

Exploring Forensic Nursing Ethics and Practice:
Roles, Loyalties and Photodocumentation Practices

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Abstract

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Forensic nurses find themselves at the intersection of healthcare and the law, yet there remains a dearth of research and normative articles addressing topics such as dual loyalty (e.g., to the patient and society; to nursing and the criminal justice system), professional values (e.g., conflicts of interests and conflicting interests), and role clarity. The purpose of this dissertation work was to contribute to the dialogue in these important areas.

Exploring Forensic Nursing in the Context of Roles, Loyalties, and Interests: Role clarity is essential for forensic nurses to effectively respond to questions about their practice and to address incongruence between expectations of the ideal role and the enacted role. A focused literature review was conducted to explore role confusion and role conflict, dual loyalties and dual roles, and conflicts of interests and conflicting interests. This review revealed that use of the expression “we are nurses first” may be a symptom of role confusion and conflict for forensic nurses. However, ranking roles in this way may fuel incongruences between both internal and external expectations for what the role of a forensic nurse entails. Implications include the need

to socialize new forensic nurses and to reconcile the aspects of one's role that come with a unique specialty practice such as forensic nursing.

Forensic Medical Examinations – Equity for Those Suspected and Accused of Violence: Forensic exams are conducted for both those who are identified as victims of violence and those who are accused of causing violence. However, there has been little attention on describing current practice, recommended standards or guidelines for collection of samples, or a dialogue about possible inequities for those accused or suspected in sexual assault cases versus those identified as victims. To examine this issue, a review of the scholarly literature, the grey (or lay) literature, and targeted articles was conducted. This review stimulated important questions. If a forensic nurse collects samples from a person, does that activity confer status as “a patient” thereby granting that person the rights generally considered part of a nurse-patient relationship? Should language regarding persons being seen by forensic nurses be consistently neutral and nonjudgmental, eliminating the labels of “victim”, “accused”, “perp”, “assailant”, etc.? Should those accused of violence receive the same rights and consideration around a forensic medical examination as those who are considered victims of violence? How should disparate care for those who are affected by violence be addressed?

Photodocumentation Practices Among Forensic Nurses: Use of photographic documentation of physical observations has grown with the widespread availability of digital recording technologies (e.g., digital cameras, digital video cameras). In clinical forensic practices, photodocumentation is frequently used, but best practices have not been established resulting in wide variations in practices. To explore this gap, a 96-item, web-based survey was developed and completed by 563 forensic nurses, primarily in the U.S. and Canada, to describe current photodocumentation practices. Findings included that one-third of respondents reported

experiencing a time when they decided not to collect any images, often for nonstandard reasons. While digital cameras were the primary device used, respondents also reported they would use their personal electronic devices (e.g., cell phones or tablets) if their usual equipment was unavailable. The security of the images, including how images were protected from unauthorized access and during transfer, was not known by approximately 10% of respondents. The survey also revealed, depending on age of patient population served, between 5% and 13% of nurses were not using photodocumentation during forensic medical examinations. Implications include the need for guidelines to address providers who are not practicing what appears to be an emerging professional consensus, determining competency in photodocumentation practices, and implications of maintaining competency in low-volume settings.

Dedication

This dissertation is dedicated to all of the individuals, families, groups, communities, and populations that have been, and continue to be, affected by violence – it is because of your lived experiences that I continue to ask, “How can we do better?”

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Chapter 1: Exploring Forensic Nursing Ethics and Practice - Roles, Loyalties and
Photodocumentation Practices

Introduction

Forensic nursing, formally recognized by the ANA in 1995, is a relatively young nursing specialty. Although ethical concerns and dilemmas abound, there remains a paucity of published research studies on the ethical dimensions guiding forensic nursing practice. In addition, there is a lack of educational resources related to ethics from sources such as the forensic nursing society's professional organization, academic texts, and journals. Yet, forensic nursing practice occurs in an environment where providers are at substantial risk for role confusion and role conflict. Forensic nurses may also experience conflicts of interests or conflicting interests. They encounter ethical dilemmas that may create moral distress and have extremely limited resources for guidance. Forensic nursing is a specialty practice that encounters situations involving sexual assault, child abuse, homicide, torture, and other tragedies that are emotionally charged and involve medico-legal implications. The outcomes associated with these events may have life-long negative effects for the patient, their families and loved ones, their community as well as for the accused, suspects and perpetrators of the violence and his/her family and loved ones.

Issues related to clinical, professional, and organizational ethics within forensic nursing practice span the realms of clinical practice, research, education, administration, and policy. Forensic nurses find themselves at the intersection of healthcare and the law, yet there remains an absence of forensic nursing research on topics such as dual loyalty (e.g., to the patient and society; to nursing and the criminal justice system), professional values (e.g., value development, response to conflicting values), and ethical decision making processes. There is also a lack of published articles addressing conflicts of interest and conflicting interests, and where the two concepts overlap, in clinical forensic nursing practice. Interestingly, within the *Scopes and Standards of Forensic Nursing Practice* (2009), there are several references to the ethical

paradigms of forensic nursing practice although a literature search for such a paradigm or their application to practice was unsuccessful within the forensic nursing literature and textbooks.

Discourse surrounding forensic medical services for unconscious patients serves as an exemplar of the concerns described above. During discussions of potential ethical conflicts, many forensic nurses become focused solely on the pelvic exam, specifically, the insertion of a speculum into the vagina of an unconscious female patient. Considerations are not given to other related invasive procedures (e.g., sample collection from anal or oral cavities), equivalent concerns for male or transgender patients, nor grounds for suspicion of assault itself. Individual decisions and even program policies have been based on what the forensic nurse would want if s/he were the patient or based on an assumed fear on the part of the forensic nurse of risking his/her professional nursing license(s). These decision processes are not consistently evidence-based nor patient centered and represent a weak ethical decision making process.

A second exemplar, and the impetus behind the data generating section of my doctoral studies, involves the practice and policy surrounding photodocumentation, particularly digital photodocumentation. Concerns around the use of digital imaging technology for photodocumentation emerged through formal and informal discussions during an International Association of Forensic Nurses symposium on photodocumentation, posts on general and sub-specialty discussion boards, articles exploring the use and purpose of digital imaging technology, and questions posed during forensic nurse training and presentations. Much of the formal and informal discourse appeared to be anecdotal at best and similar to the exemplar shared above. These conversations tended to focus primarily on female patients and their genitalia. Yet there was a lack of evidence-based or research-informed literature related to the use of digital imaging for photodocumentation among forensic nurses. The same held true for forensic nurses concerns

involving the practice of photodocumentation and use of digital imaging technology. This gap in the literature included both extra-genital and ano-genital photodocumentation practices. To develop best practices, policy statements or guidelines, and to address ethical concerns surrounding the use of digital imaging technology in clinical forensic nursing practice, it is critical to move beyond anecdotal accounts. A review of the current state of practice among forensic nurses across different populations, systems, and roles was needed.

I returned to earn a PhD in nursing because I wanted to make a difference. My goal was to serve as a change agent by creating safe professional environments that promote informed conversations about difficult subjects. Informed dialog and questioning the “what is” is critical to enacting change within forensic nursing practice. Positive change can create a ripple effect across all domains of practice helping us achieve the “how it should be”. By doing so, we enhance our capacity to better serve populations affected by violence and mass disasters regardless of how they self-identify or how they may be labeled by society or the legal systems: victims and survivors; the accused, suspects and perpetrators; secondary survivors; individuals, families and communities.

My hope is to collaborate with others in the future who wish to do the same for the populations they serve. I am dedicated to serving as a change agent and I understand the risks associated with raising my head above the crowd and objectively speaking out about emotionally charged and controversial subjects. Speaking up for those whose voices are not valued, or whose voices are actively silenced, carries risk. These goals were the impetus for this dissertation.

Structure of the Dissertation

In Chapter Two, I explore forensic nursing from the perspectives of role confusion, role conflict, dual loyalties and conflicting interests. Chapter Three introduces a dialogue highlighting

inequities related to forensic medical examinations for persons identified as suspects or the accused in sexual assault cases versus those identified as victims. Chapter Four explores photodocumentation practices among forensic nurses and begins discussions related to variations in practices in this important area of forensic nursing practice. In the final chapter, I offer reflections on implications of my doctoral work for forensic nursing practice, education and research.

References

American Nurses Association. 2009. *Forensic Nursing: Scope and Standards of Practice*. Silver Spring, MD: American Nurses Association.

Chapter 2: Exploring Forensic Nursing in the Context of Roles, Loyalties, and Interests

Introduction

Forensic nurses function at the crossroads of the healthcare and legal systems. Forensic nursing education starts from a foundation of nursing education and then adds basic and advanced tenets of forensic science, legal processes, and population health. Forensic nurses practice in diverse settings across a myriad of systems from acute healthcare institutions to correctional facilities to community-based service settings. Forensic nurses serve patients including individuals, families, groups, communities and populations affected by violence, both intentional and unintentional injury, and disasters caused by nature or humans. Multidisciplinary collaboration involving law enforcement professionals, advocates, social service providers, legal professionals, and forensic scientists is a central feature of the practice role (ANA, 2009).

Given the unique and diverse practice for forensic nursing, where expectations emerge from both within and outside of the profession, it may not be surprising that forensic nurses have found themselves declaring, “We are nurses first!” Yet, these statements may contribute to greater confusion about the role of the forensic nurse, creating a false distinction among the many duties that are integrated into a single unique role. After all, if you are a nurse first, then you must be something else second, third, or fourth. This approach to clarifying one’s role and role expectations across a variety of stakeholders may have simply exacerbated confusion. As nurses, forensic specialty nurses continue to have a primary ethical commitment to the patient (ANA, 2015).

Role conflict and role confusion are not unique to forensic nursing nor new to the nursing profession as a whole. Research exploring the prevalence of role conflict and confusion, subsequent effects on patient care, job satisfaction, and contribution to role stress or moral distress appear in the nursing literature dating as far back as the 1950s (Benne & Bennis, 1959).

Dual loyalty and dual roles are raised in discussions about healthcare provider roles in correctional, detainee and forensic psychiatric settings (Mason, 2002; Sekula et al, 2001). However, there is little discussion about the differences between dual loyalty (or dual roles) versus dual duties with a single role. For example, is there a dual loyalty or an obligation (loyalty) to a single entity (e.g., the patient) with multiple duties within that obligation? Does conflict stem from inconsistent role expectations or secondary to incongruence among expected duties of the role? Similarly, are concerns about healthcare provider conflicts of interest different than concerns about conflicting interests, or are these terms being used synonymously but perhaps incorrectly? Conflicts of interests and conflicting interests rest on the same conceptual continuum. Conflicting interests, on one end of the continuum, may cross a threshold to become conflicts of interest at the other end. Is one concept more applicable to forensic nursing than the other?

Role clarity is essential for the forensic nursing community to effectively respond to questions about forensic nursing practice, from both within and outside of healthcare settings, and to address incongruence between expectations of the role and the enacted role. The aims of this paper are to (1) explore the concepts of role confusion and role conflict; (2) introduce the concept of dual duties within a single role as an alternative to dual roles or dual loyalties; (3) highlight the difference between conflicts of interest and conflicting interests, all within the context of forensic nursing practice. Current dialogues on listservs, at forensic nursing conferences and professional meetings, and between forensic nursing experts include these concepts. It is time to bring these discourses forward and set the foundation for future research on forensic nursing practice.

Background

Role Conflict and Role Confusion

Experiences of role conflict and role confusion among professional nurses in the United States dates back to the 1870s. Nurses found themselves in what was described as competing ethical loyalties to the patient and patient's family, a known physician requesting their service, the registry employer, and self (ANA, 2008). With the shift of nursing to the hospital setting following World War II, nurses still faced role conflict with loyalties to the patient, an institution, a physician (who might not be known to them), and self. This also marked a time in nursing history when there was an explicit loyalty expectation to obey and serve the physician. This paradox between *what should be* based on nursing values (loyalty to the patient) and *what was* (loyalty to the physician) jeopardized patient care (ANA, 2008).

After the 1950s, treatment of illness and the roles of nurses became more complex. The 1950s heralded the use of mechanical ventilation while the 1960s brought a flood of technologies including cardiopulmonary resuscitation, hemodialysis, cardiac monitoring and cardioversion, all offering life-sustaining possibilities. Nurses' roles changed in response to this explosion in technology and greater emphasis on treatments offered in the acute care setting. It was during this time of transition that a two-part article series, *Role Confusion and Conflict in Nursing: What is Real Nursing* and *Role Confusion and Conflict in Nursing: The Role of the Professional Nurse* (Benne & Bennis, 1959a; 1959), appeared in a leading professional publication, the American Journal of Nursing. Since that time, unionization, collective bargaining, third party payer systems, complex healthcare organizations, increasing costs of healthcare, and continued development of technology all have been identified as adding to competition for the loyalties of nurses. But, are these truly competing loyalties or are they incongruent internal and external role

expectations or duties? Although included in the Nightingale Pledge, loyalty remains a vaguely defined and under-researched concept that should be further explored (ANA, 2015).

According to provision two of the Guide to the Code of Ethics for Nurses with Interpretive Statements (ANA, 2015) a nurse's primary commitment, or loyalty, is clear; the nurse's primary duty is to the patient, which may be an individual, family, group, community or population. Section 2.1 of the ANA Code of Ethics (2015), identifies a nurse's commitment to the patient as carrying "the greatest weight and priority and consequently it trumps all other loyalties". A classic example includes the conflict between a nurse's obligation to patients and the obligation to ones' own family, including children, in times of threat, disaster or emergency. While leaving one's patients without nursing care would be abandonment in most other circumstances, in the setting of a disaster where one's familial obligations also need to be attended to acutely, a nurse would be unlikely to be held professionally accountable for abandoning his/her patients.

Role conflict includes both intra-role and inter-role conflicts. Intra-role conflicts stem from internal expectations or competing ideals (e.g., forensic nurse as both a nurse and the collector of items holding potential evidentiary value). Inter-role conflicts arise from external or environmental factors (e.g., conflict between the emergency department nurse who becomes a forensic nurse and emergency department nurses) (Hazel, 1985). Role confusion results from the nurse's lack of clarity, or uncertainty, about expectations of others regarding one's role (e.g., the forensic nurse with an employer, law enforcement, or patients) (Benne & Bennis, 1959). This confusion may be related to practice level (e.g., scope of practice), inconsistent role definitions or descriptions, or specific roles within a given setting (e.g., specialty role within an emergency department versus community setting). Role confusion is also referred to in the literature as role

ambiguity, focusing on specialty roles or settings, or role clarity, focusing on practice level or inconsistent role definitions and descriptions.

Considering the medico-legal nature of forensic nursing, multidisciplinary collaboration is essential, yet conflicting professional values among multidisciplinary professionals will inevitably surface. Coupled with expectations from patients, forensic nursing colleagues, health care providers, agents of law enforcement, victim advocates, criminal justice professionals and the public, it is arguably understandable that competing loyalties and dual roles have been identified as factors contributing to role conflict or confusion among forensic nurses (Downing & Macking, 2012; DuMont & Parnis, 2003; Mason, 2002). This still begs the question of the actual existence of a dual loyalty or role. It is possible that there are role specific duties or functions that are in conflict, or perhaps incongruent expectations, rather than a true dual loyalty or role.

Conflicts of Interest and Conflicting Interests

Section 2.2 of the 2008 ANA Code of Ethics, although titled Conflict of Interest, speaks to potentially *conflicting interests* that may arise for nurses in the context of professional duty, personal obligations or societal needs usually due to conflicting expectations:

“Nurses are frequently put in situations of conflict arising from competing loyalties in the work place, including situations of conflicting expectations from patients, families, physicians, colleagues, and in many cases, healthcare organizations and health plans. Nurses must examine the conflicts arising between their own personal and professional values, the values and interests of others who are also responsible for patient care and healthcare decisions, as well as those of patients. Nurses strive to resolve such conflicts in ways that ensure patient safety,

guard the patient's best interests and preserve the professional integrity of the nurse.”

The 2015 ANA Code of ethics more clearly focuses on defining and identifying conflicts of interest rather than conflicting interests. In this revision of the Code, there is a focus on the factors that must exist for potential and actual conflicts of interest and provides an example in the context of financial gain of an institution in conflict to the nurse's concern for patients' best interests.

Forensic nursing practice incorporates nursing science, forensic science, principles of public health, and the legal system. These diverse roots inherently add to the potential for competing and oftentimes conflicting roles or duties. Kent-Wilkinson (2008), identified the uniqueness of forensic nursing as a role of providing care *and* a matching forensic role unique to each forensic nursing subspecialty. Wilkinson emphasized the importance of using “*and*” to describe these roles to emphasize that the aspects of the forensic nursing role are not a dichotomy of one *or* the other, but *both/and* (Kent-Wilkinson, 2008). As seen in Wilkinson's research, forensic nursing is often explored in the context of separate dual roles rather than an integrated role with multiple duties specific to that integrated role. In considering the “nurses first” language, discussed earlier in this paper, a prioritizing of roles may perpetuate the perspective that forensic nursing consists of dual roles requiring a prioritizing of allegiances - allegiance first to the patient's biopsychosocial needs and second to collecting items holding potential evidentiary value.

While limited, there are additional discussions of dual-roles associated with forensic nursing practice, including subspecialty practices, in the literature (Downing & Macking, 2012; DuMont & Parnis, 2003; Mason, 2002). For example, some authors have explored how

competing or conflicting roles, duties, or loyalties can adversely affect patient care, suggesting further exploration, understanding, and development of strategies to reduce conflict and confusion (Benne & Bennis, 1959; Fain, 1987; Rosse, 1981; Tarrant & Sabo, 2010). An area that has received less attention is defining existing conflicting interests among forensic nurses and determining if, or when, conflicting interests rise to the level of a conflict of interest. This important topic has yet to be explored in the literature.

Methods

To address the aims of this paper three focused reviews of the literature were conducted using PubMed, CINAHL and WorldCat. Relevant abstracts were scanned and citations selected and reviewed. To address the first aim, to explore the concepts of role confusion and role conflict, a purposeful article selection was completed to ensure representation of role confusion and role conflict across the history of professional nursing, across the domains of nursing, and practice areas relevant to forensic nursing. To address the second aim, to introduce the concept of dual duties within a single role as an alternative to dual roles or dual loyalties, a second, more abbreviated, purposeful literature review was conducted to explore role conflict and role confusion resulting from dual loyalties or dual roles. Finally, to address the third aim, to highlight the difference between conflicts of interests and conflicting interests, a targeted review was conducted focusing on the concepts of conflicting interest and conflicts of interests.

Role Confusion and Role Conflict

Focused literature searches on role confusion and role conflict in nursing resulted in citations dating from 1959 (Benne & Bennis, 1959, 1959a) to the present. Search results included articles related to the domains of nursing practice (Heikkinen, et al., 2007, 2006; Bryant-Lukosius, Alba, Browne, & Pinelli, 2004; Hazel, 1985), education (Fain, 1987), research

(Colbourne, 2004), administration (Tarrant & Sabo, 2010) and nursing as a whole (ASRN, 2008). Discussions specifically related to role confusion in nursing revealed three main areas of concern: 1) role confusion stemming from licensing or scope of practice (e.g., confusion about the roles of registered nurses, clinical nurse specialists, advanced practice nurses, nurse practitioners and physicians), 2) confusion arising from nomenclature and inconsistent definitions (e.g. nurse specialist, advanced practice nursing, advanced nursing practice, nurse practitioner), and 3) role confusion related to specific roles within settings (e.g. nurse/nurse executive, nurse/nurse educator, nurse/nurse researcher). The first two focal areas appeared to correspond to historical shifts in nursing practice, for example, development of a specialty or advanced practice roles. These three areas of concern are discussed in more depth below.

Role Confusion Stemming from Licensing or Scope of Practice

Benne & Bennis (1959) approached role conflict and role confusion from the perspective of the social environment of nursing (e.g. professional organization, facility, self, etc.) and associated role expectations of these social environments. Different sources of expectations may reinforce each other, or together the meaning becomes ambiguous leading to role confusion. Alternatively, sometimes different role expectations may be in tension with each other leading to role conflict. Benne & Bennis' second publication (1959a) explored tensions resulting from role conflict and confusion including the difference between an individual nurse's image of a 'real nurse' and his/her actual nursing practice, the nurse-doctor relationship, and promotions that create conflict between new duties and a continued desire to provide direct patient care.

Benne & Bennis (1959, 1959a) did not identify the theoretical framework for their research, however their descriptions are consistent with Kahn's (1964) role theory originally described by Fain (1987). The basic premise of Kahn's role theory was that people are exposed

to various expectations from their work environment. This environment includes the employing institution, members of one's roles set, and individual expectations. Hazel (1985) introduced Sarbin's (1968) role theory including the two concepts of intra-role conflict (e.g. nurse-midwife as both a nurse and midwife) and inter-role conflict (e.g. between the nurse-midwife and obstetric nurse). Sarbin defined role conflict as the situation of being in two or more positions concurrently, which requires contradictory role enactments. Others have referred to this as dual-roles (Dupont & Parnis, 2003; Kent-Wilkinson 2008, 2009, Sekula, 2001) and dual-loyalty (Mason and Carton, 2002; Miles, 2009; Solomon, 2005).

Role theory incorporates external role expectations, role conception, and role performance (Glover, et. al, 2006). External expectations include expectations by employers, colleagues/professional peers, and outside groups. Institutional expectations of forensic nurses may vary greatly by type of employer such as hospitals, community organizations, law enforcement agencies, state government, social services, for-profit companies, and more. Immediate colleagues and peers of forensic nurses include multidisciplinary professionals whose expectations may reflect differing priorities of their respective roles. Expectations of outside groups may include professional organizations, task forces, legislative committees, advisory boards, and members of the community itself. These groups may assume the forensic nurse shares priorities congruent with their goals. Expectations of self includes self-role conception of *what should be*. Role performance reflects *what actually is* - role conception may be based on the ideal role and role performance is based on the actual realized role.

Employer expectations may potentially conflict with expectations of immediate colleagues or professional peers, expectations of outside groups and patients, as well as expectations of self. Interprofessional colleagues with different disciplinary roles therefore have

different loyalties and guiding codes of ethics. What these professionals expect of forensic nurses versus what forensic nurses expect of themselves (or actually do in practice) may also be in conflict. Other conflicts may arise from the expectations of fellow forensic nurses, non-forensic nurses, other members of the healthcare team, the multidisciplinary response team, etc. Simply put, when others do not understand the role of forensic nurses as forensic nursing understands it, role conflict and role confusion may occur. Additionally, self-role conception may be in conflict with role performance if the ideal is not realistically attainable (Benne & Bennis, 1959a). Although beyond the scope of this paper, considerations of the “CSI effect” (i.e., effect of exaggerated forensic and legal portrayals on television shows including inaccurate role depictions for forensic nurses and other multidisciplinary professionals) may contribute to discordant expectations.

Role Confusion Arising from Nomenclature and Inconsistent Definitions

Confusion arising from nomenclature and inconsistent definitions related to nursing in general is found in many areas of nursing literature. Examples of inconsistency include the use of the terms nurse specialist, advanced practice nursing, advanced nursing practice, and nurse practitioner. The American Nurses Association addresses pertinent ambiguity around the terms *registered nurse*, *advanced practice registered nurse*, and *graduate level-prepared registered nurse* and clarifies the expected competencies for practice standards for all three categories (ANA, 2015)

The International Association of Forensic Nurses Scope and Standards Taskforce adopted the ANA definitions and methodology of differentiating role and expected standards in the Forensic Nursing Scope and Standards of Practice Draft recently submitted to ANA. For each forensic nursing practice standard, there are corresponding competencies for the registered

nurses, advanced practice registered nurses, and graduate level-prepared registered nurses. In spite of this, the forensic nursing specialty may contribute to nomenclature induced confusion internally through the use of various titles assigned at a practice level, subspecialty focus, or used throughout state or local legislation. For example, sexual assault nurse examiner (SANE), sexual assault forensic examiner (SAFE), and forensic nurse examiner (FNE) are all used to describe the forensic nursing sub-specialty role. However, FNE also is used interchangeably with forensic nursing specialist to describe the more generalized forensic nursing practice. In some jurisdictions, FNE also may refer to forensic nurses specializing in death investigation. To further compound this confusion, forensic nurse death investigators in one jurisdiction are referred to as forensic medical examiners which rightfully may be confused with the use of medical examiner to refer to physicians specializing in forensic pathology!

Role Confusion Related to Specific Roles within Practice Setting

After a comprehensive review of the literature for a doctoral dissertation, Kent-Wilkinson (2008, 2009) described forensic nursing as a complex role with conflicting ideologies, role tensions and identity issues. These dual roles were applicable to forensic nursing practice in general, but also to care and concepts of specific subspecialties. Mason & Carton (2002) published similar findings regarding a dual role component to forensic nursing. They applied this concept specifically to forensic psychiatric nursing and found the dual roles were often contradictory yet equally important and necessary to forensic psychiatric nursing practice. DuMont & Parnis (2003) also discussed dual role and role conflict related to the subspecialty of sexual assault nurse examiners. These authors found conflict to arise between the dual roles of providing care and collecting evidence for forensic nurses.

Forensic nurses perform functions of nursing plus functions often attributed to another profession such as law enforcement (e.g., forensic technicians or crime scene investigators). For example, forensic nurses collect items that may hold evidentiary value in a criminal investigation or judicial process, functions typically associated with law enforcement units such as crime scene investigations units. This may result in intra-role conflict within the nurse and inter-role conflict between nurses and other RNs. Additionally, misconceptions of roles and unclear role definitions may lead to role conflict between providers and other multidisciplinary professionals (e.g., law enforcement officers). Value differences may also come into play to further compound the issue.

The dual and conflicting roles of care and custody are the most recognized in current forensic nursing literature. Forensic psychiatric settings are secure custodial environments and forensic nurses must provide care and maintain custody (e.g., United Kingdom). In other forensic psychiatric settings, there may be correctional officers for the purpose of custody and security where conflicting professional values may result in role conflict and confusion (Mason, 2002). Forensic nurses in these settings recognized the need for a practice grounded in the core values of nursing. This led to subsequent discourse in the literature of forensic patients needing care *and* custody, not one or the other (Sekula, Holmes, Zoucha, Desantis, & Olshansky, 2001).

Principles of public health are part of forensic nursing education and conflicts may arise between a clear duty to an identified, individual patient and a sense of social responsibility to others. For example, this might include the health and safety of those close to the patient, an extended community associated with the patient, or even to the public at large (Kent-Wilkinson, 2008). There are also considerations related to the legal system that may create another sense of duty. Forensic nurse examiners may experience a dual-role conflict or confusion as both caregivers and evidence collectors (Dumont & Parnis, 2003), between providing care and

maintaining chain of custody, and providing care and serving as fact/expert witness in the courtroom (Kent-Wilkinson, 2009). Lastly, role confusion may surface from the multiple and often conflicting expectations of others in the forensic nurse's social environment.

When expectations by employers, colleagues, outside groups and self are consistent, they reinforce each other, and role definitions are stable, motivation increases, job satisfaction is higher, and productivity is increased. When these expectations are inconsistent, it can lead to role confusion. When role confusion is left unaddressed, it can lead to role conflict thereby increasing stress, anxiety, and burnout with a reduction in job satisfaction (Benne & Bennis, 1959; Fain, 1987; Rosse, 1981; Tarrant & Sabo, 2010).

Dual Duties within a Single Role as an Alternative to Dual Roles or Dual Loyalties

Literature describing the nurse executive specialty role, describes nurse executives as experiencing conflict between nursing values and non-nursing values and the challenges related to prioritizing these dual responsibilities. Among nurse executives, the conflict arises between the duties to the organization and duties to the nursing profession. These competing priorities can lead to role conflict (Tarrant & Sabo, 2010). For forensic nurses, these competing responsibilities are often described as dual role or loyalty – or as nurse versus evidence collector. This again highlights the need to clarify if these are in fact dual roles or normal expectations of an integrated specialty role.

Although dual loyalty has been explored in nursing and medical literature, the concept itself has not been clearly defined (ANA, 2015). Dual loyalty is often depicted as having obligations to the patient while at the same time having obligations (formal or informal; explicit or implicit) to act on behalf of another entity. The interest of the patient and this additional entity may be in conflict. Examples of dual loyalty can include patient versus managed care interests

(e.g., controlling healthcare costs), individual patient versus public health interests (e.g., reporting of communicable diseases), patient privacy versus risks to a third-party (e.g., a patient with psychiatric illness threatening the safety of others), or a patient in conflict with his/her employer (e.g., occupational health concerns versus costs of employee safety measures). These situations involve a dual loyalty (duty) to a third-party entity in addition to the loyalty (duty) to the patient (Solomon, 2005).

A particularly important area of concern around dual loyalty relates to healthcare for persons who are legally detained. Healthcare for detainees raises serious issues or conflicts for any healthcare provider. These may include compromised judgments in care, imposing procedures on detainees for the benefit of the state (versus the patient), tolerating lower quality of healthcare, or remaining silent as a provider about unjust practices (Solomon, 2005). Forensic nurses also provide services to persons who are accused, suspected, or perpetrators of crimes. Hence, concern around dual loyalty in this context may be particularly valid to consider. Further exploration and research is needed to understand if forensic nurses who are directly employed by local, state or federal government agencies experience greater tensions or conflicts around potential dual loyalties. Recognizing the potential for direct or indirect patient harm from dual loyalties or dual role responsibilities is critical to developing, implementing and evaluating mechanisms such as formal peer review of forensic nursing practice to guard against patient harm.

Conflicting Interests and Conflicts of Interest

Considerations related to conflicts of interest in forensic nursing practice parallel those of other nursing and medical specialties. This includes research, entrepreneurial pursuits, consulting with industry, and providing expert consulting services or expert witness services. Unfortunately,

there is no one uniform definition of conflict of interest and the nuances of defining the concept have been debated for over two decades (Ruble, 2015). Thompson (1993) described conflicts of interest as a set of conditions where professional judgment concerning a primary interest may be unduly influenced by secondary interest. Primary interest may include responsibilities and duties to patients, research based on sound scientific inquiry, educational responsibilities, and leadership roles. Secondary interest may include financial gain for the individual, family members, company, and employing institution. Additional secondary interest may include prestige, power and privilege for self, family or friends or even nondisclosure of errors and protection from legal recourse.

In addition to conflicting professional expectations and interests, ethical principles may also be in conflict. For example, acts of commission or omission enacted with the goal of beneficence may have a foreseeable negative effect. The weights and balances of positive and negative effects are perceived differently by the patient, forensic nurse, law enforcement officer, and victim advocate. Considering the value nurses place on respecting patient autonomy, focus on patient centered care for healthcare providers, and a national movement towards victim-centered responses by law enforcement, the informed choices of a patient with capacity should be respected. Yet coercive techniques to compel a patient to consent to a forensic medical examination, such as creating a feeling of guilt or responsibility to strangers in the community, are an area of active discussion (Downing & Mackin, 2012). The Code of Ethics for nurses clearly states this should not occur and is in direct conflict with the Code. Yet, this may be a common occurrence in forensic nursing practice due to the clinician's strong beliefs around the potential good of collection samples for forensic analysis ("evidence"). Forensic nurses may also question if non-maleficence is actually feasible given external constraints in particular situations.

This can also lead to conversations of respect for persons as autonomous beings and the safety of others at the cost of the individual (e.g. chemical/physical restraints or search warrants to facilitate collection of samples).

Justice is a complex principle within forensic nursing practice in that it carries a medical and a legal connotation. Justice from the perspective of the nurse can be quite different than justice from the perspective of the patient or law enforcement officer. Nurses may view justice from the perspective of fair and equitable care (including forensic nursing services) for all patients. This perspective represents distributive justice (Beauchamp & Childress, 2013). For victims of violence, accountability for harms caused to them at the hands of another person may include receiving deserved care, services, responses and even compensation for losses, both physical and social. These expectations of justice represent two additional perspectives - retributive justice and restorative justice. In retributive justice, a balance is sought between punishment for harms caused and the suffering experienced by the person harmed (Pollock, 2010). Whereas restorative justice takes into consideration the victim, offender and their community from a compensation perspective (Pollock, 2010; Brathwaite, 2004). Law enforcement professionals approach justice predominantly from a criminal justice perspective that incorporates both punishment and rehabilitation depending on the nature of the crime.

Veracity, privacy and confidentiality become entangled when provision of nursing care intersects with laws related to acts of violence, especially for legally recognized vulnerable populations, whether they are labeled as victims, suspects, or accused (i.e., children, vulnerable older adults, or persons with disabilities). Veracity within the clinical setting refers to “accurate, timely, objective and comprehensive transmission of information, as well as to the way the professional fosters the patient’s understanding” (Beauchamp & Childress, 2013). Concern may

be raised about the ability to uphold veracity in the context of multidisciplinary responses to violence where professionals from different disciplines have very different roles and responsibilities. Similar concerns can be raised about privacy and confidentiality. Although closely related, privacy and confidentiality are different in that privacy addresses a person's choice to share information and confidentiality refers to protection of shared or collected information about a patient (Beauchamp & Childress, 2013). Last, issues may arise that threaten the fidelity, or trusting relationship that the patient's interest remain priority (Beauchamp & Childress, 2013), between the forensic nurse and patient because the patient's expectations may not be compatible with the role and capabilities of the forensic nurse (e.g., privacy and confidentiality).

Conflicting interests are not as well described in the literature as conflicts of interest. In conducting a literature review on conflicting interests, the specific phrase was identified in a few titles or abstracts, however the associated journal articles did not delineate the concept from conflicts of interest. In other articles, conflicting interests was used interchangeably with conflicts of interest. For forensic nurses, conflicting interests may be secondary to the integrated role itself or secondary to the varied interests of multidisciplinary collaborations when healthcare and legal systems intersect.

Discussion

Nurse educators have been described as nurses who adopt a second profession, that of education. Nurse educators are socialized first as nursing professionals, with the associated internal and external expectations, and then incorporate education into their existing nursing role. This second role layers additional internal and external expectations onto the existing ones and hence, these two sets of professional expectations must be reconciled or role confusion and

conflict will occur (Fain, 1987). Similarly, forensic nurses are socialized as nurses initially and then incorporate aspects of forensic science, legal processes, and population health into their new, specialized roles. Considering the use of the “nurses first” statements in presentations, formal and informal discourse, and even as taglines on the internet, it appears that the forensic nursing profession has yet to reconcile the additional professional expectations associated with this specialty practice into an integrated specialty role.

Additional research exploring and defining the integrated forensic nursing role is greatly needed. As long as forensic nurses perceive a need to identify themselves as “nurses first”, an incongruence or confusion clearly exists regarding roles and role expectations. Recognizing that the “nurses first” declaration is used both within and outside the forensic nursing profession, there exists confusion both internally among forensic nurses and externally among their multidisciplinary colleagues and the public. Without role clarification, a consistent norm for socialization into the specialty cannot exist. These inconsistencies in role identification and role expectations can result in inequities across patient populations, such as patients who are identified as victims versus those who are identified as suspects or the accused.

Additional Considerations

Conflict arising from the nurse-doctor relationship has been identified as one of the five main stressors affecting nurses (Leatt & Schneck, 1985). Nurses have also been identified as lacking assertiveness related to communicating the scope of their valuable services when interacting with physicians (Nelson, et. al, 2008). This suggests the following question: does this lack of communication and assertiveness also exist when forensic nurses interact with law enforcement officers, attorneys, or other multidisciplinary professionals? If so, this may further magnify role confusion and conflict. Research has shown significant differences between

physicians' views of nursing practice roles and nurses perspectives of their own roles as nurses (ASRN, 2008). These findings suggest that further research exploring the perspectives and expectations of multidisciplinary team members as compared with forensic nurses' role identification could be useful.

An additional area not found in the literature, yet deserving of consideration, is the potential for moral distress or moral disengagement related to role confusion, role conflict, competing interests and conflicting obligations among forensic nurses. This is especially relevant as forensic nurses may find themselves in roles where they may have more responsibility than authority. Additionally, pressures from outside entities (e.g., law enforcement, employers, community, or even family members of patients) to "collect evidence" may be in direct conflict with respecting the informed choices of patients. For example, consider a case involving a series of sexual assaults during a 3-month time frame where each assault has become more aggressive. The assailant is targeting teenage girls in a certain area of the community, an area where the forensic nurse happens to live also. To date, samples collected during forensic medical exams have not yielded a full DNA profile of the assailant. The most recent victim of the suspected assailant reports actions that are associated with an opportunity to collect samples with high probative value (i.e., the ability to obtain a DNA profile to potentially identify the assailant). However, the patient declines the forensic medical exam. Patient encounters such as this scenario can create significant distress for forensic nurses as they balance respect for the patient's wishes with a strong desire to protect members of the community from further harm, including potentially their own children. Additional questions related to the implications of developing moral distress and disengagement include the subsequent effects on forensic nursing practice, decision-making processes, and the health and wellbeing of the forensic nurse.

Conclusion

Forensic nursing must reconcile the various duties associated with this specialized, integrated nursing specialty practice. Supporting “nurses first” language may exacerbate both internal and external role confusion and conflict. This confusion and conflict may adversely affect patient care, job performance, turnover and the overall well-being of forensic nurses. Until this role confusion in forensic nursing is resolved, internal role expectations of forensic nurses will continue to be in conflict with the forensic and legal expectations of other professionals and with the healthcare expectations of patients.

Several questions remain unanswered and unexplored in this paper regarding role conflict and role confusion, perceived or actual dual roles and competing loyalties, and conflicting interests in forensic nursing practice. For example, what are the philosophical underpinnings for forensic nursing practice that may be in conflict? What are the implications for the patient, forensic nurse, other professionals, and society when these conflicts arise? What benefits are derived from the “I’m a nurse first” statements for forensic nurses?

Forensic nursing is a young profession that is making a difference in the lives of populations affected by violence, intentional/unintentional injury, and nature or human caused disasters. Forensic nursing exists in a unique space, much like public health nursing, of having both individual and public health interests. With role clarification, forensic nursing will be able to clarify what has been identified as potentially conflicting loyalties. Forensic nurses, as with all nurses, have a social contract with society and at the center of this contract is their patient. To fully meet the needs of their patients, forensic nursing must engage in new dialogues and analyze ethical issues arising from the interface of forensic nursing, healthcare, and the law. What is likely to emerge from these discussions is a more nuanced view of the role of the forensic nurse,

a view embracing rather than protesting the complexity of the ethical discernment required to provide forensic nursing services to those affected by violence.

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Chapter 3: Forensic Medical Examinations - Equity for those Suspected and Accused of
Violence

Introduction

For over a decade experts have highlighted that, depending on the type of contact involved in a sexual assault offense, samples collected from the suspect's body may carry greater probative value (i.e., useful to prove guilt or innocence in a legal case) than samples collected from the victim's body (Archambault, 2007). Consider, for example, a victim reporting vaginal digital penetration – the assailant's fingers may actually be the best source for collecting samples with probative value, especially samples collected from under the person's fingernails and around his/her cuticles (Flanagan and McAlister, 2010). Similarly, in a report of penetration of the oral cavity by an assailant's penis, samples collected from the assailant's penis and scrotum may be a better source for cellular findings than the victim's mouth. Collecting samples from objects containing materials transferred during a sexual offense is critical to the investigation of the case (Apostolov et al., 2009). However, to date, many jurisdictions do not have protocols for what should be included in the examination of someone accused of a violent act (commonly referred to as suspect examination) hence such examinations are often ad hoc at best (Archambault, 2007; Faugno, 2014; Newton, 2013).

Existing protocols for suspect examinations vary widely. For example, who conducts the examination includes evidence techs, law enforcement officers, or forensic nurses. In addition, there are no agreed upon standards for identifying anatomical locations for sample collection with known, unknown or conflicting histories; written and photographic documentation; or for the contents of sample collection kits. Suspect sample collection kits range from a small 6x9 envelope labeled "Penile Swabbing Evidence Kit" or an envelope called "Buccal Swab Kit" for collecting the suspect or accused's DNA sample, to using the same kits that are used for collecting samples from victims during examinations. The lack of standards for sexual assault

suspect examinations is so well recognized that it was an agenda topic for the Evidence Collection Subcommittee of the National Institute of Justice SAFER Act workgroup at meetings held in 2015 and 2016. Continuing discourse on professional discussion boards and at national conferences highlights persistent variations in exam procedures and the lack of consensus on best practices.

There is a dearth of research around current practice, recommended standards or best practices in the collection of samples from the accused or suspects of sexual offenses. In addition, there has been little focus on inequities of examinations of potential suspects of sexual violence. Several authors have commented on the ad hoc component of the forensic medical examinations for suspects, when they do occur, regardless of who collects samples or the location of collection (Newton, 2013). Due to this lack of reliable data, the International Association of Forensic Nurses (IAFN) created a Suspect Exam taskforce charged with writing a whitepaper and exploring best practices for “suspect examinations” (Personal Communication, S. Botello, 2015). A goal of this taskforce is for members and/or the IAFN as the primary professional organization representing forensic nurses, to take an active lead in conducting research in this area.

A Personal Journey

Despite the clear need for standards related to forensic medical examinations for persons identified as suspects, or those accused of a sexual offense, my motivation for writing this paper is more personal. Over 15 years of practice as a forensic nursing expert, I frequently have heard statements from law enforcement officers and other forensic nurses that illustrated the ethical tensions they navigated as they interacted with those suspected or accused of sexual offenses.

For example:

- “There’s no evidence if the victim refuses the exam.”
- “Suspects are not patients.”
- “Our role is to collect evidence from victims.”
- “We’ve done all of these exams for years, not the nurses.”
- “The nurse who does the victim exam can’t do the suspect exam.”
- “We don’t need consent; we have a search warrant.”
- “We’ve never done a kit on a suspect.”
- “We use our victim kits if we get a suspect.”
- “What’s a suspect exam? I’ve never heard of that.”

Language Matters

The language used to describe the persons who are central to the subject of this paper, suspects and the accused, and the examination they receive deserves attention. Legal and lay terms carry recognized connotations and lend themselves to accusations of provider bias when used in the clinical setting. The first use of language to be examined is who is labelled a patient. The victim of a sexual assault will be viewed as a patient, and treated with the respect, caring, professionalism and consideration that the term carries with it. This is of course appropriate and the purpose of this paper is not to challenge that label. However, viewed differently, referring to a patient as “the victim” may infer that the clinician believes this person to, in fact, be a victim, with or without supporting factual evidence. Rather than responding to the person as a *patient* who may have been harmed, the provider is referring to the patient as a *victim* – these words hold very different meanings in the legal and lay settings. It may also present the clinician as committed to collecting items to support the victim’s account of events as the primary focus of

the encounter rather than serving as an objective forensic clinician providing specialized services for patients affected by violence – whether the patient is legally identified as a victim, potential victim, suspect or the accused.

In contrast, is the person accused of the violent act also a patient? Phrases such as “perp”, “offender”, “perp exam”, and “assailant” may be problematic in that these terms infer guilt of an offense. Unfortunately, these terms are sometimes used in documenting the “victim’s” history of events. For example, “*Victim stated the assailant Richard Davis “tore off my shirt and...”*”. The nurse could have objectively documented this same history as, “*Patient stated “he tore off my shirt and...” (Patient clarified “he” as Richard Davis)*”. In situations where the person committing the crime is not known, we often find forensic nurses documenting “the perpetrator” or “the assailant” or even “the suspect” rather than “an unknown man” or “a man not known to the patient” or in other cases, “an unknown woman” or “a group of 5 unknown persons”.

Although the person reporting an assault is commonly referred to as “victim”, there are several terms used to describe the person accused of committing the offense. These terms have very different meanings, both legally and literally, yet they are often used interchangeably and inappropriately by forensic nurses. For example: suspect, offender, perpetrator, assailant, rapist, and the accused. The term, “the accused” is interesting in that we do not refer to the person reporting an assault as “the accuser” – he or she is generally referred to as the victim. Yet whether a person is identified by the legal system as a victim or a suspect, the relevant question while the person is receiving services from a licensed healthcare professional (e.g., nurse) is whether they are a *patient*. Do some persons receive clinical forensic health care services, such as a forensic medical examination, and not carry the status of patient? While others who receive clinical forensic health care services, including a forensic medical examination, and possibly

other healthcare from a licensed health care provider do carry the status of being a patient?

Health care clinicians, in addition to other care they may be providing, also conduct a forensic medical examination that may include collecting samples for forensic analysis. The findings of this physical examination and forensic analysis of samples may serve to corroborate or to contradict either parties' report of the events. Does receiving services from a health care provider automatically confer upon someone the status of patient, and the concomitant rights and protections that accompany that status, or are other factors required to be present?

Suspects are Patients

Statements such as “suspects are not patients” have been made by law enforcement officers and forensic nurses alike. These statements are often followed by reasoning such as, “we don’t develop relationships with suspects”. The issue of caring for the “enemy” has been discussed in military nursing. In field hospitals during times of combat, nurses may receive patients from their own military services, civilian casualties or enemy combatants. This can create ethical challenges and cognitive dissonance for the healthcare team (Gross, 2010; Gesundheit, et al., 2009). In these situations, how is a healing relationship defined? How does a nurse develop a “caring” relationship with an enemy or an assailant? Are the enemy considered patients? Or does the fact that the person – friend or foe, civilian or combatant – require nursing knowledge and skills imbue upon them the label of patient? That is, patients are people who require nurses’ specialized knowledge, skills and care.

While many health care providers provide care over sustained periods due to illness or injury, others provide episodic care. Forensic clinicians, just as non-forensic clinicians, can provide brief, focused, competent episodic care. Specific to forensic situations, the forensic nurse might be seen as creating a nurse-patient relationship that includes defining the specific

boundaries of services provided, information about the examination process, conducting an examination that s/he is specially trained to provide, and documenting the examination process, findings and statements made by the patient, including consent or assent for the procedure. Does this activity earn the person receiving the nurse's attention, the label of patient? The specialized skills required to do the exam could be taught to another person, but this training would require a level of competence commensurate with a nurse. Hence, does a clinician, providing a forensic medical exam, establish a patient-provider relationship?

Alternatively, the forensic exam could be conducted differently. In contrast to the accepted approach to conducting a forensic nursing examination detailed above, including sample collection by a licensed health care provider, another approach is used in some situations. Some nurses collecting forensic samples may not establish a relationship with the person/patient, may not ensure consent or assent for collection of the sample, and include only documentation that is required for payment of services. In these cases, an argument has been made that the nurse is not practicing nursing, but rather serving as an extension of law enforcement. Is this substandard nursing care, or enactment of skills when the person does not carry the label of patient? Do nurses who apply their knowledge and skills do so for some who are deserving of the status of patient, and others who have another (lesser) status? Or do some care encounters not rise to the level of earning patient status?

The recognition that *language matters* has resulted in the move to more neutral language. Previously, persons reporting a sexual assault originally had "sexual assault exams" or "victim exams" done with a "rape kit". Forensic clinicians have purposefully moved toward nonjudgmental language and now commonly refer to these examinations as forensic medical exams or medical forensic exams and the collection kit as a Physical Evidence Recovery Kit

(PERK). However, this same effort towards neutral, nonjudgmental language has not been made in reference to examinations provided for persons accused or suspected of committing a sexual offense. These examinations are commonly referred to as suspect exams although the purpose of this examination is the same as that provided for “victims” – to provide for the clinical forensic health care needs of the person, including collecting samples for forensic analysis that may or may not hold probative value once analyzed. One might ask if there is a concern about the patient who is a suspect and a sensitivity to the ability of the evidence to prove innocence as well as guilt.

“There’s no evidence if the victim refuses the exam.”

Traugher and Spear (Traugher, 1999) conducted a feasibility study to demonstrate the presence of female DNA on swabs collected following consensual, post vaginal coitus from the penis and scrotum of a male partner. All samples were collected within 15-hours following coitus. Glycogenated epithelial cells from the female partner were identified in 11 of 13 penile swabs and 10 of 13 scrotum swabs. Similar results were found in a study by Cina et al. (Cina et al., 2000) where cells shed by a woman during vaginal coitus were collected from the penis of a male partner during a 1 to 24-hour post-coital interval. DNA extracted from the collected cells were analyzed by PCR analysis to identify the female participant. The findings suggested that penile samples collected from sexual assault suspects could associate a male suspect with a female victim reliably within 1 to 24 hours following physical contact.

Caain (Caain, 2002) reported the results of a research study involving the analysis of forensic laboratory results of suspect kits from 77 sexual assault cases involving known suspects. The study revealed that in cases involving an adolescent victim, 44% of analyzed suspect kits identified the victim’s DNA during sample analysis. The most common source of DNA for

victim identification was epithelial cells found on penile swabs collected from the known suspect during the suspect examination. In cases involving an adult victim, up to 30% of the analyzed suspect kits identified the victim's DNA. With adolescent victims, DNA analysis of epithelial cells found on penile swabs of the known suspect were the most common source for victim identification.

The findings from these studies illustrate a key principle from forensic science, Locard's exchange principle. According to Dr. Edmond Locard (1877-1966), "It is impossible for a criminal to act, especially considering the intensity of a crime, without leaving traces of this presence" (Morrish, 1940). Today, this concept is described in terms of an exchange principle. Anytime a person makes contact with another person, place, or thing, there is an exchange of physical materials. Transfer of these biological and non-biological materials is not unidirectional.

Items can be transferred from perpetrator to scene, scene to perpetrator, victim to scene, scene to victim, perpetrator to victim, and victim to perpetrator.



In addition, with the advent of modern technologies, investigation of sexual offenses must also take into consideration video or digital evidence corroborating or contradicting the detailed report of a crime. Video-recorded accounts of a sexual assault may be the only proof that a crime occurred. For example, recently incapacitated victims did not know they had been sexually assaulted until videos of the assault surfaced. In some instances, the recordings surfaced within a few days of the assault and the victim received a forensic medical examination. One high profile case revealed no physical injuries at the time of examination, no DNA evidence from forensic analysis of samples collected, yet video evidence of the assault revealed

instrumentation with a foreign object. This video evidence contributed to convictions related to the assault. This case illustrates the possibility of evidentiary items that can be collected even when a victim declines sample collection for forensic analysis or is unaware that an assault occurred and did not receive a timely examination.

Who provides the forensic medical examination and on whom?

When sample collection from suspects or the accused occurs, it is typically done by law enforcement officers or forensic nurses. In some jurisdictions, law enforcement officers are taught by their local sexual assault nurse examiners to collect these samples. In jurisdictions where law enforcement personnel are expected to collect the samples, officers may view the necessary actions as inappropriate considering the intimate nature of the examination or they may be concerned about their lack of expertise related to anatomical collection sites and techniques.

Unfortunately, regardless of who collects the samples, collection kits often used for suspect examinations may be missing elements necessary for a thorough examination and sample collection. When collected by law enforcement officers, documentation is less detailed and critical information may be missed (Archambault, 2007). Hence, perhaps the key question to ask is *who should* provide forensic medical examinations rather than *who is* providing these examinations. Joanne Archambault, Retired Sex Crimes Detective, continues to state during trainings, “To obtain the best forensic evidence possible, I believe suspect exams must be conducted by examiners with specialized training and clinical experience such as forensic nurses” (2014). In reference to forensic medical exams for victims or suspects, Newton (2013) states these examinations, “should only be conducted by doctors and nurses who have received relevant, up-to-date specialist theoretical and practical training. Clear evidence shows that few

other criminal offences require as extensive an examination and collection of forensic evidence as that of a sexual assault.”

There are assumptions regarding sexual offenses and resulting forensic examinations that are worth challenging. The first is the overarching assumption that people committing sexual offenses are men and their victims are women. This assumption appears in the literature and is inferred by the contents of sample collection kits developed for suspect exams. Suspect collection kits often are labeled “Penile Swabbing Evidence Kit” or “Suspect Kit” with a limited number of identified anatomical collection sites, specifically male genitalia, perpetuating this assumption. It also perpetuates the myth that the focus of collection should be the penis rather than hands, fingers, or mouth. Whereas, especially in cases of child victims, fondling or oral contact with the victim’s genitalia should be considered. Furthermore, women also commit sexual offenses against men, women, and children. While less common than male assailants, women commit sex crimes such as those illustrated in the news headlines and excerpts below:

- A woman charged with raping a man while he slept has agreed to plead guilty to 2nd degree assault and 3rd degree attempted rape.
- While she was driving, Ross pulled out a black revolver and ordered the man, who was in the passenger seat, to get in the back and have sex with her friend...the woman in the backseat demanded that he take off his clothes and the man complied by taking off his shoes, pants and underwear before he was assaulted...
- Temple woman charged with sexual assault of fifteen-year-old girl
- Waco woman charged with sexual assault after boy under 15 contracts gonorrhea, chlamydia

- A Jonesboro woman, 21, is charged with sexual assault after having sex with a teen, 14
- SW woman charged with sexual assault of son's 13-year-old friend during sleepover
- Northeastern Iowa woman charged with sexual assault of 2 girls

In jurisdictions where non-clinical professionals may be assigned to complete sample collection, there may be an explicit assumption that the examinations do not involve body cavities other than the oral cavity for buccal reference samples. At a regional law enforcement training in the mid-south (Faugno, 2014), a law enforcement detective stated, "We've done all of these exams for years, not the nurses". He went on to explain how the forensic nurses provided the training for the officers. Two primary concerns were voiced by the presenters and other experts in the audience. The first concern involved dignity. The person having forensic samples taken in a physical examination has a right to being treated with human dignity. This includes having their privacy protected to the degree possible during intimate examinations, being treated nonjudgmentally, and being treated without fear of abuse.

The second concern raised by experts was related to disparate treatment based on gender. An example similar to that voiced by fellow a law enforcement officer during the presentation will illustrate the key issues. Consider a case involving a 34-year-old teacher suspected of a sexual offense involving a 14-year-old boy that had occurred less than 12 hours before detaining the suspect. The question was posed, "Would your officers do the suspect exam?" The first detective did not hesitate in responding, "Yes." The officer then added to the scenario that the suspect was female and the reported offense involved vaginal-penile acts with ejaculation and again asked, "Would you do the exam?" The answer now changed to "No" because the law

enforcement officers present reported they cannot do speculum exams on women. A follow-up question was asked related to who would complete the exam and the answer was unclear. This led to a discussion among the presenters and audience about the ethics of disparate treatment of people needing the same services based on their sex.

Another assumption that underlies the collection of forensic evidence is its basic purpose. Is forensic evidence collected from the accused and the accuser primarily for the purpose of establishing guilt or proving innocence? For example, consider a situation where an accused and accuser are both men, one stating that sexual acts were not consensual and the other stating these acts were consensual. In such a case, the accused reports previous sexual contact with the accuser, stating that he engaged in consensual receptive anal intercourse with the accuser. The accuser denies these acts occurred. If samples are not collected from the accused's rectal cavity, the opportunity to corroborate the accused claim that consensual sexual contact occurred is lost. To not collect this evidence, expresses a bias towards corroborating the accuser's version of events as non-consensual sex rather than corroborating the accused's account of consensual activity. In this scenario, to effectively obtain samples, a specialized instrument called an anoscope should be used to collect sample from the rectum. Law enforcement personnel are not trained nor comfortable with using this medical device, similar to their lack of comfort with speculums for vaginal samples. Hence, who provides the forensic medical examination influences both how it is done and whom receives it.

Justice

Exploring the concept of justice is essential in discussing individual, multidisciplinary, and social responses to violence. The same can be said about services for those affected by violence – the victim, their family, friends, loved ones and community AND the accused, their

family, friends, loved ones and community AND the offenders, their family, friends, loved ones and community. Distributive justice approaches justice from the perspective of fairness, equity and distribution of resources (Beauchamp & Childress, 2013). Retributive justice is grounded in the perspective of determining punishment for harms caused – in finding an acceptable balance between the pain and suffering assigned the offender in association with that suffered by the victim (Pollock, 2010). Lastly, restorative justice turns the focus on compensation rather than punishment and takes into consideration victims, offenders, and their communities (Pollock, 2010; Brathwaite, 2004).

Distributive justice requires forensic nurses to treat similar people in similar ways. Yet, forensic medical examinations for persons identified as victims or potential victims and persons identified as suspects or the accused vary significantly. Arguably, those who are accused or suspected of sexual crimes receive lower quality of care. Is this difference a result of tensions between distributive and retributive justice perspectives? Reasons for disparate care include: 1) forensic medical exams may not be done with the same attention to establishing innocence as guilt, 2) gender assumptions may disproportionately affect suspects of sexual offenses, and, 3) many suspect specific sample collection kits are designed for limited sample collection.

These disparities beg the question of whether victims, or potential victims, the accused, and suspects of sexual offenses are viewed as having equal worth. An obvious answer is “No” when eligibility for services available to those who are identified as victims is considered (e.g., access to Victim’s Compensation funds, advocacy services, and prophylactic medications). Some of these services might be viewed as society’s compassion towards victims of violence or leaning towards restorative justice. Others, such as free prophylactic medications, might be seen as fair in broader terms however. Those convicted of crimes enter a special class, prisoners, who have

special rights to healthcare. Hence, one might claim that by offering victims healthcare, fairness is increased. A question that remains however, and is the focus of this paper, relates specifically to forensic nursing care. If forensic nurses truly are objective, impartial, forensic healthcare providers, a legal difference in a patient's status ought not to justify providing different levels of care for the same procedure, in this case, clinical forensic interventions. All parties to a sexual crime, regardless of legal labels, are in need of a competent forensic medical examination.

Autonomy: “We don’t need consent; we have a search warrant.”

A strong value in the United States and many other Western countries is respect for personal autonomy. Respect for autonomy includes acknowledging a person's right to have individual views, make choices, and to act on his/her values and beliefs (Beauchamp & Childress, 2013). In healthcare, this is embodied in the practice of obtaining informed consent prior to all healthcare procedures and treatments. Generally speaking, informed consent involves assisting patients to make decisions for themselves that are consistent with their values and their view of themselves. For forensic medical examinations and forensic nurses, if both the accused and the victim are considered patients, then both are therefore deserving of respect for their autonomy. But this core practice of healthcare is challenged in forensic nursing practice. For example, as supported by legislation in one State, force can be used to collect samples for forensic analysis from a suspect – consent and or cooperation is not *legally* required even when collection occurs by a forensic nurse. In other jurisdictions, search warrants and court orders are issued to collect forensic samples. While the presence of a search warrant or court order does not automatically exclude a clinician's ability to obtain informed consent, in actuality, it may hinder informed consent in that it raises questions about legal coercion or coercive settings.

Both victims and suspects may experience coercive settings. There may be expectations of victims, similar to that of being a good patient, to cooperate and be a “good victim”. For patients identified as victims, the examination environment may create a coercive setting in particular when it is a hospital emergency department with hospital staff, a forensic nurse who has been called in just for their examination, victim advocates, and law enforcement officers. Suspects or the accused may experience coercion secondary to a search warrant or court order. The exam setting for patients identified as suspects may be a uniquely coercive setting such as a police station with several uniformed law enforcement officers or plain clothed detectives present. An additional coercive factor for suspects or the accused involves being detained, cuffed, or otherwise restrained. Both groups may experience a loss of autonomy when objectification occurs and they are treated more as a crime scene than as people who may have been present at a crime scene.

Search warrants and court orders have been construed to remove the need for respecting the autonomy of patients around informed consent for forensic medical examinations and obtaining samples. Search warrants are issued to protect a person’s Fourth Amendment rights: “The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized” (U.S. Constitution, Amendment IV). Most suspects will consent to a forensic medical examination when asked and this consent should be documented in writing (Archambault, 2007). They should also be informed, just as a patient identified as a victim is informed, that they are free to pause or stop the examination at any time or refuse any part of the examination (Faugno, 2014).

Harms and Nonmaleficence

Nonmaleficence requires healthcare providers to abstain from causing harm to their patients (Beauchamp & Childress, 2013). If we again presume a definition that suspects and the accused both are considered patients, are we disproportionately causing harm to the accused when we conduct a forensic medical examination? One may argue that we are causing harm in the context of collecting samples that will be forensically analyzed and can be used to prove guilt. However, the forensic clinician does not know if the person receiving this forensic medical examination is guilty or innocent of the accusations or charges, just as the clinician does not know if a patient reporting an assault is being truthful or dishonest in the history provided or person identified of assaulting him/her. The forensic analysis of samples collected by a forensic clinician may assist in identifying the assailant and/or eliminate potential suspects.

Harm, within the context of becoming incarcerated, is not due to a forensic medical examination. Being found guilty and incarcerated is secondary to acts committed by the person. Just as harm experienced if charges are dropped or found not guilty (e.g., loss of employment, wages, relationships) is related to protracted criminal and judicial processes, not the forensic medical examination. An outcomes-based approach to analyzing harm from a forensic medical examination would need to consider both the possibility of proving guilt and establishing innocence for each of the involved parties, the victim and the accused. Many consider the biopsychosocial harm that occurs during a sexual assault and the subsequent post-assault sequela. However, there have been high profile cases where innocent people have been convicted of crimes that they did not commit. A well-known case was portrayed in the book *Picking Cotton* (Thompson-Cannino et al., 2009). The book is a memoir of Jennifer Thompson, a victim of sexual assault, and Ronald Cotton, the person wrongly convicted of her assault and released after

eleven years in prison. Mr. Cotton and others like him, suffer the harm of loss of employment, years of their lives lost to detention, disenfranchisement from their families, loss of their homes, and more.

Additional Considerations

An exhaustive representation of practices that support inequities of forensic medical examinations is beyond the scope of this paper. However, there are several additional topics that should be mentioned. When forensic nurses state, “Our role is to collect evidence from the victim”, they highlight an all too common lack of understanding of forensic nursing. The Forensic Nursing Scope and Standards of Practice (2010) and the revised draft (2016) specifically remind forensic nurses of their duty to the accused, those who are suspected, and the accuser in criminal situations. Yet, this statement also brings to the surface a bias for supporting the legal case of the victim that may be present in an individual forensic nurse’s practice.

Statements such as, “the nurse who does the victim exam can’t do the suspect exam” highlight a lack of critical thinking related to forensic principles and a double standard in practice that could be extrapolated again to favoring services for “victims”. The concern behind this statement may be twofold. One is a fear of cross-contamination if suspect and victim examinations are provided by the same clinician. However, this concern would appear ill-founded as multiple victim cases with the same suspect or accused may be completed back-to-back by the same nurse in the same exam room. A second concern is that the same nurse cannot interact with both the victim and the accused because of personal feelings, that is because his/her feelings of anger or judgment will override professionalism or exacerbate moral distress. This issue is worthy of further exploration. Health care clinicians in emergency settings regularly provide care for trauma patients, some of whom actively caused the trauma for themselves and

others. A common example is the driver of a vehicle, driven recklessly or while under the influence of drugs or alcohol, where passengers or bystanders were injured in addition to the driver.

There is a strong movement related to trauma informed care for patients who are victims of assault or abuse. However, there are not similar discussions about trauma for the accused or suspects of the sexual offense, recalling that while some will be found guilty of a crime, others will be found innocent. Efforts to prevent victims and suspects from seeing each other are focused on trauma informed practices for the victim. There are no discussions, within a trauma informed care context, about trauma that may be experienced by a misidentified suspect seeing the victim, especially if the victim is in distress or has visible injuries. The same holds true for potential trauma experienced related to being wrongly accused or misidentified for a sexual offence.

In sexual offenses involving condoms, there tends to be even less emphasis on obtaining forensic medical examination. Considering the sensitivity of current forensic science technologies for obtaining probative profiles from samples as small as a few skin cells, concerns about a limited amount of trace sample is an antiquated rationale for not collecting from the accused or suspects in a sexual offense case. Additionally, all involved in the decision making for obtaining and providing forensic medical examinations must understand that cellular and other materials of importance (e.g., lubricant, spermicide) can be collected in cases where a condom is reportedly used during the act. Although non-cellular items may not result in an identity profile, these items can contribute a corroborative link between the victim and suspect (Musah et al., 2012).

Conclusion

This paper serves to initiate a much needed conversation in the clinical forensic and law enforcement communities – a conversation that begins to address unjust practices and inequities in clinical forensic health care services. It is critical to question practices that encourage or support disparate standards of care for different groups. To achieve equity in the provision of forensic medical examinations for all patients receiving these services, there must be a universal recognition that all persons receiving these examinations are patients. The language used to discuss those who receive forensic medical examinations needs to be neutral and nonjudgmental. Nurses are expected to respect the dignity, autonomy, and privacy of patients regardless of patient demographic or personal characteristics. Yet this is not occurring for patients accused of sexual offences. According to the Code of Ethics for Nurses and the Forensic Nursing Scope and Standard of Practice, if nursing care is being provided, the recipient of that care is a patient. This essential tenet must be integrated into forensic nursing practice.

During the past 24 months alone, law enforcement officers from over 15 different jurisdictions have shared that they have either never heard of a suspect examination or have never known of such an examination being requested (personal knowledge, 2016). This lack of awareness still exists despite over a decade of research supporting the collection of the victim's DNA from the body or clothing of the suspect. In these jurisdictions, one group of people, the accusers, are receiving forensic medical examinations that include head to toe examinations, documentation of the history of events by a clinician, written and photographic documentation of findings during the examination, and sample collection for medical and forensic analysis. Considering the exigent nature of biological substances and items considered as trace evidence in a sexual offense case, persons considered to be victims of such crimes are encouraged to have a

forensic medical examination as soon as possible following the offense. Unfortunately, the concern about loss of collectable samples is not extended to the accused or those suspected of the same crime (Newton, 2013).

With exposure to more trainings related to suspect exams, the trends of an increasing number of requests for these examinations may continue to increase (DeVore and Sachs, 2011). Law enforcement officers are responsible for investigating an allegation of a sexual offense and determining the facts surrounding the case. This responsibility includes discretion on how to fulfill their responsibility (Alderden and Ullman, 2012), including if or when to request an examination for a suspect or the accused. Future studies should explore the decision making processes of law enforcement officers in their requests for these examinations plus the factors that may affect their decisions to request or not request an examination for a suspect or the accused in a sexual offense case.

This paper has explored the inequities between the established best practices for forensic medical examinations when the patient is identified as a victim compared to as a suspect. In order to address clinical forensic healthcare disparities, forensic nurses must identify and call attention to inequities in forensic health care services. To avoid magnifying injustice, forensic nurses have an increased obligation to confront false assumptions and myths, to address their own biases, to adopt nonjudgmental language, and to research and utilize best practices within their specialty area. To do less would be to acknowledge injustice and accept it. We can do better.

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Chapter 4: Photodocumentation Practices Among Forensic Nurses

Introduction and Background

Introduction

Clinical photodocumentation is an adjunct to written documentation during a medical examination – it provides a visual representation of what was observed during the examination. The resulting images, primarily photographs, of clinical photodocumentation may include normal findings, anatomical variants, clinical conditions, and injuries. The routine use of digital imaging technology such as digital cameras, digital video cameras, or even cell phone and tablet cameras, for photodocumentation in clinical care is a relatively new practice. Forensic nursing practice quickly adopted digital imaging because of the higher-quality images and the ability to immediately view, store and transfer captured images. However, the use of digital imaging technologies for clinical photodocumentation practices with patients receiving forensic medical services also brought forth an array of clinical questions and ethical concerns.

With the advent of digital media, such as digital photographs, and accessibility to digital photodocumentation equipment has resulted in widespread use, especially within forensic related fields such as clinical forensics, forensic pathology, and crime scene investigation. The anecdotal variations in practice across forensic nursing is concerning at best. For example, providers independently deciding whether or not to collect images based on their opinion of how it “will help” the legal case thereby allowing legal outcomes to define clinical practice or even based on opinions about photographing genital anatomy with rationales that are reflective of societal taboo surrounding the genitalia. Forensic nurses have referred to these images as “graphic” or “too sensitive” and treated collection, storage, security, use and transfer of these images differently than other images and clinical documentation. However, they first should provide a defensible

argument on exactly how or why these images are different than other clinical images involving the genitalia (e.g., pre- peri-, and post reconstructive genital surgery).

Background

The earliest documented use of photography for forensic purposes traces back to a courtroom proceeding in 1839. Shortly thereafter, in the 1840s, application of photography to *medicine* was documented. Early medical photography was primarily used for educational purposes including illustrations in medical publications (Burns, 1979; Gernsheim, 1961a; Hansell, 1946). The earliest known documented *clinical* use of photography, now known as photodocumentation, occurred in 1856 and involved case presentations and case consultations (Burns, 1979). Although the use of photography as evidence of physical abuse of a person occurred in 1859 (Green & Schulman, 2010), it did not involve medicine or a health care provider. An extensive review of the literature revealed the developing use of both clinical medical photodocumentation and legal or investigative forensic photography; however, it is not clear when photodocumentation was first used within *clinical forensic* practices.

Prior to the 1980s, the use of clinical forensic photodocumentation for assessing and documenting the effects of violence was variable at best. In the mid 1980's initial reports began to appear in the medical literature related to the use of photodocumentation in evaluating and documenting child sexual abuse. Clinical forensic photodocumentation has since served to:

- improve medical diagnoses through case consultation and peer review processes;
- provide a means for standardizing terminology related to clinical findings including anatomical variations, injury, and pathology;
- inform research surrounding clinical findings related to various types of intentional and unintentional injury; and,

- enhance education of clinical forensic medical providers.

Photodocumentation has become both a standard of care and best practice for clinical documentation of interpersonal violence, abuse of older persons, child maltreatment and sexual assault (Brennan, 2006; Green & Schulman, 2010) among clinical forensic specialists and non-forensic providers (e.g., emergency department staff) (Smock, 1994; Smock & Besant-Matthews, 2007).

As with their physician counterparts, clinical forensic nurses use photodocumentation within their practices for the same purposes of evaluation, documentation, case consultation, case/peer review, research and education related to physical abuse and assault, sexual abuse and assault, neglect and other forensic medical patient encounters involving intentional and unintentional injury. In 2010, members of the International Association of Forensic Nurses (IAFN) began to formally inquire about a position statement or guidelines on the use of photodocumentation, especially related to images of the genitalia among adolescent and adult patients reporting sexual abuse or assault. Since the IAFN did not have a position statement or guidelines addressing photodocumentation, organizational leadership turned to the literature and membership for further inquiry. In reviewing the literature, they found an inadequate research base for developing evidence-based position statements and guidelines. An informal member survey (Fuller, 2011) revealed great variability in existing practice among the 1,020 survey respondents with the greatest variability involving informed consent for photography, release of photographs, and security of images. To engage in a more formal discourse on the subject, a forensic photography symposium was convened in March 2011. Several themes emerged from the 2011 symposium including concerns surrounding role conflict, informed consent, lack of

protocols, and lack of evidence-based practice related to clinical forensic photodocumentation involving certain populations (Fuller, 2011).

In the 1980s, tools for clinical forensic-medical photodocumentation included colposcopes, Polaroid cameras, and 35mm film cameras. Since that time, the advent and integration of digital imaging technology into photodocumentation practices have occurred. Digital imaging technologies provide higher quality images and the ability to immediately view, store and transfer the captured images to other people easily. Hence, these advancements brought forth new questions and concerns and gave a new perspective to forensic nursing discourse related to photodocumentation practices. However, a review of the literature revealed a lack of knowledge about the appropriate use of this new technology, digital imaging, by forensic nurses.

Discussions about the use of digital imaging technology for photodocumentation in forensic nursing have occurred, including discussion about the subsequent ethical and practical concerns. For example, the IAFN's 2011 symposium included concerns about the purpose for photographic documentation and extrapolating established standards for children to adult patient populations. Posts on general member and sub-specialty area discussion boards for the International Association of Forensic Nurses have raised concerns about the use of photodocumentation (Personal Knowledge). In addition, a limited number of articles have explored the use and purpose of digital imaging technology (White & DuMont, 2009, Brennan, 2006). Much of this formal and informal discourse has been anecdotal. There is a lack of knowledge about current practice surrounding clinical forensic photodocumentation including forensic nurses' use of digital imaging for photodocumentation, variations in practice across jurisdictions and populations, and forensic nurses' concerns involving photodocumentation practices using digital imaging technology.

Problem Statement

For developing best practices, policy statements, or guidelines, and to address ethical concerns surrounding the use of digital imaging technology and the resulting digital photodocumentation in clinical forensic nursing practice, information about current practice is needed beyond anecdotal accounts. To meet this need, forensic nurses were surveyed about their current practices across populations, systems, and roles surrounding photodocumentation. This paper describes the development of a survey to assess current photodocumentation practice and findings from this survey. The goal of this paper is to initiate a dialog about the professional responsibilities and ethical practices surrounding digital photodocumentation in the forensic setting and to set a foundation for future research related to clinical forensic photodocumentation.

Methods

Design and Data Collection

To assess current practices around digital photodocumentation, a descriptive, cross-sectional design was used with a national sample. To assess forensic nursing practice around photodocumentation, a survey was developed called the Forensic Nursing Photodocumentation & Digital Imaging Study (FN-PDIS) survey. Initial items were developed by a content expert in the area of forensic nursing (RE) based on a review of the literature and expert knowledge of forensic nursing practice and clinical photodocumentation. Each item was then reviewed two ways. First, subject matter experts in forensic nursing practice and digital forensic imaging reviewed all items for content, missing items, and appropriateness of imaging and forensic practice terminology. Second, each item was evaluated with the Question and Understanding Aid (QUAID) tool for readability and clarity. The QUAID tool assists in recognizing unfamiliar

technical terms, vague or imprecise relative terms, vague or ambiguous noun phrases, complex syntax and working memory overload for respondents. Results from the QUAID analysis and expert reviewer feedback were used to revise survey items. Following revision, the survey was reviewed again by the original subject matter experts. Based on feedback, minor modifications were made.

The resulting FN-PDIS survey is a 96-item web-based survey designed to capture data on digital photodocumentation practices, concerns and potential ethical issues related to practice, and non-identifying personal characteristics of respondents. Survey items are grouped into three sections. First, 25 fixed response and open-ended items on current clinical practice for digital imaging and photodocumentation. Second, 53 Likert-scale, fixed response and open ended items related to occurrence and levels of concern involving specific digital imaging and photodocumentation situations for four specific patient populations served (i.e. prepubescent, pubescent/adolescent, adult, older adult). Respondents are able to answer the subsections for population/s they serve. The third section includes 18 fixed response and open-ended items related to personal characteristics of respondents.

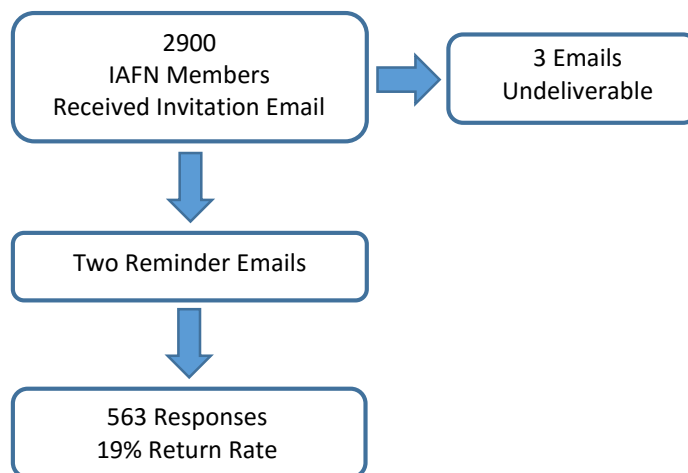
The FN-PDIS survey was converted to a web-based design using an online research survey product, Web-Q. Conditional skip-logic, or branching, was used where appropriate (e.g., questions related to population served) to create custom pathways through the survey. When applied, respondents were directed to a relevant destination question based on response to the previous question. This allowed respondents to skip questions that were not relevant to their individual clinical practice. The survey was disseminated electronically using the anonymous security option.

Study Population

Members of the International Association of Forensic Nurses (IAFN) whose occupation was identified as nursing and who had an active email address were invited to complete the survey. There were no exclusions to participation. Email invitations included an introduction to the survey and instructions for participating in a study incentive. The study incentive was a drawing for either an iPad2 or a forensic medical library from STM Learning. Participation in the drawing for the incentive required providing identifying information such as name and email address. Therefore, respondents who wished to participate were directed to a separate, secure link. Incentives were awarded within 4 weeks of the study being closed to participation.

Invitations to participate in the study were sent by email to 2,900 regular members of the IAFN between June 26 and August 3, 2013 (Figure 1). Three email invitations were returned as undeliverable. Each IAFN member received an initial invitation to participate followed by two reminder emails. A total of 563 completed surveys were returned.

Figure 1



Human Subjects Protection

All study procedures and instruments were approved by the Human Subjects Division of the University of Washington, Seattle, Washington prior to subject recruitment and data collection.

Analysis

The Statistical Package for Social Science (IBM SPSS, New York, NY), Statistics GradPack was used to analyze survey responses using descriptive statistical procedures.

Results

Description of Sample

Surveys were completed and returned by 563 forensic nurses, nearly 20% of the total population of forensic nurses who were current members of their professional organization, IAFN. Personal characteristics of the respondents are presented in Table 1. The majority of respondents were licensed to practice in the United States. Respondents ranged in years of nursing practice from 2 - 53 years (n=526) with over half reporting 20 or more years of experience as nurses. The range for forensic nursing practice was 1 - 29 years (n=528) with two-thirds reporting less than 10 years of experience perhaps reflecting the newness of the specialty. The majority of respondents (88%, n=488) identified a clinical role in forensic nursing with 68% (n=330) reporting a clinical role in combination with a second forensic nursing role (e.g., administrator, non-academic educator, consultant, academic educator, or researcher).

Over a quarter of respondents (28%) skipped the survey item inquiring about career total of patients seen as a forensic nurse, yet all survey participants (N=563) provided an estimate of how many patients they had seen as a forensic nurse in the past 12 months. Of those responding to career total (n=408), the majority appear to have limited experience, reporting less than 250

patients across their forensic nursing career. Just over a quarter of all respondents provided services to 10 or fewer patients in the past 12 months, suggesting low volume settings or services. On a programmatic level, patient volume was reported as 150 or fewer patients per year for half of the forensic nursing programs that the respondents were associated with, again suggesting relatively low volume settings. Persons in custody and students (i.e., university/academic settings) were poorly represented across communities served by these respondents.

The educational distribution of survey respondents was representative of the IAFN general membership with nearly one third of respondents holding a graduate degree in nursing (31%) [IAFN, personal communication). In addition to the personal characteristics presented in Table 1, information was obtained regarding source of forensic nursing education, special training regarding photodocumentation and types of violence or trauma experienced by the populations served. These data are summarized here.

Approximately three-fourths of respondents reported some type of certification related to their forensic nursing practice with 71% (n=389). The majority of respondents reported non-academic forensic education including being self-taught (18%, n=101), obtaining on the job training (61%, n=343), attending lectures and/or presentations (82%, n=462), or attending conferences (75%, n=419). For photodocumentation training, the majority of respondents are self-taught and/or receive on the job training with 2% reporting no photodocumentation training. Respondents sought lectures/presentations and/or photodocumentation trainings/workshops to learn photodocumentation skills (72%, n=405 and 66%, n=372 respectfully). Almost one-third of respondents (32%, n=151) have <8 hours of photodocumentation training and 29% (n=140) have 8-15 hours of training.

Respondents were also asked about the mix of their patient population. The majority of respondents served living patients (89%, n=497), while less than 1% worked only with deceased persons, and 11% (n=59) served a combination of living and deceased patients. The types of exams performed by respondents varied. Just under half (45%) reported engaging in a generalized clinical forensic practice, serving patients who had suffered all forms of injury, abuse, neglect or harm. A slightly larger group (54%) served a narrower sub-specialty practice involving populations only affected by sexual assault or sexual abuse.

Table 1: Personal and professional characteristics of survey respondents (N=563)

Variable	Percent	n	
Country of professional licensure	United States	93	525
	Canada	5	29
	Other	<2	8
Years of nursing practice	< 5 years	4	23
	5-9 years	14	72
	10-19 years	29	152
	≥20 years	53	279
Years of forensic nursing practice	< 5 years	32	170
	5-9 years	32	170
	10-19 years	30	154
	≥20 years	6	34
Number of patients served as a forensic nurse in past 12 months	≤ 10	26	144
	11-50	44	247
	51-150	19	109
	≥151	9	52
	Don't know	2	11
Number of patients served as a forensic nurse in career	<50	29	120
	50-249	38	153
	250-999	25	104
	≥1000	8	31
Number of patients served by forensic nursing program in past 12 months	≤50	24	136
	51-150	26	142
	151-300	20	111
	301-500	12	69
	≥501	11	60
Communities served as a forensic nurse	Don't know	7	40
	Urban	67	373
	Rural	53	297
	Military	14	78
	Native/Indigenous/Inuit	7	37
Highest degree completed	Other	2	11
	Associate or diploma	28	141
	Bachelor	41	227
	Master	25	141
	Doctorate	6	34

Table 2: Photodocumentation practices reported by forensic nurses (N=491)

Variable		Percent	n
Types of forensic medical examinations/evaluations completed	All forms of injury, abuse, neglect or harm	45	254
	Unintentional or accidental injury	<1	3
	Self-harm	1	7
	Emotional abuse/neglect	3	15
	Physical abuse/neglect	14	77
	Sexual abuse/assault	54	301
	Other	5	26
Age of populations served	Prepubescent children	64	314
	Pubescent children/adolescents (<18 years of age)	91	444
	adults (18-64 years of age)	93	452
	older adults (>64 years of age)	90	437
Purpose of photodocumentation	Forensic medical photodocumentation	100	487
	Evidence for law enforcement	81	395
	Peer or case review	66	321
	Education	50	242
	Second opinions or consultations	42	204
	Research	9	42
Types of images collected during a forensic medical examination	Patient identification/appearance	90	440
	Non-genital anatomy	96	470
	Genital anatomy	92	451
	Medical conditions	32	155
	Pre-existing injuries	46	223
	Normal variants and birthmarks	28	135
	Tattoos and piercings	27	132
	Clothing and trace items	2	9

Photodocumentation Practices

Photodocumentation was a common community based standard of care during forensic medical examinations for the majority of respondents (84%, n=471). Similarly, 87% (n=491) reported photodocumentation as part of their individual practice when completing forensic medical examinations. The 72 respondents (13%) reporting photodocumentation was not part of the forensic medical examination skipped to the demographic questions. Unfortunately, data was not collected related to age of patients served for respondents not using photodocumentation. However, 49 respondents not using photodocumentation during forensic medical exams provide services for patients reporting sexual abuse/assault examinations. An additional 22 respondents who were not engaging in photodocumentation practices reported providing forensic medical examinations for *all forms of injury, abuse, neglect or harm*. All respondents identified forensic medical photodocumentation as a purpose for collecting images during forensic medical examinations (100%, n=487) with a large number also selecting evidence for law enforcement (81%) as a purpose for collecting images (Table 2).

The most common images collected included patient identification or presentation and non-genital and genital anatomy (Table 2). Of the respondents providing services to pre-pubescent children, 87% collect images of non-genital anatomy and 95% collect images of ano-genital anatomy. As expected, a larger number of respondents provide services to adolescents, adults and older adults (Table 2). Unlike services to prepubertal children, non-genital and genital images are equally collected (91%) during forensic medical examinations of adolescents. Respondents serving adults and older adults are slightly more likely to collect images of non-genital anatomy (93%, n=417; 93%, n=401 respectfully) than images of ano-genital anatomy (91%, n=410; 90%, n=391, respectfully).

One-third of the respondents (n=162) experienced an occasion when they decided NOT to take pictures during a forensic medical examination/evaluation. Reasons included the patient declining to be photographed (91%, n=148), equipment unavailable or not working (47%, n=76), the forensic nurse decided images were not needed (22% n=36), and patient discomfort (3%, n=5). Interestingly, 65 respondents (13%) reported they would use their personal cell phone or other personal device to capture images if their normal equipment was malfunctioning or not available.

Collection, Storage, Security and Transfer of Digital Images

The majority of respondents (94%) use some type of digital technology to capture images (see Table 3). The most common type of technology used to capture digital images was a digital camera (85%, n=416). Three reported using a non-digital device (e.g., disposable camera), and 27 (6%) used both non-digital and digital devices. Over half of the respondents (53%) reported that access to stored images was tracked or monitored either electronically or manually. However, 21% (n=101) reported no tracking or monitoring mechanisms in place for accessing images and 26% (n=128) did not know if access to images was tracked or monitored.

Table 3 also reflects the types of images collected by respondents during a forensic medical examination/evaluation, storage of these images, and how images were protected from unauthorized access. Once stored, the forensic nurse completing the exam may retain access to the images (65%, n=316). In contrast, program administrators or coordinators may have access (76%, n=369) or the entire forensic team may have access (27%, n=132). Almost half of respondents transfer images via a portable storage device person-to-person (47%, n=230) with a small number (12%) printing and physically delivering printed images or using electronic

transmission (e.g., electronic file share) (9%). Approximately 11% reported not knowing how images were transferred to other persons or agencies.

Table 3: Collection, storage, security and transfer of digital images collected during the forensic medical exam

Variable		Percent	n
Digital technology used for photodocumentation	Digital camera only	64	312
	Colposcope only	14	66
	Digital camera & colposcope	17	82
	Video camera only	1	4
	Combination of digital camera and devices other than colposcope	4	22
Storage of digital images	With electronic medical record (EMR)	19	94
	Secure network separate from EMR	35	170
	Computer or external hard drive	12	58
	Disc or other portable media (e.g., jump drive)	31	149
	Digital images are not stored or don't know	3	17
Protection of images from unauthorized access	Password protection	56	264
	Software encryption	30	144
	EMR security	8	40
	EMR security plus additional measures	18	87
	Printed, erased, and physical secured	17	81
	Digital storage media physically secured	9	45
	With physical (hardcopy) record	4	18
	Don't know	9	41
Transfer or release of images to other persons or agencies	Portable storage device person-to-person	47	230
	Images printed and delivered	12	58
	Secure portal or secure file sharing	9	43
	Portable storage device via mail or courier	4	19
	Images are never released	3	15
	Other means not listed above	13	62
	Don't know	11	54

Discussion

The results from this descriptive survey of a large sample of forensic nurses licensed predominately in the United States is the first report of current practice around forensic medical photodocumentation to our knowledge. As such, these findings represent crucial, guiding information for forensic clinicians, educators, scientists and policy makers. Three key findings are discussed below.

The majority of nurses who participated in this study had 20 years or less forensic nursing experience. This was expected for two reasons. First, most nurses practice for several years in a general area of nursing before entering a specialty area such as forensic nursing. Second, forensic nursing is a relatively young specialty, only achieving formal recognition from the ANA in 1996, with many sub-specialties (e.g., sexual assault nurse examiners, medical death investigators). Additionally, over half of the nurses in this study reported a narrow clinical sub-specialty practice - forensic medical exams related to sexual assault/abuse. This may be reflective of how forensic nursing came to exist. Unlike other nursing specialties where sub-specialties emerge from the general specialty, forensic nursing subspecialties were established prior to the specialty itself and merged to form one specialty group.

These findings also raise concerns about forensic nurses' knowledge of and ability to provide an accurate estimate for their professional experience. This is an important issue because of the critical intersection between forensic nursing and the legal system. Forensic nurses are expected to be able to accurately represent their experience and expertise, particularly during judicial proceedings. This is similar to a nurse midwife who is expected to be able to provide an overall estimate of deliveries, including by presentation and complication. Yet these survey findings suggest that forensic nurses may not recognize this professional expectation.

Respondents were asked how many patients they had provided forensic nursing services to in the past 12 months, and in the role as a forensic nurse overall. While all participants responded regarding how many patients they have served in their role as a forensic nurse over the past 12 months, nearly a third did not respond when asked to estimate over their career.

In addition to the lack of clarity regarding career expertise, there is concern across the forensic nursing community about overall lack of expertise among forensic nursing educators, trainers, and consultants. A little over a quarter of survey respondents (26%) reported providing services to 10 or fewer patients in the past year. Just over two-thirds reported providing services to 50 or fewer patients in the past year. This raises the question of what frequency of practice is necessary to maintain proficiency and expertise, and how to support competence in settings, such as rural communities, that are anticipated to be low-volume. Practicing a skill 1-4 times a month may not be adequate to maintain competence without a robust just-in-time consultation mechanism. Options that have been utilized in similar situations of low-frequency healthcare skills include telemedicine support, national expert consultation available by phone 24/7, or clinical guidelines available through professional societies. One current national project is exploring the use of telemedicine to address low-volume areas and a recent national RFP was released to fund a state-wide initiative (www.ovc.ncjrs.gov). Perhaps simulation labs, live patient-model labs, or virtual simulation programs should be explored for remote and low-volume regions, programs or individuals.

Anecdotal accounts by forensic nurses of photodocumentation practices related to sexual assault/abuse forensic medical examinations have suggested wide variations in practice based on the patient's age. The results of this study suggest that while there are differences, there is great commonality. Photodocumentation of ano-genital structures is relatively consistent across all age

groups, suggesting that it is viewed as standard of practice by all forensic nurses, regardless of the age group they predominantly serve. These data showed a concerning exception however. Nearly 13% of the nurses in the survey reported not using any type of photodocumentation during a forensic medical exam regardless of type of violence reported. In addition, of the forensic nurses who do use photodocumentation, almost 5% who provide forensic medical examinations for young children take no images at all. Forensic nursing needs to identify the reasons behind these variations in care. Are these variations reflecting regional differences? Or variations related to source of education and training? Perhaps acquiring equipment is a barrier resulting in no photodocumentation? Most importantly, forensic nursing must address if this is a variation in practice or a breach in the standard of practice?

How images are taken, transmitted and stored is critical and, with rapidly changing technology, often may be perceived as a moving target for procedures and policies. The findings from this study highlight the seriousness of the issues surrounding the privacy, security and integrity of forensic images. While the majority of survey participants reported they would not use a personal cell phone or device to take pictures during an examination if their workplace equipment was not available, 13% said they would. This finding supports anecdotal accounts of personal cell phone use in forensic nursing practice and is very concerning as it represents a clear breach of privacy and confidentiality, may harm patient perception, and raises serious criminal implications for the healthcare professional, such as images of children being considered child pornography if collected (“produced”), found stored (“possession”) and/or transmitted (“distributed”) via a personal device.

A second area of serious concern revealed by these findings centered around tracking and monitoring of access to photodocumentation of forensic exams. Access to the photographic

documentation is typical in the healthcare settings. Images of wounds, intraoperative surgical findings, and other visual records are stored in the electronic chart allowing access to this important information by the interprofessional team. Are forensic medical examination images different? If so, how are they different. Some nurses may believe that by their very nature, these images are intimate, often shocking, intensely personal, and carry legal import in addition to their value for patient direct care. However, are other types of medical images also considered intimate, often shocking and intensely personal such as images related to gross congenital malformations or anomalies, gender affirmation surgeries, or reconstructive surgery following a mastectomy? Should images from the forensic medical examination be in a patients' medical records?

Almost one-quarter of survey respondents did not have a way to track or monitor who accessed the photographic documentation they took during the forensic medical examination. Respondents reported multiple methods for storage and encryption including with the electronic medical record (EMR), on a secure network but not part of the EMR, and on portable drives, suggesting that no method has evolved yet as best practice. Coupled with the findings regarding the low volume of cases for some forensic nurses and forensic practices, this raises grave concerns about privacy, confidentiality and integrity of photodocumentation of forensic examinations. In addition, forensic nurses may be naively putting themselves at risk of criminal charges by having images of ano-genital structures of minors on their personal cell phones or other digital devices because of the legal definitions around producing, possessing and distributing child pornography.

All respondents on this survey who use photodocumentation in their forensic nursing practice reported using photodocumentation in the forensic medical exam for medical purposes.

However, nearly all of these respondents also identified evidence for law enforcement as a purpose. Does this reflect a dual role or obligation for the forensic nurse? Is there a need to differentiate between the *purpose* for collecting images and the *potential use* of the images? When forensic nurses identify evidence for law enforcement as a purpose rather than a potential use of the images (e.g., used in the investigative or judicial processes), they may inadvertently confuse their own professional role.

Limitations

There are three important limitations to this study. First, the sample was drawn from the International Association of Forensic Nurses (IAFN) membership although there are forensic nurses who are not members of their professional organization creating the opportunity for a biased sample. However, professionals who belong to their specialty organizations are more likely to be active in their practice, see themselves as leaders, and practice within their specialty area more frequently. Therefore, our sample of IAFN members is likely to have reported greater frequency of forensic practice and more adherence to current trends in practice than the overall population of forensic nurses. Hence, we believe any bias in responses is likely to have exaggerated the positive aspects of practice rather than negative findings.

A second limitation was conducting the survey using online technology. Online methods are known to result in lower response rates due to email delivery failures (e.g., spam filters, changed or neglected email accounts), email fatigue, and technology and software issues (e.g., connectivity speed, problems with opening a survey, etc.). To overcome this limitation, two strategies were employed: multiple reminders and a sample-specific choice of incentives. The overall return rate was 19%, representing nearly 1/5 of the population of IAFN members.

A third limitation relates to response options to questions such as types of pictures taken and storage of images, which over represented practice of forensic nurses who are engaged in sexual assault and physical abuse exams and working with a hospital or free standing clinical setting. Other types of forensic nursing specialists sometimes included comments when their routine practices were not reflected in the available response options. Future research should include expanded response options to incorporate more roles such as forensic nursing death investigators, coroners, and others, and more settings.

Implications of Findings for Practice

This is the first study to our knowledge to gather data on forensic nursing photodocumentation practices and therefore presents a valuable snapshot of current practice to assist the development of clinical guidelines and standards of practice. Not surprisingly but very importantly, the forensic nurses who participated in this research overwhelmingly identified photodocumentation as a recognized standard of care during forensic medical examinations and evaluations for patients of all ages. This finding should drive policy makers to adopt guidelines for standard of practice that address the 5-13% of forensic nurses who currently are not practicing to what appears to be the emerging professional consensus.

Future research around photodocumentation practice and effective training is needed. For example, these findings suggest that forensic nurses consider vendor and non-clinical trainings as clinical forensic photodocumentation education. In addition, the photodocumentation presentation, demonstration and perhaps limited simulation practice during Sexual Assault Nurse Examiner (SANE) trainings may have been misinterpreted by these survey respondents as academic courses in photodocumentation and as sufficient training for competent photodocumentation practice. This lack of clarity is concerning. Forensic nursing needs to better

differentiate the theoretical training that forms the foundation for the practice, skills training that may be required for a certification, versus continuing education that forensic nurses should seek to stay current in their practices.

Finally, forensic nursing practice is a critical nursing specialty as we grapple with the epidemic of violence and abuse in modern society (IAFN, 2009). Inevitably – and thankfully – many forensic nurses will practice in low-volume settings. A critical issue for forensic nursing educators and policy makers to address is the educational, training, and clinical support needed for just-in-time and ongoing education and consultation to ensure that those affected by violence and trauma receive competent care during what may be one of the most difficult times of their lives.

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Chapter 5: Reflections and Continuing to Initiate Difficult Dialogues

Introduction

Ethical issues and concerns within forensic nursing practice are often complex and emotionally charged in nature. In a practice setting where clinicians serve populations affected by violence and trauma, ethical questions and concerns may involve conflict among professionals from different disciplines. Members of the healthcare team, patients and family members may disagree about how to meet individual patient needs and protect groups or populations. Professionals who intersect with those who have been affected by violence include law enforcement professionals, community and system victim advocates, judicial professionals, forensic scientists, and clinical forensic healthcare providers.

Although ethics is often perceived as a poorly understood enigma during conversations among providers, in fact it is a part of daily life for clinicians. Other than an ethics or professionalism course in nursing school, forensic nurses in general receive limited or no exposure to methods of resolving ethical questions and dilemmas. During professional conference presentations and through postings on professional discussion boards, forensic nurses often voice their frustration with not being able to “find the answer”. Unfortunately, many also try to seek a single ethically defensible solution that will apply to all patients in a similar condition or situation (e.g., unresponsive patients). Yet, similar to other areas in healthcare, the circumstances and values of individual patients, families and communities are unique. In addition, the issue at hand may not be one of ethics or morality, but rather an issue related to the law and/or community norms and/or social sanctions.

Ethics in Forensic Nursing Practice

Ethical issues in forensic nursing practice may include informed consent, capacity to consent, confidentiality, and whether or not to provide forensic nursing services. The reasons for

seeking forensic nursing services include abuse, maltreatment, and violence; the accompanying ethical issues are directly affected by medical, legal and social considerations relevant to those issues. Within this emotionally charged environment, we must also consider the perspectives of the multidisciplinary professionals responding to the immediate needs of patients who are categorized as victims, suspects, the accused or perpetrators. These professionals have very distinct roles which at times can result in additional conflicts, especially in the light of inappropriate role expectations.

Unfortunately, these ethical questions and concerns arise in the presence of time sensitive scenarios. For example, the holding or release of a sexual assault suspect or loss and/or biodegradation of collectable samples for DNA analysis. As with general clinical ethical questions, addressing these complex questions requires specific knowledge and skills – good intentions and empathy are not sufficient for achieving ethically defensible decisions (Aulisio, 1999). Considering that 5% of people providing clinical ethics consultations in the United States have completed any type of formalized ethics education (e.g., fellowship or graduate program in bioethics) and less than half received formal direct supervision or mentorship in providing ethical consultations (Fox, Meyers, & Pearlman, 2007), one can better understand the limited likelihood that forensic nursing professionals or interdisciplinary professionals possess the requisite skills for responding to ethical questions and concerns in general, not to mention in time sensitive situations.

Ethics is not a new or novel concept for forensic nurses. The sub-specialty forensic nursing practice of Sexual Assault Nurse Examiners came into existence due to concerns about the response, or rather the greatly delayed response, to sexual assault patients in emergency departments. Questions were raised about quality of care, experience of healthcare providers,

inequities in services provided, and how to better meet the specialized needs of patients reporting sexual assault or abuse. It was considered unjust for patients who may have been sexually assaulted or abused to experience long waits in excess of 4 hours in emergency department waiting rooms, unable to eat or urinate, and then to receive care by providers without specialized forensic medical or nursing education.

Not only do forensic nurses contend with ethical concerns or issues related to specific patient encounters, they are faced with issues of injustices and inequity in response to the needs of patients affected by different forms of abuse or violence. The decisions resulting from ethical discourse can have direct biopsychosocial affects for the patient. The decisions may also directly or indirectly affect persons within the patient's family and social environment, community as well as society in general. The consequences involving clinical action or inaction also affect the forensic nurse, their program, and even the forensic nursing profession.

Reflections

At the start of my doctoral studies, I was asked, "How do you want people to see you, you need to choose the hat you are going to wear. Are you a forensic nurse? A nurse practitioner? A researcher? Or, do you want to be known as a respected nurse scientist?" My response, "all of the above". Their reply, "You can't be. If you try to wear more than one hat, your focus is divided and you will never be as successful as you would if you choose a single identity and commit to it." Fast forward to today, my answer remains the same – I am all of the above. As a clinical forensic specialist, my scope of practice is that of an advanced practice registered nurse. As a clinical forensic specialist, my scholarly interests include forensic nursing practice and establishing standards of care that best meet the needs of all populations affected by violence. As a clinical forensic specialist, I am an expert in forensic nursing practice and

violence across the life cycle. As a clinical forensic specialist, I am a leader and a follower, a teacher and a student, an entrepreneur and an innovator. I am a change agent and choose to make a difference. A common thread throughout all of these “hats”, what is at the core of all that I do, is ethics and accountability. More specifically the ethical dimensions of forensic nursing practice, education, research, and the subsequent accountability of individuals, groups, and organizations.

Difficult conversations are required related to ethical practices and accountability in forensic nursing. When these conversations do occur, they often become emotionally charged anecdotal debates rather than informed discussions and objective analyses. How do we, as a profession, take *what should be* and transform it into *what is*? I believe we start by engaging in collegial discussions with a focus on identifying inequalities in services, differences in core practices, and variability in quality. It is critical for forensic nurses to conduct research and disseminate the findings. As a specialty group, I believe we need to engage in open and objective dialogue, propose solutions modeling best practices and serve as change agents. Importantly, we need to model ethical and accountable forensic nursing practice across the continuum of the populations and settings that we serve.

The opportunity to do this body of work has led me to reflect on where forensic nursing is relative to research, education and practice and how my dissertation work contributes to these agendas. Through exploring the concepts of role confusion and role conflict, dual roles and dual loyalty, and the continuum of conflicting interest to conflicts of interest, I realize that we may be directly contributing to the confusion both within and outside our profession. It has made me question the existence of dual loyalty/dual roles and the acceptance of negative outcomes related to such duality. Perhaps, we should rethink underlying assumptions and consider the possibility

of positive synergistic effects of our integrated role that brings together nursing, forensic science, law and public health.

Research to inform writing the chapter on inequities related to forensic medical examinations for suspects and the accused in sexual offenses brought to the forefront several areas for future inquiry. We must explore practices that perpetuate disparate care across other clinical forensic services. In doing so, underlying assumptions should be explored for ethical defensibility and sound clinical practices. For example, how to respond to an unresponsive patient – how do we as a profession support policy that does not allow examinations yet at the same time support policy that directs an exam be completed.

It may be difficult for non-forensic readers to fully appreciate the importance of my research on photodocumentation practices therefore I will share some additional context. In late 2013, IAFN leadership contracted a writer for creating a recommended practices document for clinical forensic photodocumentation among forensic nurses. After the writer discovered the lack of information related to existing practices, she sought advice from forensic nursing experts. These experts shared their knowledge about the Forensic Nursing Photodocumentation Digital Imaging Survey (FN-PDIS) and how this research was the first to systematically query and gather data specifically related to forensic nursing photodocumentation practices. Following these communications, I met with the Executive Director of IAFN who placed the photodocumentation recommended practices writing project on hold pending the release/publication of the descriptive practice findings resulting from the FN-PDIS.

Shortly thereafter I received a request to share preliminary data with a Canadian scholar trying to effect change across her province. Her goal was to establish photodocumentation as a standard practice during forensic medical examinations for patients (“victims”) regardless of age.

She was challenged by those in power to provide “real data” rather than assumptions and anecdotal accounts of individual’s or individual program practices. The data collected through the FN-PDIS was the only data that could address the questions posed to this scholar by persons with the authority to direct local practice changes.

Finally, professional codes of ethics reflect the core values of members of the profession. Considering multidisciplinary collaboration is at the core of effectively responding to violence, I also want to explore the core values of the different professional codes and how they are similar or different. In addition, I want to know how identified differences may contribute to interprofessional conflicts and how these conflicts impact responding to the needs of populations affected by violence, intentional and unintentional injury, and mass disaster caused by nature or humans.

Conclusion

As with other area of nursing, forensic nurses are faced with the reality that the most ethically defensible option may not be legal and the legal options may not be the most ethically defensible choice. Forensic nurses must understand that the resolution of ethical problems is not the sole responsibility of any single professional or of one specific discipline (ASBH, 2009). Just as the patient/victim’s perspective of possible solutions is affected by personal values, each professional involved will be influenced by his or her professional training and role. At times, these professional influences may limit the professional’s perspective of the ethical issue. In addition to effective communication skills, it is essential for those charged with making an ethical decision possess the capacity to view the issue from various perspectives, values, and contexts.

Forensic nurses and other professionals involved with resolving ethical issues should have an understanding of ethics, morality and related concepts; resources for guidance; methods for resolving ethical issues or responding to ethical concerns; and, understand the difference between ethical, legal and professional issues. In addition, to arriving at a solution, there must be effective and respectful communication. For effective interprofessional communication to occur, forensic nurses and other involved professionals must also understand the influence of their professional codes of ethics, recognize the potential effects of different value systems, and consider the influence of one's profession and/or specialty practice. Forensic nurses must be open to differing perspectives and actively strive to understand the basis of these different perspectives in order to better respond to the patients they serve.

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