

“With the Disruption to Your Family Life, It’s More A Vocation than A Job”: Favours and Family in the Forensic Nurse Examination of Sexual Assault Survivors

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Abstract

For those involved in the management of the forensic intervention following a rape assault, the attendance of a survivor is unpredictable. Rotas are produced to attempt control; however, as the forensic intervention is an example of bodywork (determined by body time), it necessarily poses a challenge to clock time. To solve this dilemma, nurses offer “favours” (Cohen, 2010) to colleagues in the form of flexibility over shifts. Nurses are also flexible with the end of their shifts in order to provide survivors with a sense of control over their bodies. While these favours necessarily problematise nurses’ non-work commitments, it is exactly these familial/maternal responsibilities which provide them with the empathy and caring skills necessary to carry out their work. Based upon a qualitative, international comparative study, this paper will explore the favours nurses offer and the complex ways they manage the relationship between their family responsibilities and forensic work.

Keywords: sexual assault nurse examiners, forensic nurse examiners, favours, family, care

1. Introduction

The forensic medical intervention following a rape and/or sexual offence is a highly intimate and invasive affair. The survivor, who has suffered an assault upon their bodily/sexual autonomy, is required to undress, lie on a couch and present their naked body to a stranger in order to undergo medico-legal procedures. Their body is observed from head to toe in order to identify physical phenomena (from injuries sustained during the assault to tattoos and piercings), and then their ano-genital region is “swabbed” (both externally and internally) in an attempt to find trace material (for example semen) that could help corroborate their claim of assault. Clearly, it is imperative that this work is conducted in a caring and empathetic manner, and in recent years forensic practitioners have emphasised the importance of survivor choice concerning their own bodies in order to grant them a sense of control. Such a practice is noble and commendable, but does come at a price: the expectation that forensic practitioners’ “work temporality” (Roberts, 2008) should extend into their non-work time.

The focus upon the body of the survivor of a rape assault means that the forensic medical examination is a form of “bodywork” (Gimlin, 2007; Twigg, Wolkowitz, Cohen, & Nettleton, 2011; Wolkowitz, 2002, 2006). Scholars interested in bodywork, i.e. “work that takes the body as its immediate site of labour, involving intimate, messy contact with the (frequently supine or naked) body, its orifices or products through touch or close proximity” (Wolkowitz, 2002: 497) have drawn attention to its tactile, messy and, importantly, gendered nature. Investigating a range of occupations wherein workers engage directly with the body, for example hairstyling (Cohen, 2010), residential care workers (Twigg, 2000), and nail technicians (Kang, 2003), bodywork scholars have emphasised that these professions are generally staffed by women, the assumed providers of care for unpleasant work (Widding Isaksen, 2005), and have limited flexibility in terms of time and location (Twigg et al., 2011). Bodywork necessitates that the body worker be available whenever the body of the patient, resident or client requires them. Bodies often cannot wait until the time is suitable for the worker, meaning that work must be performed as swiftly as possible. “Body time” becomes the arbiter of work, potentially being “24 hours a day, 365 days a year” (Twigg et al., 2011: 177), which poses a challenge to organised shift patterns based upon

“clock time” (Roberts, 2008). Likewise, as bodywork is highly labour intensive, workers can only deal with one body at a time (Cohen, 2011). The relative unpredictability of body time means that it is often difficult to know how many members of staff are required to cover the demand; when numbers of practitioners are low, body workers may be faced with periods of high demand (“peak periods”), whereas at other times, demand may not be so high, resulting in what Cohen labelled “baggy time”. Bodywork therefore requires “flexible bodies and flexible workers” (Twigg et al., 2011: 177).

One manner in which the flexibility necessary to meet bodywork demand is achieved is via the performance of “favours” (Cohen, 2010). Lara Cohen found that salaried hairstylists would often “knowingly over-step the formal job requirements... *for clients*” (Cohen, 2010: 207 emphasis in original). Hairstylists perform extra tasks, in order to meet their clients’ needs, for instance extending working hours, or going to the client’s home if they were unable to travel. While for some the justification for this altruistic behaviour was maintenance of a client base, for others it was out of a sense of community and “doing being friends” (Cohen, 2010: 210). Similarly, researchers investigating paid care work have identified that carers will often perform additional tasks for those for whom they care (Himmelweit, 1999). For instance, England and Dyck (2011) noted that while the regulatory policies for paid care work only provided time for corporeal tasks (“caring for” clients), carers who travelled to peoples’ homes ensured that they made time to address the client’s emotional needs as well (“caring about” clients). As with the hairstylists, such additional jobs (or, as I will call them (for reasons I will discuss below), “favours”) were justified as a result of the development of strong relationships between carer and client, leading Himmelweit to suggest that “caring... can and does consist of both labor and love.” (Himmelweit, 1999: 32)

As I will explore throughout this paper, forensic practitioners, particularly forensic nurses, also offer favours - not only to those that they care for, but to their colleagues as well. While the survivor can be a repeat victim (Mulla, 2008), this is not always the case, and so a prior relationship between the survivor and the practitioner cannot be guaranteed. Another explanation is therefore needed to explain why forensic practitioners offer favours, often at the expense of their personal time. Before I discuss these favours, I will outline the context behind the introduction of nurses to forensic medical intervention, and in particular the importance of time to the development of the forensic nurse role.

2. Forensic Nurse Examiners and Body Time

Traditionally, forensic medical work was the province of doctors; however, a groundswell of negative opinion formed around the examination in Anglo-American jurisdictions during the 1980s and 1990s. Amongst these criticisms was the fact that survivors of sexual assaults often had to wait many hours before they were seen by a doctor, and that during this period they were prohibited from drinking or relieving themselves for fear of losing forensic evidence. Additionally, feminist activists and scholars drew attention to: the fact that the overwhelming majority of medico-legal practitioners were men, which eliminated the opportunity for the survivor to request a female examiner; *his* attitude towards the survivor (more often than not disbelieving); and the shortage of skills doctors received (Chambers & Millar, 1983; Temkin, 2005). Against this background, and alongside the development of nurse specialisation in the 1990s, the Sexual Assault Nurse Examiner (SANE) role was introduced (Rutty, 2006). SANEs have come to dominate forensic provision in North America and are generally seen as a positive intervention (see for example Sievers, 2003).

The uptake of the FNE role in the United Kingdom has been a somewhat slower affair; but is now following a similar trajectory to North America. Introduced to St. Mary’s Sexual Assault Referral Centre (SARC) in Manchester in February 2001, FNEs would address two of the major criticisms levelled at forensic provision: the introduction of female nurses would provide survivors with some choice over the gender of the examiner (albeit still limited), and nurses would be contracted to work during the daytime (9am-5pm), a period that had always been difficult as doctors were busy in their other roles (for instance as General Practitioners – Regan, Lovett & Kelly, 2004). Covering the day shift, the nurse reduces the time that the survivor has to wait to be seen by a forensic practitioner. Given that the body rapidly decomposes biological material, time is of the essence in terms of recovering that material before it degenerates, and waiting many hours for a doctor to perform the examination risks the loss of evidence that could identify the assailant. While there is still resistance to the widespread implementation of nurses into forensic intervention in the United Kingdom (Rees, 2012), victim-oriented practice and the need to recover material from the body of the survivor as quickly as possible following the attack requires coverage of the day shift, which is a strong justification for the use of FNEs.

The number of FNEs practising in the United Kingdom is still quite small; however, institutionalising nurses into forensic medicine is a first step towards ensuring that clients are not left waiting. Conversely, placing nurses on

the rota to cover the day shift is not, in itself, sufficient to meet the bodywork demand; as I will go on to demonstrate, managing baggy and peak periods is difficult in forensic medicine and in order to ensure there is sufficient coverage of the rota, nurses are required to be flexible with their shift patterns. In addition to the collection of forensic material (“caring for” the survivor), nurses are also concerned with the empowerment of the survivor (“caring about”). In the latter part of the paper I will discuss nurses’ flexibility with regards to the length of time of the forensic examination in order to ensure the survivor’s control over their own body.

3. Methods

This paper is taken from a larger study comparing the work of the FNE in England with the more established SANE in Ontario (Rees, 2011a). There is a growing social scientific literature on the forensic medical intervention in rape and sexual assault cases (Du Mont & Parnis, 2000, 2001; Mulla, 2008, 2011a, 2011b; Rees, 2010; Rees, 2011b; Temkin, 1998; White & Du Mont, 2009); however, each of these studies has focused upon a single jurisdiction with no comparison across countries. The study was a preliminary investigation into the feasibility and utility of comparative qualitative social scientific investigations of forensic medicine. The United Kingdom was chosen as it had recently introduced FNEs and it was felt that the study would be able to offer some reflection upon the development of the nurse-led intervention. Comparison with a more established programme would enable identification of potential future pitfalls. The established programme chosen was the Ontario Network of Sexual Assault and Domestic Violence Treatment Centres (hereafter “Network”), as it had been the focus of various studies in the past (Du Mont & Parnis, 2000, 2001), and Canadian law is sufficiently similar to English law to provide a “most similar” (Pakes, 2009) comparison.

Semi-structured interviews were chosen as the main method for evidence-gathering. Access to nurses in the United Kingdom was generated via the United Kingdom Association of Forensic Nurses. Five nurses agreed to be interviewed, from five different centres (UK1-5). Due to the small number of FNEs (those interviewed constituted all nurses who have performed this work in the United Kingdom up until the end of the fieldwork period), I also interviewed two doctors (known as Sexual Offence Examiners, or SOEs) who are involved in the training of nurses. In Ontario, access was generated via the Network. Eight nurses were interviewed from three hospitals across Ontario (ON1-3). These hospitals were randomly selected from the 33 centres that treat adult survivors. Ethical approval was provided by a university research ethics committee and the three Ontario hospitals. Interviews were semi-structured and lasted between one and two hours; they were digitally recorded and transcribed verbatim. Once all interviews were transcribed, Framework Analysis (Ritchie & Lewis, 2004) was performed, whereby the data was reviewed and indexed into core and subsidiary themes. The development of these matrices enabled comparison between respondents and, crucially, across jurisdictions, enabling the comparative aspect of the project.

In addition to the interview data, I also analysed a range of documents, including training materials, the reporting documents nurses use during the examination and a collection of media reports concerning the forensic medical examination in both jurisdictions, published during the fieldwork period. These documents were analysed in the same manner as the interviews and used predominantly as a means to triangulate the interview data. In this paper, I will make reference to a number of Canadian media reports concerning a young woman who was denied a medical examination in her local centre due to a lack of available SANEs. This will flag up the ongoing difficulties forensic practitioners have to overcome in order to ensure that the need for a forensic medical examination is met.

4. Coverage of Shift Patterns

4.1 Ontario

The Ontario Network’s policy is to classify cases based on time: if a survivor reports to the hospital within 72 hours of the assault then her body is considered a potential site for forensic evidence and an examination must be performed as soon as possible in order to attempt to collect this evidence (although this can sometimes be delayed if there is still time within the 72 hour window, depending upon the survivor’s consciousness, tiredness or state of intoxication); if the disclosure is made outwith 72 hours then the need to conduct the examination is not so pressing, and the survivor can attend at a time suitable to them (generally during the daytime). This demarcation influences the decision over who performs the examination. Each of the Ontario Network’s centres has one nurse who is contracted for full-time hours and works during the day. The full-time SANE performs the examination of survivors who disclosed outside the 72 hour window, and is involved with counselling and follow-up work for all those treated at the centre. She also coordinates and trains the other nurses employed by

the centre who work “on-call” and perform the forensic medical examination of survivors that attend within the 72 hour window. As their on-call label suggests, these nurses are not required to be present at the centre while on shift, but must arrive within 45 minutes of receiving a call. On-call SANEs have part-time contracts and often work other jobs. As part of their contract, on-call SANEs are expected to work a set number of hours per month in order to cover the rota. The centre coordinator (the full-time SANE) organises the time commitments of the on-call staff and makes sure that the rota is covered by enough nurses. Centre coordinators found it difficult to prepare the rota given the unpredictability of cases presenting themselves, and one of the coordinators used proxy indicators to arrange the rota.

Weekends are usually busier, if you can do weekends you get a better shot, but then we get quiet weekends and busy weekends... Sometimes it’s around sporting events, if there’s a lot of alcohol consumption we sort of expect to be busier, sometimes you can’t work out why, and the thing that is hard is you don’t know for sure whether there is less sexual assault or whether there is less reporting (Emma (all names are pseudonyms) ON2).

Emma estimates that there will be more sexual assault cases reporting to the hospital on weekends and/or in connection with sporting events, and therefore tries to ensure that more nurses are available during those periods. However, as she makes clear, there can also be quiet weekends where nurses are on-call (and being paid), but are not required. Hannah (an on-call SANE) recalled that when she was first employed many months went by between cases:

So all we have to take in our job is four shifts a month, four twelve hour shifts, but I remember when I first started, that first weekend after training I was on-call and I had three cases, and that it was in November and I didn’t see another case until the end of February (Hannah ON3).

The need for on-call SANEs fluctuates and is unpredictable. Centre coordinators attempt to manage this uncertainty by using proxies (for instance sporting events and weekends) as periods when staff numbers should be increased, but this is no guarantee that the demand will require high staffing levels or, alternatively, that the personnel levels will be sufficient. Likewise, assuming other times will be quiet is also risky.

In July 2010, a media storm developed around a young woman who was refused treatment at the Ottawa centre (CBC News, 2010a, Jackson, 2010). There were no trained nurses on the rota, and the survivor was given the choice of either waiting until a SANE was on-call or being transferred to a different city. The survivor transferred to another centre and was accompanied by the police, who, along with victims’ groups, expressed their displeasure with the situation (CBC News, 2010a). Responding to the event, Sheila Macdonald (the coordinator of the Network) indicated that SANEs’ low pay had resulted in nurses leaving the programme to find better paid work.

It’s lack of coverage happening with increased frequency... The only reason it [survivor being turned away] hasn’t happened more is that the program coordinators are filling in all the blanks in the schedule... This role is unique and specialized nurses need to be trained, and nurses are poorly compensated. When we’re on call for our service, I dedicate myself for that time period. I can’t work somewhere else, I can’t go to a movie or out for dinner... because at any moment I could get paged in to work and the on-call pay for nurses is \$3.20 an hour (Macdonald quoted in CBC News, 2010b).

Alongside the difficulties in predicting when nurses would be needed, the low rate of recompense paid to on-call SANEs (not untypical for bodywork - Twigg et al., 2011) resulted in nurses leaving the work. This placed greater pressure on the remaining staff, with the coordinator eventually deciding to leave periods uncovered. It is clear from Macdonald’s quotation, however, that while the same phenomenon had occurred in other centres, coordinators were often working unpaid overtime to ensure that the rota was covered. Their flexibility with their own time served as a favour to their on-call colleagues who would otherwise have had to work more shifts.

On-call SANEs mentioned that while the work was generally performed individually, and as a result they seldom interacted with other practitioners during the course of their work, an effort was made to attend a team meeting once a month. SANEs enjoyed these meetings as they enabled sharing of working practices and a space to debrief about difficult cases, but stated that the opportunities the meetings provided for enabling shift swaps was the most important facet.

Because everybody also has another job, so you take calls in twelve hour blocks, and that fits around our other jobs, but sometimes you run into scheduling conflicts, so it’s nice to be able to have a face at the end of the phone to say can you swap, so it makes it a lot more informal (Gail ON3).

Team meetings generate a sense of camaraderie amongst the SANEs, which in turn makes it easier for nurses to ask each other to perform shift swaps if scheduling conflicts arise. SANEs offer each other a level of flexibility over their own shifts as a result of the sociality established amongst the community. FNEs in the United Kingdom discussed the ways they demonstrated similar flexibility in the context of their colleagues' struggles with the emotionality of the work.

4.2 United Kingdom

FNEs have full-time contracts and to this end hold a similar position to the centre coordinator in Ontario, rather than the on-call nurses; however, they still arrange rotas with the other practitioners at the SARCs. While it is expected that FNEs work during the day, nurses discussed the benefits of rotas, in particular the potential for both doctors and nurses to become emotionally involved with cases.

You have to have the support, you have to work with somebody who can recognise, who you are comfortable and confident with to say "look I need some time out here" and I think *having the working relationship I do*, I know if I've had a bad case the people I work with I can say "I'm really not dealing with this at the moment, I need to take time out, I'm sorry I can't take another case" your colleagues, the way we do our rota someone would come in, you'd take a couple of hours out (Betty UK2 emphasis added).

The emotive nature of the work can take its toll on forensic practitioners and as a result they may need to take unscheduled breaks. The relationships between practitioners at UK2 enable colleagues to empathise with one another and cover the rota if necessary. Flexibility is a favour that forensic nurses are willing to offer their colleagues out of a sense of community. However, the centre coordinator in UK2 (an SOE), was acutely aware that covering too many shifts could result in its own problems.

When we're short [FNE] will say, she'll take a day off during the day and do a weekend, she'll do nights as well if we need to. I think, one has to guard, if someone is doing this job nine to five, five days a week one has to guard against getting absolutely burned out, so if she does a weekend, she'll have a day off in lieu during the week so she's not bombarded with it 24/7 (Amanda UK2).

Akin to SANEs, FNEs have developed a sense of community with the other forensic practitioners they work with. The camaraderie enables colleagues to empathise with each other; however, performing too many favours can result in the burnout of a practitioner.

It is difficult to predict when a survivor is going to present for forensic examination and rotas are produced in both Ontario and in the United Kingdom in an attempt to ensure that there is sufficient coverage to meet demand. The rota is problematised, however, by peak/baggy periods, low pay, scheduling conflicts and stress. To compensate for these pressures, forensic nurses are flexible and provide favours to their colleagues out of a sense of community and friendship.

5. Work Temporality and Survivor Empowerment

5.1 Ontario

As mentioned in Sheila Macdonald's quotation above, SANEs exist in a liminal state during their on-call periods, potentially working but also not-working. During that period they are required to spend time in ways that enable them to leave abruptly if a survivor reports for examination.

Well within our programme, and maybe in other centres, there's an unwritten rule that we have to be able to get to the centre in 45 minutes... Most of us live fairly local, I remember the first weekend I was on-call I never left, thinking the pager would go off, my husband said, if you are on-call and you do that every time, you are going to have an awful life. So it takes a while to get used to finding activities, or doing activities that you are prepared to leave abruptly, but in order for it to work with your other life, you have to carry on and then just make your apologies and leave (Gail ON3).

An on-call SANE's life is shaped by her on-call requirements; the requirement to attend to the client within 45 minutes of the phone call has an effect upon where the SANE can live (within 45 minutes of the hospital) and the activities and hobbies in which she can partake. In order to practise successfully as a SANE, Gail has chosen to shape her life to fit with the requirements of on-call work (choosing hobbies from which she can walk away, etc.), which includes the unpredictability of a client's arrival. To put it another way, Gail's "work temporality" (Roberts 2008) structures her domestic activities.

Furthermore, the forensic medical examination is quite a time-consuming process and “even cases that aren’t that complicated take a good two or three hours” (Diane ON2), potentially requiring nurses to stay after the end of their shift. Prior to meeting with the client, SANEs are unaware of the specificities of the case and have very little knowledge of the survivor’s situation. They may be informed of the type of sexual assault that has been committed (assuming the case is a police referral), but other information, such as the survivor being tired or still intoxicated, having any injuries that require treatment, or just wishing to talk to someone, will not be forthcoming until the SANE first meets with her. This initial dialogue can extend for many hours depending on the survivor’s requirements.

When I get them up here, that’s when I explain what I’m going to do, um, and I’ll have her sitting there and this is the place where we’ll talk, it can be three hours before we even open the forensic kit, um, because that is what the person needs (Hannah ON3).

SANEs place great emphasis upon the survivor taking control over the forensic intervention and, importantly, over their own bodies. They realise that they are dealing with persons who have recently had their autonomy removed and consider themselves the starting point in empowering the survivor. To this end they impress upon the survivor that “if you want me to stop, I’ll stop, you’re the driver here, not me” (Carole ON2). For SANEs, it is the survivor who decides the way in which the forensic intervention will proceed, and they attempt to pass control of the examination to her. Clearly there are some limits to the extent to which such a transfer of power can take place (cf Twigg et al., 2011); however, granting a certain degree of choice to the survivor does constitute the beginning of a therapeutic process that endeavours to give them back some control over their own bodies. At the same time, this can mean that the examination takes many hours. It is considered best practice that once a nurse has begun an examination, she should complete the case (Dalton, 2004); as a result the case may extend to beyond the end of the nurse’s shift. SANEs were well aware of this fact; however, they maintained that the importance of giving the survivor control over the examination takes precedence over their own interests.

They need to sleep, they need to rest, we know it’s critical that the police are insisting that it needs to get done, or we are almost at the end of the 72 hour window, or even my shift, well what’s important there, it’s this person (Carole ON2).

In order to provide the best quality of care and attempt to return control to the survivor, SANEs will continue with the case for as long as it takes. Completing a case at the expense of their non-work time clearly constitutes an example of a favour; the nurses are going beyond their contractual obligations in order to ensure that the survivor is properly cared for, and regains a sense of control over her own body. While a similar discourse of survivor choice was espoused in the United Kingdom, some FNEs found it far tougher to stay late.

5.2 United Kingdom

FNEs also used the rhetoric of survivor choice in the timing and content of the forensic intervention.

It’s very much about the client, the complainant survivor, very much about it being at their pace, that it’s not my job to go, to knock on the door and go “Are you ready yet?” because they may not be, and they might never be, so very much with the complainer at the centre of it really, feeling like they have got some control back was the most important thing for me (Alice UK1).

While most FNEs had lifestyles with adequate flexibility for staying late, some found the duration of the forensic intervention problematic as it interfered with their non-work commitments. As a result one nurse had decided not to accept cases after a certain time, and so postponed them until the start of the next practitioner’s shift.

That was typical, a case would come in just when I was meant to be coming off shift. That is a really interesting point in itself to be honest because the issues... I couldn’t leave on time and I have other priorities... but generally speaking you get a call in the afternoon... and you are often in this dilemma then of “do I take the case, do I have to say actually the case will have to go to tonight” which I actually got better at doing and that sounds awful because in some ways the client does come first but then I think it’s extremely important, doing this work, to be clear about your boundaries as well, and be very clear about when you do and don’t work because the work is tough at times and to stay in the work and to not burn out, you need to be very strong about those boundaries... From a personal point of view it was difficult saying no (Alice UK1).

Alice makes clear that other priorities in her life meant that she was unable to extend her shift. Knowing that cases have the potential to run on for many hours, she chose to postpone new cases after an undisclosed period so that she could leave on time to meet her other commitments. While Alice felt that doing so was important to

avoid her own burnout, there is clearly an ambivalence over whether she believed that to be appropriate, evidenced by “and that sounds awful”, and that she found it “difficult saying no”. Alice was not practising during the fieldwork period, and it is clear from her statement that she found it difficult not being able to stay after the end of her shift. Care workers interviewed by Husso and Hirvonen (2012) admitted feeling guilt when they were unable to aid a patient, as it produced feelings of incompetence, and in particular that as a woman they had not lived up to their gender role as carer. It may be the case that Alice felt a similar degree of guilt when she postponed a survivor.

The uncertainty surrounding the length of time of the examination necessitates that the nurse voluntarily stay on after the end of her shift, unpaid, in order to provide the best level of care. Of course such an expectation is doubly problematic for nurses (like Alice) who have other commitments; due to the gendered division of domestic labour (James, 1989, 1992), they are more likely to have other priorities that cannot easily be rescheduled if they have to work late, resulting in feelings of guilt and inadequacy. An SOE summed up this difficulty for forensic practitioners when she said “with the disruption it does cause to your family life, it’s more of a vocation than a job” (Amanda UK2). Forensic nurses are paid far less than SOEs, and the low rate of pay given to SANEs for their on-call time has already been discussed. Forensic nurses therefore have little reason to offer favours, particularly when they interfere with family life. Interestingly, however, when family was mentioned by forensic nurses in both jurisdictions it was often considered to enable the work.

6. Family Life and the Forensic Medical Examination

As previously discussed, it is sometimes the case that the emotional aspect of forensic medicine becomes too much for a practitioner. However, even those that are able to function without requiring time out may carry the trauma of their cases after the end of their shift.

But it’s really weird, you drive around one day and you’ve just done a case and you start crying and you think why has that case affected me, and it was a young boy and I just wanted to take him home and look after him, because he wasn’t much older than my little boy, and I was thinking who is looking after him (Catherine UK3).

As with other body workers in health and social care settings, the emotional burden of forensic medical work transcends the end of a shift and carries over to non-work time (Twigg et al., 2011); however, Catherine’s quotation also demonstrates the extent to which her empathy for survivors is linked to her own family. Catherine compared the boy she was examining to her own son and felt a great deal of compassion and a need to care for him. Emma was more explicit about the links between her own family and her ability to empathise with the survivor.

I think it’s a fabulous job, the majority of people when I tell them I work, their reaction is always very negative, they think “oooh, that’s not very pleasant” but I have daughters and if they ever were in a situation where they needed it, it would be there for them, as well as seeing my job as down the way, I see it as immediate with what I can offer my client at the moment, to get them through a rough patch to make them feel better about what happened, if I can do that, then I’ve done my job and I really love it (Emma ON2).

Emma receives emotional fulfilment from being able to get the survivor through that initial period of time. Underpinning Emma’s compassion is the idea of family; she hopes that if such a tragedy were to happen to her daughters, a forensic practitioner would be equally compassionate towards them.

Family relations were not only discussed in terms of developing a sense of empathy; nurses also mentioned that their experiences as mothers provided them with practical skills that they could use in the examination. For instance, Catherine described the ways she drew upon her maternal skills when dealing with difficult teenagers.

But then one of them survivors, she had an attitude, and I’ve got teenage kids and the eldest has got a bit of an attitude, so I said “you’ve got a bit of an attitude” she went, she just looked at me, and I said “You know, I’d like to help you, but I can’t if you’ve got a bit of an attitude problem, we have to look after each other in there, I’ve got to look after you and you’ve got to look after me, we have to work closely together” and she was superb (Catherine UK3).

Catherine justified her success as the result of her own experiences with her children; the tools she had developed in order to generate compliance with her daughter were transferred to the forensic medical environment in order to assist in her work. Such “mothering” was not lost on the survivors themselves, as each nurse reported an anecdote where a survivor had returned following the forensic examination and had claimed “she was like a mum to me” (Betty UK2).

7. Favours and Empathy

Throughout this paper I have chosen to label forensic nurses' choices to extend their work beyond their contractual obligations as "favours", drawing upon Cohen's (2010) concept from her analysis of hairstyling bodywork. I felt that "favour" was more appropriate than the more traditional interpretation of such acts as "gifts" (see for example Bolton, 2000), as the latter is normally understood as something that is offered freely. A favour, on the other hand, is usually performed with the expectation that recompense will be made in the future. For instance, the favour of the shift swap is an example of a reciprocal favour, as one nurse covers for her colleague, with the expectation that one of her own shifts will be covered in the future. Favours offered to the survivor, for instance staying beyond the end of the shift, are a little different; nurses develop a sense of empathy with their survivors, comparing them to their own families, and as a result perform the forensic medical examination in the manner they would expect from a colleague, if it was their child.

The emphasis upon familial, and specifically maternal, relations as a basis for favours is reminiscent of Bolton's (2005) study of gynaecology nurses. In that study, the nurses explained that their work required "special skills" and that those who were mothers had certain "insights", their experiences enabling them to perform their work in a more caring and considerate manner. For instance, gynaecology nurses who were mothers appreciated that they too could have miscarried, and as a result treated their patients with considerable empathy. For both gynaecology and forensic nurses, the experience of being a mother provided them with a set of skills for interacting with a range of patients/survivors (for instance the unruly teenager as evidenced by Catherine above), and their maternal empathy provided reason to go beyond the strictures of their contractual obligations. As Bolton makes clear, however, "there can be little doubt that recourse to women's 'special skills' is a potentially precarious strategy, especially in a 'feminine' profession such as nursing." (Bolton, 2005: 170) Such special skills are not appreciated within a clock time culture, with the result that the nurses are required to do this extra caring work outside of their working hours (often unpaid); this can have implications for their outside-work commitments, including caring for their own families, and could potentially result in feelings of guilt and incompetence. However, for the time being, the majority of the nurses consider the survivor to be key, and thus continue to inconvenience themselves and offer favours in order to ensure the continuation of best quality of care for the survivor of rape.

It's working, we're covering the patterns, we're covering the rota, at the end of all this we're victim focused, we're offering that service that we should be offering to maintain that status (Betty UK2).

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