Editorial

Forensic Nursing: Changing Our Future, Keeping Our Past

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In this issue we have some key articles related to the history of forensic nursing competencies and specialization, a comparison of sexual assault care then and now, as well as some excellent articles on factors affecting current forensic nursing care. Forensic nursing has only fairly recently been identified as an area of specialization in North America and a few other countries. Nurses in some countries are still struggling to be recognized for the strengths and skills we bring to care of those involved in trauma and violence.

One of the key changes we have seen is the development of technology to support education and training. In nursing education, we finally stopped using the old "Trainex videos" on 16-mm projectors, and overhead acetates. These were gradually replaced with increasingly more advanced technology starting with PowerPoint presentations, interactive web-based education, virtual webinars, as well as telehealth to support practice, continuing education, and experiential learning/simulation. More recently, we have begun to find applications for simulation using a range of modalities. One early use of technology was virtual tours of a sexual assault centre to walk new forensic nurses through care of sexual assault patients (Ferguson & Faugno, 2009). Later examples include simulations for education on human trafficking (Ellis et al., 2025), child abuse (Han et al., 2025), and the role of the nurse in death investigation (Cannon, 2024). This issue includes an article by Janson, Gary, and Mitchell on the creation of a virtual community of practice. Simulations are increasingly being used and are becoming more complex with advances in technology such as integration of artificial intelligence, virtual reality, and augmented reality. Some even include pre-programmed clinical situations, and the ability to verbally interact with the simulated or virtual "patient" in a way that is unique to the participant.

In our clinical practice we similarly see increasingly sophisticated technology. We have moved from identification of basic injuries to classification of injuries by type of forces and

standardization of injury nomenclature (Carter-Snell, 2011) to more sophisticated methods of injury identification with alternate light sources for bruises and to examine bruising over time (Scafide et al., 2013; Scafide et al., 2020), and progressively improved techniques to better identify injuries in people with darker skin colors (Sommers et al., 2019). The previous use of traumagrams and SLR film cameras progressed to digital cameras, and the integration of colposcopy with cameras and photodocumentation.

Even documentation has shifted to technology. We have moved from the paper-based chart of the 1990s when forensic nursing emerged, to computer-based documentation. This has raised the level and volume of documentation, but has also enabled improved auditing and data collection across large samples of patients. The computer data can be further augmented with tools such as artificial intelligence. For instance, colleagues in Boston are developing an AI tool using probabilities, clinical data, and radiology results to predict risk for intimate partner violence. The vast data collected electronically has enabled an enhanced patient issues, risks, and outcomes, as well as supported research and evidence-based practice.

Our capacity to expand our evidence-informed practice has also been facilitated by technology. We no longer have tables covered in index cards or need to sift through rows and rows of index card files to find library books. Instead, we have massive searchable databases, reference management software to retain thousands of articles we have found, and programs that can help us analyze large datasets such as SPSS, R, and NVivo. Open-source publishing has made research findings more easily available to clinicians, shortening the delay of implementation into practice, and has enabled higher level analyses such as systematic reviews.

These are only a few of the technological advances we have seen in forensic nursing since the 1990s. What has not changed throughout the years is the patient—they are still scared, vulnerable, and can greatly benefit from interactions with nurses to promote healing and prevent complications or long-term consequences. A young nursing student recently said to me she was so excited because the hospital was going to let the nurses take on a technological skill previously only done by the residents. My question to her was "what about that makes it 'nursing care' rather than something that gives you less time to spend with your patient?" Nursing is a relational profession; interactions with patients and their families is the core of our practice, not the type of swab, nor the technology we use. It is not the technology of the swab or light, nor the computer application we use that makes a difference to them. It is the fact that we provide empathy and knowledgeable care. As Maya Angelou once said, "Patients may not remember all you said, but they will remember how you made them feel." Forensic nursing is about comprehensive, trauma-informed nursing care for those involved with trauma or violence, with an understanding of forensic implications and how these impact the patient's care and recovery.

Victims of violence such as sexual assault or intimate partner violence have rates of healthcare utilization up to five to seven times higher than those without assault histories (Fleury et al., 2014; Vogt et al., 2022; Wells et al., 2012). While technology may improve the way we perform skills or documentation, it is our interactions and the way we care for them that may make a critical difference to their recovery and resilience. It has been demonstrated that early comprehensive and sensitive care soon after sexual assault has significantly reduced rates of posttraumatic stress disorder (Dworkin & Schumacher, 2018). Similarly, positive reactions to disclosure of trauma also reduces the risks of psychopathology (Dworkin et al., 2019; Ullman, 2025).

Someone once said to me that it was too bad I didn't "go all the way to become a real doctor, rather than just a PhD." I tried to tell her that medicine and nursing were two different careers. One of my favourite graduate school professors, Dr. Phyllis Giovannetti, used the analogy that it was like the difference between "doctoring a drink or nursing a drink." One drops something in and leaves, and the other stays and looks after it. I am honoured to stay with my patients and find as much time so I can to help them find their strength and potentially resilience to the trauma. While technology can help provide me more of that time, or provide a mode for us to better prepare new nurses, it should not be the main focus. It is tempting to research the fancy new equipment, but we need more research to support the importance of our core nursing care. For example, let's look at the impact of trauma-informed nursing care on patients' resilience and health outcomes, or the most effective strategies to support them to promote posttraumatic growth. I hope that as forensic nursing moves further into the future, that we remember to keep our past—ensuring the patient and our relationships with them are at the core of what we do.

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