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Review Article

Sexual assault medical and forensic examiners in regional and rural New South Wales, Australia: a qualitative study of experiences impacting workforce participation

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Abstract

Introduction: People who have experienced sexual assault have many acute needs requiring timely attention. In New South Wales (NSW), Australia, reported sexual assault rates have been increasing over the past decade, with reported rates increasing at a higher rate outside metropolitan areas. These regional and rural areas experience chronic shortages of medical and forensic examiners able to deliver timely care. The aim of this study was to identify the motivations, barriers and facilitators affecting the recruitment and retention of examiners in regional and rural NSW, Australia.

Methods: Doctors and sexual assault nurse examiners who have worked as examiners for NSW sexual assault services in a non-metropolitan area were recruited to participate in semi-structured interviews. Written informed consent was obtained, and interviews were recorded and transcribed. Data were coded using a combination of deductive and inductive approaches. Themes were developed according to Braun and Clarke's thematic analysis approach.

Results: A total of 13 participants were interviewed, of whom 11 were female and 2 were male; 9 were doctors and 4 were nurses. Five key themes were identified: structural challenges of rural service delivery, near invisibility in the health system, isolation and missed connections with colleagues, inability to thrive, and sense of duty to patients, colleagues and community. While motivated by obligation to colleagues and community, barriers of travel time over large geographic areas and insufficient examinations to maintain skills were present. Potential facilitators such as peer support, contributing to policy and funded training opportunities were considered to be lacking.

Conclusion: To ensure the sustainability of rural sexual assault medical workforces, change addressing isolation and invisibility is needed. Future changes to services should be considered from a rural lens, as rural examiners face unique barriers to workforce participation and are essential to service delivery.

Keywords

Australia, forensic medicine, medical examiners, rural health services, sex offences, workforce.

Introduction

Sexual assault is broadly defined as when a person is subjected to sexual acts against their will or without their consent, and includes penetrative sex, sexual touching and oral sex[1]. In a 2021–22 survey in Australia, 14% of people aged 18 years and older reported they had experienced sexual violence since the age of 15 years[2]. Reported rates of sexual assault are increasing, which may reflect increased occurrence, increased awareness and reporting, or a combination of factors[2]. New South Wales (NSW) reported an 8% increase in reports of sexual assault from 2021 to 2022, and rates have been increasing for 11 consecutive years[3]. This is even more pronounced in regional and rural NSW, where sexual assault reports increased by 47% from 2019 to 2023[4].

Following sexual assault, acute needs may include emergency contraception, treatment of genital and bodily injuries, post-exposure prophylaxis for HIV and mental health care[5]. Timely evidence collection may be required as part of a forensic response. This includes samples for DNA analysis[6] but may also include toxicology specimens and documentation of injuries[7]. In NSW, the medical and forensic responses are conducted in one examination by a trained doctor or nurse, known as a medical and forensic examiner (MFE). As part of their role, MFEs prepare documents for and attend court, often months to years after the examination took place. An integrated response is delivered in NSW, with MFEs working alongside psychosocial workers within sexual assault services[1].

Rural areas, while disproportionately affected by sexual assault, are simultaneously experiencing chronic healthcare worker shortages[8]. This is exacerbated by high turnover among rural healthcare workers, and difficulties recruiting staff to positions in these areas[9]. Research has played a key role in characterising rural workforce challenges and forming a basis for policy and investment changes[9]. However, there has been insufficient focus on the sexual assault MFE workforce, despite the challenges of service delivery in rural Australia being recognised as a concern[10]. As such, targeted research on the rural MFE workforce is needed to investigate the motivations, barriers and facilitators impacting staff retention and recruitment. The aim of this article is to investigate this gap, which may inform strategies to foster sustaining work environments to ensure rural and regional service delivery.

Methods

Study design

This is a secondary analysis of a qualitative interview study on motivations, barriers and enablers for doctors and nurses to work as medical and forensic examiners in NSW Health Sexual Assault Services[11].

Setting

NSW is the most populous state in Australia. Six local health districts (LHDs) cover the Sydney metropolitan region and nine cover rural and regional NSW[12]. While some regional and rural LHDs include metropolitan centres, for example Newcastle in the Hunter New England district, all provide services to people living in rural areas.

Each LHD must provide at least one 24-hour, week-round service, in accordance with NSW Health's *Responding to Sexual Assault (Adult and Child) Policy and Procedures*[1]. Essential to the service are MFEs, who may be doctors from various specialties, or nurses, known as sexual assault nurse examiners (SANEs). MFEs complete expert certificates for court, which include a record of the examination and expert opinion of the case. Expert certificates must be peer reviewed by another MFE. Doctors often come from backgrounds in women's health, sexual health and general practice, although any medical officer meeting their district's requirements can become an MFE[1]. Nurses must be a nurse practitioner, or a registered nurse with minimum 3 years clinical experience in a relevant specialty and have or be working towards

a qualification specific to sexual assault[1]. Despite an MFE's unique skills, most work for a sexual assault service solely in an on-call capacity, having primary employment elsewhere.

Examiners provide highly specialised care, even more so for those providing examinations for children, which, in NSW, must be a medical officer[1]. Most LHDs do not currently provide forensic examinations for domestic violence situations specifically, although they provide examinations when it co-occurs with sexual assault[1].

Participants

Eligible participants consisted of MFEs – doctors and nurses – who currently worked or had worked in the previous 3 years for a sexual assault service outside of Sydney, the largest city of NSW.

Recruitment

An email, with participant information sheet and consent form attached, was sent by NSW Health Education Centre Against Violence (ECAV) to their database of examiners. Email recipients were encouraged to assist in snowballing by sharing study details with colleagues. A second email and purposive sampling by EF, a peer, directly contacting key informants followed. Interviews from participants who worked in rural or regional services were selected from the total of 31 interviews, for thematic analysis in this study.

Data collection

Semi-structured interviews of approximately 1 hour were conducted for the primary study. The interview schedule covered participant employment background, and rewards and challenges of the role. First-hand experiences of working in rural health were contributed by NE to inform questions for rural examiners on rural specific experiences (Supplementary material 1). Pilot interviews were conducted and the interview schedule refined.

SS conducted the interviews; they had no relationship with participants prior and no connection to the workforce. They were trained on qualitative interview techniques and clinical and workforce issues relevant to sexual assault. Written and verbal consent was obtained before interviews, which were conducted via videoconferencing, audio-recorded and transcribed by NVivo v14.23.2 (Lumivero) [https://lumivero.com/products/nvivo]. There were no repeat interviews. Transcripts were checked by researchers prior to offering participants the opportunity to review, comment and correct their transcripts if desired.

Data analysis

A codebook was developed for the primary study by six researchers. In-depth reading of transcripts contributed inductive codes, and existing workforce theory contributed deductive codes. Researchers trialled the codebook before meeting to discuss and refine it[13].

This primary codebook was adapted by TF for this study. A literature review on rural workforce retention and recruitment factors identified rural specific codes to be included. Transcripts were then re-read to add codes identified inductively. The new codebook was discussed with fellow researchers before applying it to transcripts using the NVivo software. Code summaries were made for each code. Themes were developed using Braun and Clarke's thematic analysis methodology[14]. Themes were modified following in person discussions with one researcher, and emails and annotated drafts shared by other co-authors.

Reflexivity

The research was initiated by NE and EF, who have experience as MFEs. SS, RP and SR (all with PhDs) have extensive qualitative research experience. TF completed her final 2 years of medical school at a rural clinical school. All researchers are female. Reflective discussions with the team, or subsets, were held prior to commencing research and throughout the analytical process.

Ethics approval

Ethics approval was obtained from the Western Sydney Local Health District Human Research Ethics Committee (approval number 2022/ETH01945). Extended consent was obtained for transcript inclusion in secondary analyses.

Results

Thirteen participants completed interviews, of which the majority were doctors, currently employed by a sexual assault service, female and aged over 50 years (Table 1). Years worked as an examiner and estimated cases seen varied greatly (Table 2). Interviewees spoke about their experiences as examiners and their perceptions of the experiences of victim-survivors of sexual assault. From the interviews, five key themes were developed: structural challenges of rural service delivery, near invisibility in the health system, isolation and missed connections with colleagues, inability to thrive, and sense of duty to patients, colleagues and community.

Table 1: Participants' gender, pseudonym, position and employment status

Pseudonym	Male or female	Position	Employment status with sexual assault service
Sarah	Female	Nurse	Not employed
Elaine	Female	Doctor	Not employed
Lucy	Female	Doctor	Not employed
Courtney	Female	Doctor	Employed
Alyce	Female	Doctor	Employed
Anika	Female	Doctor	Employed
Barbara	Female	Doctor	Not employed
David	Male	Doctor	Employed
Jane	Female	Nurse	Employed
Greer	Female	Nurse	Employed
Christina	Female	Nurse	Employed
Caroline	Female	Doctor	Employed
Rufus	Male	Doctor	Employed

Table 2: Summary of demographic information

Variable	Median	Range
Age (years)	54	35–74
Time in service (years)	7	1.5–23
Estimated cases seen	50	6–650

Theme 1: Structural challenges of rural service delivery

Non-metropolitan services frequently cover large geographical areas, with small populations, spread across the district. This necessitates significant travel for service delivery and creates inconsistent case loads.

Populations outside metropolitan areas are often widespread, meaning MFEs may reside or work at some distance from where examinations are conducted. In their on-call capacity, examiners may be required to travel substantial distances to conduct examinations within recommended time frames. This was described as unsatisfactory by participants as it contributed to fatigue and increased call-out times, stretching already thin resources. Remuneration did not always reflect the work; some were paid a fixed rate for call-outs regardless of hours worked or travel time, and rates between SANEs often differed.

> *If I get a call out, I think I'm paid 2 and a half hours … but there's no equity … the 4 of us nurses in* [location] *… we're all on different* [payments]*, whatever our substantive jobs are or were, is what we are paid per hour.* (Jane)

Examiners described occasions when patients are asked to travel, as opposed to an MFE coming to them, particularly at times when no examiner was available in their district. Participants noted patients are often reluctant to travel for examinations. In these instances, patients miss out on services, potentially impacting evidence for court as well as medical care. Participants described spending considerable time attempting to arrange for a patient to travel for an examination, yet patient circumstances precluded the travel occurring.

One participant described a telehealth model that their service implemented to reduce travel, whereby the patient videoconferences with an MFE and sexual assault counsellor to determine if they want a medical and forensic examination before either party travels for the service. Videoconferencing was also used for court attendance and acted as another facilitator to the role by eliminating the need for travel to and waiting at court. This arrangement was particularly beneficial in helping participants balance their MFE role with other employment.

> *Sexual assault's a major disruption full stop, but you don't need to add travel on top of it.* (Barbara)

Caseloads reported varied greatly across non-metropolitan LHDs. Some participants felt gaining a co-worker was needed to balance the workload, whereas others found case numbers so low that maintaining skills was difficult. Anika described a supervisor who would arrange simulation cases if examiners had not had a case for a while, which helped mitigate concerns of skill regression. However, many others found supervision and training hard to come by, meaning less support for those with low case loads. Participants, regardless of case load, felt adding medical and forensic examinations for people experiencing domestic violence to rural MFE's scope of practice would require more staff. Some felt domestic violence cases are worse in rural areas, meaning non-metropolitan services in rural areas would have a larger workload increase.

> *There wasn't the case load and if they're doing you know less than 6 in a year, I don't feel like I would be very good if I was doing one or two forensic call-outs a year … so having less colleagues, is probably a reflection on the case load. We don't want that to increase … it's a catch 22.* (Christina)

Non-metropolitan services commonly rely on on-call MFEs. Those with high case loads can expect frequent call-outs, and those with low case loads usually have few examiners, meaning frequently being scheduled on-call. Participants described many restrictions created by on-call work, such as staying nearby and being ready to drop everything to come in at moment's notice as burdensome, for them and their families. Some participants spoke of having prioritised work over family by being on call so much.

Theme 2: Near invisibility in the health system

Not being consulted for policy and service changes, combined with a lack of presence and recognition by hospitals, devalues MFEs and creates additional burdens that disproportionately affect rural MFEs and patients.

Rural MFEs commonly experienced exclusion from decisions on policy and service changes. This, at times, led to implementation of counterproductive policy that disproportionately impacted rural MFEs. One example is the 2-hour time frame given to examine patients after presentation, which is challenging due to the geographic spread of non-metropolitan services, necessitating longer travel to reach patients. An example of a counterproductive procedure is a service not permitting electronic transmission of forensic records. An examiner from this service explained examiners must travel back to the site of examination to access these records, which are needed to write medico-legal reports. The situations in both of these examples disproportionately impact rural MFEs who cover large geographic areas, resulting in increased time demands.

Barriers to attending team meetings, or absence of meetings entirely, excludes MFEs from a pathway to provide feedback on policies and procedures. Travel, lack of compensation for attendance and not receiving invitations to meetings with psychosocial staff from within the sexual assault service were reported by examiners.

Needing to continually advocate for job necessities was perceived as another symptom of rural MFEs' invisibility. Two participants reported issues with needing to occasionally share their examination room, and struggling to have the room cleaned in a sterile manner. Additionally, when attending to conduct an examination, supplies required were sometimes out of date or unavailable.

> *We don't necessarily have dedicated forensic rooms … we are a regional site and we're doing the best we can with what we've got, and what we've got is better than some.* (Christina)

Some participants felt unsupported by hospital executives at their rural services. Sarah explained her hospital executives had not known she was employed there, and she received continual

pushback when asking for appropriate payment for her time, making her feel underappreciated and invisible. Lucy felt executives in her area avoided talking about sexual assault services due to their own discomfort and underlying stigmatisation of the service, perpetuated by the area's conservative political climate. These experiences – not being involved in policy development, barriers to team meeting attendance and insufficient recognition by executives – contributed to MFEs feeling devalued.

> *Just forever being told 'couldn't afford you' … made you feel a bit worthless.* (Sarah)

Lack of visibility on a service level was described as a barrier to involving other hospital departments in service delivery, such as human resources departments supporting recruitment. Many participants had not been recruited formally. As Lucy explained, without knowledge of services, potential applicants would never know where to, or that they could, apply to be an examiner. This left many participants feeling as if recruitment was their responsibility – particularly Courtney, who was reaching retirement and wanted to leave the service with sufficient replacements. Several other participants also spoke of approaching retirement.

Some participants described benefits of a medical lead role for business hours, to combat the lack of visibility and voice felt by rural services. Courtney's service was implementing this role, which she said had facilitated discussions with relevant stakeholders, like the emergency department, which had previously not been done.

Theme 3: Isolation and missed connections with colleagues

Exclusion from or absence of team meetings, combined with solely on-call work, leaves MFEs feeling isolated and disconnected from psychosocial team members, the few fellow examiners in their district and those in other districts.

Some participants reported their district did not have any daytime MFEs, meaning all work was on-call. Given the common peaks of sexual assault presentations – weekends and night-time – MFEs in this predicament were mainly working outside business hours. This left them operating, sometimes for many months, with little contact with colleagues. Minimal contact with co-workers was isolating and a barrier to debriefing, which contributed to participants' emotional burden. For Christina, who had a dedicated colleague for debriefing, this would often not occur until the following week, because they infrequently worked from the same location. Others had no colleagues with whom to debrief.

> [Able to talk to colleagues?] *Well, there aren't any out here. So, there was no one else really to discuss it with and it's highly personal sort of stuff because it's people that we know. So no, not really.* (Elaine)

Team meetings can present debriefing opportunities, although these were not standard or regular for all participants, particularly those with few MFEs in their district. David found meetings to be more prevalent in metropolitan services and would seek these meetings out to gain the benefits of gathering with colleagues. The majority of participants expressed a desire for more opportunities to connect with peers.

> [Metro hospital] *had these monthly meetings … It was just that sense of coming together, and perhaps that's an advantage of being an urban-based practitioner, those opportunities might exist. But you can get lost out in rural districts.* (David)

Contact with team members was frequently described as social and informal, making debriefing and case-sharing difficult given the public location. Attendance was not necessarily paid and sometimes required significant travel given non-metropolitan services cover large areas. Social contact also placed the burden of organising gatherings on MFEs, who often already felt stretched for time.

Rural MFEs felt that connection with other districts, particularly metropolitan services, was needed and entirely possible with videoconferencing. This would facilitate case-sharing, continued learning in the field and the development of mentoring relationships, particularly those with no potential mentors within their service. MFEs with low case loads who struggle to maintain skills and keep up with changes in the field would especially benefit. Participants thought it would also validate rural MFEs regarding the number of cases and skills they have.

> *I didn't have any kind of local clinical supervision when I got started. So the support that I received via the telephone was certainly very helpful.* (Caroline)

While videoconferencing significantly increases the possibility of connection, participants noted that the benefits of face-to-face meetings are not fully replicable through digital communication. Providing financial compensation and dedicated time to attend meetings was suggested to make at least some in-person meetings accessible to rural MFEs.

Theme 4: Inability to thrive

Training, mentoring and debriefing opportunities in rural areas are often minimal, limiting MFEs' ability to thrive by continually developing skills to deliver quality services.

Having few co-workers, and no medical lead, in rural services makes it difficult to provide mentoring and training opportunities for MFEs in-person. This led some participants to seek mentorship from metropolitan staff in other services. Those individuals had good experiences, particularly Caroline, whose mentor would take calls at odd hours and was described as instrumental in her ability to grow and continue in the role in the initial stages.

However, a distance-mentoring arrangement required pre-existing relationships with metropolitan staff. Having a mentorship relationship limited to videoconferencing due to physical distance restricted the guidance mentors could give on patient interactions and clinical skills. For formal feedback, Lucy experienced having performance reviews only every 5 years.

> *If you're a GP VMO* [visiting medical officer] *you do a performance review once every 5 years … You come in at two o'clock in the morning, you go home, that's it, you have no manager. If I had a manager, I have no idea who it was.* (Lucy)

Both initial training for the role and continued professional education were described as difficult in rural settings. Lucy found her initial training to be insufficient, so she sought additional training herself. This was difficult due to her location and lack of online attendance options, necessitating considerable travel. Elaine

had been unaware more support and guidance were available as no one had pro-actively offered it, leading her to assume it did not exist.

> *… the first that I knew that there was any supports out there was in the last couple of years, before I stopped … I didn't realise there was any more help available.* (Elaine)

It is required that expert certificates are reviewed by a second MFE, which is challenging with a small workforce. Some explained one person would do most reviewing, and other participants' services outsourced certificate reviewing to metropolitan services. Both present a missed opportunity for the development of expert certificate writing skills, as feedback is mainly coming from one person or someone who is unable to discuss feedback in real time respectively.

Participants found the current number of supported workdays dedicated to attending training, conferences and general self-study inadequate. Most rural MFEs held other employment simultaneously, further complicating being able to find time for travel to training, and the training itself.

Theme 5: Sense of duty to patients, colleagues and community

Examiners' main motivation to stay in the role is often a sense of obligation and duty to their patients, colleagues and community, even if this comes at personal expense.

Many participants felt, at least partly, compelled to stay in the role, take on more work or do more call-outs, as otherwise colleagues would be under more pressure or areas would be left completely unstaffed. Courtney had delayed retirement because no replacement for her had been found. A similar sense of duty was felt towards the patients, with Elaine expressing that without her, patients would need to travel much further, which would also likely push the patient outside the time frame for gathering usable evidence.

> [Ever thought of leaving?] *No! No, because then that would just leave one!* (Greer)

Wanting to provide a better service and experience for both staff and patients motivated Rufus to work with multiple rural services. Doing this was not without risk, such as conflict of interest, and potentially overload if all services needed his assistance at once. However, he felt the benefits to communities and his colleagues outweighed the risks.

> *The other thing in regional areas is that, you're basically seeing your brethren – your brothers and sisters really affected by, say, the lack of forensic expertise or on-call staff. And I've decided to take on more than what would be comfortable in order to serve them.* (Rufus)

Some participants described providing examinations for patients even if they were a friend or acquaintance, or the examination was particularly confronting, which is often the case with child examinations. While nurses could not examine children aged under 14 years, some doctors in rural areas were seeing younger children, explained Anika. Courtney felt paediatricians were becoming less willing to see children who had been sexually assaulted. Children would need to travel to the nearest service with paediatric examiners, often in metropolitan centres many kilometres away. Families may be unwilling or unable to travel, meaning examiners such as Courtney felt compelled to provide paediatric examinations despite her own discomfort. Participants on the whole were aware of this dynamic; if they did not do an examination, there would be significant barriers to the patient receiving the service and/or one of their colleagues providing the service. Many also recognised that any barrier to providing a medical and forensic examination was a barrier to justice.

> *The thought of sending a kid from* [regional location] *to Sydney for a sexual assault examination just seems horrible and in many, many, many cases that's just not going to happen because the family won't have the means or the desire or whatever to do that.* (Courtney)

Despite feeling an obligation to the community, the addition of domestic violence to MFEs' scope was not unequivocally welcomed. Courtney was concerned living in a small community would make it easier for violent perpetrators to find her and retaliate for perceived advocacy for the victim. This made her unwilling to examine people who had experienced domestic violence.

Some examiners identified possessing a unique skillset, with tangible community benefits contributed to job satisfaction and self-worth. The clear connection to the job and improving outcomes for those who experienced sexual assault, and the wider community, aligned with the values of the participants. The trust patients have in MFEs was seen as an honour. Contributing to court outcomes through detailed examinations and court reports was a motivator to continue improving their skills.

Discussion

Our study is the first to explore Australian rural MFEs' perspective on their work. A previous small study of SANEs from the US found challenges of maintaining competency and patient privacy to be the key distinguishing experiences when compared to urban SANEs[15].

With the inclusion of doctors, our study has identified challenges of large distances, isolation, inconsistent remuneration and insufficient opportunities for training, mentoring and debriefing. Despite the challenges of the role, an enduring sense of commitment to colleagues and community was a strong motivator for MFEs to stay in the role.

Australian rural MFEs face challenges with travel inherent to the location and large geographic areas they work in. Travelling for cases was burdensome as it extended call-out times and hence workload, but was described as particularly problematic when MFEs were not compensated for it. Travelling long distances for work may contribute to burnout, particularly when combined with inadequate supervision and peer support[10]. Minimising the need for travel for non-clinical aspects of MFE work could be achieved by secure electronic transfer of medico-legal reports requiring review within and between districts. Videoconferencing should be implemented where possible to reduce unnecessary travel for court attendance. Telehealth consultations can be used to provide information and advice to patients who may not desire a medical and forensic examination, mitigating the need for patient and MFE travel.

Geographic isolation and time constraints impact continuing education, with significant impacts on the availability of specialised practitioners such as SANEs[15,16]. Many participants in our study expressed a desire for increased supervision. Supervision facilitates ongoing learning and allows networking for otherwise relatively isolated allied health workers in rural NSW[16]. Supervisors who either lived in, or had experience with, rural communities, were preferred, as was someone who could provide in-person supervision for review of practical skills[16]. Supervision has a role in rural retention for nurses[17] and in reducing vicarious trauma for MFEs[18].

Peer support, collegiality and mentoring were other factors identified by the participants as needing improvement. They largely felt peer support and mentoring opportunities were limited and difficult to access, despite desiring these. A systematic review of mentoring for first-year doctors found numerous benefits including improved job satisfaction, retention and resilience[19]. Improved competence and professional growth alongside connection from mentorship were described by rural nurses in Canada, yet insufficient time and few trained mentors remain barriers to access[20,21]. Peer support and time with peers has numerous benefits in improving work satisfaction and participation and reducing emotional exhaustion described across numerous professions[22-24]. Both MFEs[18] and rural nurses[17] desire opportunities for peer support.

This prior research, along with the findings of our study, supports the notion that peer support plays a role in both professional growth and personal wellbeing. Visibility of peers may also support SANEs to access ongoing training and certification to practice[25,26]. Rural MFEs would benefit from paid and dedicated time for peer support, clinical supervision and education. The opportunity to connect with and review practices with metropolitan colleagues would facilitate establishment of interdistrict mentorship relationships. Rural examiners would benefit if the responsibility of organising meetings and peer support time were not an additional individual responsibility. Local leadership is important to support increased confidence and capacity to deliver services, and has a crucial role in advocacy for rural service delivery.

Despite the importance of rural input into policy, rural MFE input is logistically challenging due to on-call work, geographical spread and, frequently, secondary employment, making mutually suitable times for meetings difficult. In addition to time constraints, management and organisational factors that sideline less-connected individuals, including nurses, impact participation in health policy[27]. These structural issues are likely to have an impact on all rural examiners, particularly SANEs. Despite barriers to consultation, involvement in policy development is essential because, without it, working conditions are impaired through creating policies unsustainable in rural settings. Insufficient consultation of rural MFEs could be particularly harmful when expanding examiners' scope of practice. All districts should have representation at statewide meetings, either via a medical lead or delegate. Policy should be reviewed from a rural lens, allowing rural examiners to give input on proposed changes.

The findings of this research have applicability to the rural response to sexual violence worldwide. Barriers to disclosure and help-seeking and problems with service delivery described in rural Australia[10] have been previously reported in the US[28]. Strategies to improve rural workforce retention, including minimising travel demands, access to training and local supervision, peer support and input into policies, are likely to be effective in supporting service delivery in many rural areas.

Limitations

All participants who worked in NSW districts outside of the largest city were classified as rural for this study. Due to the small sample size, it was not possible to further classify degree of remoteness, which varied greatly, without making participants identifiable. Experiences of very remote examiners may be less visible compared to those with closer connections to metropolitan centres. The sample size, while small, is reflective of the limited number of examiners in rural NSW. Those with large workloads or under significant stress, while perhaps potential useful informants, may have been less likely to participate, as the interview required a dedicated hour of time. This was a secondary data analysis, an efficient tool for focusing on a small population. The aim of the study was closely aligned with the larger study, and all investigators were involved in the larger study, maintaining rigor; however, a dedicated study of rural examiners would potentially enable greater depth.

Conclusion

Commitment to colleagues and communities motivates rural MFEs despite the barriers of isolation, invisibility and limited opportunities for ongoing training, mentoring and supervision. Rural MFEs play a vital role in the response to sexual violence, making it imperative to listen to their experiences and needs to ensure they are supported in their roles.

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Conflicts of interest

Natalie Edmiston is the medical lead and an on-call examiner for Northern NSW Sexual Assault Services. She has worked for 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 NSW Health ECAV and also works as an on-call specialist sexual assault examiner.

AI disclosure statement

Generative AI or AI-assisted technologies were not used for any purpose in this research or article.

Data availability

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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