Knowledge and Attitude of Basic Psychiatric Trainees in Ireland to the Clinical Indemnity Scheme

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Abstract

Objectives: To assess the knowledge of basic psychiatric trainees in Ireland of the Clinical Indemnity Scheme (CIS) and to ascertain how many basic specialist trainees in psychiatry had obtained additional medical indemnity cover and reasons for obtaining additional cover.

Method: A structured questionnaire was distributed by post to 300 basic specialist trainees in psychiatric training schemes in Ireland. The questionnaire enquired about demographic details and examined the level of trainees' knowledge of the clinical indemnity scheme. Results were compiled and analysed using descriptive statistics and SPSS version 14.

Results: The response rate was 49%. The bulk of respondents were male (65.5%), aged between 30-35 years of age (44.6%). The majority of the respondents were aware of the CIS, with approximately half of the respondents having acquired additional medical indemnity cover. The level of awareness of the CIS was proportionately more amongst male respondents (69.1%), compared with females (58.5%). However, more females (61.5%) had additional medical indemnity cover compared with males (45.5%). Irish national trainees were more aware (72.9%) and had additional medical indemnity (80%), compared with non-Irish national trainees of whom approximately 61% were aware of the CIS and only 40% had an additional cover. The level of knowledge regarding details of what the CIS provided coverage for was quite poor. Respondents who had obtained additional indemnity were unsure what cover their additional indemnity provided. Only 10 respondents had been involved in medico-legal cases and of these, five had medical indemnity at the time of the case, stating that the legal advice and support was helpful.

Conclusion: Our survey has highlighted that a considerable number of basic specialist trainees in psychiatry in Ireland had no detailed knowledge of what the CIS indemnifies them for and what situations were not covered by the scheme. Additionally, it revealed a clear split in favour of Irish national trainees in comparison to non-Irish national trainees in terms of awareness of the CIS and the procurement of additional medical indemnity. There needs to be an educational drive to provide more information to psychiatric trainees regarding the CIS and other medical insurance schemes. Furthermore, it would be important to examine factors that influence trainees in obtaining/not obtaining additional cover.

Introduction

Systems for managing health care accidents are designed to deliver two primary outcomes: accident prevention and, if accidents occur, compensation to victims.[1] The Clinical Indemnity Scheme[2] (CIS) was established in 2002 and it is managed by the State Claims Agency[3] (SCA). It was established to address the fragmented nature of medical insurance and indemnity in Ireland. This fragmentation had resulted in duplication of effort, longer times for claim processing and inflated costs. The CIS is based on the concept of enterprise liability,[4] whereby responsibility for defending malpractice claims rests with institutions or organisations instead of individual practitioners and their indemnity bodies. This concept has also been applied in the United Kingdom, Australia, New Zealand and the United States.[5, 6]

In establishing the CIS,[2] the state assumed full responsibility for the indemnification and management of all clinical negligence claims through the SCA. The CIS is funded by the Department of Health and Children on a 'pay as you go basis', with the department reimbursing costs made for payments in respect of legal costs.[7] The scheme covers all Health Service Executive (HSE) facilities, public hospitals and other agencies providing clinical services.[3] It also covers consultants, non-consultant hospital doctors, nurses and other clinical staff employed by health agencies whether permanent, locum or temporary; clinical support staff in pathology and radiology services; clinical activities of public health doctors, nurses and other community-based clinical staff and dentists providing public practice.[3] All clinical claims arising from the diagnosis, treatment and care of patients are covered. Furthermore, the scheme provides representation at coroners' inquests, covers personal injury claims against staff who provide emergency treatment on the island of Ireland, and covers claims from patients whose treatment was part of a clinical trial or other approved research project.

The CIS does not provide representation at disciplinary proceedings or before professional regulatory bodies. Cover is not provided for Good Samaritan acts outside of Ireland. In general, it does not provide cover for work carried out in private hospitals. Additionally, it does not cover employer's liability or public liability claims against

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health agencies which are already covered under policies of insurance with commercial insurers. Due to those areas of practice not covered by the CIS, medical staff tended to obtain additional cover from private insurers. The Irish Medical Organisation (IMO) National Benchmark Study[8] revealed that 78% of non-consultant hospital doctors in Ireland stated that legal issues were one of their greatest concerns.

The aims of this study were to assess the level of knowledge of the CIS amongst basic specialist trainees in psychiatry in Ireland, and to ascertain how many of these trainees had obtained additional medical indemnity cover and reasons for obtaining additional medical indemnity cover.

Methodology

A structured questionnaire (available on request) which was designed by the researchers collected data on demographic characteristics of trainees, postgraduate training scheme, length of psychiatric training, Royal College of Psychiatrists membership status (MRCPsych), knowledge of the CIS, whether additional medical indemnity cover was obtained, reasons for and benefits provided by additional cover. Three hundred basic specialist trainees in psychiatry in Ireland were identified and their contact details obtained from the Irish Psychiatric Training Committee. A copy of the questionnaire was circulated by post to each basic psychiatric trainee in Ireland accompanied by a letter explaining the aims of the study, proposed deadline date of return of questionnaires and a self-addressed envelope for returning completed questionnaires to researchers. The results were analysed using descriptive statistics and SPSS version 14.

Results

One hundred and forty eight completed questionnaires of the 300 distributed were returned giving a response rate of 49%. Demographic details are shown in Table 1. Two thirds of respondents were males and approximately 45% of our respondents were aged between 30-35 years of age. A third of respondents were of Irish nationality and half of respondents were of African descent. These proportions were mirrored in the country where the primary medical degree was obtained. Approximately 66% of respondents were married. Postgraduate psychiatric training scheme representation of respondents is shown in Table 2. Only 20% of respondents had obtained MRCPsych. The groups were evenly divided in terms of years of psychiatric experience.

Overall, 62.2% of trainees surveyed reported that they were aware of the existence of the CIS. Approximately 73% of Irish national trainees were aware of the CIS versus 61% of non- Irish national trainees.

Trainees' knowledge of the activities covered by the CIS is shown in Table 3. Of trainees surveyed, 70.9% correctly answered that the CIS covered clinical work in public hospitals. Approximately a quarter knew that the CIS covered locum work in public hospitals, with less than a fifth correctly identifying that the CIS does not cover clinical work in private hospitals.

Less than nine percent (8.8%) of trainees correctly identified that the CIS covers Good Samaritan acts in Ireland while 22.9% correctly identified that it does not cover Good Samaritan acts outside of Ireland. Only 13.5% correctly identified that the CIS does not cover disciplinary hearings or Medical Council Fitness to Practice inquiries. The average rate of incorrect and 'don't know' answers was 42.6%. Approximately 50% of respondents reported that they had purchased additional medical indemnity cover (Table 4), with the Medical Protection Society (MPS) having more subscribers (70.7%). Some respondents cited cost as a reason for choosing one private provider over the other. Eighty percent of Irish-national trainees obtained additional medical indemnity cover whereas only 40% of other nationalities did so. Of those who obtained additional cover, advice from colleagues was the main reason reported for obtaining additional cover (60%).

Table 1

Demographic data	Male	Female	Total
	97 (65.5%)	51 (34.5%)	148
Age range			
20-25	2 (2%)	3 (5.9%)	5 (3.4%)
26-30	15 (15.5%)	12 (23.5%)	27 (18.2%)
30-35	40 (41.2%	26 (51%)	66 (44.6%)
36-40	33 (34%)	9 (17.6%)	42 (28.4%)
41-45	3 (3%)	1 (2%)	4 (2.7%)
46-50	4 (4.1%)	0	4 (2.7%)
Nationality			
Irish	22 (22.7%)	22 (43.1%)	44 (29.7%)
European	3 (3.1%)	6 (11.8%)	9 (2%)
African	60 (61.9%)	15 (29.4%)	75 (50.7%)
Asian/Middle East	10 (10.3%)	7 (13.7%)	17 (11.5%)
South American	1 (1%)	1 (2%)	2 (1.4%)
Australian/NZ	1 (1%)	0	1 (0.7%)
Marital Status			
Single	31 (31.9%)	18 (35.3%)	49 (33.1%)
Married	65 (67%)	32 (62.7%)	97 (65.5%)
Divorced/separated	1 (1.1%)	1 (2%)	2 (1.3%)

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Table 2			
Psychiatry training and experience	Male 97 (65.5%)	Female 51 (34.5%)	Total 148
Basic specialist training scheme			
Cavan/Monaghan	3 (3%)	0 (0%)	3 (2%)
Donegal	3 (3%)	1 (2%)	4 (2.7%)
Mater/UCD	14 (14.4%)	6 (11.8%)	20 (13.5%)
Longford/Westmeath/Laois/Offaly	5 (5.2%)	1 (2%)	6 (4%)
Clare/Limerick/North Tipperary	3 (3%)	2 (3.9%)	5 (3.4%)
Sligo	3 (3%)	2 (3.9%)	5 (3.4%)
South Eastern region	5 (5.2%)	4 (7.8%)	9 (6%)
Cork/Kerry	7 (7.2%)	3 (5.9%)	10 (6.8%)
Galway/Mayo/Roscommon	8 (8.2%)	5 (9.8%)	13 (8.8%)
RCSI	13 (13.4%)	10 (19.6%)	23 (15.5%)
St. John of God	13 (13.4%)	5 (9.8%)	18 (12.2%)
Dublin University Psychiatric Rotational Training Programme	20 (20.6%)	11 (21.6%)	31 (20.9%)
General Practice trainee	0 (0%)	1 (2%)	1 (0.7%)
Years of psychiatric experience			
0-1	16 (16.5%)	12 (23.5%)	28 (18.9%)
1-2	23 (23.7%)	13 (25.5%)	36 (24.3%)
2-3	18 (18.6%)	10 (19.6%)	28 (18.9%)
3-4	18 (18.6%)	6 (11.8%)	24 (16.2%)
>4	22 (22.7%)	10 (19.6%)	32 (21.6%)

Table 3				
The Clinical Indemnity Scheme covers me for: N=148 (*Correct answer is highlighted)	Yes	No	Don't Know	Unanswered
Clinical work in public hospital	***105 (70.9%)**	0 (0%)	13 (8.8%)	30 (20.3%)
Locum work in public hospitals	***40 (27%)**	14 (9.5%)	38 (25.7%)	56 (37.8%)
Clinical work in private hospitals	20 (13.5%)	***28 (18.9%)**	44 (29.7%)	96 (64.95%)
Good Samaritan acts in Ireland	***13(8.8%)**	25 (16.9%)	54 (36.5%)	56 (37.8%)
Good Samaritan acts outside of Ireland	1 (0.7%)	***34 (22.9%)**	57 (38.5%)	56 (37.8%)
Coroner inquests	***18 (12.2%)**	11 (7.4%)	63 (42.6%)	56 (37.8%)
Clinical drugs trials/research	***8 (5.4%)**	27 (18.2%)	57 (38.5%)	56 (37.8%)
Disciplinary hearings	25 (16.9%)	***20 (13.5%)**	47 (31.8%)	56 (37.8%)
Medical Council Fitness to Practice inquiries	24 (16.2%)	***20 (13.5%)**	48 (32.45%)	56 (37.8%)

Discussion

When a healthcare accident occurs as a result of a medical error, it may result in an inquiry by the Fitness to Practice Committee of the Medical Council, review by the SCA and/or a court action. Inquiries by the Fitness to Practice Committee are primarily held to determine if a doctor acted in such a way as to have breached the code of practice of his profession. The SCA and the courts primarily determine culpability on the balance of probabilities and they award appropriate compensation for damages caused and costs incurred.

Since the middle of the twentieth century medical liability litigation has increased in severity and frequency.[9] In the UK, this increase has been attributed to the increasing tendency of patients to seek legal redress and to the rising amount of damages awarded for such legal settlements rather than due to an increase in clinical negligence.[10] There has been considerable debate about whether there has been a parallel increase in medical errors but all are agreed that the number of claims currently litigated represents only a small proportion of medical error cases.[9] This is further highlighted by the fact that autopsy studies have revealed that doctors misdiagnose one in five fatal illnesses[9]. The Department of Health in its report entitled 'Building a Culture of Patient Safety', published in 2008 stated in relation to medical errors that "although there are no available statistics for Ireland in this context, it must be assumed that the rate of preventable error in Ireland matched those described (internationally)". With the widespread introduction of the European Working Time Directive in Ireland, shorter shifts worked and more frequent handovers may also lead to an increased risk of medical error.[11]

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Table 4 Additional medical indemnity cover	
Additional Medical Indemnity Cover	**Total N=148**
Obtained additional medical indemnity cover	
Yes	75 (50.7%)
No	73 (48.6%)
Medical Indemnity Company	N=75
Medical Defence Union (MDU)	22 (29.3%)
Medical Protection Society (MPS)	53(70.7%)
Duration of additional medical indemnity cover (yrs)	N=75
0 – 1	13 (17.3%)
1 – 2	18 (24%)
2 – 3	19 (25.3%)
3 – 4	9 (12%)
> 4	16 (21.3%)
Reason for obtaining additional medical indemnity cover	
(allowed more than one choice)	N=75
Involvement in medico-legal case	10 (13.3%)
Mandatory at place of work	20 (26.7%)
Advice from colleagues	45 (60%)

The SCA which oversees the CIS may expect that their payouts for medical negligence claims will increase in the coming years. This is not only due to the number of claims which are expected to mature in time, but also to a forecasted increase in the number of claims in line with 'higher compensation awards and the chance for successful claimants to win back their legal costs'.[12]

Indeed, with the rising medical litigation rate and the cost of these cases, organisations like the British Medical Association (BMA)[13] and the General Medical Council (GMC) have advised that all medical practitioners must obtain adequate indemnity for any part of their practice not covered by the employers' indemnity scheme, for the patients' best interests as well as that of the medical practitioner.[14] This guidance presupposes that the medical practitioner has or should have a detailed knowledge of what employers' indemnity scheme is and what it covers. In order to heed this advice trainees need to acquaint themselves with the CIS viz-a-viz their practice.

The Medical Council advise that if it receives a complaint concerning a doctor, that doctor should refer to their Medical Defence Organisation for 'advice and guidance' in providing a response to the complaint.[15] The Medical Council makes it clear that the CIS does not cover such complaints to the Medical Council or representation at Fitness to Practice Inquiries. Medical defence organisations like the MDU and the MPS provide advice on medico-legal and ethical aspects of clinical practice. They also provide professional support, legal representation, assistance with media relations and offer useful tips on inquiries into professional competence.[16, 17] They may also help to advice on potential grey areas in a clinical incident report.

However, despite the expected rise in cases of medical litigation and the advices offered by the Medical Council, research on cases of medical claims/complaints involving non-consultant hospital doctors (NCHDs)/'junior' doctors in Ireland remains limited. Oglesby in her analysis of data from the SCA and CIS in relation to emergency medicine incidents and claims in Ireland found that senior house officer grade and registrar grade doctors were more likely to be involved in claims (74% and 14% respectively) than consultant grade doctors (14%). Additionally, an analysis of claims by specialties documented by the SCA from the inception of the STARSWeb reporting system to 2008 revealed that mental health-related claims ranked fifth behind medicine, surgery, obstetrics and gynaecology[18] in that order.

Our study has shown that Irish national psychiatric trainees had a better awareness of the existence of the CIS than non-Irish national trainees. They were also more likely to have obtained additional medical indemnity cover. As these trainees obtained their medical training in Ireland with clinical postings in hospitals in Ireland, we believe that they received greater exposure to the CIS via conversations with senior colleagues and also via the mass media. Overseas-trained trainees may lack awareness of the medical indemnity issues that pertain to practice in Ireland as these may be quite different to their previous jurisdiction of basic medical training and practice.

This study has revealed considerable gaps in the knowledge of trainees regarding the coverage of the CIS. These gaps may not only lead to a risk of exposure of personal financial assets to court awards but may also result in overspending on additional indemnity. Furthermore, it may lead to an unduly restrictive choice of career path or impede practitioners in their work. This is an area which merits further exploration in future studies. We have also demonstrated that while the majority of basic psychiatric trainees are aware of the existence of the CIS, their level of knowledge about the coverage it offers them is limited. Because certain aspects of practice are not covered by the CIS, trainees in our survey invested in additional cover mainly on the advice of

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colleagues. However, it is worth noting that approximately 16% of trainees regard it as the duty of the State to indemnify them against personal fitness to practice costs (Table 3). This finding draws attention to a flaw in the current system of publicising the CIS. Indeed, although we did not explore the information given to trainees in induction programmes into psychiatry, anecdotal evidence and our personal experiences would suggest that this is an area that receives only a fleeting mention in the majority of these programmes. As such, consideration should be given to including standardised information on medical indemnity in induction programmes for trainees with refresher sessions every six months during rotational placements. This is currently the case for trainees who rotate through the Central Mental Hospital Dundrum where an additional medical indemnity cover is a mandatory prerequisite for commencing postings and is included in the trainee induction programme. However, all trainees have a responsibility to educate themselves on the CIS and other medical insurance schemes available in Ireland, and on what their additional medical indemnity cover provides.

Conclusion

There is scant research on issues relating to clinical indemnity amongst NCHDs in Ireland in general and more specifically, amongst psychiatric trainees. This study has shown considerable deficiencies in basic specialist trainees' knowledge of the CIS. In particular, the poorer knowledge of non-Irish national trainees is of concern. As a result individual trainees may be at risk of adverse professional and financial consequences. In order to improve knowledge of the CIS, stakeholders (including hospital management, consultants and supervisors) must play an active part in providing more information at regular intervals to trainees. Additionally, more research is required to determine trends of medical litigation; Fitness to Practice cases involving trainee doctors in general, and psychiatric trainees specifically. Future studies may also examine the impact of the current economic recession on such cases and on the uptake of additional medical indemnity cover by trainees.

The limitations of this study included the lack of enquiry from respondents about whether medical indemnity was covered in their induction programmes. Additionally, while trainees were asked about their involvement in a medico-legal case as a reason for obtaining additional cover, no distinction was drawn between Fitness to Practice inquiries and court actions for medical errors.

Conflict of interest

None.

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