“Recovered Memories” and the Court

By Scott L. Feuer, Esq., Principal, Law Offices of Scott L. Feuer, P.C.

In the past few decades there have been many civil and criminal cases involving “recovered memories,” most often centering on allegations of past sexual abuse. The treatment of patients with recovered memories presents important challenges. The emergence of recovered memories during the course of psychiatric treatment may also present profound legal ramifications, not only for the patient and the abuser, but for the psychiatrist as well.

Recovered memories of abuse that occurred many years prior, often lead to lawsuits brought against the abuser. The abuser, a third party non-patient, may then in turn sue the treating psychiatrist alleging that the psychiatrist acted negligently by playing a role in creating, nurturing, and/or publicizing false memories that have harmed the abuser. These recovered memory cases filed against the provider essentially ask courts to establish liability by creating a duty to a third party, where typically no duty exists. Traditionally, courts have been reluctant to find such a duty, but courts have not been unanimous when deciding these issues. Indeed, the outcome of such cases may very well depend on the specific state and court hearing the case.
From a liability perspective, recovered memory cases are difficult because the alleged abuse happened a long time ago and because the patient’s “memory” is often the only evidence of the abuse. Typically, the memory is recovered long after the statute of limitations has expired. However, many states have enacted “delayed discovery” laws that extend the statute of limitations in cases involving sexual abuse of children.

This article reviews the liability issues associated with recovered memory claims, discusses emerging law that may expand a physician’s liability to third party, non-patients allegedly injured by recovered memories, and offers suggestions on how to prevent such claims.

**Theories of Liability**

Although there are numerous types of legal claims that can be brought against psychiatrists, negligence is the primary liability theory alleged in medical malpractice cases. In a negligence claim, the plaintiff must prove the following elements: 1) a duty was owed to the plaintiff; 2) something that the psychiatrist did or did not do breached that duty; 3) the breach caused an injury; and 4) as a result of that breach, the plaintiff suffered damage.

The formation of a physician-patient relationship creates the duty owed to the plaintiff. Thus, in recovered memory cases there is a duty owed to the patient, but not necessarily to the alleged abuser because that person is a third party or a non-patient.

In medical malpractice cases, courts have traditionally limited the duty owed by physicians to third party non-patients to situations involving circumstances where the physicians were aware of a foreseeable injury to a foreseeable third party. For example, in the seminal case, *Tarasoff v. Regents of the University of California*, the California Supreme Court held that a mental health professional could be held liable for failure to warn a victim (third party non-patient) of an imminent danger posed by a patient. In *Tarasoff*, however, there was no claim of malpractice concerning the treatment itself that implicated the therapist’s professional judgment. Rather, the claim was that the therapist had a duty to warn the potential victim.

**Is There Liability to a Third Party?**

When determining whether liability to a third party exists, courts often look at public policy considerations that may be affected by creating such a duty to third parties and whether certain factors exist that warrant the creation of a duty owed to the third party. Specifically, some of the factors the courts consider include:

- Was the harm caused by the defendant foreseeable?
- The severity of the harm caused.
• Was the defendant’s conduct morally blameworthy?
• Will imposing a duty help to prevent future harms?
• How much of a burden it would be for the defendant to prevent such harms?
• What is the cost to the defendant of insuring against this type of harm?
• Who does society believe ought to be responsible for preventing the harm?

Courts have been reluctant to create a duty owed to non-patient, third parties for the following reasons:

• Concern of increased litigation would serve to have a damaging effect on a mental health provider’s practice
• Unwillingness to hold a mental health provider liable for the patient’s personal decisions made in response to his treatment, i.e., deciding whether to sue the alleged abuser
• Concern that the fear of being sued by a third party may hamper the provider’s duty of care to the patient and possibly compromise the patient’s treatment
• Fear that the provider would be unable to defend himself if the patient did not waive patient confidentiality and grant him the ability to use to the information in the medical record. If the patient declined to waive the protections, the provider would be unable to adequately defend himself.

Emerging Law

In recent years, some courts, however, have expanded the potential liability to non-patients in “recovered memory” cases. Specifically, the Michigan Court of Appeals in Bromley v. Mallison, recently recognized such a cause of action, joining the states of Washington, Wisconsin, New Hampshire, and Colorado. In contrast, the states of Arizona, New Jersey, Pennsylvania, Oklahoma, Illinois, Maine, Connecticut, and Texas have rejected such claims. In these cases, the alleged abusers filed suit against the alleged victims’ mental health professionals for negligence in treating the patient with techniques that caused or allowed the patient to recover a false memory of abuse.

Most states do have laws requiring reporting of suspected child abuse. This type of warning or reporting prevents harm. Retrospectively imposing liability on a psychiatrist, by making it possible for a suspected abuser to recover money from the psychiatrist, is quite another issue. The courts do not impose liability on lawyers for harm done to persons who are not clients, with the exception of reporting an imminent crime that may occur. The same rationale should be applied to physicians. In addition, some courts have found liability holding that the alleged abuser is a “quasi-patient” to whom a physician owes a duty of reasonable care. These courts reasoned that so-called “quasi-patients” are also entitled to be protected from false allegations of abuse and that holding psychiatrists liable to “quasi-patients” can provide such protection.

Focusing in on Patient Care

Despite the harm that false allegations may cause, the psychiatrist must, during treatment, be focused on the duty owed to the patient. The foundation for any successful psychiatric treatment is patient trust and confidentiality in communications with the therapist. The threat of such liability to potential non-patients may likely alter the very nature of the treatment. Considerations of being sued for malpractice by non-patients should not be permitted to interfere with the care being provided.

How to Minimize Liability in False Memory Cases

Although potential malpractice considerations should not interfere with the therapeutic relationship, there are steps a prudent psychiatrist can take to diminish the risk of a false memory claim. First, document clearly who the patient is. As indicated, there may later be an argument that another family member was a “quasi-patient.” You want to ensure that a review of the medical record shows who your patient was. This is particularly important in situations in which you talk to or meet with other family members.
If the patient recovers a memory of something that was not previously remembered, carefully document how the memory was recovered in detail. Do not hesitate to document that the patient recovered the memory without any prompting or suggestion from the psychiatrist. In a number of cases, the claim was that the psychiatrist “implanted” the false memories. To the extent possible, the documentation should demonstrate that such memories were not “implanted,” or even suggested by the psychiatrist. If the patient recovers the memory after the patient has begun treatment, detail the substance of the discussion and how the memory came about. Often lawsuits are filed years after a session with the patient. After suit is filed, there may be a long time before the physician testifies, either in a deposition or in court. Doctors are often not able to provide specific testimony as to what was discussed with the patient. There is usually a difference between what the patient and what the physician recalls being discussed.

The credibility between the patient and the physician is critical. Juries may reach a verdict in malpractice trials more often based upon who they like better, the patient or the doctor, rather than on any medical, psychiatric, or legal technicalities. Without a clearly documented medical record, the doctor is at a disadvantage in building a defense. The psychiatrist will typically speak to thousands of patients between the time of the session in question and the time he testifies. The patient, on the other hand, will have seen only a small number of doctors and will, therefore, usually testify that he has an excellent memory of what was said during a session. For example, the medical record will contain phrases such as “discussed family issues.” Years later, when asked, the psychiatrist may have no memory of what the “family issues” were that were discussed. The bottom line is, in cases of recovered memory, the more specific, objective documentation, the better. Psychiatrists should practice within their area of competency and according to their profession’s ethical principles.

**Conclusion**

Treating victims of abuse can be challenging enough, and treating victims of abuse with a recovered memory may pose additional challenges. As some states are now allowing for such lawsuits, to minimize risk, prudent psychiatrists should take extra caution in such cases, such as by: employing sound documentation principles; practicing within their area of competency; and adhering to their profession’s ethical principles.

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So, Your Patient Wants to Record Your Session

By Moira Wertheimer, RN, JD, CPHRM, Assistant Vice President, Psychiatric Risk Management Group

During your career, there may be occasions when patients either request permission to record their treatment sessions, or do so without notice by using their smart phones or some other type of audio or video recording device. These types of recordings may raise significant risk management and ethical issues that must be considered.

Patients who request to record their sessions may have the best of intentions. For example, patients may be seeking ways to remember the details of treatment discussions such as instructions or action plans. It is also possible, however, for patients to record their treatment sessions without the knowledge or consent of the psychiatrist. Reasons for such secretive recordings may be similarly benign – the patients may be looking for ways to remember the details of their sessions to further treatment. Other reasons why a patient secretly records may, however, be less benign. For example, some patients could record sessions for adversarial purposes such as filing a lawsuit or initiating a regulatory action (i.e., a board complaint). In addition, patients may use recordings to further their position in a legal proceeding such as a contentious divorce or custody matter.

Each patient may have differing reasons why she wishes to record sessions. It is important to keep in mind, however, that regardless of the reasoning, recordings of treatment sessions may not only erode the physician-patient relationship, they may also raise privacy and confidentiality concerns. It is important to be aware of the issues before these circumstances arise.
Some Pros and Cons of Patients Recording Sessions

Regardless of whether your patient asks for “permission” to record his session or does so secretly, psychiatrists should understand some of the issues of such recordings, some include:

**Benefits: Recordings may:**
- Support patient education and improve informed decision making
- Help psychiatrists defend themselves against claims of medical malpractice by supporting their treatment, medication, and plans of care
- Help improve overall physician-patient communication

**Risks: Recordings may:**
- Result in a loss of privacy of protected health information should the information be revealed or reach an unintended source
- Result in the disclosure of identifiable patient information and may impact the patient’s and/or the psychiatrist’s reputation
- Impede the free-flow of information and discussion sharing between the psychiatrist and the patient
- Be altered, which raises additional concerns when addressing allegations of malpractice

**Risk Management Considerations**
Both federal and state laws govern when conversations between private parties may be recorded. Physicians should understand whether their jurisdiction permits recording private conversations and, if so, under what circumstances. Some states have what are known as “one party consent laws,” which allow recordings of conversations so long as at least one of the parties is aware that the conversation is being recorded. Other states, however, such as California and Florida, require that all parties to the conversation give consent before a conversation may be recorded. If a psychiatrist does not support recording treatment sessions or learns that a patient secretly recorded his sessions, the psychiatrist may consider terminating the physician-patient relationship.

In addition to the applicable recording laws, state privacy laws and federal regulations (including HIPAA) need to be taken into account. Specifically, psychiatrists need to understand how these privacy laws may affect the protection of their patient’s mental health and/or substance abuse records when in a recorded form (audio or video). Often the degree of protection afforded will depend upon the purpose of the recording (i.e., consultation, treatment, supervision, telepsychiatry, etc.). For example, there may be times when treatment sessions are recorded with the patient’s consent for the purpose of providing staff supervision, evaluating treatment, teaching interns/students, augmenting treatment, etc. In these situations, the recordings may receive protection as “psychotherapy notes,” under HIPAA. As you may recall, HIPAA defines “psychotherapy notes,” as:

*Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.*

Just as with written psychotherapy notes, in order for a recording to receive “psychotherapy notes” protection from disclosure, it is important that the recording fit the definition under HIPAA and be kept physically separate from the patient’s medical record. Failure to keep the recording separate results in the recording being considered as part of the patient’s “designated record set,” and, as such, must be released when legally requested. In addition, you should have a process for retaining the recording as a part of the medical record. Should you have questions concerning this issue, please consult with your risk management or legal professional.

If a psychiatrist does not support recording treatment sessions or learns that a patient secretly recorded his sessions, the psychiatrist may consider terminating the physician-patient relationship. In addition, the application of privacy laws to treatment session recordings can be complex. Again, when faced with these issues, to ensure compliance with applicable laws and regulations,
it is important to consult with your risk management professional or attorney.

**When Your Patient Records...**
Although not a psychiatry case, a recent *Washington Post* article highlighted a case example:

*A patient undergoing a clinical procedure set up his smartphone prior to being sedated to secretly record his providers’ conversation in order to capture any necessary aftercare instructions. This recording revealed that his providers made several disparaging comments and inappropriate assumptions. Based on these recordings, the patient filed suit against the providers for mocking and insulting him while he was under sedation.*

*While the action against one of the providers was dismissed during the trial, the plaintiff’s attorney played the recording for the jury in the action against the other provider. The trial resulted in a jury verdict against the physician and awarded a judgment for $500,000. Following the trial, one of the jurors commented, “there was not much defense, because everything was on tape.”*

This case illustrates not only the ease with which patients can record their treatment session without the physician being aware, but the negative effects that can occur as a result. The use of technology in healthcare can positively affect treatment. At the same time, however, technology can have many undesired consequences, including the breakdown of the physician-patient relationship, a potential violation of state and federal confidentiality regulations, and the possible misunderstanding of the recording which may result in an allegation of medical malpractice. Just as with written or verbal communications, the psychiatrist is responsible for protecting the confidentiality of communications made/stored electronically.

As noted in the case study, a patient may end up using the recording in an allegation of negligence in court proceedings against a psychiatrist. Imagine the potential impact the audio or video may have if a jury listens to the audio or views the video, which may have been edited to elicit an angry response from the jurors. Additionally, what if you are treating a child whose parents are in the stages of divorce? One of the parents could potentially play a recording of a therapy session with the child to retaliate against the other parent in a contentious custody or divorce proceeding. Proactive policies prohibiting the recording of sessions and the using of recording devices in the office may help alleviate these risks. Again, if you learn that you have been recorded without your knowledge, consult your risk management professional or attorney for further guidance.

**What if the physician and patient agree to record sessions?**
Although not often done in psychiatry, there may be circumstances when, after careful discussions, the physician and the patient may agree to record therapy sessions. Agreeing to recording sessions is not an issue that should be taken lightly. Prior to recording, the psychiatrist should assess and document the patient’s suitability for having sessions recorded. Also, ensure that you have a documented informed consent discussion that includes discussion of how long the recordings will be retained, where they will be stored, and how will they disposed of or erased at the appropriate time.

Another area of concern is the potential that a patient may accuse the psychiatrist of a boundary violation. Despite previously consenting to the recording, a patient with unpredictable behaviors may become suspicious or paranoid about recorded sessions and make erroneous allegations that the psychiatrist is utilizing these tapes to ‘manipulate’ the patient. In order to reduce potential liability exposures in this type of situation, psychiatrists should:

- Consult with an attorney or risk management professional regarding legal, federal, and regulatory considerations concerning recording sessions
- Develop a policy and procedure for your practice that specifically addresses recording sessions
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Incorporate a process to define how to assess which patients would benefit from recorded sessions, along with the appropriate documentation to support this decision

Obtain a signed informed consent document that specifically addresses the recording and is retained within the patient’s medical record

Document the informed consent discussions and specify that the patient is requesting to record sessions. The documentation should include discussions on the risks, benefits, and possible alternatives.

Have the patient also provide consent verbally on the recording itself

Document the purpose for and details of the recording

Document the patient’s understanding that, at any time, the patient or the psychiatrist has the ability to request to stop recording sessions

Establish responsibility for storing and maintaining the recordings and document the process

Prior to each treatment session, review with the patient the request to continue taping the sessions. Obtain the patient’s verbal consent to continue the recording session and document prior to initiating.

Develop a policy and procedure that incorporates the action steps necessary to ensure an adequate informed consent process is completed and documented within the medical record

Develop a policy and procedure to address storage of audio or video recordings. Include in your policy the encryption of recordings, the need to access the audio or video recordings in the future, and how will these recordings be secured.

Conclusion

The ethical and legal structure of the physician-patient relationship must be maintained at all times, particularly in psychiatric practices. Recording psychiatric treatment sessions, whether done with or without consent, requires an understanding of the potential liability issues involved, as well as knowledge of relevant state and federal laws. Consider consulting your local attorney or risk management professional when faced with this situation.

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Risk Management Tips:

- Consult with an attorney to determine your state’s specific laws regarding the type of consent needed when recording a conversation.
- During new patient intake discussions, review your policy that expressly prohibits recordings without the written consent of all parties.
- Develop a policy, procedure, and process to address patient requests to record sessions. The policy should include documentation expectations, patient responsibility, physician responsibility, and potential impact of HIPAA laws.
- Post signage in your office asking patients or visitors to turn off all electronic devices.
- Consult with your risk management professional regarding your HIPAA responsibilities if you discover that your patients taped sessions have been stolen or posted without authorization.
- Do not respond to recordings posted online. Consult your attorney or risk management professional.
Recent FCC Ruling Impacts Calls/Text Messages Sent by Healthcare Providers

On July 15, 2015, the Federal Communications Commission (FCC) published guidance on calls/text messages made by healthcare providers, under the Telephone Consumer Protection Act (TCPA). Additionally, the FCC clarified that the TCPA applies to text messages as well as telephone calls.

The FCC Ruling clarified that under the TCPA, “the provision of a phone number to a healthcare provider constitutes prior express consent for healthcare calls that are subject to HIPAA.” However, this express consent applies only “within the scope of the consent given, and not necessarily to all calls/texts placed by a provider.” The FCC provided an exemption to this “express consent” requirement for those calls/texts of an exigent nature or made for a healthcare treatment purpose. Examples of calls/texts falling within this exemption include:

- appointment and exam confirmations and reminders
- wellness checkups
- hospital pre-registration instructions
- pre-operative notifications, and
- home healthcare instructions.

In addition, the FCC guidance further stated that calls/texts containing “telemarketing, solicitation, or advertising content, or which include accounting, billing, debt-collection, or other financial content” do not fall within the “express consent” exemption.

According to the FCC’s Ruling, in order to meet the exemption requirements, calls must satisfy the following criteria:

1. Calls/text messages may be sent only to the cellphone number provided by the patient
2. Calls/text messages must state the name and contact information of the healthcare provider (for telephone calls, these disclosures would need to be made at the beginning of the call)
3. Content of calls/text messages are strictly limited to exigent situations with a healthcare treatment purpose and:
   - must not include any telemarketing, solicitation, or advertising
   - may not include accounting, billing, debt-collection, or other financial content, and
   - must comply with HIPAA privacy rules
4. Calls/text messages must be concise, generally one minute or less in length for voice calls and 160 characters or less in length for text messages
5. Healthcare providers may initiate only one message (either telephone call or text message) per day, up to a maximum of three calls or text messages combined per week from a specific healthcare provider
6. When placing a call/text message, healthcare providers must offer recipients:
   - an easy means to opt out of future such messages
   - calls that could be answered by a live person must include an automated, interactive voice- and/or key press-activated opt-out mechanism that enables the call recipient to make an opt-out request prior to terminating the call
Legal Updates (continued)

• calls that could be answered by an answering machine or voice mail service must include a toll-free number that the consumer can call to opt out of future healthcare calls

• text messages must inform recipients of the ability to opt out by replying “STOP,” which will be the exclusive means by which consumers may opt out of such messages

7. Healthcare providers must honor the opt-out requests immediately.16

In addition to meeting all of the above requirements, the patient must not be charged for the text messages (i.e., the patient cannot be charged for receiving the text, and the text cannot count against their plan limits).17

With respect to healthcare facilities using texting as a means of communication, the Joint Commission’s 2011 statement regarding texting orders remains in effect. Specifically, the Joint Commission explained, “It is not acceptable for physicians or licensed independent practitioners to text orders for patients to the hospital or other healthcare setting.”18 The Joint Commission recently reiterated its opinion that “using regular smartphone texting is simply too unreliable for patient care and safety in most cases.”19

It is advisable to consult your risk management professional prior to beginning any texting program with patients. For information about safeguarding your mobile device, please see “Securing Your Mobile Device,” In Session with Allied World, Vol. 4, Issue 3 (Summer 2014).

Ohio Supreme Court Considers Element of Foreseeability within a Medical Negligence Claim

Although not a case specifically involving a psychiatrist, the Ohio Supreme Court recently examined a medical malpractice claim and determined that the question of the “foreseeability of the risk of harm” did not require a specific jury instruction. Specifically, the Court listed the elements of a medical negligence claim (duty, breach, causal connection between breach and injury, and damages) and stated that, “[t]he standard of care applicable to medical professionals is to exercise the degree of care that a medical professional of ordinary skill, care, and diligence would exercise under similar circumstances.” The Court continued, “[b]ecause physicians are expected to recognize medical symptoms and be aware of the risks, they are expected to foresee a risk of harm that a medical professional of ordinary skill, care, and diligence would foresee under similar circumstances.”20 The Court ruled that a jury need not determine whether the patient was in a class of people who could foreseeably be injured as the physician’s duty to the patient was already clear.

California Prescription Drug Monitoring Program (CURES)

The Department of Justice (DOJ) and the Department of Consumer Affairs (DCA) in the State of California recently announced that California’s new Controlled Substance Utilization Review and Evaluation System (CURES 2.0) went live on July 1, 2015, and will be rolled out to users over the next several months. Universal adoption of CURES is expected by January 2016.

CURES is a database containing information on Schedule II through IV controlled substances dispensed in California, and maintained by the California Prescription Drug Monitoring Program (PDMP). The PDMP allows authorized users (including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards) to access patient controlled substance history information maintained in CURES.

Online access to CURES allows authorized prescribers and pharmacists to review information contained in the Patient Activity Reports (PAR) in an effort to identify and deter drug abuse and diversion of Schedule II through IV controlled substances. For more information, please visit the PDMP at https://oag.ca.gov/cures-pdmp.
New Federal Guidelines for Opioid Treatment Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently updated the "Federal Guidelines for Opioid Treatment Programs" which were last updated in 2007. The new Guidelines indicate how the regulations may be applied to the clinical and medical issues faced by opioid treatment programs (OTPs). There are some important differences between the 2007 and 2015 Guidelines. Among the topics covered in the 2015 Guidelines are:

- Electronic health records
- Prescription drug monitoring programs (PDMPs)
- Nursing scope of practice
- The role of non-physician authorized prescribers
- Telemedicine
- Benzodiazepine misuse in the context of opioid agonist therapy
- The rule that went into effect January 7, 2013 that removed the "time in treatment" requirement for patients receiving buprenorphine for take-home use from OTPs


End Notes

Protection From Liability to Non-Patients in Cases of Recovered Memory

1 American Psychiatric Association, "Position Statement on Therapies Focused on Memories of Childhood Physical and Sexual Abuse," (reaffirmed July 2013).
3 Id.
8 Behnke, S.
9 Id.

Legal Updates

Recent FCC Ruling Impacts Calls/Text Messages Sent by Healthcare Providers

12 Id.
13 Id.
15 The Joint Commission; Standards FAQ Details; Record of Care, Treatment, and Services (CAMH/Hospitals); Texting Orders; (November 10, 2011.).
16 Pelletier, M., “To Text or Not to Text,” The View from the Joint Commission, (April 10, 2015).

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