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ORIGINAL RESEARCH

Navigating Ethical and Legal Tensions in Mandatory Reporting of Intimate Partner Violence: Insights from Norwegian Assault Centers

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Purpose: The aim of this study was to examine how health-care professionals in assault centers in Norway navigate biomedical ethical principles, health-care legislation, and the mandatory reporting law when working with victims of intimate partner violence (IPV). The study was guided by the following research questions: How do health-care professionals in assault centers apply the law for mandatory reporting of IPV (MR-IPV)? How do they navigate various factors when they consider applying the MR-IPV law?.

Methods: This qualitative, explorative study is built on 12 individual, semi-structured interviews with nurses and medical doctors working at assault centers. The data were analyzed using Braun and Clarke's reflexive thematic analysis, with themes developed based on biomedical ethical principles, including relational autonomy.

Results: Two main themes were found. First, MR-IPV was perceived as subsequent but parallel to emergency medical treatment. Some participants used risk assessment tools, and they all emphasized the importance of making patients safe following medical treatment. However, only a few acknowledged that their duty to respect the MR-IPV law was a factor in prioritizing patient safety. Second, ethical principles and health-care legislation were recognized more than the MR-IPV law, which created dilemmas for nurses and medical doctors. These actors faced challenges in navigating patients' autonomy and beneficence in relation to the MR-IPV legislation. Conflicts between patient autonomy and beneficence can lead to paternalistic behavior, which creates ethical dilemmas.

Conclusion: The findings show tensions between medical practices and legal and ethical standards, which contributed to hesitation in reporting severe IPV cases to the police. Health-care professionals prioritized therapeutic relationships and patient confidentiality, sometimes at the expense of their responsibilities concerning the MR-IPV law. Addressing these challenges requires enhancing legal literacy and fostering a cultural shift in health care to align professional autonomy with legal requirements and institutional responsibilities.

Keywords: biomedical ethical principles, healthcare legislation, qualitative methods, health-care professionals, victims

Introduction

Intimate partner violence (IPV) is a widespread public-health problem.[1–3] According to the WHO, nearly 30% of women aged 15–49 have reported experiencing physical and/or sexual violence from an intimate partner.[2,4–8] Between 30% and 40% of women seeking care for intentional injuries in an emergency department are victims of IPV, and they report having more unmet health-care needs than nonvictims.[9,10] Therefore, health-care providers and the health-care system are important gateways to care for victims of IPV.[11] Furthermore, IPV can result in long-term societal problems. In a report by Menon Economics, it was estimated that the social costs of domestic violence in Norway in 2021 amounted to NOK 92.7 billion, which includes the costs associated with homicides and decreased quality of life.[12]

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The strategy to prevent IPV includes ensuring that health-care providers have specialized knowledge to recognize and adequately address IPV. Health-care providers play a crucial role in identifying signs of IPV, delivering care, referring victims to support services, and earning the trust of victims regarding their personal experiences.[8,13–18] However, researchers have found that some health-care professionals do not believe that addressing IPV is part of their role.[19]

Many countries have legislation that requires health-care professionals to report cases of IPV. Who is obligated to report, what must be reported, and to whom one must report differ among countries.[6,20–23] The present study was conducted in Norway, where health-care professionals, such as assault center employees, are included in the law for the mandatory reporting of IPV (MR-IPV). The main purpose of mandatory reporting laws is to prevent future crimes or the consequences thereof.[23] Hence, assault center employees play a crucial role in practicing MR-IPV. However, scholars have shown that mandatory reporting laws are a debated topic that can pose challenges for health-care professionals.[13,18,24–28]

To the best of our knowledge, few researchers have qualitatively explored how mandatory reporting laws influence health-care professionals when working with IPV victims.[29] Moreover, several of the available studies are old, and there is a general scarcity of scholarship on mandatory reporting legislation related to IPV.[30,31] Thus, in this article, we contribute to the literature by examining how emergency primary health-care and assault center employees navigate Norway's mandatory reporting law, biomedical ethical principles, and health-care legislation when working with victims of IPV.

Research on the Barriers to Mandatory Reporting and Ethical Considerations

Health-care professionals often witness the consequences of IPV firsthand, and they play a pivotal role in identifying and treating IPV victims, thus benefiting both individuals and society.[2,14,18,32–36] Their unique position makes them essential mandatory reporters from the perspective of the police and the criminal justice system, and their actions can protect IPV victims and ease the latter's burdens when it comes to reporting their abusive partners.[1,6,30,31,37] However, recent research, including a systematic review, shows that very few professionals report IPV cases based on mandatory reporting legislation.[31,38] Scholars have found that a lack of awareness about IPV and not being sufficiently prepared to ask patients about IPV and/or make appropriate referrals seem to influence MR-IPV.[13,39–41] In addition, the results of a study conducted in the USA show that health-care providers were grossly underprepared to identify and respond to IPV in a medical setting due to insufficient training and knowledge about this form of violence.[17] Furthermore, MR-IPV laws can be perceived as leading to a breach of confidentiality on the part of the physician, which compromises the patient's autonomy and their trust in health-care services.[22,34,37,42–45] Reporting IPV can interfere with efforts to ensure the victim's safety due to the possible violent retaliation by the perpetrator, and it can discourage the latter from seeking treatment.[45]

Smith et al[42] identified 16 variables affecting nurses' decisions to report domestic violence in Florida. In this state, reporting laws obligate health-care providers to report suspected violent injuries when the damage is severe or the action that caused it appears illegal.[6] The three most reported barriers were insufficient evidence (32%), patients' reporting reluctance (16%), and respect for patient autonomy (9%).[42] However, the small sample size (N = 184, 18% response rate) and the characteristics of Florida's reporting laws limit the generalizability of these findings.

In their study of older adults in California, Rodriguez et al[46] reported findings similar to those of Smith et al.[42] In California, health-care professionals are legally responsible for reporting to the police when they treat a patient who has sustained physical injuries from a firearm incident, assault, or abuse.[6] Rodriguez et al found that 59% of emergency and primary care physicians might not report abuse if the patient objected, as they believed that mandatory reporting laws could create barriers to care (60–79%), escalate violence (53–82%), breach confidentiality (59–85%), and violate autonomy (62–75%).[46] However, respondents agreed that specific circumstances, such as children or guns in the home, pregnancy, obvious injuries or repeated complaints of partner abuse, and immediate threats to a patient's safety, required police reporting.[46]

In their qualitative study conducted in Portugal, Moreira and Pinto da Costa[37] found that the doctor-patient relationship and the patient's unwillingness to report were barriers to IPV reporting. Although anyone in Portugal can report domestic violence, health-care professionals and the police have a professional duty to do so.[30,37] In this study, family

doctors desired to respect the victim's autonomy, but they felt discouraged from reporting if the victim was unwilling to interrupt the abusive relationship.[37]

McLaughlin[29] examined possible ethical challenges associated with treating victims and perpetrators of IPV. The author found that professionals involved in the treatment of IPV frequently confronted ethical and legal dilemmas when attempting to abide by the law and adhere to ethical codes. McLaughlin recommended, among other things, that professionals should focus on informed consent for treatment, particularly the limits of confidentiality, as an essential topic to cover before treating an IPV client.[29]

WHO Recommendations

The WHO recommends that policymakers and health-care providers use a supportive, informed, and rights-based approach with survivors of IPV.[1,47] It also recommends that health-care providers use mandatory reporting laws with caution due to the possibility of undermining the victim's autonomy and willingness to disclose abuse and seek treatment for their injuries.[1,47] According to the organization, health-care personnel should inform IPV victims of their legal rights and offer assistance in reporting to the police if they want to. However, women have reported that interactions with health-care professionals who expressed support and concern made them realize that they deserved and could achieve safety and improved conditions.[48] Also, scholars have shown that victims who disclose IPV to health-care professionals expect them "to do more than just listen".[49,50] Among the recommended responses is reporting to the authorities. Thus, between the WHO's recommendations and national laws may place health-care professionals in challenging situations.

The Norwegian Legal Context

In Norway, where this study was conducted, all professionals who are bound by confidentiality rules and all individuals aged 15 or above have a duty to prevent severe or persistent IPV.[23] Three sections of the Penal Code cover MR-IPV: 196, 282, and 283 (Table 1).

Sections 282 and 283 deal with domestic violence and aggravated domestic violence, which are the categories of IPV pertaining to MR-IPV. These categories fall under Section 196, which outlines the rules for MR-IPV.[23] The primary aim of Section 196 is to prevent future crimes or the consequences thereof. This duty includes reporting incidents to the

Table 1 The Norwegian Penal Code, Sections 196, 282, and 283

Section	Title and Content
Section 196	*Duty to avert a criminal offence* Anyone who fails, through reporting or in another way, to attempt to avert a criminal offence or its consequences at a time when this is still possible, and when it appears certain or most likely that the offence is or will be committed, shall be punished with a fine or imprisonment for up to 1 year. The duty to avert applies regardless of confidentiality obligations.
Section 282	*Abuse in close relationships* A person who seriously or repeatedly abuses another through threats, coercion, deprivation of liberty, violence, or other violations may be punished with imprisonment for up to 6 years if the victim is: a) their current or former spouse or cohabitant, b) a descendant of their own or their current/former spouse or cohabitant, c) an ascendant relative, d) someone in their household, or e) someone under their care.
Section 283	*Aggravated abuse in close relationships* Punishable by imprisonment for up to 15 years. When determining whether the abuse is considered aggravated, particular emphasis shall be placed on whether it has resulted in significant injury or death, and additionally: a) the duration of the abuse, b) whether it was carried out in a particularly painful manner or caused significant pain, or c) whether it was committed against a defenceless person.

police and averting IPV "by other means"; thus, it allows for discretion and encompasses actions beyond contacting the police. A wide range of interventions is available to avert criminal acts or their consequences. Section 196 applies only when prevention is possible, and it is triggered if one has information indicating that it is "certain or most likely" that a crime will be committed. The threshold for triggering the duty to report is severe or persistent IPV (Sections 282 and 283), and reporting can be required even against the will and consent of the victim, as well as in cases where the information about IPV is initially confidential.[23] Section 196 takes precedence over health-care legislation, and failing to report is a crime under this section.[23]

The Theoretical Framework

The four principles of biomedical ethics—autonomy, nonmaleficence, beneficence, and justice—have greatly influenced medical ethics and the understanding of ethical assessment among health-care professionals.[51–54] In addition, they are core principles in Norway's health-care legislation, where their aim is to protect patients' rights.[55] Beauchamp and Childress[54] emphasized the importance of not prioritizing one principle over the others. Hence, the best strategy is to recognize the contributions and limitations of each.

Autonomy involves respecting the patient's choices and aligning their care with their values and preferences.[54] Patient autonomy is upheld by obtaining voluntary and informed consent as per the relevant health legislation. Informed consent empowers patients by providing them with the knowledge to make reasoned decisions about a proposed treatment or procedure. It also enables patients to take an active role in their treatment. Beauchamp and Childress[53] emphasized that autonomy presupposes liberty (independence from controlling influences), agency (the capacity for intentional action), and understanding. Moreover, autonomy should be viewed not as an independent factor but as the ability to make meaningful choices as part of supportive networks—relational autonomy. According to this perspective, individual choices are influenced by various intersecting factors, such as gender, class, and ethnicity. These factors can either limit or enhance a person's capacity to act independently.[56] Because the social environment influences individuals' behaviors, supportive relationships are important in promoting true autonomy; this challenges the belief that independence requires isolation or self-reliance.[56,57] Adopting the relational autonomy perspective allows researchers to acknowledge and respect the fact that social contexts and relationships shape individuals' autonomy.

The principle of beneficence pertains to the moral obligation to act for the benefit of others. This principle, which is central to medicine's goal and justification, is at the heart of the Norwegian Health Personnel Act.[55] Beauchamp and Childress defined beneficence as "actions with the goal of benefiting or promoting the well-being of others.[51,54] Beneficence includes norms related to relieving harm, preventing harm from occurring, and providing benefits. Health-care professionals should actively promote patients' well-being, which involves protecting and defending the rights of others, preventing harm from occurring to others, removing conditions that may cause harm, helping people with disabilities, and rescuing persons in danger.[51] Beneficence also involves considering the best treatment options based on the individual's circumstances and preferences.[54]

The principles of autonomy and beneficence can sometimes conflict. For example, in the Norwegian context, if health-care professionals deem that there is a high risk of severe IPV and the patient does not consent to contacting the police—perhaps due to fear that the violence will worsen if the partner is provoked—a tension arises between the principles of autonomy, beneficence, and nonmaleficence. Legally, the obligation to prevent severe IPV overrides the principle of autonomy. However, Norwegian health-care legislation contains a strong emphasis on patient autonomy and participation in decision-making. This creates a complex framework for health-care professionals' decisions regarding cases of IPV.

In some instances, the duty to avert severe IPV may require the health professionals to act paternalistically. According to Beauchamp and Childress, paternalism involves an "intentional nonacquiescence or intervention in another person's preferences, desires, or actions with the intention of either preventing or reducing harm to that person or benefiting them".[51] The rationale behind paternalism is that "a professional has superior training, knowledge, and insight and is thus in an authoritative position to determine the patient's best interests".[51] For Beauchamp and Childress, two versions of paternalism exist—soft and hard. With soft paternalism, an intervention is justified only when a patient's actions are not

entirely voluntary or informed. In contrast, with hard paternalism, an intervention is justified even when an individual's actions are voluntary and informed.[54]

Aim

According to Norwegian legislation, health-care professionals in emergency primary health-care and assault centers (hereafter assault centers) are obliged to report IPV. However, knowledge regarding how professionals at these centers apply the mandatory reporting law is scarce, and there is a lack of research on how health-care professionals deal with ethical and legal factors when considering the law in question. Therefore, the aim of this study was to examine how these professionals navigate biomedical ethical principles, health-care legislation, and the mandatory reporting law when working with victims of IPV. The study was guided by the following research questions:

1) How do health-care professionals in assault centers in Norway apply the MR-IPV law?
2) How do such health-care professionals navigate ethical and legal factors when considering the application of the MR-IPV law?

Materials and Methods

Design

The analyses in this article are based on data from semi-structured interviews conducted as part of a multidisciplinary, mixed-methods project called MANREPORT-IPV. The project examined the experiences, awareness, and attitudes of service providers and help-seeking IPV victims and perpetrators regarding MR-IPV. In total, 59 professionals, including doctors and nurses in assault centers, child welfare workers, police officers in preventive units, domestic violence shelter workers, and therapists in competence and treatment centers for IPV, were interviewed. Among them, Linge et al[58] identified a general lack of awareness of the mandatory reporting law and inconsistencies in professional laws and guidelines, particularly among health-care professionals. To explore how staff at assault centers navigated their ethical and legal responsibilities, 12 interviews with nurses and doctors were conducted with members of the sample, after which data collection was stopped because these interviews did not provide any new insights compared to the data collected initially.

The Setting: Assault Centers

In Norway, assault centers are part of the public health-care system, and they are typically located in emergency primary health-care settings. They operate as a part of Norwegian Hospital Trusts, but they may be organized differently due to geographic factors. Some assault centers are part of special clinics or general medical practices. As in many other countries, many of them are small and not in hospital emergency departments; they can be isolated and far from hospitals. Depending on the size of the municipality, the number of staff on duty at any given time varies from one to several people, mainly medical doctors, whose presence is mandatory, and nurses.

These centers maintain separate patient records and treat victims of IPV and sexual assault, providing a safe space for medical examinations and counseling. They also facilitate access to police, free legal support, child welfare services, the Norwegian Labour and Welfare Administration, and domestic violence shelters. Many staff members at these centers work part-time and are involved in other emergency medical roles. The Norwegian Hospital Trust ensures that health-care staff at these centers are trained in psychosocial, medical, and forensic care, as well as the legal documentation of sexual assaults.

Procedure and Recruitment

Every assault center in Norway was contacted via email. If no reply was received, the first author followed up with a phone call to the assault center managers. Health-care professionals who agreed to participate received a letter that included information on the purpose of the research, potential benefits and risks, voluntary participation, confidentiality, and contact details; they also received a consent form. After data collection, the participants were invited to a lecture about the mandatory reporting law.

Interviews

The interview guide was developed by the authors of the present study and members of the MANREPORT-IPV project to explore attitudes toward and knowledge and experiences of Norway's MR-IPV legislation. The guide was based on theoretical and empirical literature concerning IPV and relevant laws; it featured general questions and specific situations and experiences. The participants were first asked about their responses to receiving information about severe IPV from a victim, followed by their decision-making processes regarding these cases with respect to contacting the authorities, such as the police. Then, they shared their understanding of Norway's mandatory reporting law. Afterward, the interviewer explained the law and sought their opinions and attitudes toward it. Finally, the interviewer addressed internal and external routines, as well as collaboration, related to IPV cases.

The first author conducted interviews between September and November 2022; three interviews were carried out in person, while nine were conducted via Microsoft Teams to facilitate participation. Each interview lasted between one and one-and-a-half hours and was digitally recorded following written consent. All the audio files and transcripts were stored on a secure research server approved for sensitive patient information; only the project group had access to the files. The participants were anonymized using pseudonyms and categorized by age and years of experience. All the interviews were carried out in Norwegian, and while no financial compensation was provided, travel expenses were covered if needed.

Participants

A total of 12 participants (11 women and one man) aged from 35 to 64 years (mean: 47.8 years) were interviewed. Nine interviewees were nurses, and three were medical doctors; all held at least a college or university degree. Their experience in assault centers ranged from 1 to 22 years (mean: 8.7 years). The participants represented the health trust regions of the south, east, center, and north of Norway (Table 2).

Reflexive Thematic Analysis

The data were analyzed using Braun and Clarke's six-phase reflexive thematic analysis.[59] The first author produced one transcript, while the rest were generated by dedicated personnel. The first author reviewed and revised the transcripts against the digital recordings, ensuring that the nuances and subtleties of the interviews were accurately captured and minimizing the potential for error or misinterpretation. The transcripts were imported into NVivo Collaboration Server (version 1.7), which was accessible to all the authors.

Table 2 Characteristics of the Participants

Gender, n (%)		
Female	11	(91.7)
Male	1	(8.3)
Age of healthcare professionals, mean	47.8	
Age categories, n (%)		
30-39 years	2	(16.7)
40-49 years	6	(50.0)
50-59 years	3	(25.0)
60-69 years	1	(8.3)
Participant groups, healthcare professionals, n (%)		
Nurses	9	(75.0)
Doctors	3	(25.0)
Years of experience in an assault centre, n (%)		
Up to 5 years of experience	3	(25.0)
5+ years of experience	4	(33.3)
10+ years of experience	2	(16.7)
15+ years of experience	3	(25.0)

The first author primarily conducted the analyses, with contributions from all the authors to enhance reflection, quality, and reliability. The inductive analytic process started with the first author's familiarization with the data, followed by collaborative discussions to identify relevant patterns pertinent to the study's research questions. A code book was created to document items of interest. The second step involved closely reading and coding keywords relevant to the participants' experiences of the mandatory reporting legislation. In the third step, the transcripts were coded to identify core ideas, meanings, and themes, thus simplifying complex data related to the research questions (see Table 3). All the authors held multiple meetings to discuss the key elements of the data.

In the fourth step, the transcripts were coded into meaningful themes based on the authors' psychology, ethics, and medicine backgrounds, which represented a range of subjectivities, theoretical preferences, and practical experiences.[59] Two main themes were developed, with the second one containing three subthemes. The fifth step involved defining a structure based on the patterns in the themes. The theory of biomedical principles and health-care legislation was considered and incorporated into the analytic process, which significantly shaped the final theme development. The themes described the health-care professionals' medical practices regarding the MR-IPV law and how they navigated ethical and legal factors during relevant moments. This step also included naming the themes based on their content, relevance, and essence before the final step of producing the results section and writing the article.[59]

The analysis was conducted through a series of interactive steps rather than as a linear process. The authors engaged in detailed discussions of the initial findings both throughout the analytic process and when writing the results section. Writing what we did and what we found hopefully makes the messy process of transforming interviews into a coherent and informative presentation of results transparent.[59,60] Participant quotes were used to underscore the findings and showcase the precision of the analysis.[59,61]

Ethics

The present study was approved by the data protection officer of Oslo University Hospital (ref. 22/00221). All medical and health research on human beings, human biological material or personal health data must seek pre-approval from the

Table 3 Example of the Process from Quotation to Themes

Quotations	Keywords	Codes	Sub-Themes	Themes
The first thing we do is to attend to the **patient's physical and mental health.**	Physical and mental health	Medical treatment		MR-IPV perceived subsequent but paralleled to emergency medical treatment
Our work often involves **conducting safety** or **risk assessments.**	Risk of recurrence	Safety and risk assessment		
We always ensure they have **a safe place** after being here.	Safe place	Preventing IPV		
Once they **receive the information** and the services, they often gain enough confidence to report.	Information to the patients	Empowerment	Informed consent	Ethical and legal ambiguities in enacting MR-IPV
If the patient is alone, I believe it's **essential to empower them.** The patient should be able to make decisions and come **to conclusions independently** rather than having someone else dictate their choices.				
In healthcare, there's much more focus on the **patient's right to decide or choose treatment.**	Patients' right to decide	Professional guidelines and ethics	The patients' autonomy	
What can we do if she **[the patient] wants to continue living in it** [IPV]?	Patients' opinions matter			
Can we bring this up and **discuss it a bit with the police – anonymously**? What do they think they would have done?	Desperate to do something	Anonymous calling the police	Autonomy collides with beneficence	

Notes: Bold text indicates words or items of interest in the initial phase of the analytical process.

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Norwegian Regional Committees for Medical and Health Research Ethics (REK). REK evaluated the MANREPORT-IPV project 2017/573 as an instance of health-service research, which falls outside the REK's remit (ref. 257644). The Critical Appraisal Skills Programme's checklist for qualitative research was used.[62]

Informed consent was obtained from all the participants, which included the publication of anonymised responses and direct quotes. They were made aware that they could withdraw at any time until the data analysis was completed.

Ethical principles concerning the participants' anonymity and confidentiality were maintained, and each participant was assigned a title indicating their profession and age category.

Results

Overall, the analysis revealed how deeply committed the health-care professionals were to the victims of IPV and the obligation to provide clinical emergency health care to them. In addition, the following two themes regarding MR-IPV in assault centers were evident:

1) MR-IPV was perceived to be subsequent but parallel to emergency medical treatment.
2) Ethical and legal ambiguities were found in the enactment of MR-IPV. This influenced the application of the relevant law when nurses and medical doctors struggled to navigate patients' autonomy, beneficence, various factors, and MR-IPV.

MR-IPV: Subsequent but Parallel to Emergency Medical Treatment

All the participants expressed the importance of their main aim in assault centers, which primarily involved providing medical and psychosocial care. A medical doctor (41–45 years old, 5+ years of experience) provided the following typical example of their work and responsibilities: "Mainly, we need to ensure that their physical needs are sufficiently met and that they receive the treatment and preventive care that is crucial to avoid infection". The medical treatment was explained in detail, and it included emergency medical examinations, administering treatment, offering follow-up care, and providing forensic services. The participants also considered whether patients were capable of taking care of themselves.

In addition to offering medical treatment, some of the participants considered the patient's situation and assessed the risk of further IPV. Two risk assessment tools for IPV were described: the Danger Assessment[63] and the Spousal Assault Risk Assessment (SARA, version 3).[63] These tools have been adjusted and incorporated into the *Norwegian Emergency Room Manual*. Typical questions from the manual include the following: "Has there been IPV during pregnancy?", "Are there weapons at home?", "Has someone threatened to kill you?", "Is the IPV escalating?", and "Has the IPV increased recently?" A nurse (51–55 years old, 5+ years of experience) emphasized that these tools were not limited to identifying and assessing the risk of further instances of IPV but were also used to determine whether there was a duty to avert IPV. Specific answers from the victim could lead to what they called a "red response", which required action, such as contacting the police or other public institutions to prevent IPV.

The participants explained that after the key examinations, they helped the patient contact the police, domestic violence shelters, lawyers, and other services. A nurse (31–35 years old) said, "I always ensure that they [the patients] have a safe place after being here". However, the health-care professionals' understanding of ensuring patient safety appeared to be influenced more by their professional guidelines and practice than by Norway's MR-IPV legislation. For example, the interviewer asked another nurse the following question: "Do you think it is your responsibility to avert IPV from occurring again?" The nurse replied:

> As I've said, create good relations, [maintain] confidentiality, and help them get to a safe place. We work in an acute setting, where our main objective in the acute phase is documenting injuries. But as health-care personnel, we must use our expertise to assist them further. (Nurse, 31–35 years old, 5+ years of experience)

This quote shows that the nurse did not answer the question directly but rather talked about the emergency department's main objectives, the importance of confidentiality, and the significance of supporting patients, building trust, and ensuring

safety in the context of IPV. Although the nurse did not explicitly mention the MR-IPV law, they referred to using medical expertise anchored in health-care professional legislation and ethical principles to prevent further IPV. The quote may suggest a perceived tension between maintaining patient confidentiality and the MR-IPV law. It should be noted that mandatory reporting takes precedence over confidentiality.

The findings indicate that the participants mainly prioritized medical treatment when dealing with IPV cases. The absence of emphasis on the MR-IPV law can result in inconsistent practices among health-care professionals, which potentially undermines both the quality and equity of the care provided to victims. This gap can result in missed opportunities for early intervention and may cause health-care providers to neglect their legal responsibilities regarding MR-IPV.

Ethical and Legal Ambiguities in Enacting MR-IPV

The interviewees often mentioned how they dealt with their professional obligations related to MR-IPV when considering the patient's situation and mapping the risk of further IPV. Three subthemes were prominent in this regard. The first one pertained to how the participants communicated with patients to make them understand the severity of the IPV and ensure their ability to make autonomous choices regarding MR-IPV. The second subtheme concerned the patient's right to decide on treatment options. When a patient's right to decide and their autonomous choices conflicted with the legal requirement of MR-IPV, the participants hesitated to report the IPV to the police. The third subtheme pertained to the moral dilemmas that occurred in medical practice when professional legislation and ethical principles clashed with the requirement of MR-IPV.

Navigating Informed Consent and the MR-IPV Obligation

The participants spent time informing patients about how IPV could affect them and their children to make them understand their situations. A medical doctor described how many of the participants thought of communicating with and informing the patients.

> When I've informed them, they've become confident that here they would get good help, and things have gone well once they've gotten in touch with the right services. However, I think that if they get to the point where they lose faith in getting help, even though they've been given access to these services, then things can get tough. (Medical doctor, 41–45 years old, 5+ years of experience)

These findings suggest that providing patients with proper information plays a key role in building trust and ensuring effective follow-up in support systems. In this statement, the participant emphasized the need to provide information to empower patients to be autonomous. However, several interviewees indicated that if the situation required it, they would do more than inform patients. One participant said, "I use all my charm, knowledge, and communication skills to explain that they cannot go home" (medical doctor, 41–45 years old, 5+ years of experience). This participant used motivational interviewing techniques to assess patients' understanding of their IPV situations and provide useful information. They said that they always asked themselves, "Can I give the patient any other piece of information?" Both quotes illustrate the desire to empower patients to make their own decisions.

The participants explained that the purpose of providing patients with information was enabling them to better understand their IPV situations and leave their abusive partners. However, the findings indicate a tension between providing the necessary information for patients to make autonomous decisions and pushing them toward reporting to the police. This tension underscores health-care professionals' ethical and practical dilemmas in IPV cases. Some of the participants said that, as they empowered patients, they never needed to report IPV cases to the police. They argued that with dialogue, encouragement, and time, IPV victims often better understood their situations and realized the need for change; this frequently happened thanks to the influence of those around them. The participants said that the information provided enabled patients to make their own decisions, which led them to contact the police on their own. Although empowering patients through clear and caring communication is essential, the pressure to encourage police reporting can unintentionally undermine patient autonomy.

Trade-Offs Concerning Patient Autonomy in Relation to MR-IPV

One key finding in this theme regards the complex balance between the MR-IPV law and the patient's right to be involved in treatment decisions. The participants emphasized the need for informed consent to uphold patients' autonomy, which also influenced their decisions to report incidents of IPV to the police in accordance with the law on

MR-IPV. According to the interviewees, applying the MR-IPV law could be difficult due to the strong focus on autonomy in health-care laws and the patient's ability to give consent.

> [Our professional] legislation greatly influences us. We see this individual who is neither demented nor psychotic and who can understand and reason about their options. We should respect their autonomy within those limits. (Medical doctor, 41–45 years old, 5+ years of experience)

This quote emphasizes that a patient's capacity to consent highly influenced the participants. While legal requirements were acknowledged, the importance of patient autonomy was still stressed. The patient's mental capacity to consent was viewed as the threshold for MR-IPV. The participants believed that since patients have the ability to consent, their choices should be respected; this reflected a commitment to patient-centered care and ethical principles. However, the words "within those limits" suggest that a patient's autonomy is not absolute; if necessary, health-care professionals may act against the patient's wishes. As highlighted in the introduction, decision-making capacity is only one of the several aspects of autonomy.

A number of the participants argued that reporting to the police without the patient's consent was only justified when it served the patient's best interest. The interviewees expressed concern that breaching trust, even when legally mandated, could harm the therapeutic patient-clinician relationship and potentially discourage victims from seeking further help. They considered reporting to the police appropriate if they were certain that doing so would stop the IPV or if the lives of the patient, their children, or their pets were in danger. An experienced nurse (age 51–55 years, 15+ years of experience) said,

> What can we do if she [the patient] wants to continue putting up with it [IPV]? I can certainly report it to the police and prevent it [IPV], but that might make a bad situation worse.

The participants described situations where patients, though competent, decided not to involve law enforcement—decisions that professionals felt conflicted with their responsibility to prevent harm. This dilemma was particularly pronounced when the potential negative consequences of reporting to the police, such as escalation of violence or loss of trust, were weighed against the perceived benefits of doing so. The findings show an additional layer of complexity: the ethical tension health-care professionals experienced when navigating respect for autonomy and the principles of beneficence and legal responsibility. This situation illustrates how the MR-IPV law can place professionals in ethically ambiguous positions.

Ethical Principles and MR-IPV as Incompatible Features

Despite being given information to encourage autonomous decision-making and reporting their IPV to the police, some patients refrained from contacting law enforcement. As a result, examples of moral dilemmas were found when the participants had to navigate autonomy, beneficence, and legal responsibilities.

Most of the interviewees explained that calling the police anonymously was an important way of discussing the case or assessing whether the IPV incident was severe enough to be reported. An experienced nurse (46–50 years old, 15+ years of experience) strategically used these calls in situations where the need to report to the police clashed with the patient's autonomy. Often, victims of IPV were afraid of the police and did not want them involved. The nurse in question always called the police when the patient was present and had agreed to make the call anonymously, which allowed them to hear and participate in the conversation. The nurse knew that the police could intervene without notifying the patient due to the criminal nature of the case. The nurse admitted that anonymous calls were questionable, but they explained the urgent need to find solutions for patients. The following exchange highlights this aspect:

Nurse: I often ask, "Can we bring this up and discuss it a bit with them [police officers]—anonymously—to see what they would have done?"

Interviewer: What does the patient say when they suddenly find themselves in a situation where the police officers say, "We have to report this"?

Nurse: They become relieved.

Interviewer: Hm … they say they are relieved?

Nurse: Very relieved! They often become very relieved. They do not feel deceived, but they also do not quite realize that they have been tricked [*laughs*] into getting the police involved. They think it's a relief that someone has said "This is illegal"—that someone has defined what has happened to them as not okay.

> I think many victims are perplexed, and I know that many are confused. They have become so accustomed to experiencing IPV in their daily lives that they no longer consider it a criminal act.

This nurse hesitated to apply the MR-IPV law because the patient did not want the police involved. Anonymously contacting police officers can be viewed as a way to protect the patient while minimizing potential harm. The nurse explained that patients did not feel "tricked"; rather, they experienced a sense of relief because the IPV was recognized as a criminal case. However, this action can still lead to outcomes the patient did not consent to. Even if the patient does not feel deceived, transparency about the call's possible outcomes is crucial to uphold trust and ethical integrity.

The nurse's decision to report anonymously suggests an attempt to act in the patient's best interest. However, definitions of what constitutes the "best interest" can be subjective and must be weighed carefully against the patient's wishes. Health-care professionals must consider whether their actions could unintentionally expose patients to retaliation, legal issues, or emotional distress.

Health-care professionals have a legal and ethical duty to respect patients' right to make informed decisions about their lives. Encouraging autonomous decision-making is essential, but this must be balanced with the professional's obligation to protect patients from harm. Calling the police anonymously could pressure the victim into a situation that ideally should have been handled as part of the nurse's responsibility concerning the MR-IPV law. While our interviewees showed awareness of the MR-IPV requirement, they seemed to overlook the fact that the Penal Code took precedence over health-care professional legislation and guidelines.

Discussion

In the present study, we examined how health-care professionals in assault centers applied the MR-IPV law and how they navigated various factors when they considered the need to avert IPV. The results can be summarized into two main themes. The first one shows that MR-IPV requirements were perceived as subsequent but parallel to emergency medical treatment. The second one indicates that health-care legislation and ethical principles were more widely known than Sections 196, 282, and 283 of the Penal Code. This seemed to influence the application of the MR-IPV law when nurses and medical doctors struggled to navigate patient autonomy and beneficence in relation to this law.

Unsurprisingly, all the participants emphasized the provision of medical and psychosocial care in the assault centers. Risk assessment and ensuring patient safety were important tasks for the interviewees. However, remarkably few of them mentioned that these processes were considered due to the duty of the MR-IPV law. This finding is consistent with a recent study from Norway conducted by Vølstad et al,[64] who found that despite experiencing severe and persistent IPV, more than half of the victims of IPV had not come across the MR-IPV law being applied. All the participants in their study reported severe psychological aggression, while 70% reported severe physical assault, 54% described severe sexual coercion, and 55% mentioned severe injury.

Moreover, previous research indicates that health-care professionals who lack sufficient knowledge of IPV may be unable to assist patients in addressing this form of violence.[13,39–41,64,65] In line with this, Pratt-Eriksson et al[27] argued that health-care professionals, social workers, and the police should improve their awareness of IPV. Educational interventions have positively impacted health-care providers' attitudes toward and compliance with the MR-IPV laws.[13,25,26] Furthermore, in their educational intervention study, Brevik et al[13] found that participants significantly agreed that MR-IPV takes precedence over client confidentiality six months after attending lectures on the relevant sections of the Penal Code.[13] Despite the Norwegian authorities' efforts to combat severe and/or persistent IPV, there is still a lack of awareness of MR-IPV among help-seekers, service providers, and others in society.[7,58]

Making patients safe is important; however, not using the MR-IPV law may undermine trust in the legal system and negatively influence public-health authorities' efforts to combat IPV.[45] Without reporting, other criminal IPV offenses may remain undiscovered, and IPV perpetrators might not be prosecuted.[45] This raises concern, as numerous IPV homicide victims, both in Norway and globally, have been known to experience severe or repeated IPV.[66,67] Additionally, noncompliance with mandatory reporting laws can result in personal consequences for the victim, such as feelings of guilt and psychological stress, particularly when they realize that reporting to the police could have prevented further violence.[45,49]

Understanding and applying ethical principles and the laws governing the health-care profession are pivotal for good medical practice.[29] In the present study, the participants emphasized communication with patients to ensure that the latter could make autonomous choices, as well as to alleviate fears or other conditions that hinder or disrupt autonomous decision-making.[54] Theorists of relational autonomy maintain that autonomy must be conceptualized in terms of what is at issue for individuals who are situated, with others, in the real-world context of moral, social, and political exchanges. This means that a plausible account of autonomy must abandon the premise that autonomous agency is atomistic or individualistic.[56,68]

The interviewees faced moral dilemmas when patients, despite understanding the severity of the IPV they experienced, decided not to involve the police. Reporting without the victim's consent was only justified under the following circumstances: when the interviewees thought that it was in the patient's best interests, when it was certain that reporting would stop the IPV, or when the lives of the patient, their children, or their pets were in danger. This finding aligns with the study by Nordby et al,[69] in which perception of compliance was a factor influencing the decision not to report cases of IPV to the police. While the MR-IPV law provided a framework for practice, the participants often found themselves in a gray area where patient autonomy, safety, and trust had to be weighed carefully. The participants' hesitation to report to the police may reflect their efforts to reconcile the MR-IPV requirement with patient autonomy and beneficence. Health-care professionals have a duty, which is grounded in beneficence and justice, to protect individuals seeking medical care whenever possible;[54] however, the interviewees seemed to prioritize patient autonomy.

Critics of biomedical ethical principles argue that patient autonomy overemphasizes individualism to the detriment of all other principles.[51] In contrast, according to the concept of relational autonomy, individual choices should not be viewed in isolation; rather, they are part of supportive networks.[56] In the context of IPV, health-care professionals may experience moral distress when trying to balance respect for the victim's wishes and the duty to prevent serious harm. The results of this study indicate that reframing the concept of autonomy could offer a new understanding of how medical responsibility regarding MR-IPV is understood. Expanding the assessment of patient autonomy in IPV cases beyond the focus on decision-making capacity to include understanding (eg, understanding of the severity and consequences of the violence), freedom (eg, whether the patient's decisions are influenced by threats from, or fear of, the perpetrator), and agency[51] may allow health-care professionals to gain new analytical tools. These tools could help them interpret the patient's situation and recognize the influence of their broader social network on their choices, including whether to report the violence to the police. The findings of this study are consistent with new research showing that health-care professionals tend to be more skeptical of mandatory reporting compared to other service providers.[65] Understanding autonomy in the way suggested above shows its relational and gradual character; from this perspective, autonomy is an ethical principle in addition to being a legal concept.

The study's results also indicate that the decision to report without consent is not taken lightly; rather, it emerges from a deep concern for the immediate and long-term safety of those involved. These results align with the studies by Smith et al[42] and Rodriguez et al.[46] In these studies, health-care professionals reported reluctance to apply the MR-IPV law when the patient did not wish to contact the police. Postponing reporting was also recently documented by Moreira and Pinto da Costa, who highlighted the doctor-patient relationship and the patient's unwillingness to report incidents as barriers to contacting the police.[30,37]

Reporting without consent, even with good intentions, may negatively influence the trust between victims' and health-care professionals'.[20,21] Critics of MR-IPV laws argue that reporting to the police without consent can affect the victim's autonomy and decision-making, causing the person exposed to IPV to lose trust in support services and break contact with them.[1,46] However, Kristiansen et al[49] found nuances related to breaches of trust among victims and perpetrators of IPV with experience of MR-IPV legislation. In their study, the perpetrators and one victim of IPV spoke of a breach of trust when IPV was reported to the police. In contrast, the other victims of IPV expressed betrayal when IPV was not reported at an earlier stage. The victims were more supportive of MR-IPV than the perpetrators.[49]

In the present study, the finding concerning calling the police anonymously with the patient present may reflect an attempt to navigate ethical principles, health-care legislation, and the MR-IPV law. Discussing a case with the police can be a way of determining whether it is severe enough to be reported under the MR-IPV legislation. In Norway, the MR-IPV law applies only when it is certain or most likely that a crime will be committed. Consulting the police may guide

the patient and the health-care professional in deciding what should happen next. The need to do so could reflect uncertainty about the legislation's content, which would confirm previous research.[13,39–41] Seeking advice in this way can also enhance the patient's well-being, be most suitable to the patient's circumstances and preferences, and align with the ethical principle of beneficence.[54]

Another interpretation of calling the police anonymously is that the participants decided not to involve the authorities to avoid escalating the situation. While they acknowledged the patient's autonomy and ensured that they were informed about their circumstances, they chose not to involve the police based on the Health Personnel Act,[55] and they demonstrated a form of soft paternalism.[54] Soft paternalistic actions can be morally complicated and create ethical dilemmas as they challenge the patient's autonomy and the legal requirements of the MR-IPV law.[70]

Anonymously calling the police, knowing that officers will intervene due to the criminal nature of the case, may blur the boundaries of confidentiality and informed consent, as the patient is present but not formally consenting to the reporting. The nurse who admitted to deliberately withholding information about the potential consequences of the phone call acknowledged that her action was somewhat questionable. Although they did this with the best intentions, in this case, an important moral value—telling the truth—was overlooked. This can be controversial because it can be interpreted as undermining the patient's right to make fully informed choices about their care.[54] It can place the patient in a vulnerable position, especially if they feel pressured or exposed during the call.

The core of this dilemma is the need to find a moral balance between the obligation to protect IPV victims and ensure justice for them and the victims' autonomy concerning their lives and families.[65,71] In Norway, anonymously reporting to the police is a legal practice that allows individuals to discuss cases without revealing their identities. Still, establishing clear guidelines and providing training to health-care providers on ethical decision-making can help navigate these complex situations. Also, establishing a dialogue around these ethical dilemmas might promote transparency and build an environment where patient autonomy and beneficence do not need to be in competition.[54] In this way, the MR-IPV law does not necessarily need to clash with patient autonomy or breach victims' trust in confidentiality.

The Norwegian MR-IPV legislation simultaneously diverges and aligns with other countries' laws in this field. Several countries have implemented legislation that mandates the reporting of ongoing IPV or the risk of future IPV by specific professionals or the public (ie, MR-IPV).[6] The USA has different MR-IPV laws in different states.[47] Some states only require the reporting of injuries caused by weapons or injuries caused in violation of criminal laws; other states specify MR-IPV, while some do not have any MR-IPV laws.[47] Even though Norway is in Europe, the Norwegian legislation diverges from that of other European countries. Furthermore, MR-IPV laws vary significantly across European nations. In Europe, some countries have broad reporting obligations for all professionals, while others have more limited requirements. For example, in Portugal, public servants must report all crimes they become aware of in the course of their duty, including domestic violence.[72] This is in contrast to the Norwegian legislation, where the MR-IPV duty extends beyond professionals; all individuals have a duty to contact the police when they believe it is certain or most likely that IPV will occur, as well as a duty to avert IPV by other means.[23]

An important point of divergence from most other MR-IPV laws is that fulfilling the MR-IPV duty in Norway can involve reporting to the police, but this is not required if the violence can be averted effectively by other means. In many other MR-IPV laws, the primary objective is reporting IPV. The goal of the Norwegian MR-IPV legislation is averting future violence rather than investigating or prosecuting past crimes. This difference should be taken into account when comparing our results to those of other MR-IPV studies and when discussing the results in relation to international practice frameworks (eg, those of the WHO, American Psychological Association, and National Institute for Health and Care Excellence. Moreover, even though systemic pressures, such as institutional protocols, understaffing, and lack of training, were not investigated in this study, they might also have had an impact on the participants' behaviors and should be considered when interpreting health-care professionals' MR-IPV practice.Ethical principles are important to uphold good medical practice, and the findings show that these principles played a significant role in views of the MR-IPV legislation. However, in Norway, health-care professionals cannot choose noncompliance based on ethical considerations, opinions, or their narrow understanding of autonomy. Still, the results indicate that the MR-IPV law was a debated topic that created challenges for the participants, which is in line with previous studies.[13,24–28] Therefore, more awareness of Norway's MR-IPV legislation and dialogue about ethical dilemmas are necessary. Given the scarcity of relevant research,

health-care professionals' understanding of ethical principles, legal requirements, and the practical implications of these two elements, as well as how to navigate them, should be further examined.[13,25,29,37,42]

Strengths and Limitations

The present study adds to the limited scholarship on health-care professionals' considerations and decisions pertaining to MR-IPV. The participants provided rich and nuanced data revealing the complex balance between ethical principles and health-care legislation when considering the MR-IPV law. They expressed their thoughts in their own words, which provided unique access to the phenomenon. Data analysis was conducted on a shared platform (NVivo Collaboration Server), which allowed all the authors to contribute to the analysis and its results individually and as a group. All the authors engaged in comprehensive discussions about the data and their implications. These discussions promoted a shared understanding of the material and enabled a comprehensive examination of its potential impact on and relevance to the study's research questions.

The present study also has some limitations. The participants' experiences and perceptions of the MR-IPV law may not align with the content of related laws in other countries. Norway's MR-IPV legislation does not mandate police reporting; it allows for averting IPV "by other means" when possible. This can create confusion regarding the distinction between the general prevention of IPV and the MR-IPV law. Furthermore, the participants may have been influenced by their interest in the topic. This may have led to a biased sample that did not represent the broader population of health-care professionals at assault centers.

Implications for Research and Practice

Awareness of the MR-IPV law among health-care professionals working in Norwegian assault centers is limited. For this reason, this study represents a valuable contribution to the field and has multiple implications.

The lack of attention to the MR-IPV law may indicate limited awareness of this requirement. One way to address this issue might be to include references to Section 196 of the Penal Code in the laws governing health-care professionals. A similar approach has been chosen regarding the duty to notify child welfare services, with the Health Personnel Act[55] clearly specifying that the duty is personal. Based on the study's findings, it might be advantageous for the Norwegian government to consider revising the wording of Section 196 of the Penal Code. Instead of listing crimes, the new wording should provide more specific examples of what aggravated abuse entails.[73] Additionally, more education about the MR-IPV law might improve health-care professionals' awareness of this duty in assault centers. The topic of the MR-IPV legislation could be included in the training of such professionals, particularly regarding their duty of confidentiality.

In this study, it was also found that ethical principles, especially patient autonomy, played an important role when the application of the MR-IPV law was considered in concrete cases. This contributed to complexity in the participants' medical practice and the need to navigate ethical principles, health-care legislation, and mandatory reporting. The findings show that the MR-IPV requirement is a debated topic; thus, further research on how to deal with ethical principles when addressing the MR-IPV law in assault centers is needed.

Conclusion

In this study, we examined how health-care professionals in Norwegian assault centers navigated biomedical ethical principles, health-care legislation, and the country's MR-IPV law when working with victims of IPV. The findings raise important issues regarding medical practices that may conflict with legal and ethical standards, which can lead to hesitation in reporting severe IPV cases to the police. In some situations, a health-care provider's commitment to building therapeutic relationships, maintaining patient confidentiality, or acting in the patient's best interests may unintentionally overshadow their mandatory reporting responsibilities. This dynamic indicates that various factors, such as knowledge, health-care legislation, ethical principles, and personal values, influence medical practice behavior regarding MR-IPV. When a patient's autonomy conflicts with the principle of beneficence, paternalism can arise in medical practice, which creates ethical dilemmas between legal requirements and ethical principles. Addressing these issues requires an increase in legal literacy and a broader cultural shift in health-care settings to align professional autonomy with legal requirements and institutional responsibilities.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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