaden the scope of the types of injuries practitioners would be documenting and assessing. Concerns over whether people experiencing domestic violence would come forward were also raised given the often tacit and complex nature of domestic violence. The inclusion of domestic violence in SAS was described as potentially more traumatic and challenging due to the inclusion of children and intimate partners. The prospect of an increased workload was troubling to a number of participants, particularly in LHDs with existing staff-shortages. A potential increase in medico-legal documentation and court attendance with the inclusion of domestic violence was also considered; this may exacerbate anxieties around court. Suggestions were also made regarding the relationship between domestic violence and ED, such as having clear protocols regarding "who is looking after what."

Some people would like to see examinations for people experiencing domestic violence as part of their work. Many felt they already had some skills in this area, and they saw it as a natural part of their work. Several were concerned that their organisation did not have sufficient staffing to manage more presentations. It was noted that having a counsellor present was essential for domestic violence presentations as there is often more trauma within the consultation.

> ***"And so, we have been doing all of the DV warm and fuzzy plus the medical side just us, and that for me feels like heavy, heavy work. It's really hard to have both hats I find, all the time. It's only if it's just like a one or two, but it is emotionally exhausting providing that support, regularly. Yeah. So, like today I'm gonna be knackered because it's two DV, one after the other and with no counselling support."***
> **(Ruth, F, Nurse, Metropolitan)**

Very few examiners were interested in the scope of their work including children and several made it clear that this was something they would not consider doing.

> ***"I think the moral weight of it would be unbearable for me. So, I see kids in emergency, and it was a very conscious decision for me not to do kids. I have kids myself and I just can't, I can't do it and I haven't regretted that decision actually. So, I've gained expertise in adults, and I'm happy to see teenagers but yeah, not children."***
> **(Alicia, F, Dr, Metropolitan)**

REGIONAL/RURAL

The responses from rural and regional were highly varied. Rural and regional examiners wanted to hear more about what was happening in other parts of the state. They worried about lack of expertise related to doing less examinations. The demands of being on-call often were considered to be greater for those that did work in regional areas, because of the lack of other staff. However rural examiners did acknowledge that the actual workload was less in regional areas and that potentially protected them from the burn out and exhaustion that they might have experienced if they worked in a busy metropolitan service.

> ***"It's a very serious space but sometimes I feel like that it's not seen that if you do two a month compared to if you do 20 a month, that it's okay. Like my colleague and I were saying, we always feel like we have to just be constantly reviewing literature or doing this or doing that to try and feel like we're keeping up with perhaps the ones that are doing more in the metropolitan places."***
> **(Greer, F, Nurse, Regional/Rural)**

Positive experiences occurred when the LHD and management demonstrated support, and non-supportive management was highly destructive in smaller regional areas. Regional examiners felt a degree of responsibility to people experiencing violence in regional areas. This related both to the fact that there were high levels of violence in some regions, and also an awareness that it is more challenging for people to access timely medical and forensic care in regional areas. A fear of being identified by perpetrators of domestic violence was a deterrent for working as a domestic violence forensic examiner in regional areas.

SANEs

Working as a sexual assault nurse examiner was considered to be a unique role that was a good fit for some people, in particular nurses from an emergency background.

> ***"It's not for everybody, but I think that nurses that do like it, really like it. It seems to be a lot of emergency nurses seem to like this sort of work. I think nearly all of us in our unit worked in emergency. That was my background years ago and we've got three other nurses that come from emergency, so I don't know if it's something that's – because you get something different all the time and those skills are useful in this job as well. I think it's a very rewarding job but you gotta be prepared to commit a bit of time to it."***
> **(Lori, F, Nurse, Metropolitan)**

Nurses considered themselves to be very well qualified and skilled to provide immediate care during a time of distress. However, nurses had unique challenges in relation to the medico-legal aspects of the work. Some mentioned that they found it challenging as a nurse is trained to be a patient advocate and forensic work requires impartiality. Going to court was anxiety provoking for most nurses, even if they had not gone to court. Some nurses described experiences of having a doctor attend court on their behalf and the potential benefit of not having to attend court in attracting nurses to work as SANEs.

> ***"I had that one random situation where I had done the call-out, done the forensic examination, done the experts certificate but then a doctor gave the evidence on my behalf. If that could somehow be an option, I think it would really ease pressure, and I think it would make it a lot more attractive … When you get into nursing you don't get into nursing to go to court, like that's not why you do it, so I think that that is a huge barrier from what I have understood from talking to other nurses."***
> **(Julia, F, Nurse, Metropolitan)**

Nurses highly valued having a medical lead available to them at all hours and appreciated leads that made themselves available.

Nurses with permanent positions and daytime hours were generally the most satisfied. Payment structures for nurses were problematic, particularly for predominantly on-call roles. Issues included the relatively low payment for being on-call, sometimes lack of any on-call payment, payment according to another substantive role for on-call only nurses and the resulting differences in payment for a role that is perceived to be the same.

"[The SANE role] needs to be advertised and recruited towards … It almost needs to be pulled back and rerolled out again through executive at the hospital, and you know, a job description needs to be written. I don't even think there's a consistent job description. Is it women's health nurses, is it midwives, is it – do you know what I mean? … So regional adaptation needs to occur and the people that are recruited to the roles, it needs to be looked at, how many hours are they going to be employed through their health service and what is required of them, and what is their paygrade going to be, and what is their direct line of communication? Are they in the nursing field, are they in the counselling field, are they in primary health? You know, who owns you, I'm still not even sure."
(Sarah, F, Nurse, Regional/Rural)

Nurses in training, unaware of an existing SANE network, expressed an interest in having a SANE network, for the support and collegiality. Similarly having more than one SANE work for an LHD was considered to provide some support.

"When we were at the face-to-face (ECAV training), which was last week, there was a call out from the nurses to go we need a network. We need to stay in touch. We need to be able to support each other. And I suspect that's partly also the role because different services, particularly in, you know, rural areas, it's very hard to fight for standards, training, support … I mean, there is Sexual Health Nurses Association. I think there needs to be a sexual assault nurses association."
(Anita, F, Nurse, Metropolitan)

SANEs expressed frustration over the inconsistency of paygrades – between and within LHDs, believing them to be dependent on their "substantive" job qualifications. Completing extra and/or unpaid work led them to feel their work was unrecognised and undervalued. The implementation of standardised paygrades was described as desirable, as well as paid training. Nurses wanted an award that would provide them with a better rate of pay for being on-call and a reasonable call out.

"There are actually no clear guidelines around what rate of pay sexual assault nurse examiners should receive in NSW. Is it CNS 1, is it CNC 2? Should they be CNC, they're actually functioning as nurse practitioners in the absence of a doctor through policy and procedure guidelines, so it was all just so ad hoc."
(Sarah, F, Nurse, Regional/Rural)

For SANE's starting in workplaces that did not already have someone in the role, there was added burden in trying to work with the LHD to create the role. There was a sense of responsibility in needing to do this for the future of the SANE workforce.

Discussion

This report has described the outcomes of a research study that sought to understand the motivations and barriers for sexual assault medical workforce in NSW, Australia. Increased demand for expert forensic services for people experiencing sexual assault requires a large expansion of the workforce of examiners. In NSW, doctors and nurses work alongside social workers to provide integrated medical, forensic, and psychosocial responses across 15 LHDs. Despite consistent interest from doctors and nurses in entering the workforce, transition to practice and long-term retention remain challenging. In order to understand the workforce dynamics, we undertook a qualitative study of the motivations of people who work, have worked or have sought to work as sexual assault examiners in NSW. This discussion will build upon existing literature to outline the key themes of the study.

The responsibility burden of a highly motivated workforce

Conflict arose for female participants between an empathetic desire to achieve justice for women, and a sense of over-responsibility that ultimately led to burnout. In this sense, emotional investment in the work was both a motivator to enter the workforce, and overtime a barrier to workplace satisfaction. This was exacerbated by staff shortages wherein participants felt they had to "take one for the team". Recruitment was often directed at those intrinsically predisposed to the work, and once employed, examiners felt great pressure to continue in the role despite its challenges. Women practitioners described experiences of over-responsibility – to not only eradicate sexual assault, but to do so with little remuneration. This responsibility was a gendered experience both described by women and attributed to them. Ontological claims that women simply "are" or ought to be more empathetic than men are socially widespread (Lobb, 2013). This assumption and its implications are particularly stark within caring professions – including SAS. Indeed, this was reflected in the data which showed that male doctors had similar motivations to women doctors and nurses though did not express the same levels of responsibility and distress related to the work. Conversely, the outcome of empathism's asymmetrical gender order meant that women participants felt an overwhelming sense of duty to remain in the service, despite experiencing distress. This echoed the findings of Lobb (2013, p.434) where we too saw a "disproportionate channelling of women's affective energies and flows of attention towards others, in ways and degrees simply not expected of men". This meant that male doctors were able to place less emotional investment in the work and, by extension, could more easily step away from it – avoiding burnout as a result. The recruitment of women with a high intrinsic motivation towards justice for women alongside societal expectations of empathy risks their exploitation. This is exacerbated by neoliberal organisational structures that prioritise revenue generation and place the responsibility of burnout on the individual (Hendrix et al., 2021). This has been theorised elsewhere (Bubeck, 1995, p.246) as the "exploitation dilemma" of women's care work." The burden of over-responsibility experienced by women in SAS is likely to continue unless it is offset by "a politics of affective redistribution between the sexes" (Bubeck, 1995, p.426). The findings of this study demonstrate the importance of organisational support in managing the emotional responses of workers. Given the role of compassion satisfaction in workforce motivation, resilience (Burnett, 2017), and increased ability to cope (Crivatu et al., 2023), a shift from empathy to compassion may help to mitigate the burden of over-responsibility for women examiners, including distress and burnout. However, this alone is insufficient to address the responsibility burden of the workforce. Adequate staffing and relocating responsibility to the organisation, rather than individuals is required alongside a culture of compassion.

On-call: experiences of isolation and invasion

There was an overwhelming consensus amongst participants that being on-call was the most problematic aspect of the workforce structure currently. The current requirements of on-call – its often sporadic, out of hours nature – impeded the very support, therapeutic modalities and strategies of self-care required to flourish both individually and in the role. Being on-call out of hours led many participants to feel isolated from their colleagues and workers in other LHDs and meant they struggled to maintain a healthy work-life balance, bringing work into their home lives. These findings extend upon the few previous studies available regarding on-call and its impacts (Geiger-Brown et al., 2011; Gonnering, 2015; Hatmaker et al., 2002; Maier, 2011; Sievers & Stinson, 2002), and indicate the urgency of organisational support, increased daytime staffing and greater flexibility in employment arrangements for medical and forensic practitioners.

Workforce diversity

The role of medical and forensic examiner is not a unifying identity. SAS is a highly diverse workforce with differing motivations and barriers, dependent on profession, background, gender, and age. Participants of all kinds noted an unclear professional development trajectory in forensic sexual assault and no professional pathway. This was particularly problematic for nurses, who faced pay discrepancies dependent on their "substantive" job qualifications and were expected to undertake extra training. Addressing global nurse shortages (Drennan & Ross, 2019), including those working in SAS, means providing flexibility in role uptake and adequate remuneration. WHO's guidelines for attracting, retaining and sustaining all health care professionals is primarily evidenced from studies of doctors (World Health Organisation, 2020). This indicates a gap in knowledge given that, "the demographic profile, status, education, career options and remuneration levels for these two professions are very different and assumptions that evidence from one professionally is automatically applicable and relevant to the other is contestable and at worst misleading" (Drennan & Ross, 2019, p.130).

There was a divide in the ways participants understood their relationship to work, not only across professions but in relation to age. Building on previous research (Wrzesniewski et al., 1997), the study found older individuals viewed their work as a career and positioned this as a "calling", inseparable from their lives. Younger participants, however, positioned their work as a means to acquire needed resources and expressed concerns over job security. Those with a calling strived for fulfillment gained through working itself, not through gaining status or remuneration. As such, when people are called to a particular type of work, it is viewed as socially valuable (Bemiller & Williams, 2011). Given the diversity of the workforce, diversifying the roles available to examiners, providing greater flexibility in employment arrangements and remunerating staff equitably may facilitate a "calling" orientation towards SAS, in turn retaining those who may otherwise leave.

Limitations

This research is focused on the experiences of examiners and therefore has limited perspectives from those required to manage services or service delivery. The Advisory group provided valuable insights into the service delivery challenges which informed recommendations, but the recommendations are primarily grounded in the study data, which is examiner experiences. Collection of data took place in 2023, during which time health workforce challenges were being experienced across the board, but particularly in SASs. A predominance of doctors, and of examiners who worked on-call means that the perspectives of nurses in substantive positions are not as well represented.

There was no specific examination of the child sexual assault workforce and therefore recommendations are applicable to services for people 14 years and older and may or may not be generalisable to the child sexual assault workforce.

Recommendations

1. NSW Health should increase medical and forensic examiners daytime staffing

Daytime staffing is urgently required in all LHDs, and this should be for a substantial proportion of the week, to allow genuine participation. Research participants described limited daytime roles impacting on service delivery, support and training opportunities and career pathways. Daytime staffing could be with nurses, doctors, or ideally, a mixture of both. Increased daytime staffing would benefit individual staff, both those in permanent daytime roles and those working predominantly on-call and enable LHDs to meet the expectations of *NSW Health Responding to Sexual Assault (adult and child) Policy and Procedures.*

Important considerations in increasing daytime staffing are:

- Medical support is available to nurses, particularly for clinical advice and governance. In LHDs where there is no doctor in a medical lead role, there needs to be a formal arrangement for doctor availability for nursing staff, either from another LHD or via other arrangements.
- Clear responsibilities and lines of management within the broader VAN service. While different organisational structures may be utilised, both governance of medical and nursing staff and value alignment with VAN psychosocial services need to exist within the structure. Nurses may be able to contribute substantially to service management and consideration should be given to structures that enable this, where appropriate.
- Access to appropriate nursing senior support for SANEs. Nursing managers from within community health or emergency department may be appropriate. Although a close relationship with social work management and VAN services is acknowledged as important, a supervisory nursing role is highly valued by SANEs.
- Ensuring examiners have peer networking opportunities plus opportunities to work as a team with day time social workers and the VAN service as a whole.
- Service leads, whether medical or nursing, have an important role to facilitate communications with Ministry of Health, and within and between LHDs. Examiners expressed a desire for visibility within the LHD and interactions between LHDs to support effective local service delivery. They would also like feedback on outcomes in other LHDs, such as statewide quality assurance reports on DNA collection.
- Articulating a shift in responsibility to respond to sexual assault from individual on-call doctors and nurses to the VAN service with adequate daytime medical and nursing staffing. This may address some of the responsibility burden expressed by on-call examiners.
- Daytime staffing would allow the expectations of the NSW Health Responding to Sexual Assault (adult and child) Policy and Procedures to be met. Except for very small services, there is likely sufficient work to justify daytime staff with current examination numbers considering medical follow up, education and training, expert certificate writing and review.

2. NSW Health should reduce demands and increase support for on-call examiners

Research participants almost universally described on-call as problematic and impacting workforce participation, so there needs to be mechanisms to reduce the demands of being on-call, and also provide more support for primarily on-call roles. The following are recommended as potential mechanisms to reduce demands.

- Increased daytime staffing, particularly extended hours, can reduce the reliance on on-call staff, as examinations can be conducted in rostered hours. For individual examiners the opportunity to work during the daytime increases confidence and comfort with on-call work.
- Examiners questioned whether all sexual assault examinations needed to occur within two hours and whether there could be arrangements to generally avoid examinations in the early hours of the morning. This was considered to benefit examiners, but also provide a better response because the examiner and patient are not tired. There was strong sentiment that domestic violence responses should not be required after hours so as not to add unnecessarily to the on-call burden, and as forensic specimens were rarely part of domestic violence responses.

Mechanisms to support those working on-call include:

- A 24-hr advice line as suggested by participants. This could operate similarly to CASACAL for adult examiners. It would provide remote supervision and expert advice and support, which was considered particularly useful for rural examiners and for new SANEs. A 24-hr advice line had good support from the Advisory group and was considered an easy first recommendation to implement.
- Enhanced supervision. Whilst all medical and forensic examiners should have access to informal and formal supervision to mitigate vicarious trauma, it is crucial that on-call staff without access to peers are actively engaged in a process that allows debriefing and processing of their on-call experiences.
- Peer networking. Examiners that worked primarily on-call would benefit from opportunities to meet with peers, plus access to information from the LHD and from Ministry of Health. Paid time to attend conferences or training sessions would be valued.
- Appropriate remuneration particularly for primarily on-call roles. There is a strong preference for being paid for on-call because being on-call requires forgoing other paid work or dedicated time for family or recreation. Where on-call is the majority of an examiner's work, the payment needs to be sufficient to provide a decent income in the absence of examinations. The Advisory Group considered the payment for on-call was problematic for everyone but it was noted that SANEs in particular are financially penalised for being on-call compared to working a shift, and that a need to earn an income can deter SANEs from the work. Payment determination for on-call sexual assault responses including the ability for use by nurses was briefly discussed.

3. NSW Health should support a flexible approach to scope of practice to retain examiners

Research participants demonstrated high intrinsic motivation, making them vulnerable to distress if personal and organisational expectations exceed resources. Additional pressures on a short-staffed workforce risks losing examiners for whom SAS is a secondary role. A supportive framework for workforce participation, alongside a culture of compassion will be crucial to grow the workforce. Future changes are likely to cause some dissatisfaction for at least a component of the diverse workforce. To minimise this, consultation and flexibility rather than a prescriptive top-down approach would be valuable. Suggested approaches include:

- Allowing medical and forensic examiners to provide a limited range of services based on availability and expertise. Some SANEs are very highly motivated by compassion and caring and would continue to work if they were able to have a scope of practice that focused on immediate patient care, including recording of forensic information and collection of evidence, but not preparing medico-legal reports or going to court. Such a role may be appropriate for SANEs solely working on-call. This would not be at the exclusion of on-call SANEs doing this work, if desired and appropriately remunerated. This process could also be considered for new SANEs until sufficiently experienced to provide expert certificate.
- Requests for expert certificates and subpoenas managed as a responsibility of the service, not just the examining doctor. Where examiners are on leave or otherwise unable to produce an expert certificate and attend court, the potential for a non-examining expert to produce the expert certificate and attend court should be considered.
- Continuing flexible approaches to rostering and on-call expectations, as highly appreciated by participants. Approaches include reduced on-call hours and periods of leave from on-call responsibilities.
- Ensuring consultation and resourcing for potential expanded roles. Whilst the benefits of an integrated response are acknowledged, the existing SAS workforce is not ready to provide examinations for people experiencing domestic violence. Workload pressures, skillset and expertise misalignment and lack of input are some of the concerns of examiners. There was general agreement from the Advisory Group that domestic violence work would require considerably more resources and that the workforce is not ready for domestic violence until the sexual assault responses are able to be delivered consistently.
- Transparency of expectations. The scope of practice for medical and forensic examiners in domestic violence needs to be clearly defined, alongside clarity of the role of emergency departments. Participants articulated that domestic violence examinations should be supported by social workers both for the benefit of the patient and staff. Nurses in particular, are at risk of burnout if not supported by social workers, as the advocacy focus of the nursing profession increases feelings of responsibility.

4. NSW Health should review current pay and conditions

Fair payment is important both for equity and for visibility of the workforce. Research participants noted payment disparities between doctors and nurses, between doctors employed in differing capacities and between nurses employed in different positions, as well as disparities in remuneration for medico-legal tasks. It is crucial that large payment disparities are reduced, particularly where the expectations of the examiner are equivalent; noting that renumeration review is subject to NSW Government wage policy. Advisory group members provided input into the following potential solutions.

- Review of nursing payments. Daytime payments for nurses vary, due to position requirements that may result in different pay gradings. The industrial award requirements allow for different gradings depending on the role requirements. Standardisation of role descriptions to allow equivalent positions to be graded consistently across the state would reduce disparities. The expectations of SANEs are to work independently and with expertise in a specific area of practice and to contribute to their own professional development. Daytime roles would allow contribution to the development of clinical practice in the service, and an advisory role for others in the LHD, meeting the requirements of a clinical nurse specialist at a minimum.
- Pathways for experienced nurses to be regraded to clinical nurse consultant level or other senior levels would make a career path visible for nurses. The responsibilities of those in leadership positions should be clearly articulated as justification for nurse grading differences.
- The designated medical director or lead responsibilities for overall coordination and quality assurance of the medical and forensic response were generally visible but the differential payment for doctors providing on-call only responses alongside nurses presents challenges.
- Addressing on-call arrangements for medical and forensic examiners who are employed as staff specialists. Examinations require several hours of dedicated time, and participants considered this to be incompatible with an additional workload for staff specialists. Staff specialist medical leads are frequently available after hours to advise other examiners within their LHDs. Availability to provide advice is the level of expectation required in most other staff specialist roles, where a registrar, or trainee specialist is usually available within the hospital. Conducting examinations and filling roster gaps were considered an excessive expectation of staff specialist on-call and separate arrangements for allocation and remuneration are needed.
- Increased communication between LHDs would potentially facilitate harmonisation of responsibilities and payment across the state, particularly for SANEs.
- Appropriate remuneration for expert certificate writing and court attendance is required, whether this be paid time or a reasonable payment.

5. NSW Health and ECAV should review approaches to recruitment and training

Increasing the medical and forensic workforce may require new approaches to recruiting and training examiners alongside opportunities for existing examiners to maintain and increase their knowledge and skills. Whilst satisfaction with existing training was high among participants, limits on developing expertise and unpaid time spent on training were noted. The following are recommended.

- Consideration should be given to changing recruitment strategies, rather than continuing to target women already working in similar fields as they may already be carrying a high "responsibility" burden. Increase visibility within medical education and recruiting more broadly, including men who are perhaps less impacted by vicarious trauma and empathic burden, is a possible strategy.
- Emergency nurses may have skills and interests more in line with potential future domestic violence work, notwithstanding the likely need to upskill in genital examination.
- There is a need to either have a professional body for medical and forensic examiners or align with a larger professional body. Emergency Medicine may be a suitable professional body to support medical and forensic examiners, particularly if domestic violence becomes a large part of the work. The increased professional recognition would be valued and proportionate to the increased professionalism of the work which currently is seen as only increasing the demands of the work without rewards.
- Paid training opportunities are required as there is a strong preference for face-to-face opportunities which requires examiners to take time out of other work. Face-to-face and statewide opportunities are valued for peer support and networking. For regional examiners there are travel costs, in addition to time away from other work. The Advisory Group expressed strong support in favour of facilitating peer support and training both across the state and within LHDs.
- Although ECAV courses are free, examiners may benefit from other training which may have fees. Ongoing training could include training beyond skills of examination, for example, self-care, working with cognitively impaired or drug affected individuals and providing psychological first aid.
- To build capacity, particularly amongst the SANE workforce, the anxiety related to attending court needs to be addressed. Consideration should be given to reviewing the approach to medico-legal training within ECAV's Graduate Certificate. Workforce development within paid roles with appropriate medical lead support may be a more supportive framework.
- Some doctors would like opportunities to further develop further expertise, particularly in medico-legal aspects. This diversity should be considered as an opportunity rather than a risk.
- Increasing activities and visibility of the SANE network. Participants expressed a desire for a SANE network, focused on the workforce needs of SANEs, but also for peer support. As an informal network does currently exist for SANEs employed in NSW, it is apparent that this network has limited visibility for potential new SANEs. Administrative support to enable this network to flourish would be a worthwhile investment, improving opportunities for meetings and its visibility to SANEs in training.

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