Nigerian Medical Journal
NIGERIA MEDICAL ASSOCIATION
Print ISSN 0300-1652, E-ISSN 2229-774X

Original Research

Evaluating the Knowledge and Awareness of Professional Indemnity Insurance among Medical Doctors in Nigeria

***Ayodele Kabir Alao[1], Adewumi Oluwaseun Taiwo[2], Adeniyi Olanipekun Fasanu[3], Ayodeji Oluwaseun Owolabi[4], Saheed Ademola Balogun[5], Raliat Modupeola Anjous-Alao[6]**

[1]Department of Obstetrics and Gynaecology, Broomfield Hospital, Chelmsford, Essex United Kingdom, [2]Department of Obstetrics and Gynaecology, Morning Star Hospital, Port-Harcourt Nigeria, [3]Department of Obstetrics and Gynaecology, UNIOSUN Teaching Hospital, Osogbo, Nigeria. [4]Department of Obstetrics and Gynaecology, Royal Surrey County Hospital, Guildford, United Kingdom. [5]Department of Obstetrician and Gynaecologist, Yobe State Teaching Hospital, Yobe, Nigeria. [6]College of Natural and Applied Science, Fountain University. Osogbo, Nigeria.

Abstract

Background: Professional Indemnity Insurance (PII) is an important cover for health professionals against the risks of legal and financial consequences of medical malpractice lawsuits. Nigerian medical doctors are still not adequately informed about it. This cross-sectional study evaluated PII knowledge and awareness among 300 registered physicians across different settings in Nigeria, including urban tertiary hospitals, rural clinics, and private practice.

Methodology: A self-validated questionnaire collected socio-demographic data, medical specialties, and the extent of PII knowle1dge. Descriptive and inferential statistics were used to analyse the data. Outcomes revealed that merely 32% of participants possessed sufficient knowledge about the purpose and scope of PII. Knowledge was significantly correlated with years of experience ($p=0.03$), with senior physicians exhibiting higher awareness, as well as practice setting ($p=0.04$), with doctors working in urban tertiary institutions performing better than those practising in rural clinics.

Results: In particular, 45% of urban tertiary hospital physicians expressed familiarity with PII, compared with 22% of rural clinic physicians, presumably due to greater access to professional resources. These disparities indicate a large gap in PII awareness, particularly in the countryside.

Conclusions: To address this, the integration of medico-legal modules into medical training, as implemented in South Africa, would enhance knowledge among newly qualified doctors. Targeted education interventions, such as workshops and continuing medical education courses in diverse practice settings, would be required to bridge the gap. This would empower Nigerian doctors with the knowledge needed to access PII and hence better protect themselves and patients.

Keywords: Knowledge; Awareness; Indemnity; Nigerian; Doctors.

***Correspondence:** Ayodele K. Alao. Department of Obstetrics and Gynaecology, Broomfield Hospital, Chelmsford, Essex United Kingdom.
Email: harlahow@yahoo.com

How to Cite: Alao AK, Taiwo AO, Fasanu AO, Owolabi AO, Balogun SA, Anjous-Alao RM. Evaluating the Knowledge and Awareness of Professional Indemnity Insurance Among Medical Doctors in Nigeria. Niger Med J 2025; 66(4):1479-1485.https://doi.org/10.71480/nmj.v66i4.956.

Quick Response Code:

Introduction

Professional Indemnity Insurance (PII) protects medical professionals against malpractice claims by covering the cost of legal fees, compensation, and other expenses [1]. In low- and middle-income countries (LMICs) such as Nigeria, where the health system is marred by chronic shortages of resources, high out-of-pocket expenditure, and rising levels of litigation, PII is particularly vital but underused [2,3]. Nigeria's legislative mandate, as stipulated in Section 45 of the National Health Insurance Scheme Act (1999), is indemnity coverage for health practitioners, and there are penalties for default [4]. There is poor enforcement and thus low take-up amid increasing medico-legal risk. The latest statistics from the Nigerian Insurance Association show that PII penetration within healthcare providers is below 30%, and medical PII premiums are below 0.5% of the total premiums on non-life insurance at the national level [5]. Estimated malpractice suits ranging between 15– 25 per annum in state and federal courts are on the rise [6]. Professional bodies such as the Nigerian Medical Association (NMA) only recently included medico-legal protection of risks in national conventions [7], yet awareness is patchy.

A review of existing literature shows that LMIC studies always report low PII awareness and use, always due to voluntary programmes, weak enforcement, and thin insurer penetration [2,6,7,8]. In contrast, developed countries like the UK have near-universal uptake driven by legal mandates and strong professional advocacy (4). Within sub-Saharan Africa, research in Ghana and South Africa shows higher awareness where medico-legal education is embedded in training curricula [6,9]. In Nigeria, prior studies found awareness rates of about 30% [8], with misconceptions about PII’s mandatory status. These trends signify three dominant patterns in LMICs: regulatory guidelines typically exist but are poorly enforced, knowledge gaps are greater among early-career and rural practitioners, and low emphasis on medico-legal themes in medical education continues to drive low utilisation.

Problem Statement

While medical malpractices against physicians are increasingly occurring, and despite legislative interventions, PII is underused among Nigerian physicians. Such a gap in usage and awareness undermines both practitioner cover and patient care within a litigious healthcare environment.

Objectives

The study objectives were to evaluate the level of awareness of Professional Indemnity Insurance among medical doctors in Nigeria; To identify the knowledge of medical doctors regarding the purpose, benefit, and coverage of PII and to provide an appropriate recommendation based on the outcome.

Methods

A cross-sectional design study was conducted among 300 registered medical doctors in Nigeria, stratified based on geographic location (North, South, East, West), environment of practice (teaching institutions, private clinics, public hospitals), and experience in years (0–5 years, 6–10 years, >10 years). Inclusion criterion for "good knowledge" was provided by having answered ≥3 of 4 key knowledge questions regarding PII correctly. Data was collected over three months via a validated, self-reported questionnaire (Cronbach's alpha = 0.82), administered via Google Forms and face-to-face at medical conferences and hospitals. Use of Google Forms for distribution may have introduced digital literacy bias and possibly underrepresented older or rural doctors with inadequate internet access. Informed consent ensured anonymity. Data was analysed via SPSS to generate descriptive and inferential statistics, including chi-square analysis and logistic regression.

Results

Table 1: Socio-demographic Characteristics of Respondents (n=300)

Variable	Category	Frequency (%)
Age	<30 years	60 (20%)
	30–40 years	150 (50%)
	>40 years	90 (30%)
Gender	Male	180 (60%)
	Female	120 (40%)
Practice Setting	Urban	180 (60%)
	Rural	120 (40%)
Years of Experience	0–5 years	90 (30%)
	6–10 years	120 (40%)
	>10 years	90 (30%)

In terms of age, the majority were between 30 and 40 years old, comprising 150 individuals or 50% of the total, while those under 30 years accounted for 60 participants (20%), and those over 40 years made up the remaining 90 (30%). Males predominated with 180 participants (60%), compared to 120 females (40%). Of the total respondents, 60% were based in urban areas, whereas 120 (40%) operated in rural environments.

Table 2: Specialty of Respondents (n=300)

Specialty	**Frequency (%)**
General Practice	120 (40%)
Surgery	75 (25%)
Internal Medicine	60 (20%)
Others	45 (15%)

Regarding the specialty distribution among the 300 participants, General Practice was the most common, with 120 individuals (40%) identifying in this category. Surgery followed with 75 participants (25%), while Internal Medicine accounted for 60 (20%). The remaining 45 participants (15%) fell into other specialties.

Table 3: Knowledge of Professional Indemnity Insurance (n=300)

Question	Correct Response (%)
PII covers malpractice claims	96 (32%)
PII includes legal fees	105 (35%)
PII is mandatory in Nigeria	60 (20%)
Overall adequate knowledge	96 (32%)

Among the study participants, 96 individuals (32%) correctly indicated that PII covers malpractice claims, and 105 (35%) knew that it includes coverage for legal fees. However, only 60 participants (20%) were aware that PII is mandatory for medical practitioners in Nigeria. Overall, just 96 participants (32%) demonstrated adequate knowledge of PII.

Table 4: Association between Socio-demographic Data and Knowledge of PII

Variable	Adequate Knowledge (%)	p-value (Chi-square)
Years of Experience		0.03
0–5 years	18 (20%)	
6–10 years	36 (30%)	
>10 years	42 (47%)	
Practice Setting		0.04
Urban	68 (38%)	
Rural	28 (23%)	

The analysis revealed significant associations between adequate PII knowledge and both years of experience (p=0.03) and practice setting (p=0.04). Knowledge increased with experience: 20% for 0–5 years, 30% for 6–10 years, and 47% for >10 years. Urban practitioners showed higher knowledge (38%) than rural ones (23%), highlighting the need for targeted education in less experienced and rural groups.

Discussion

The finding that only 32% of Nigerian doctors manifested adequate PII knowledge is an endemic knowledge gap that has been found in earlier Nigerian studies [8] and, to a lesser degree, in other LMICs such as Ghana [6] and India [10]. Despite legal requirements under the NHIS Act mandating indemnity cover [4], the lack of effective enforcement mechanisms renders these legal safeguards more theoretical than practical. This regulatory gap might explain why PII uptake has levelled off over the past decade despite noted increases in malpractice claims [7,11]. Knowledge was strongly correlated with years of practice experience (p=0.03) and practice site (p=0.04) in our study. These patterns are consistent with prior South African literature, where sensitisation was strongest among older physicians and those practising in urban tertiary institutions [9]. The observed experience gradient could be due to built-up exposure to medicolegal occurrences, peer discussion, or firsthand experience of litigation issues that are a basis for the perceived need for indemnity cover.

Higher urban awareness could be a consequence of enhanced access to CME, conference participation, and insurer promotional activities, as well as more intense professional networks. This aligns with broader evidence of urban-rural disparities in access to opportunities for professional development in Nigeria's health system [3,12].

The 80% under perception among the respondents that PII is obligatory in Nigeria, despite a poor enforcement climate, indicates how misinformation directs gaps. Such misperception can be the result of ambiguous messages in regulation reports, partial orientation of licensures, or absence of harmonized delivery of information by the NMA and other authorities. It opens the door for targeted public information campaigns that articulate both the legal and functional benefits of PII. From a systems point of view, low PII knowledge is not only an individual shortcoming but also a sign of deeper structural problems. Nigeria's medical curricula do not automatically include medico-legal modules, in contrast to South Africa and some other LMICs [6,12,13], resulting in a professional culture that makes legal preparedness reactive as opposed to preventative. This has patient safety implications, as poor PII coverage can cause undue delay in compensation in cases of malpractice, which reduces public confidence in the health system. Secondly, the limited size of the PII market, constituting less than 0.5% of non-life insurance premiums [5,13,14] which is an indicator both of ignorance on the demand side and of supply side constraints like insurer hesitancy to venture into a niche market in the absence of policy incentives.

The persistence of these gaps despite heightened medico-legal exposure suggests that awareness interventions will be inadequate without accompanying reforms in enforcement and financing. Mandatory PII linked to annual licensure renewal, similar to the UK model (4,14), would provide uniform coverage. Subsidized rural and early-career physician premiums, perhaps with public-private partnerships, could provide a financial incentive while at the same time incentivizing insurer entry in underserved markets.

The close interactions between experience, geography, and knowledge infer that interventions need to be location-specific and career-stage–specific. Mandatory medico-legal training for intern doctors can benefit early-career physicians, and decentralized CME delivery via mobile learning platforms or local workshops may be required for rural physicians. These measures, in addition to enforcement of policies, can be sufficient to stimulate PII take-up from voluntary, low-priority spending to a professional norm, hence promoting both practitioner protection and patient safety in Nigeria.

Conclusion

This study reveals a striking gap in Nigerian doctors' knowledge of Professional Indemnity Insurance (PII), grouped around seasoned and city-based doctors and remaining far lower in early-career and rural doctors. Despite such provisions in the statutory law under the NHIS Act, poor enforcement, absence of formal medico-legal training, and unequal access to professional resources have kept PII take-up low. These findings underscore that PII is not just an individual protection measure but a building block of an effective, responsible health system. Inadequate coverage and education erode patient trust, delay fair compensation in malpractice cases, and expose physicians to legal and financial risks. These shortcomings may be addressed with more than voluntary educational initiatives it will require collaborative effort involving curriculum reform, focused CME delivery, public–private partnerships for premium financing, and robust policy enforcement. If implemented, these measures would make PII a norm of professionalism at every level of career and in all practice settings, strengthen Nigeria's medicolegal system, and move the health system more in line with international best practice in professional responsibility and patient safety.

Recommendations

To correct the gaps in knowledge and uptake of Professional Indemnity Insurance among Nigerian doctors, there is a need for an extensive intervention on the part of stakeholders. The Federal Ministry of Health, in collaboration with the Nigerian Universities Commission, must ensure that medico-legal education is integrated into medical undergraduate and postgraduate courses as a statutory requirement. Including stringent medico-legal training at an early level in the careers of doctors will create a knowledge base and legal consciousness. Furthermore, the Nigerian Medical Association (NMA) must take charge of targeted continuing medical education (CME) programs directly for rural practitioners and young physicians, who have the lowest levels of awareness. The programs may be offered through workshops, webinars, and low-cost online courses that can be accessed by practitioners regardless of physical location or digital knowledge. These interventions will help reduce the urban-rural divide in professional indemnity awareness and promote lifelong learning. Professional associations and insurers should work together to create plain, clear, and widely distributed information materials on PII coverage, benefits, and procedures. Joint action of this sort could cut through misunderstandings and enhance uptake by making the information more understandable and accessible to doctors.

On the regulatory side, there should be enhanced enforcement of current legal measures, including tying PII coverage to medical license renewal under the National Health Act. The regulatory sanction would provide incentives for doctors to keep indemnity insurance throughout their careers. In addition, the introduction of subsidized premiums or mechanisms for financial support, potentially through public-private partnerships, could help remove financial hurdles, especially for young doctors and those practicing in rural areas who can find premiums unaffordable. Together, these strategies—curriculum reform, targeted CME, insurer collaboration, policy compliance, and financial assistance can assist in creating an enabling environment in which professional indemnity insurance is an available and normative aspect of medical practice across Nigeria.

Limitations

Response bias could have occurred if doctors who knew at least something about PII were more likely to participate. Web delivery may have excluded less computer-savvy doctors. Self-reported expertise may not have comprised applied skill; future research should include observation or qualitative measures to capture applied skill.

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