Report on a Multidisciplinary Analysis *of the* Protection of Life During Pregnancy Act 2014 *and the* Guidance Document for Health Professionals on its Implementation

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Contents

Introduction

The authors of this Report conducted research with multidisciplinary teams of medical and medico-legal experts who analysed and problematized three hypothetical case scenarios. The purpose of the research was to determine how the multidisciplinary teams analysed the three hypothetical scenarios under the Act with reference to the Guidance Document in order to ascertain what they would consider to be the appropriate medical and legal response to these scenarios, including whether the case met the legal requirements for the certification for a termination of pregnancy. The case scenarios were written by the authors to the Report, and included issues known to them to be potentially problematic in practice. The findings demonstrate that, following the discussions, the group as a whole observed that while the Guidance Document was generally useful, clarity and consistency was required in a number of areas.

In this Report the authors first outline, the methodology utilised, followed by a discussion of the issues which arose during the course of the research. The case scenarios are set out, with both the 'answer' given by the group, and the problems associated with it.

The purpose of this research is to inform Department of Health policy in this area, and we hope that it is of use to those with responsibility for updating and amending the Guidance Document. The authors of the Report are available to discuss the findings with Departmental officials if requested.

Methodology

Participants were recruited through purposive sampling of clinicians (obstetricians, physicians, nurse/midwives in director positions) and barristers. Clinicians were recruited on the basis of expertise and specialty (obstetrics, internal medicine, cardiology, oncology and psychiatry) and all at senior/consultant level. Purposive sampling techniques also sought to ensure that clinicians from urban and regional centres were represented. Barristers were similarly recruited on the basis of their areas of practice and speciality including medical law and judicial review, and included both junior and senior counsel.

Three clinical scenarios were developed by the research team to form the basis of the discussion and analysis. These case scenarios contained both medical and legal issues deemed by the researchers to be particularly relevant to the operation of the Act.

Participants were initially contacted by letter (Appendix 1). When they confirmed their availability, they were sent an information pack outlining the research process (Appendix 2), including a copy of the clinical scenarios, the Act and Guidance Document. Upon arrival and prior to the discussion of the scenarios, the research process was outlined to the group, offering the opportunity to ask and answer any questions arising. The importance of maintaining confidentiality in terms of participation was reiterated by the professional mediator, Mr Donal Moore, who acted as Group Moderator for the workshop (Appendix 3).

Two groups were established for discussion and analysis of the clinical scenarios. Each group was given the same clinical scenarios. Participants (n=21, 4 lawyers; 17

clinicians) were split into two multidisciplinary groups by the researchers based on expertise. The groups were asked to consider different factual scenarios, to comment on the decision making pathway, the influence of the Act, the utility of the guidelines and the consequent decision as to whether a lawful abortion could be performed in such a scenario. The groups were asked to nominate a chairperson who would ensure that the discussions took place in a timely manner, and a scribe, who documented the key findings of the group on a flipchart. Any issue which was deemed particularly problematic was 'parked' by the group for discussion at a later point. Otherwise, the notes were considered to reflect the decision of the group, reached through consensus.

Two researchers (one clinician and one lawyer) were present at each of these groups. Prior to the groups beginning their discussions, the researchers met and prepared an aide memoir of issues they believed to be particularly relevant for the purposes of the discussion. The researchers who were in the prompting/observational roles were charged with ensuring that the groups remained focussed on the central issue of whether the case met the requirements of the test for a lawful abortion. The Group Moderator moved between the groups to deal with any issues that might arise and to assist the group in resolving any roadblocks that might have arisen relating to 'parked issues'. In keeping with best practice the participants were encouraged to self-direct the conversation and the researchers intervened only to prompt discussion on an issue of particular concern identified *a priori* that had not emerged spontaneously. However, this was not always possible given time constraints.

Following the small group discussions, all participants met as a larger group and fed back to each other and the researchers on their findings in relation to the case scenarios, a discussion which was facilitated by the mediator. At this point, further discussion and analysis took place on the clinical scenarios. The group as a whole agreed on the findings of the research, which were simultaneously typed and projected in the room, and it is those findings which form the basis of this Report. Further, a discussion was had in relation to some general issues which arise under the Act, and those findings are set out in the Report following the discussion of the case scenarios.

Research Findings

Case Study 1

The patient is 39 years old, and is a stay-at-home mother with two children aged 10 and 6. Following the discovery of a breast lump she is referred by her GP to the breast clinic for triple testing. She was diagnosed with breast cancer and tumour is Her 2+. The cancer is at stage 2 and the sentinel node positive requiring surgery, chemotherapy (6 cycles), radiation therapy (6 weeks) and Herceptin are part of her treatment protocol. Immediately following her diagnosis she visited her GP as follow up and for support and indicated that her period was late. Her GP did a pregnancy test which was positive, indicating that she is around six weeks pregnant. As no pregnancy test was carried out by her oncologist, she has not been to an obstetrician to date. Chemotherapy cannot be given before she is fifteen weeks gestation, and radiation therapy and Herceptin cannot be given in pregnancy because it is dangerous to the developing foetus. Delay in treatment poses a significant risk in treatment success and remission.

The GP refers the woman to an obstetrician and she is seen within one week. She has just had her first consultation with this obstetrician and requests a termination of pregnancy. She said that she feels that if there is any chance that the pregnancy will put her life at risk, she should terminate the pregnancy so as to protect her two children.

Aide Memoir

- Impact of delay in treatment on long term prognosis
- To whom would the obstetrician refer the case for discussion
- Is a multidisciplinary team required? If so, who should attend?
- Does this type of case fulfil criteria of 'substantial risk to the life of the mother'? Does the Guidance Document provide sufficient direction/advice in this case
- If the test is satisfied and certified, how will TOP proceed?
- Can the risk only be averted through termination? Which test/part of the Guidance Document are the participants referring to when analysing the issue?
- Has the GP acted with sufficient speed in referring her case to the obstetrician? What sort of time limit is acceptable or unacceptable given the requirement in the Guidance Document to act 'expeditiously'?
- Are there any data protection concerns in relation to the form of notification in SI No 546/2013?

Group Findings

Real and substantial risk?

Overall there was uncertainty as to whether or not this case constituted a 'real and substantial' risk to the life of the mother: some felt that it did and others did not agree. It was asked whether a delay in treatment for the cancer as a result of the pregnancy constituted a risk to her life: the groups discussed whether the risk was to be determined when she was pregnant, or whether it applied to her life post-pregnancy. The issue of hormone sensitivity in the case was discussed, with an assessment of the impact of both delayed and/or modified treatment on the woman's 5 year survival rate.

The general group discussed what a 'substantial risk' amounted to and it was noted that no guidance on what amounts to 'substantial' was included in the document. Consensus in the group was that it was circa 0.5%-1%, although it was acknowledged that this was a subjective assessment, and some clinicians may consider a figure as high as 25% as appropriate. There appeared to be consensus that it was not appropriate that 'substantial risk' would be clearly defined in the legislation or Guidance Document as this would not allow for flexibility with regard to improvements in clinical practice

If so, can that risk only be avoided by terminating the pregnancy?
The Group felt that it needed hormone sensitivity information for quantification, but that a treatment pathway could potentially include:

- Surgical treatment for the cancer at 10 weeks gestation;
- Modified chemotherapy at 16 weeks which may or may not incorporate Herceptin.
- Modify the chemotherapy to allow for Herceptin later (after birth)
- Consider earlier delivery of fetus
- Radiation – coming in at the end so it would be after delivery

The question arose as to whether exposure of the fetus to Herceptin should be considered to avoid the termination of pregnancy in light of the requirements of the second limb of the test, that is, that the risk can *only* be averted by a termination. There were differing perspectives from the clinical and legal experts on this issue. Some of the legal experts argued that the second limb of the test required exposing the foetus to treatment contraindicated in pregnancy irrespective of the harm caused, as this was a lesser harm than termination of the pregnancy.

General Comments
There was a difference of opinion between clinicians and lawyers as to whether treatment which would harm the fetus (following a denial of termination of pregnancy) was permissible. It was agreed that if a TOP was denied, that was an effective denial of treatment. The group were of the opinion that this is a very realistic case scenario, and a very emotive and complex one.

TOP Permissible?
When both groups rejoined to share and broaden the nature of their discussions, it became evident that uncertainty as to whether a termination of pregnancy was permissible in this case remained. The group was split between those that were uncertain (n=12) as to whether the case met requirements of the test or not, and the remainder that were evenly divided in terms of being certain a TOP was permissible OR certain the case did not meet the requirements of the test and was not permissible.

This finding is of critical importance as it demonstrates that with the benefit of the guidance document to support the Act, it was not possible to reach agreement,. The significance of this finding relates to the fact that the scenario presented to the group is typical of cases that occur in clinical practice. This highlights the significant challenges facing clinicians in the application of legal frameworks given the complex nature of individual cases.

Impact of Guidance Document

It was felt that the Guidance Document was not helpful in this case, but that it could not necessarily address this case scenario in any event. The guidance document is unable to clearly delineate each and every possible medical scenario that may present. However, it is important to emphasise the importance of multidisciplinary team input into the management of these complex cases. There was general consensus that risk to life included a risk to life of the woman both during pregnancy and in the longer term.

Case Study 2

A 17 year old woman discovers she is pregnant. She has little education, is functionally illiterate, is unemployed and lives in poor housing in an area of high social deprivation. She has no partners and no family support. It is an unplanned and unwanted pregnancy.

She suffers from hypertrophic cardiomyopathy and her ejection fraction is 25%. As she is in cardiac failure she is hospitalised in coronary care, on diuretics and her condition is getting progressively worse. Cardiac output increases in pregnancy by 30% between 15-20 weeks. Her condition is going to deteriorate. She requests a termination of pregnancy from her cardiologist which she would like immediately. She is now 20 weeks pregnant. Her parents have found out that she is pregnant and vehemently oppose her terminating her pregnancy.

Aide Memoir

- Is there an obligation to prolong the pregnancy to 24 weeks in the fetal interest?
- Impact of vaginal birth v caesarean section on mother's health?
- What are the options if the woman's condition deteriorates?
- Is there any significant in the fact that the Guidance Document (Table D) refers to a pregnant woman while the Act refers to the woman?
- Under Irish law is fetocide legally permissible in cases between 20-23 weeks gestation?
- Is the pregnancy 'approaching viability' as the Guidance Document refers to?
- If so, what happens now? Who should be on the multidisciplinary committee? What if she disagrees with the decision of the multidisciplinary committee? Can its decision be reviewed or appealed? If so, by whom? Can she trigger a review through the executive?
- Do her parents have any say in the management of her care?
- What, if any, right to legal aid or formal assistance does she have in accessing the review stage of the procedures?
- How soon does the TOP have to take place, if it is agreed that her life is at risk?

Group Findings

Real and substantial risk?

Both groups were in no doubt that there was a real and substantial risk to the life of the young woman in this case scenario as she was in danger of dying from heart failure. The question was raised as to whether a TOP could be delayed for 4 weeks in order to bring her to viability, though it was not clear if the delay could be quantified in terms of the risk to her life. However, it was also suggested that there was no need to bring the young woman to viability, noting that continuing the pregnancy might deny her the opportunity to get definitive treatment by way of a heart transplant. Further, it was noted that even though at 24 weeks there is potential for viability, there are poor outcomes for the neonate at this stage. All that said, it was ultimately suggested that a TOP might not actually save her, as she might die during the procedure. While it was acknowledged again in the context of this case scenario that there was a problem in defining and assessing 'substantial' in the context of the risk required, it was agreed that this amounted to a substantial risk.

General Comments
There was some discussion as to whether the young woman involved fell under section 7 or section 8. It was suggested that section 8 be avoided where possible to protect both the woman and clinicians, and to get the best range of treatment options.

The question was asked by both groups as to the young woman's competency and capacity to make medical decisions. It was generally agreed that she had the capacity to consent, though it was suggested that a formal assessment of this might be wise in the circumstances. Her ability to consent on the basis of age was discussed and it was generally felt that she could, though the Children First document was raised in the context of whether parental involvement was required. It was felt that this particular issue was not as clear-cut in law as it might be.

Feticide
The issue of feticide was discussed. There were varying opinions as to whether feticide is permissible under the Act, as no reference is made to the procedure in the Guidelines. It was suggested that clarification is required as to whether feticide is part of the TOP procedure or a separate action. The base question is whether, under the Act, is it allowable to perform feticide, or whether practitioners are required to deliver the fetus in the expectation of death. An amendment to the Guidelines to address this issue is suggested.

General consensus in the group was that feticide would not be permissible due to the third limb of the test set out in the Guidelines (part of the second limb of the test as set out in the Act) which requires practitioners to have 'due regard for the fetus'. Consequently, clarification regarding this would be useful.

Further, the absence of a legal definition of viability (which is referred to in the Guidance Document) was raised as a potential issue. The difference between a fetus having the capacity to be born alive (utilising the legal definition of the term) and the fetus being viable (according to medical expectations) was raised. Some of the legal practitioners urged caution in terms of the approach to be taken when the pregnancy is approaching viability, given the requirement to have due regard to the life of the foetus. This applies particularly if it has been established (from a clinical perspective) that a termination is the only way of averting the risk to the life of the woman.

TOP Permissible?
Generally, it was felt that a TOP was permissible in this case, though a minority of participants remained uncertain. When the group considered the potential of prolonging the pregnancy to give due consideration to the life of the fetus, an emphasis was placed on the importance of multidisciplinary discussions. As these clinical cases are multifactorial, it was agreed that any guidance document could not clearly describe a course of action for all potential scenarios.

Impact of Guidance Document

The operation of the certification process was queried and the question of how long a certification lasts once the medical practitioners involved have certified that the requirements of the Act have been met. If a TOP has not taken place, the Guidance Document might clarify when the permissions expire (if at all). Further, it was felt that although a definition of viability was not practicable, further guidance on management for cases approaching viability would be helpful.

Case Study 3

The patient is 26 years old, and is an architect at a busy Dublin practice. The patient has a history of anxiety and depression with no history of self-harm, psychosis or previous hospital admissions. She is ten weeks pregnant and says to her obstetrician, "I can't take this, I don't want this pregnancy, I don't want to live." The pregnancy was neither planned nor wanted and she is not in a stable relationship. Her obstetrician refers her to a consultant psychiatrist in the local regional hospital and she expresses similar sentiments to him. Her consultant offers her treatment, counselling, medication and community mental health support, all of which are accepted by the patient.

Two weeks later, the patient asks to see another doctor at the same hospital and this time formally requests a termination of pregnancy, saying that if she has to see the pregnancy though to term, she will kill herself. Following a psychiatric assessment for suicidal intention, the consultant psychiatrist informs her that he does not believe that she meets the requirements of for certification under the Protection of Life During Pregnancy Act 2013 and informs here of her right to a second opinion and her right to review. At fourteen weeks gestation, the patient's distress is growing, and she is now engaging in self-harm (cutting). She has now requested a review of the decision to deny a termination. As part of her application a review committee is established. The decision of the committee is that the test is not satisfied. She has just learned that one of the consultants on the committee created has written an academic article which suggests he does not support the termination of pregnancies in cases of suicide.

Aide Memoir

- How to access to psychiatry opinions – if no perinatal psychiatrist is available locally how is this referral arranged?
- Is the pregnant state precipitating the suicidal condition? Will termination of pregnancy improve her symptoms?
- What is the process of appeal?
- What sort of language by the woman is needed to trigger the process of certification or non-certification? Does she have to say, 'I want to kill myself, I want to terminate the pregnancy' or does the language she used in either the consultation with her obstetrician or psychiatrist suffice?
- If certification is not granted, what obligations are on the non-certifying doctor?
- Can a decision of the committee be judicially reviewed? Can the composition of a panel be challenged either before or following its decision?

Group Findings

Real and substantial risk?

Whilst the patient's distress was noted, none present was of the opinion that the woman presented in this scenario satisfied the test in section 9 of the Act as the psychiatry opinion is that she is not suicidal.

General Comments

A lot of time was spent discussing whether there was bias (either real or perceived) in this scenario which would allow for a judicial review of the case. It was noted that writing academic articles is not uncommon by experts, and that in order for bias to be established, it would have to be shown that the article clearly articulated that the author

would 'never' support a termination of pregnancy in a set of particular cases. It was asked what would constitute an appearance of bias in this context.

It was suggested that prior to an individual being nominated to a review Committee, they should be under an obligation to state that they could foresee clinical situations where they would be willing to both grant and refuse a TOP.

Some discussion was had as to whether the words used by the woman in the case here constituted an appropriate 'triggering' of the process: it was stated firmly that in order for the Act to come into play, the woman must clearly and explicitly request a termination of pregnancy. Anything less than that would not suffice, as medics cannot be seen to 'lead' people to make a decision in relation to terminating a pregnancy.

Impact of Guidance Document
It was noted that there is no mention of judicial review in the Guidance Document, but that it would not be necessary to include this.

It was also noted that the option of a second review is not in the Act, and that the Guidance Document does not say such reviews are possible. It was suggested that it would be helpful if the Guidance Document stated if a woman could start the process again following non-certification.

General Discussion Points: Conclusions and Observations

"Real and Substantial Risk"

The question as to what a 'substantial' risk to the life of the woman constitutes was discussed at length by both groups. While it is not defined in either the Act or the Guidance Document, it was felt that the interpretation of the term was perhaps best left to clinicians. However, when asked to enumerate what percentage risk a 'real and substantial' risk amounted to, general consensus within the larger group discussion was that it was circa 0.5-1% (though it was acknowledged that an individual practitioner might consider a figure of 25% as appropriate).

There appeared to be consensus that it was not appropriate that the term 'substantial' would be defined as such definition would not allow for flexibility with regard to improvements in clinical practice. Further, the Guidance Document is unable to clearly delineate each and every possible medical scenario that may present, emphasising that importance of multidisciplinary team input into the management of these complex cases is vital.

That said, it was discussed as to what occurs when a delay to treatment constitutes a risk to a woman's long-term life expectancy. Does this constitute a real and substantial risk to her life? If there is a requirement to try to progress the foetus to viability, this may put the life of the woman at increasing risk: at what point does this become an unacceptable risk, given the requirement to protect unborn life "as far as is practicable"?

"The need to preserve unborn life as far as is practicable" requires that the risk can "only" be averted by terminating the pregnancy

In terms of the operation of the test, a further issue arose in the context of the practical application of the Act. The requirement that the termination of pregnancy be the *only* means of averting the risk was seen as particularly problematic, with practitioners disagreeing quite fundamentally on what lengths a clinician would have to go to in order to avert the risk, other than by terminating the pregnancy. For example, in the context of Case Scenario 1, it was mooted that clinicians would be under a legal obligation to administer treatment which is contra-indicated in pregnancy and thus may impact on the health, though not perhaps the life of the child. This is an issue which requires clarification, given the feeling that this requirement greatly limits the application of the Act in clinical practice.

Discrepancies between the Act and the Guidance Document

It was felt that there is sometimes discordance between the language in the Act and the language in the Guidance Document. In particular:

- The Act provides for a two-stage test in section 7, whereas the Guidance Document provides for a three-stage test.
- The 'good faith' requirement contained in the Act (but absent from the Guidance Document) was discussed, and it was noted that there is an element of subjectivity to the 'real and substantial risk' test which is absent in the steps contained in the Guidance Document.

Viability and Foeticide

It was strongly suggested that the issue of fetocide be clarified in the guidance document. The base question is whether, under the Act, is it allowable to perform feticide, or whether practitioners are required to deliver the fetus in the expectation of death. An amendment to the Guidelines to address this issue is suggested.

In the context of viability, there was general agreement that the Act only applies in the context of pregnancies before 24 weeks, and that it does not apply after this point Importantly, it was generally agreed that the Act relates only to pre-viable foetuses: once the foetus is considered viable then Act does not apply and clinicians must explore other options. The question as to what 'approaching' viability means is unclear in the Guidance Document, as is the extent of the obligation on practitioner to prolong the pregnancy to viability – particularly when this is not what the pregnant woman wishes. These issues require further clarification in the Guidance Document.

The Voice of the Woman

Finally, the point was made that the voice and opinion of the woman at the centre of this decision-making process is largely absent from the Guidance Document. It was noted that the views and opinions of the woman could come into the equation from a medical perspective, but that this was not reflected in the legal test. It was also felt that the word 'pregnant' should be removed from the checklist of Arm 1 of the test to be applied as the Act refers to 'woman' rather than 'pregnant woman'.

Appendix 1: Letter of Invitation

Address for R.S.V.P.
[Redacted]

Dear XXX,

As you are aware, the Protection of Life During Pregnancy Act 2013 came into effect from the 1st of January 2014. We understand that the guidelines for the operationalization of the Act have been developed by the Department of Health, and published last Friday. From both clinical and legal practice perspectives, questions remain as to extent to which the guidelines might support clinicians and expert panel members in operationalising the requirements under the Act.

The Irish Research Council, as part of its New Ideas research scheme has provided funding to bring together key members of the medico-legal community to discuss the operation of the Act in an interdisciplinary forum. The purpose of the meeting is to explore practitioners concerns and to work together to seek potential solutions. These scenarios are theoretical and possibly typical of the cases that will present for consideration under the terms of the Act. No reference will be made to any recent cases of public interest.

This is a unique opportunity for clinicians, lawyers and policy makers to come together to bring forward concerns and solutions to practice from both a medical and legal perspective through the examination how (or if) the Act would operate in particular contexts. The discussions will be facilitated by an independent moderator.

This meeting is by invitation only and will take place between 3.00pm and 6.30pm on Friday 14th November 2014 on the third floor of 65/66, Mount Street, Dublin 2. The meeting will conclude with a wine buffet served from 6.30pm.

We should be very grateful if you would R.S.V.P to Ms Helen Stewart at the address above.

Best wishes,

Prof Joan Lalor (TCD)
for and on behalf of:

Dr Jennifer Schweppe (School of Law, UL).
Dr Eimear Spain (School of Law, UL).
Prof Fionnuala McAuliffe (Consultant Obstetrician and Gynaecologist NMH/UCD)

Appendix 2: Letter of Confirmation

[Address Redacted]

Dear XXX,

Thank you once again for agreeing to be part of the Workshop on the Implementation of the Protection of Life During Pregnancy Act 2013 which is taking place this Friday, 14 November 2014 between 3.00pm and 6.30pm on the third floor of 65/66, Mount Street, Dublin 2. The meeting will conclude with a wine buffet served from 6.30pm.

The purpose of the afternoon is to determine how a multidisciplinary team of medico-legal experts assess and problematise three hypothetical scenarios under the Act with reference to the Guidance Document issued by the Department of Health on the 19th of September 2014. As the process involves multidisciplinary group work all participants will be reminded by the professional facilitator (moderator) of the importance of anonymity and confidentiality in the focus group setting, and each individual will be asked to respect this process. Members of the research team will be present during the course of the small-group deliberations, and will make notes as to how each team processes the problem. This does not involve recording any identifying information about the participant(s).

The nominated group leader will also have access to a flip chart in order that the group can reach consensus (or highlight differing views) on the actions taken in the theoretical case based on their interpretation of the application of the Act and the guidelines. The findings that emerge from the group will not be attributable to any individual(s). The team will ultimately report on the collective findings of the groups to the Department of Health and publish in an academic journal, but again, the identity of individuals will be protected in these reporting processes, and all individuals will be anonymised using an alphanumeric code (e.g. B1 for Barrister 1, O1 for Obstetrician, P1 for Psychiatrist, MC for medical consultant, M1 for midwife etc. where necessary). This process of generating collective findings from the meeting will be undertaken by the moderator when all groups are brought together to discuss their conclusions. A copy of the Report will be made available to participants on request.

The event is strictly by invitation only, and all participants will be asked to restrict their analysis to the medico-legal questions which arise. The three scenarios for discussion are attached here, and those, as well as the 2013 Act and the Department's Guidance Document, *Implementation of the Protection of Life During Pregnancy Act 2013* will be included in your pack for you to collect on arrival. Given the scope of the meeting, it is imperative that we begin the event at the time planned, so we would very much appreciate it if you could ensure that you arrive on time. If you think you will be delayed, please phone Jennifer Schweppe on 087 7667103.

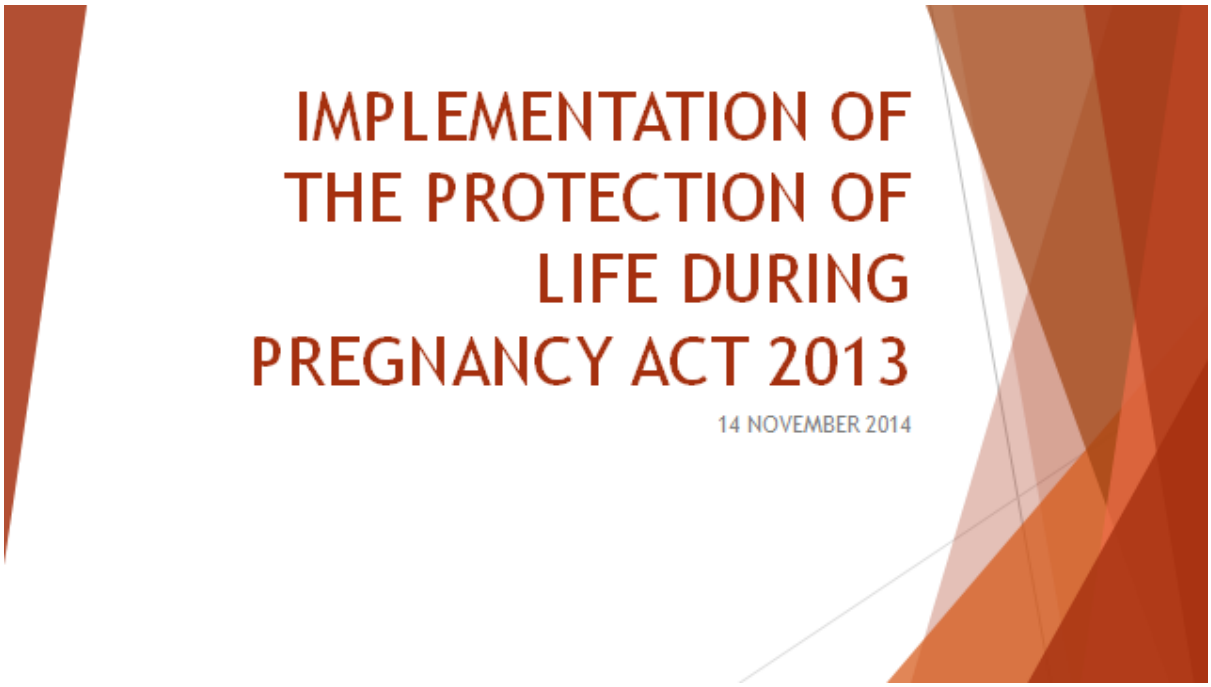
We very much look forward to seeing you on Friday, and if you have any questions, please don't hesitate to contact us.

Best wishes,

Prof Joan Lalor (TCD)
for and on behalf of:

Dr Jennifer Schweppe (School of Law, UL).
Dr Eimear Spain (School of Law, UL).
Prof Fionnuala McAuliffe (Consultant Obstetrician and Gynaecologist NMH/UCD)

Appendix 3: Introduction and Process



Purpose of this meeting

- The is a unique opportunity to work together to determine how a multidisciplinary team of medico-legal experts assess and problematize three hypothetical scenarios under the Act with reference to the Guidance Document issued by the Department of Health on the 19th of September 2014.
- Members of the research team will be present during the course of the small-group deliberations, and will make notes as to how each team processes the problem. This does not involve recording any identifying information about the participant(s).
- Each group will have access to a flip chart in order that the group can reach consensus (or highlight differing views) on the actions taken in the theoretical case based on their interpretation of the application of the Act and the guidelines. The findings that emerge from the group will not be attributable to any individual(s).
- The team will ultimately report on the collective findings of the groups to the Department of Health and publish in an academic journal, but again, the identity of individuals will be protected in these reporting processes
- A copy of the report will be made available on request

Donal Moore
MSc, M.MII, Chartered MCIPD

PROCESS

- ANONYMITY AND CONFIDENTIALITY
  - ESSENTIAL TO AGREE TO RESPECT BOTH
  - NOTE TAKING
- GROUPINGS
  - 2 GROUPS
  - MEDICAL AND LEGAL SPECIALITIES
  - JOINED BY JOAN, FIONNUALA, JENNIFER AND EIMEAR
- FOREPERSON
  - LEAD DISCUSSION and nominate a scribe for the flip chart
- TIMINGS
  - EQUAL WEIGHT TO EACH (30 mins per scenario)
  - PLEASE BE PREPARED TO PARK AN ISSUE AND RETURN TO IT AS TIME ALLOWS
- COLLECTION OF DATA
  - FOREPERSON TO PRESENT FINDINGS WITH ASSISTANCE FROM THE TEAM
  - ANY NOTES THAT ARE TAKEN DURING THE COURSE OF THE DISCUSSIONS SHOULD BE LEFT
- SUMMARY
  - MODERATED BY DONAL MOORE
  - SCRIBED BY JOAN LALOR