Motivations, barriers and enablers for medical and forensic examiners in New South Wales sexual assault services: a qualitative interview study

Natalie Edmiston[1,2], Sam Sperring[3], Rosalie Power[3], Samantha Ryan[3], Kathryn Evans[4], Jane Ussher[3], Ellie Freedman[2]

The known: Throughout Australia, there are significant medical workforce shortages for sexual assault services. Both nurses and doctors work as medical and forensic examiners with NSW Health sexual assault services, providing medical care and forensic examinations as part of an integrated psychosocial, medical and forensic crisis response to people who have experienced sexual assault, yet little is known about their experiences.

The new: Organisational structures including on-call and medicolegal requirements limit participation of an otherwise motivated and educated workforce.

The implications: Changing employment conditions and providing additional support beyond information needs of examiners can help improve workforce participation.

Abstract

Objectives: To understand the motivations, barriers and enablers for doctors and nurses to work as medical and forensic examiners in New South Wales sexual assault services.

Design: Qualitative interview study using semi-structured interviews.

Setting: Interviews were conducted from 1 May to 31 August 2023 in NSW, Australia.

Participants: Thirty-one participants (27 female; 23 doctors, 8 nurses) — who were currently working as examiners in a NSW Health sexual assault service, had left the role within the previous 3 years, or had undertaken training for this role within the previous 3 years but were not working in this capacity — were recruited by email invitation from the NSW Health Education Centre Against Violence.

Main outcome measures: Key themes affecting workforce participation.

Results: Using inductive thematic analysis, we determined four key themes affecting workforce participation: the responsibility burden, on-call challenges, high expectations of medicolegal expertise, and inadequate human resources affecting supervisor and peer support. The workforce was highly motivated and, in the absence of sufficient organisational support, this became a responsibility burden. For many participants, the most challenging aspect of their role was being predominantly on call, which made them feel isolated, invaded their personal time, and affected their preferred mechanisms for managing the traumatic aspects of the work, which were peer support and compartmentalisation. Medicolegal responsibilities were motivating for some participants but represented a significant barrier for many due to high expectations and unfamiliarity. Adequate staffing, opportunities for workplace-based education, and more supervisor and peer support were desired.

Conclusion: Additional support for medical and forensic examiners can overcome barriers, particularly regarding the medicolegal aspects of the role. Employers should ensure the work conditions of examiners enable them to participate in the workforce safely, ensuring that the strong motivations to participate are not undone by organisational factors.

Sexual violence is a serious public health and human rights issue with long term personal, social, health and economic costs to individuals, families and communities.[1,2] Sexual assault is a type of sexual violence that involves any physical contact, or intent of contact, of a sexual nature against a person's will; it has various legal definitions across Australian jurisdictions.[3] In Australia, 1.9% of women aged 18 or older experienced sexual violence during the 2021–22 financial year, an increase from 1.2% in 2012.[3] The highest rate was for women aged 18–24 years.[3] Accordingly, there is an increased demand for expert medical and forensic care, including injury documentation and evidence collection, for people experiencing sexual assault.

Care needs to be accessible in relation to geography, timeliness and being trauma informed. Significant delays in access to medical and forensic examinations can have serious health and legal consequences.[4] There is a significant lack of dedicated sexual assault services in Australia, both in rural and regional areas[5] and in capital cities.[6,7] Inadequate numbers of doctors trained as examiners and limited utilisation of nurses as examiners have been formally reported.[7] A key strategy in the United States has been development of a sexual assault nurse examiner (SANE) workforce,[8] yet retention remains challenging, particularly in rural areas.[9]

In New South Wales, sustained efforts to provide education and training to doctors and nurses to work as medical and forensic examiners has not translated into a sufficient statewide workforce. Little is known about experiences of examiners and potential effects on workforce participation. Negative impacts identified in research with counsellors and advocates include vicarious trauma and relationship changes, while positive impacts include compassion satisfaction and post-traumatic growth.[10] One Australian survey of 36 doctors and nurses working as sexual assault examiners found that vicarious trauma levels ranged widely, and significant personal impacts were reported.[11]

Understanding motivation is fundamental to providing a work environment that enables productive participation. While motivation varies widely from individual to individual and between cultures, it is generally considered to have extrinsic and intrinsic components.[12] Extrinsic motivations are those that are directed towards the attainment of a separate outcome such as income or recognition. Intrinsic motivation is the tendency to do an activity for its own rewards. Work that allows autonomy and social relatedness has been found to positively impact work motivation.[13] Frederick Herzberg, a clinical psychologist and

[1] University Centre for Rural Health, Western Sydney University, Lismore, NSW. [2] NSW Health Education Centre Against Violence, Sydney, NSW. [3] Western Sydney University, Sydney, NSW. [4] Justice Health and Forensic Mental Health Network, Sydney, NSW. n.edmiston@westernsydney.edu.au • doi: 10.5694/mja2.52679

pioneer of motivational theories, described workplaces as having hygiene factors — the physical, human resource and legislative structures that allow work to occur.[14] These external factors rarely act as motivators but, if problematic, they negatively affect work satisfaction and hence motivation.[14] There is a paucity of literature on the motivation to work as a medical and forensic examiner.

We aimed to provide a detailed understanding of the motivations, barriers and enablers for sexual assault medical and forensic examiners in NSW, Australia.

Methods

Study design

We conducted a qualitative interview study using inductive thematic analysis, with interviews held from 1 May to 31 August 2023. Our study is reported in alignment with the Consolidated Criteria for Reporting Qualitative Research.[15]

Setting

In NSW, dedicated services within local health districts provide a range of evidence-based, trauma-informed responses to people who have experienced sexual assault. Doctors and nurses work alongside counsellors to provide integrated psychosocial, medical and forensic crisis responses, including examinations.[16]

Examiners may be employed for rostered hours, as on-call examiners, or both. Doctors are employed as visiting medical officers, career medical officers, or staff specialists. As sexual assault is not a specialty, training is in related specialties. Nurses are employed in various classifications and are required to have 3 years of relevant experience, complete a Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault through the NSW Health Education Centre Against Violence (ECAV) or equivalent and provide three supervised crisis responses before being able to conduct examinations independently.[16] The NSW Health ECAV is funded to provide education for doctors and nurses to become medical and forensic examiners. An advisory group with representatives from metropolitan and regional districts of NSW, including managers, was formed to provide advice on research implementation, interpreting workforce research findings and recommending workforce sustainability strategies.

Participant recruitment and selection

Eligible participants were medical and forensic examiners who were currently working in NSW, had left the role within the previous 3 years, or had undertaken training to work as examiners in the previous 3 years but were not working in this capacity. Purposive sampling was used to ensure that examiners from throughout NSW, including nurses and people with a variety of employment arrangements, were included. We excluded examiners who exclusively provided services to children under 14 years of age, as their workforce issues and employment arrangements have unique features that we considered outside of the scope of our study.

Potential participants were recruited by email. Invitations to participate were sent from the NSW Health ECAV to examiners on a distribution list for educational offerings; they included participant information, a consent form and eligibility criteria. When scheduling interviews, the interviewer (SS) contacted participants and obtained key demographic information to inform the interview. Direct contact with potential key informants who were likely to provide important information but had not yet responded to invitations was made by a member of the research team on 3 August 2023.

Data collection and storage

A semi-structured interview schedule (Supporting Information) was developed by the research team. Open-ended questions pertaining to experiences at work, rewards and challenges, and potential improvements were included. The interview schedule was tested in pilot interviews and refined by resequencing and removing redundancy. The interviewer (SS) reviewed literature and met with three of us (NE, EF and KE) to discuss workforce context before commencing interviews. The interviews were audio-recorded and transcribed using videoconferencing software.

Data analysis and syntheses

Inductive thematic analysis was conducted to identify and describe meaningful patterns across the data.[17] The research team familiarised themselves with the data and summarised the transcripts. Transcripts were re-read line-by-line to capture relevant first order codes, which were refined into a preliminary codebook, trialled by the research team and further refined through collective discussion to achieve a final codebook. Analysis was informed by Herzberg's motivation–hygiene theory.[14] Herzberg postulated that intrinsic work motivation is often adversely affected by external factors, such as policies and environment, labelled hygiene factors. We considered emotional demands to be a potential additional factor that can have an adverse impact on motivation. Contextual reflexivity was enabled by three of us having extensive experience as examiners (NE and EF [both doctors] and KE [a nurse]) and using this experience to initiate the research and provide context throughout study design, data collection and data analysis. The other four of us are experienced PhD-qualified qualitative researchers (SS, RP, SR and JU). All of us are female. The team, or subsets, met for reflective discussion before commencing the research and at multiple points during the analysis. NVivo 14.23.2 software (Lumivero) was used for analysis.

Ethics approval

The study received ethics approval from Western Sydney Local Health District Human Research Ethics Committee (reference, 2022/ETH01945).

Results

Participants

We recruited a total of 31 participants (Box 1). Reflective of NSW medical and forensic workforce, the majority were female (27 [87%]). Ages ranged from 32 to 74 years (median, 54 years) and years in the workforce ranged from 0 to 23 years (median, 7 years). We recruited a diverse population with regard to location, experience and currency of work. Participants are identified by pseudonyms and key demographic features.

The responsibility burden

Participants voiced a strong motivation to work, because of the value of the service provided to those receiving care (Box 2, Jenny). Inaccessibility of care for those who had experienced sexual assault was considered highly undesirable and distressing. Although participants were reluctant to use terms

1 Participant demographics (*N* = 31)

	Number (%)
Healthcare professional type	
Nurse	8 (26%)
Doctor	23 (74%)
Gender	
Male	4 (13%)
Female	27 (87%)
Age	
< 60 years	20 (65%)
≥ 60 years	11 (35%)
Location	
Metropolitan	18 (58%)
Regional or rural	13 (42%)
Employment status	
Employed	21 (68%)
Not employed*	10 (32%)
Roster arrangements†	
On-call shifts only	21 (68%)
Daytime hours with on-call shifts	8 (26%)
Daytime hours with no on-call shifts	1 (3%)
Not applicable‡	1 (3%)
Years in workforce	
< 3 years	6 (19%)
3–10 years	15 (48%)
> 10 years	10 (32%)

* Not employed as an examiner; this included participants who were on extended leave and those who had permanently departed from the medical and forensic examiner workforce. † Roster arrangements in current position or last position if no longer employed. ‡ Not applicable category is used for one participant who had not commenced rostered work. ◆

of enjoyment in relation to the work, many examiners described positive feelings because of both compassion satisfaction and having time to comprehensively provide care.

Several participants described a moral responsibility to address violence and injustice in society and alignment of the work with personal values of social justice, gender equality and antiviolence. Particularly experienced examiners described satisfaction in contributing to convictions (Box 2, Alicia), and being motivated by the ability to use and develop medicolegal expertise. Participants described responsibility to coworkers, such as doctors supporting nurses in skill development. Several participants stated that they had continued in the work because leaving would mean that the number of on-call shifts would be unsustainable for the small number of remaining examiners. One doctor participated in an on-call roster while employed as a staff specialist in another service, with no arrangements for remuneration for attending examinations, demonstrating a high level of commitment to the work.

Women participants described a gendered responsibility held by doctors and nurses with skills in women's health and this being part of the approach used to recruit them as examiners (Box 2, Courtney). Almost all participants described a responsibility held by individuals, not the organisation. This became a burden when workforce shortages existed, and on-call rosters affected work–life balance, yet examiners felt unable to leave (Box 2, David).

On-call challenges

All participants had experiences of being on call — paid, unpaid, or informally by being continuously available to potentially conduct a response. The majority only worked on call, some had a small number of rostered daytime hours, and few had full-time or near full-time positions in a dedicated service. Having a small number of rostered hours was often considered to be of little benefit as it did not allow sufficient time to make connections with local co-workers and with examiners in other local health districts (Box 2, Sarah). Limited daytime hours restricted attendance at training and forums, and the visibility of the workforce was affected.

Overnight responses, including travel time, could mean several hours of lost sleep. The impact on the remainder of the week was especially noted by older participants. Working without a paid on-call roster caused significant disruption to personal lives for some (Box 2, Lucy). Many examiners spoke of arrangements to avoid on-call shifts or avoid responding between midnight and dawn, either negotiated or desired. In addition to fatigue, on-call shifts affected participants' preferred coping strategies for the traumatic aspects of their work, which were to spend time with and talk to peers and compartmentalise the work. Being on-call brought the work into participants' homes and personal lives, and impeded their ability to leave work at work (Box 2, Ruth).

The unpredictable nature of presentations meant that no examinations might occur during a rostered on-call shift, meaning that only an on-call allowance (if available) was paid. Some participants indicated they may have to leave the workforce to earn more money elsewhere, primarily by having regular hours.

High expectations of medicolegal expertise

Collecting evidence objectively while providing medical care resulted in dual responsibilities. One doctor described simultaneous expectations of perfection as both medical care provider and forensic examiner as a "double whammy". Some nurses, valuing patient advocacy, were challenged by needing to maintain objectivity during examinations, particularly without counsellor co-attendance.

Examiners also had responsibility to prepare expert witness evidence for courts and to attend court when subpoenaed. Some participants expressed anxiety about the impact of their medicolegal work on court outcomes (Box 2, Kim). Although examiners reported satisfaction with developing expertise, expectations to produce high quality certificates meant that they considered their remuneration for preparing evidence and attending court to be insufficient. Low hourly rates and opaque arrangements to obtain payment resulted in some examiners attending court without payment. Participants felt that poor remuneration, compared with that for lawyers, demonstrates a lack of recognition for the examiner's expertise. Unpredictability of court attendance and lost income from cancelled clinics were sufficient for one doctor to stop working as an examiner (Box 2, Hera). It was also problematic for SANEs with daytime roles, particularly if conducting examinations for people experiencing domestic violence, due to more frequent court attendance.

2 Themes and representative quotes

Theme	Representative quotes
The responsibility burden: the sexual assault medical workforce was highly motivated and, in the absence of sufficient organisational support, this became a responsibility burden	• "It's about realising the impact you can provide at a really difficult time in someone's life and wanting to do it well and feeling committed to making sure that the front facing medical person that that person sees is empathic and kind and skilled." (Jenny, doctor, metropolitan, employed) • "... when my expert testimony scores a conviction of the perpetrator ... means that person that perpetrated doesn't get to do the same deed to another woman, or maybe 10 women." (Alicia, doctor, metropolitan, employed) • "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, doctor, regional/rural, employed) • "The other thing is burnout, as well. I felt there was potential for my burnout there probably 10 years ago, and that was mainly from the emotional burden that I was feeling at the time. I don't know why, you know, I didn't feel letting go was an option for me." (David, doctor, regional/rural, employed)
On-call challenges: for many, the most challenging aspect of their role was being predominantly on call, which made them feel isolated, invaded their personal time, and affected their preferred mechanisms for managing the traumatic aspects of the work, which were peer support and compartmentalisation	• "I was to come in at 2 o'clock in the morning and do [an examination as] 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." (Sarah, nurse, regional/rural, not employed) • "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, doctor, regional/rural, not employed) • "Feels invasive. This work is invasive because it asks so much. And if you don't have good practice 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, nurse, metropolitan, employed)
High expectations of medicolegal expertise: medicolegal responsibilities were motivating for some but represented a significant barrier for many owing to high expectations and unfamiliarity	• "My fear was that was it my testimony or my information that potentially created the case where the victim did not seek the proper outcome. And that sort of stays with you ... So that was actually what kept me away from the field for a while because I felt like I needed more experience." (Kim, doctor, metropolitan, employed) • "Or cancelling a whole [general practitioner clinic] day, and then ultimately not being needed in court, so free with no patients then to see. Sounds really trivial but at the end of the day, if it's happening a lot, it does affect your income and all that sort of stuff." (Hera, doctor, metropolitan, not employed) • "I had that one random situation where I had done the call-out, done the forensic examination, done the expert's 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." (Julia, nurse, metropolitan, not employed)
Inadequate human resources affecting supervisor and peer support: adequate staffing, opportunities for workplace-based education and more supervisor and peer support including networking were desired to enhance workforce capacity	• "I think that's where a lot of nurses are getting sick of it as well, you know, because it's a lot of time they expect you to be on call. We aren't doctors but we're doing the same job as a doctor would if they went out and it's not equivalent, you know." (Lori, nurse, metropolitan, employed) • "I think that they need to be supported to stay up to date, not only theoretically and practically, but also connected with our colleagues and our peers ... either across the state or in the nation. Being supported to do that, and not entirely off your own back would be really helpful to feel valued." (Christina, nurse, regional/rural, employed) • "You work on your own mostly, well, I suppose you see other doctors for training and you see the counsellor. ... But some way of validating your standards every so often would be nice. Maybe even an observed consultation or an observed simulated consultation of the sort." (Bill, doctor, metropolitan, employed)

SANE = sexual assault nurse examiner. ◆

High expectations of perfection, unpredictability and variable support meant that attending court was anxiety provoking, especially for inexperienced SANEs. Some reported that training had increased feelings of anxiety about court. Negative experiences at court included feeling that one's evidence was ineffective (potentially contributing to failed prosecution) and watching a victim being subjected to distressing cross-examination. Some nurses described the attractiveness of working as a SANE without court attendance expectations (Box 2, Julia).

Inadequate human resources affecting supervisor and peer support

Challenges described by participants included having no medical lead and insufficient daytime and on-call staff. Medical leads were considered crucial for providing information and communicating with management. Reviewing expert certificates, developing relationships with other hospital departments and providing examiners with feedback about performance and outcomes were important roles for daytime staff. On-call vacancies resulted in pressure to be on call more than desired and inability to take leave. Except for those employed as staff specialists, doctors generally felt that remuneration was fair. Nurses noted that they were paid less and expected to do more training, but that they were often expected to perform the same functions as a doctor (Box 2, Lori).

Training by the NSW Health ECAV was valued as free, skill based and accessible. Participants described variable workplace training and mentoring. Educating and mentoring others was considered rewarding for experienced examiners and beneficial to services. Training in skills for responding to people with impairment due to mental illness, drugs or other causes was identified as lacking.

The need for specific training and support for dealing with vicarious trauma related to domestic violence presentations and child sexual assault was noted. Little specific support for the emotional demands of the work was described, with the desired support being time with peers both within a service and across the state. Funded opportunities for connecting with peers was described as demonstrating commitment to the workforce (Box 2, Christina). Nurses noted that peer meetings provided beneficial opportunities to develop professional standards and

negotiate roles and work conditions. Opportunities for validation of performance and support for re-entering the workforce were mentioned by both doctors and nurses (Box 2, Bill).

Discussion

This in-depth research with a diverse range of medical and forensic examiners across geographic areas provides new insights into motivations for and barriers to workforce participation. Strong motivations to provide compassionate care and access to justice for people who have experienced sexual assault can become a responsibility burden when support is insufficient. Working predominantly on call reduces access to peer support alongside challenges related to remuneration and work–life balance. Education is a significant enabler, but additional strategies are required to build a sustainable workforce.

The responsibility burden alongside vicarious trauma[18,19] can result in burnout — well described for SANEs.[20] A responsibility burden has previously been described by advocates and counsellors[21] but not for sexual assault examiners. An attitude of "good soldiering" was found to be protective against burnout for counsellors[21] and a similar attitude was noted among the participants in our study who had more experience. Our participants found that being on call was the most challenging aspect of their work due to sleep disruption, impact on work–life balance and the inability to use either peer support or compartmentalisation to manage exposure to trauma. In the US, first year SANEs found that working on call was stressful, but the stress decreased over time.[22] We found that the challenges of working on call affected examiners at all career stages and that they were common reasons for leaving the workforce or planning to leave. The inability to obtain peer support when working predominantly on call was a significant missed opportunity to protect against burnout. Almost all participants, but especially nurses, desired more peer interactions, which have been found to be beneficial for SANEs in other countries.[23]

Formal peer support through mentor–mentee relationships has significant potential benefits, particularly for the nurse workforce. In the US, a nurse-mentoring framework based on a strength focus, trust, equal power, elimination of hierarchy and barriers, relationality and reflexivity has been developed.[24] This first-of-its-kind program has significant promise in supporting mentees but requires sustained investment in the onboarding and training of mentors.[24] Formalising mentor–mentee relationships — by defining roles and responsibilities, requiring organisations to provide mentors for examiners, and remunerating both mentees and mentors — would help create a sustainable structure.

Acknowledging the impacts of working on call and being exposed to trauma has resulted in attempts to improve work–life balance for examiners and reduce burnout.[23,25] Our participants described having to negotiate individual arrangements such as less on-call work, and frustration with the failure of their local health districts to address their concerns. As such, local health districts were frequently described as having a neo-liberal approach to service delivery and focusing on individual responsibility.[26] A review of the impacts of work on counsellors and victim advocates found that the ability to manage negative impacts was influenced by overall organisational support.[10] There is growing awareness that organisations need to support the sexual assault counsellor workforce with balanced workload, team supervision and other strategies,[27,28] such as allocating work time for key individual coping behaviours, as workers who engage with these strategies report higher levels of compassion satisfaction.[27] A similar transformation in the approach to examiners was desired by participants of our study, but is challenging to deliver to predominantly on-call staff.

Medicolegal responsibilities were acknowledged to be a key part of the work of examiners, but nurses in particular found this anxiety provoking. Feeling ill prepared for court contributed to the majority of US SANEs who had testified in court describing it as intimidating or scary.[29] The challenge of dual but seemingly conflicting responsibilities has been noted for SANEs.[30] There is little literature about the impact of attending court on doctors, although an Australian study found that general practitioners' experiences of attending court proceedings related to domestic violence matters were generally negative.[31]

Education is a key enabler of workforce participation. A variety of SANE-specific programs have been described in the US, including a 40-hour course plus a 1–3-day immersion.[32,33] Simulation and blended learning are widely used educational approaches.[31,32] Challenges of keeping rural SANEs on an educational path once they complete immersive experiences have been reported,[34] but successful programs can be delivered in under-served areas.[35,36] Education should include raising awareness of vicarious trauma before starting work,[19] and should be holistic.[37] Specific psychosocial education focusing on resilience may be useful for increasing compassion satisfaction[25] and mitigating trauma. Training in the role of mentor for fellow examiners is crucial as part of formal peer support.[24] Professional career paths were important for our participants, and a lack of career pathways in forensic medicine has been reported as affecting doctors overseas.[38]

Our findings suggest that employers should actively work to support examiners in the face of vicarious trauma to avoid burnout. Our key recommendations are increasing access to peers and allowing flexibility with regard to on-call work. Examiners' abilities to compartmentalise, a commonly used strategy (particularly for older doctors),[11] can be facilitated by allocating time not on call and avoiding unpaid continuous availability arrangements. Increased daytime staffing would enable this, and would benefit both staff in daytime roles and on-call examiners. Pay and conditions warrant review for some employment arrangements, as lost income from being on call and on-call expectations of staff specialists contribute to some examiners leaving the workforce. Examiners desired more support regarding medicolegal responsibilities and access to 24-hour advice. As examiners report challenges with dual responsibility, it is crucial that counsellors continue to co-attend crisis responses. This, along with support for dealing with vicarious trauma (including from peers or mentors), is particularly important when responding to children and people experiencing domestic violence.[39] A long term approach to developing the workforce should include educating medical and nursing students, as exposure could improve comfort with the work.[40]

Limitations

This research is focused on the experiences of examiners and therefore includes limited perspectives from those required to manage service delivery. The advisory group provided valuable insights into these challenges, but our recommendations remain primarily grounded in the study data. A predominance of doctors, and of examiners who worked on call, means that the perspectives of nurses in substantive positions are less well represented. Also, our results are not generalisable to the

workforce providing responses to children, nor to jurisdictions outside of NSW.

Conclusion

Medical and forensic examiners in NSW experience high levels of motivation to participate in the workforce. Changes in conditions can likely overcome some of the barriers to participation, particularly regarding on-call and medicolegal responsibilities. Employers should ensure that conditions for examiners enable them to work safely, so that the strong motivations of examiners to participate are not undone by organisational factors.

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Competing interests: Natalie Edmiston is the medical lead and an on-call examiner for Northern NSW Sexual Assault Services. She is currently employed by the NSW Health ECAV in the Medical and Forensic Clinical Placement and Support Program. Ellie Freedman is a sexual health specialist working as the manager of the Medical Forensic Portfolio at the NSW Health ECAV, and also works as an on-call specialist visiting medical officer sexual assault examiner. At the time of the research, Kathryn Evans was a sexual assault nurse examiner and clinical nurse consultant for South Western Sydney Local Health District's Sexual Assault Services.

Data sharing: The data for this study will not be shared, as we do not have permission from the participants or ethics approval to do so. ■

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Supporting Information

Additional Supporting Information is included with the online version of this article.