A Consultation and Supervision Model for Developing the Forensic Psychiatric Opinion

Alec Buchanan, PhD, MD, Michael Norko, MD, MAR, Madelon Baranoski, PhD, and Howard Zonana, MD

Receiving feedback on one's work from colleagues is an essential part of clinical and forensic psychiatric practice. Often the material on which feedback is sought concerns past cases. When the material relates to current cases, particular safeguards are needed to protect important interests. This paper lists the interests that must be protected when feedback is provided through clinical consultation and supervision meetings in a forensic psychiatric training program. These are the interests of the person being evaluated, the attorneys, the people providing feedback to the evaluator, and the employers of the people providing feedback. The principles that the training program applies in determining attendance at, and participation in, these meetings are described. Finally, scenarios are presented that illustrate the application of these principles. Such application has allowed trainees and others to receive the benefits of consultation and supervision in the course of developing their opinions while protecting the interests of those involved.

J Am Acad Psychiatry Law 44:300–8, 2016

Receiving feedback on one's work is part of training in medicine and practicing as a doctor. From their earliest clinical placements, students and clinicians present their findings and conclusions to groups of senior physicians and other trainees. One form of feedback, academic peer review, is central to the assessment of both academic institutions and the people who work for those institutions. Feedback from senior staff is a central element of undergraduate and postgraduate training, hospital credentialing and privileging, medical licensure, continuing medical education, and hospital accreditation.

Drs. Buchanan and Norko are Associate Professors and Drs. Baranoski and Zonana are Professors, Division of Law and Psychiatry, Department of Psychiatry, Yale School of Medicine, New Haven, CT. Dr. Norko is Director of Forensic Services for the Connecticut Department of Mental Health and Addiction Services, Hartford, CT. Dr. Norko is involved in the editorial leadership of The Journal. However, he did not participate in any aspect of this article's review and acceptance, which were managed by an ad hoc editor who is not a member of the Editorial Board. Address correspondence to: Alec Buchanan, PhD, MD, 34 Park Street, New Haven, CT 06519. E-mail: alec.buchanan@yale.edu.

Disclosures of financial or other potential conflicts of interest: None.

For psychiatrists, as for other clinicians, the form that feedback can take ranges from a colleague's informal advice to an extended case consultation and written report. Professional organizations, including the American Psychiatric Association and the American Academy of Psychiatry and the Law, provide opportunities for peer review through their meetings and district branches.[1] Some psychiatrists organize their own review groups that allow for the regular presentation and discussion of current cases with peers.

For psychiatric trainees, universities and teaching hospitals use a range of teaching methods in which feedback plays a part. Faculty members perform evaluations that are observed by trainees and then discussed. Trainees with more experience, including psychiatrists undergoing fellowship training in forensic psychiatry, often perform evaluations observed by a faculty supervisor before moving on to conduct independent evaluations, the results of which are then also presented for discussion. Finally, trainees sometimes work in collaboration with faculty to evaluate a case and jointly sign the report of the evaluation.

Feedback provided through a professional organization is usually retrospective, and the benefit is reflected in the psychiatrist's future practice. The important decisions concerning the case have usually already been made. In clinical practice, however, doctors frequently seek advice regarding a current case, particularly when that case is unusual or difficult. The circumstances in which advice is sought are varied and time is often short. Feedback is often given verbally and informally. Administrative arrangements, including on-call schedules, are important determinants of how easy it is for a clinician to obtain advice of this kind, particularly outside of working hours.

The time available to complete a forensic psychiatric report, on the other hand, is usually sufficient for feedback to be provided during the course of the evaluation. In the forensic psychiatric training program where we work, forensic psychiatric trainees present the cases they are working on for discussion at consultation and supervision meetings. Whether the evaluation has been observed or not, the trainee typically writes and signs any subsequent report.

Our experience has been that the sharing of information and ideas in these meetings both improves the quality of evaluations and contributes to the educational mission of the training program. Over years of experience with this educational format, we have developed principles and practices relating to the sharing of information that are designed to protect the interests of the evaluee and to prevent information from being divulged to parties with a clear conflict of interest. We describe and illustrate these principles and practices in this article.

The sharing of clinical information is governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as state law. The HIPAA Privacy Rule prohibits the disclosure of protected health information, "except where this prohibition would result in unnecessary interference with . . . important public benefits." Those benefits include, "quality improvement activities."[2] Although we are aware of no case law to this effect, medical training, an objective of these meetings, seems to be a quality improvement activity. This interpretation is supported later in the Privacy Rule: "health care operations," for which information can be shared, includes, "training health care and non–health care professionals."[3]

Sharing clinical information is a potential source of harm in any area of medical practice, however, the nature of the information in forensic practice means that the potential for harm from inappropriate disclosure can be greater than in other areas. If the legitimate interests of the evaluee, those writing the report, and others, are to be protected, clinical consultation and supervision meetings require safeguards to regulate the flow of information. To our knowledge, the form of such safeguards has not been discussed in the forensic psychiatric literature.

The Setting

The consultation and supervision meetings we describe take place within a university Division of Law and Psychiatry (the Division), part of the Department of Psychiatry of a university medical school. The Division has close links with, and provides extensive support to, state agencies that provide court evaluations and diversion services. A fellowship program within the Division trains 6 post-residency psychiatrists (trainees) annually. The Division also contributes to the training of medical students, general psychiatric residents, and students undertaking doctoral and post-doctoral training in forensic psychology.

The Division provides forensic evaluations to courts, attorneys, state and federal agencies, and others. The results of the evaluations are used in a range of settings, including criminal and civil litigation, disability assessments, and immigration proceedings. Most evaluations are assigned to a faculty member or to a forensic psychiatric trainee. Some types of assessment, including competency-to-stand-trial evaluations, are undertaken by professional teams and follow a statutorily prescribed format. These teams can include trainees. Many evaluations require psychological testing or other specialist investigations. Each trainee receives individual supervision from members of the faculty. Feedback is provided at consultation and supervision meetings where the process of moving from clinical finding to legal conclusion is reviewed.

These clinical meetings are attended by trainees and by both full and part-time faculty of the Division. Some members of our part-time faculty are employed by the state services that the Division supports. In addition to evaluations of criminal defendants and others, meeting topics include other work in which the participants, especially faculty, are en-

gaged, including court-ordered monitoring of psychiatric and correctional facilities and mental health policy development. Those providing feedback include psychiatrists, psychologists, lawyers, social work staff, and nurses, along with medical students, psychology doctoral students, general psychiatry residents, and forensic psychiatry trainees. Although the needs of trainees are central, the meetings benefit all participants. Attendance is by permission of the head of the Division. A record is kept of those attending each meeting and of the cases discussed. No minutes are kept and no recording is made of the discussion. The importance of confidentiality is emphasized to all participants.

At each meeting, therefore, the room contains people with a range of professional approaches to understanding the material. These include the narrative approach, or "story method,"[4] of mental health clinicians, with its (nonexclusive) emphasis on the evaluee's subjective experience, and the more factual and objective approaches used by lawyers in preparing legal cases. The room also contains people with a range of experience in clinical and courtroom practice. Because the focus is on answering a legal question, the ethics concerns that arise usually relate to the legal circumstances.

Within the established approaches to forensic psychiatric ethics, however, there are differences between those that emphasize the importance of an evaluee's subjective experience, for instance as a member of a disadvantaged group,[5] and those for whom principles of fidelity (truth-telling, honesty, and trustworthiness), justice, and respect for persons suffice to inform practice. Still others emphasize a combination of professionalism with community and personal morality,[6,7] respect for dignity,[8,9] and compassion.[10,11] These principles are all brought to bear, not only during the discussion of cases (for instance, in deciding which background information should appear in a report) but also during preliminary discussions of who should be present (for instance, when someone who may treat the client in the future is excluded to prevent his having access to information obtained for the purpose of the evaluation).[12]

Attorneys who request evaluations are told about the structure of the training program and the role of supervision and consultation meetings. Some attorneys request that their case not be presented to the group and that a faculty member undertake the evaluation alone. Others endorse the group model. One recurring, although infrequent, request has been that a faculty member sign or cosign a report that has been written by a trainee. Our practice is to do this only when the faculty member has not only supervised the evaluation but also has directly participated in the process, for instance by interviewing the client.

The Interests Requiring Protection

The Interests of the Person Being Evaluated

Any disclosure of medical information by a psychiatrist, including a disclosure mandated by statute, is governed by the principles of medical ethics. Irrespective of any warning on the limits of confidentiality, those who undergo forensic psychiatric evaluations are entitled to expect, first, that information concerning their cases will be treated with appropriate care. As in treatment settings, this expectation extends beyond the person conducting an evaluation, to administrative and other staff with access to the content of the evaluation or of the report.[13] It applies whether or not medical information concerning the evaluee has already appeared in the press.

Ethics guidelines require notification of an evaluee and of collateral informants of reasonably anticipated limitations to confidentiality.[14] An evaluee is traditionally informed that the results of the evaluation will be communicated to the referring attorney or court.[15] Beyond this, information obtained in the course of an evaluation will generally be treated confidentially. Additional explanations are sometimes necessary, to ensure that the evaluee understands the requirements of child abuse reporting statutes and other limits on confidentiality.[16] If the evaluator wishes to teach or publish outside the confidential Division meetings, additional permission is necessary. Specialized confidentiality guidelines are now available for case reports.[17,18]

Second, people undergoing a forensic evaluation are entitled to expect that their future care will not be jeopardized unnecessarily. Depending on local circumstances, where forensic opinions are routinely provided by psychiatrists who also practice as clinicians or administrators there are times when an evaluator knows that he may later be asked to provide clinical care to the person being assessed. When a psychiatrist feels precluded from providing treatment by virtue of having conducted a forensic evaluation and the number of psychiatrists available to

offer treatment is limited, an evaluee can lose access to a seasoned clinician. The consultation and supervision model means that the discussants may feel precluded also.

Even when psychiatrists feel able to provide care, their involvement in a previous forensic evaluation, for instance a risk assessment for the evaluee's employer, may make them aware of information that the evaluee would otherwise not have provided to a treating clinician. Where this predicament arises in the Division, the psychiatrist is expected to discuss the implications with the former evaluee before entering a treatment relationship. In some instances, an ex-evaluee may simply not wish to be treated by someone who was a party to, or who assisted in the writing of, a forensic report.

The degree to which the evaluee's future care is jeopardized also depends on the alternatives that are available. In group practice and hospital settings ex-evaluees will usually have access to a different psychiatrist, although shared access to medical records and the widespread provision of on-call cover arrangements mean that only some of the difficulties posed by prior participation will be addressed by having a different psychiatrist as one's primary clinician. The degree to which future care is affected will also depend on the length of time that has passed, on the availability of the forensic reports, and on the quality of the memories of all involved.

In our program, criminal responsibility evaluations are reviewed in meetings that include staff of the psychiatric hospital where those found not responsible are admitted. The possibility arises that treating clinicians' knowledge of risk factors will lead to a patient's either not being discharged from the hospital or being discharged to a higher level of supervision than would otherwise have been the case. There is an argument, of course, that this is a good thing: the additional information may improve the quality of the decisions taken by the clinical team. Where a decision has been made to give the interests of the retaining party priority, however, our practice has been for clinicians not to attend where it appears possible that an evaluee could be under their care. This question is discussed further below from the perspective of employers.

Third, evaluees are entitled to expect that their ability to obtain an independent expert opinion in the future will not be unduly compromised. A clinical consultation and supervision meeting is not the only means by which forensic evaluators can become aware of information. For example, the media may already have reported the details, accurately or otherwise, but depending on the presence or absence of a link between a past case and the present one, some evaluees and their attorneys will wish to ensure that their evaluator is not additionally compromised by what has been heard during an earlier report. Members of the group sometimes recuse themselves from meetings because they may be asked to become involved in the case. We expect supervisors to disclose any prior involvement and to absent themselves from the discussion where that involvement creates a conflict.

The Interests of the Retaining Party

One concern of attorneys is that the greater the number of people who are party to sensitive information, the greater the risk of that information being disclosed. The process by which any forensic opinion is derived is open to judicial discovery and inquiry. Where the process of generating a report includes the presentation of a case by a trainee, this inquiry may seek to cast doubt, both on the validity of the opinion (did everyone agree?) and whether it properly belongs to the evaluator (was it influenced by senior colleagues?)

Even attorneys who agree that clinical consultation and supervision improve the quality of opinions or who employ equivalent methods in their own practice may be concerned that the risk of breaching confidentiality is not worth taking. Attorneys require good quality reports, but they also want to avoid the uncertainty and expense of a discovery process that calls the expert's evidence into question. Where multiple forensic evaluations have taken place in a given case, attorneys may also wish to ensure that each successive evaluation is conducted on its own merits and that the conclusions are not influenced by participants' awareness of previous discussions.

These problems are not unique to our consultation and supervision process, but the additional sharing of sensitive information, even in the context of a confidential meeting, sometimes creates concerns. Attorneys may retain both consulting experts and testifying experts as a means of addressing such problems. Experts may be asked under oath about any discussions with the attorney. By retaining a consulting expert who will not be asked to testify, attorneys can obtain advice on the merits or problems of a case without exposing the testifying expert to this possibility.

The Interests of Those Offering Clinical Consultation and Supervision

In obtaining advice in developing the forensic opinion, evaluators are constrained by what is reasonable to ask colleagues without compensating them. In some cases, for example, it is appropriate to suggest that the attorney independently retain a neuropsychiatrist or a neuropsychologist.

When developing opinions are discussed in our consultation and supervision meetings, the discussions that are of most help typically include participants with a diverse range of interests and skills. Many participants have a choice of how often to attend, and the more successful groups will sustain their interest by discussing engaging material over the course of months and years. Providing structure to the feedback can also be important, especially when evaluators are trainees with limited experience. Views that differ from the supervisor's may be expressed in review meetings, and the relative status of each opinion should be made clear to the trainee. In our program, the resolution of these differences is usually achieved through individual supervision.

In addition to the ethics-related concerns that arise from the subsequent treatment of forensic evaluees, group members ensure that information is not used in the conduct of other evaluations. Someone who has been present for the discussion of a criminal evaluation conducted at the request of the defense will not be able to evaluate the same defendant on behalf of the prosecution. Where potential conflicts such as these are identified, the usual practice is for those who may be involved in the case in the future not to attend. Of course, when senior participants, multiple members, or those with specialized knowledge are excluded, the discussion can be deprived of valuable input. The faculty has to be sufficiently deep to be able to handle these potential losses.

The Interests of Employers

Employers seem to expect that their employees not disqualify themselves from doing the work for which they are paid. Psychiatrists treating evaluees have to make use of all information available to them. A psychiatrist who has participated in the discussion of an evaluation that was conducted on behalf of the defense may have learned information that is not in the evaluee's hospital chart. During a subsequent hospital admission, that psychiatrist will not be able to avoid using information that was learned during the forensic evaluation that the evaluee has not provided and that the hospital has not obtained by other means.

Sometimes that information will relate to risk. One possibility, discussed above, is that a clinician may decide not to discharge an evaluee because of information that otherwise would not have been available. We noted earlier that the available ethics approaches for the psychiatrist include recusing himself from the initial supervisory meeting and discussing these possibilities with the evaluee before agreeing to provide care. The degree to which this places a burden on the employer will depend, among other things, on the frequency with which such conflicts arise, on the nature of the criminal cases, and on the staffing of the service in which care is to be provided. Seeking a different clinician who can provide the same service without conflicts is more onerous in some settings than in others.

In theory, it is possible for a treating psychiatrist to remain involved in a case but not participate in certain clinical discussions or recuse himself when conflicts arise, for instance over discharge. Our experience has been that partial recusal often places the treating psychiatrist in a difficult position and is best avoided.

Protecting Multiple Interests

For clinical consultation and supervision meetings to function effectively these multiple interests must be protected. They should be protected in a way that respects ethics principles and legal rules. The relevant ethics principles include fidelity (truth-telling, honesty, and trustworthiness), showing respect for the evaluee, respecting the dignity of the evaluee, and showing compassion. One challenge involves the mitigation or avoidance of conflicts between these interests.

The interests of the attorney who has commissioned an evaluation and those of the client can be jeopardized if information provided to the evaluator is not kept confidential. One element in protecting those interests is to ensure that those retained by the opposing side are not present at any discussion of the case. This protection comes at the expense of limiting the number of contributors in a context where the number of experts is limited. Less obvious conflicts arise in relation to participants' potential future roles for the opposition in a case, for instance in the event of an appeal. Whether the potential conflict lies in

the present or future, however, the rules concerning participation are similar. Without the agreement of the attorney, working for one side (or involvement in the discussion of the evaluation) precludes contact with the other.

Second, and even in the absence of conflict of interest, being able to continue to work in a legal setting means respecting the rules of that setting. Anglo-American law restricts the movement of certain information, including the results of a forensic evaluation for the defense, until the defendant's attorney indicates to the court that he intends to mount a defense based on a mental condition or use the forensic report for other purposes. Protecting information that has been provided by defense attorneys, whether it is attorney work product or is covered by legal privilege for other reasons, is not only necessary if attorneys are to have confidence in the expert, but also may be required by statute. Clinical consultation and supervision meetings also must conform to case law and regulations in the jurisdiction in which the meetings are held.

Third, transparency regarding the rules that will be applied to the process of offering clinical consultation and supervision increases the confidence of participants. In doing so, transparency probably also improves the range and quality of the feedback that evaluators receive and, hence, the quality of the subsequent opinion. It also reduces the potential for misunderstanding. Retaining attorneys may have concerns that can be addressed without disrupting the consultation and supervision process.

We have suggested here that many of these considerations can be addressed by managing who will or will not be present in each clinical consultation and supervision meeting. Not all conflicts of interest can be identified in advance, however. There will be circumstances in which participants find themselves unable to undertake future work because of what they have learned. This suggests a fourth principle that operates when the process is successful. Much of the responsibility for avoiding conflicts of interest lies with the participants. Circumstances change, and no rules designed to prevent such conflicts can be expected to address every eventuality.

Applying the Principles to Practice

Our practice of running a meeting where the developing opinion is routinely discussed as part of the training of forensic psychiatrists includes:

reviewing beforehand the suitability of all cases for discussion;

keeping a record of who was present (but not what was said);

where an evaluation is not court ordered or otherwise not confidential, excluding from the meeting faculty and others who could have a treatment relationship with the evaluee in the future;

scrutinizing the participation of past and current treaters to establish whether an authorization to release information has been obtained if required;

creating a "firewall" to prevent excluded people from becoming familiar with the content of the discussion, for instance through supervision; and

providing a description of these procedures in advance to attorneys requesting an evaluation.

In the following scenarios we describe how these rules are applied in practice.

Scenario 1

A trainee is evaluating a criminal case. The attorney has asked for an opinion addressing criminal responsibility and whether there are psychiatric grounds for mitigation. The supervisor's view is that the case for an insanity defense is very weak. Several faculty members (clinicians and administrators) who undertake work at the state hospital to which all insanity acquittees are admitted are present at the start of the consultation and supervision meeting. A discussion ensues, after which the remoteness of the likelihood of insanity acquittal is used as the basis for having all faculty members, including those who work with insanity acquittees in the state system, remain in the room and contribute to the discussion.

Scenario 2

A faculty member has a criminal case in which extreme emotional disturbance is being evaluated at the request of the defense. A trainee in the program has been assigned to the prosecutor's office in the district where the case is being heard. Her role is to provide psychiatric consultation to that office. Although it is theoretically possible to have the trainee remain in the room, provided she does not discuss the case with anyone in the prosecutor's office, it would not eliminate the appearance of conflict and might give concern to the defense attorney retaining the faculty member. The trainee in forensic psychia-

try is asked to leave the room for the discussion and during all follow-up discussions of the case.

Scenario 3

A trainee in forensic psychiatry is evaluating a case for criminal responsibility and to assist in plea negotiation. There is a reasonable possibility of an insanity acquittal based on preliminary discussions with the faculty supervisor. The psychiatry faculty members in the room at the start of the discussion all work at the state hospital. All insanity acquittees are sent to the state hospital for evaluation and treatment.

A discussion ensues about which psychiatrists should remain in the room and then be precluded from future involvement in treatment or risk management decisions for this individual. Choices are made based on minimizing the potential for future clinical or administrative difficulties for the state hospital and the state mental health agency. It is acknowledged that this decision could mean that colleagues who are recused from the discussion may well have to cover clinical or administrative duties in the future for the colleagues who remained to supervise the case review. The attendance log will be important in the subsequent maintenance of these separations.

Scenario 4

Two senior faculty members from the Division have been and remain involved on opposite sides of a high-profile insanity defense case. Both have presented to the group before on other cases, and the trainees have profited educationally from the experience. A decision is made that only one faculty member should present to the meeting. To permit the inclusion of the other faculty member's opinion in the discussion with the trainees, the plan is made to ask the other faculty member to present after the case is resolved. An alternative solution, whereby neither will present to prevent any perception that the Division is aligned behind one faculty member or the other, is discussed also.

Scenario 5

Two senior faculty members participate as monitors of mental health services in a specific prison as part of a class action settlement between the Department of Correction (DOC) of the state and an advocacy group. DOC and the Advocacy group have agreed to allow trainees to be involved in the review. The faculty members intend to share with the trainees the background of the legal action, the process of the annual monitoring visit, and their developing opinions around the compliance of the institution with the required changes. Another faculty member is an attending psychiatrist at a different state prison. Although two different facilities are involved, there is an expectation that the assessment and opinion by the monitors will remain independent of agency influence. In the event of a critical report, the prison psychiatrist could also be open to criticism that he had failed to represent his employer's position or, at least, warn them of forthcoming adverse publicity. The faculty person practicing in the other prison is excluded from the meeting.

Scenario 6

The legal firm in which one of our faculty practices law retains the Division to evaluate a defendant in a federal case. The head of the Division assigns the case to a forensic psychiatric trainee. Although he does not represent the evaluee, the faculty member from the legal firm excludes himself from the meeting for two reasons. First, the early formulation of a case is not something generally shared with attorneys, although discussions with attorneys do occur regularly later in the process when the psychiatric formulation is more settled. The presence early in the formulation of a case of a lawyer representing the defendant could challenge or appear to challenge the independence of the forensic psychiatric assessment. Second, the faculty member has responsibilities both to his firm and to the consultation and supervision meeting. These dual responsibilities could be a source of conflict.

Scenario 7

Forensic psychiatric trainees participate in several law school clinics. In one such clinic, the law professor regards trainees attending his clinic as consultants to the legal team. He requires that trainees other than those who are attending the clinic conduct all forensic psychiatric evaluations. A trainee is assigned to conduct a psychiatric evaluation on one of the clients of the clinic and will present the case for discussion in the clinical consultation and supervision meeting that all trainees attend. The meeting considers whether the trainees assigned as consultants to the law school class can remain during the case presentation. The meeting decides that the evaluating trainee may be influenced by the clinic team, its strategies, and its hopes and concludes that the consulting

trainees have to leave to maintain the independence of the evaluation.

Scenario 8

A defense attorney refers a defendant for a forensic psychiatric evaluation; the case is assigned to a trainee. At the meeting, a faculty member states that she has a social relationship with the defendant. The meeting discusses whether the faculty member should remain in the room and concludes that she should not. Were the faculty member to remain, it would create the appearance of risking the confidentiality of information known only to the defense. Her remaining also has the potential to make future social encounters where the case is discussed difficult for her, because she would be aware of information that others did not know she possessed.

Scenario 9

A trainee is to present a case of competency to stand trial ordered by the court. A faculty member who would usually be a member of the group is treating the defendant. The group discusses under what circumstances the faculty member can, first, participate in the discussion and, second, remain in the room as an observer. In relation to the first question, the group notes that the confidentiality of the evaluee's medical information will be compromised should the faculty member participate. The group therefore decides that the faculty member can participate only with the evaluee's written consent. The group finds the second question, whether the faculty member could simply observe, more difficult. The defendant has been warned that what he says is not confidential and it is possible that the psychiatrist would learn information that would benefit care. The group nevertheless decides that properly respecting the evaluee requires that he give permission before the faculty member can observe the presentation.

Conclusions

As is the case in clinical work, some aspects of presenting a developing opinion to colleagues can hinder a forensic psychiatric evaluator. Defending a conclusion before the reasons behind it are fully formed can create a bias against considering other possibilities. The limited knowledge on which the comments of a senior participant in a discussion are based may be overshadowed, in a junior evaluator's mind, by that participant's professional standing. Possibilities of this type place a responsibility, not only on the evaluator to keep an open mind, but also on those administering the clinical consultation and supervision meeting to ensure that it promotes reflection and consideration and not just the rhetorical skill required to defend a position.

Our experience has been that the benefits of consultation and supervision meetings attended by a diverse group of professionals can be made available to psychiatric trainees and others without damaging the legitimate interests of evaluees, attorneys, or the courts. The meetings help to ensure that evaluations are comprehensive and that important information is not overlooked. For trainees, however, the value of the exercise extends beyond the case itself. Discussing potential conflicts of interest, and possible resolutions, with faculty members helps trainees to appreciate what constitutes a relevant ethics-based dilemma and teaches them how to address such dilemmas in their future work. Learning to make best use of consultation and supervision is an important part of training in forensic psychiatry.

Running such meetings raises dilemmas that relate to who will take part and when and what information can properly be shared. In running consultation and supervision meetings, or in this article, we have not attempted to devise rules that can be used to guide the behavior of participants in all circumstances. We have sought to develop and describe our practice in a way that conforms to recognized ethics principles and, in particular, with approaches to forensic ethics that emphasize rationality, respect and the need for all views to be represented. Attorneys sometimes decline to participate. Some mental health practitioners also may prefer alternative models of consultation and supervision (for instance, if they regard any sharing of information in a meeting of this type as presenting too great a confidentiality risk). We suggest that any balancing of risks and benefits should take into account the potential benefit to the quality of forensic evaluations.

Consultation and supervision meetings also represent an important aspect of practice for many forensic psychiatrists who have completed their training. They provide an opportunity to reason through both novel and familiar dilemmas with colleagues. They make the process of peer review available at a point in the evaluative process when it can still affect a conclusion. The benefits of doing this coexist with other interests, however, including those of ensuring the integrity of the legal process. Some of the consequent

tensions, including that between the confidentiality of meetings and the needs of legal discovery, have yet to be fully tested in court. Applying the principles discussed here may be one way of ensuring that such challenges do not deny practitioners the benefit of consultation and supervision meetings in developing their forensic opinions.

References

1. American Psychiatric Association: Resource Document on Peer Review of Expert Testimony. December 1996. Available at: https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/resource-documents. Accessed June 7, 2013
2. 45 C.F.R. § 164.506 (2003)
3. 45 C.F.R. § 164.501 (2003)
4. McHugh P, Slavney P: Perspectives of Psychiatry. Baltimore, MD: Johns Hopkins University Press, 1998
5. Griffith EEH: Ethics in forensic psychiatry: a cultural response to Stone and Appelbaum. J Am Acad Psychiatry Law 26:171–84, 1998
6. Candilis P, Martinez R, Dording C: Principles and narrative in forensic psychiatry: toward a robust view of professional role. J Am Acad Psychiatry Law 29:167–73, 2001
7. Martinez R, Candilis P: Commentary: toward a unified theory of personal and professional ethics. J Am Acad Psychiatry Law 33: 382–5, 2005
8. Buchanan A: Respect of dignity as an ethical principle in forensic psychiatry. Legal & Criminological Psycholgy 19:30–32, 2014
9. Buchanan A: Respect for dignity and forensic psychiatry. Int'l J L & Psychiatry 41:12–17, 2015
10. Norko M: Compassion at the core of forensic ethics. J Am Acad Psychiatry Law 33:386–389, 2005
11. Ciccone R, Clements C: The ethical practice of forensic psychiatry: a view from the trenches. Bull Am Acad Psychiatry Law 12: 263–277, 1984
12. Gutheil T, Bursztajn H, Brodsky A, *et al*: Decision Making in Psychiatry and the Law. Baltimore, MD: Williams and Wilkins, 1991
13. State v. Miller, 709 P.2d 225 (Or. 1985)
14. American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry. Adopted May, 2005. Available at: http://www.aapl.org/ethics.htm. Accessed June 7, 2013
15. Zonana H: Confidentiality and record keeping, in The Psychiatric Report. Edited by Buchanan A, Norko M. New York: Cambridge University Press, 2011, pp 35–55
16. Kapoor R, Zonana H: Forensic evaluations and mandated reporting of child abuse. J Am Acad Psychiatry Law 38:49–56, 2010
17. The Journal of the American Academy of Psychiatry and the Law: Instructions for Authors. Newly revised instructions first published in Volume 40:4, 2012
18. British Medical Journal Group guidelines on Evaluee Confidentiality in publications. Available at: http://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/patient-confidentiality/patient-consent-fo. Accessed December 19, 2012