A "medical examination" of an applicant for insurance is traditional.

In much of the United States and Canada it is becoming difficult to find a reliable panel of medical examiners. Very few doctors seek appointment as medical examiners, after their first few months in practice. Even when appointed, very few examiners do a sufficient number of insurance examinations that the work is a significant part of their professional activity or income. As a consequence, there is little or no sense of personal obligation to the insurance company, or to the applicant. Appointments for "examinations" are hard to get, often entail significant delay and inconvenience and are increasingly expensive, without commensurate increases in quality. At the same time, they are often regarded by physicians as an imposition, or at least as a necessary nuisance.

A parallel situation exists with attending physicians's statements. These are very often required simply to fill out inadequate leads contained in sketchy answers on the original "medical examination". Many physicians, when asked for a.p.s. details, feel that the traditional fees offered are inadequate; as one result the physician gives preparation of an a.p.s. very low priority in time, in organization, and in content.

Careful reflection suggests that even the term "medical examination" is not correct. Nearly all of the information required for underwriting of insurance applicants is included in a detailed health statement, with little or no significant information added from physical examination.

(Possible exceptions are body build, previously unknown arterial hypertension, glycosuria or cardiac murmur. However, in these times of frequently required "examination" for school admittance, for employment, or for membership in one or another group, it is very rare indeed for a person whose maturity, income, and business or family obligations require him to have insurance, not to be aware of any such exceptions.)

Practically all the information required for underwriting an applicant for insurance is known to the applicant, without delay, at the time he applies.

No matter how approached, almost the only source of information for the health statement of an applicant,
(whether developed by a nurse, a physician, a paramedical technician, an insurance agent, or a subsequent home office letter of inquiry, or telephone inquiry), is the applicant himself.

The challenge is how to unlock the full wealth of this rich information source, at the actual moment of application.

To accomplish this will sharply speed underwriting, will expedite automatic policy issue by computer, will minimize delay, minimize irritation, and sharply minimize the underwriting expense of processing, correspondence, and phone augmentation of information which was inadequate at the time of application.

A clinical history, intended to clarify details of a current illness, is quite different from a general health statement for insurance underwriting. Inter-personal dynamics between patient and physician are vital in a clinical history development setting. They are often destructive, or at least counterproductive, in development of an insurance health statement.

The original selection of a clinical physician as an insurance medical examiner clearly assumed that he was the most intelligent and best trained person to develop a health history. This is no longer a valid assumption, or a reason to use the physician for taking an insurance health statement, if it be clearly recognized that a personal health statement is quite different in many respects from a clinical medical history.

It is now vital to discover who - or what technique - is apt to be most effective, and cost efficient, in developing the insurance health statement.

Since the usual objective of a health statement is accurate classification of the applicant with a group whose mortality or morbidity experience is - or can be - accurately known, it would appear highly desirable that an insurance health statement be developed in a predictable, comparable, and standardized way.

It is, of course, clearly logical that the way to get information in detail from an applicant is to ask him. There is usually no more effective way to get an answer to a question than to ask the question. Or to restate the same proposition, there is no way to get the answer to a question except to ask it.

However, due to many historic and developmental factors, this is not now being done.

To an agent, brevity in an application appears paramount. Following this imperative, the traditional Part II of an insurance application is compressed to the point of ineffectiveness, even when it appears to ask all the points which ALIMDA suggested several years ago to be desirable. As a matter of common practice, an office nurse is requested to ask, and to record, answers to medical questions. She does this hurriedly, in the combined form in which she finds them. The result, even by a highly motivated nurse or doctor is very inadequate.

Quite obviously, an applicant's response to: "You never had chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels - did you?" ("Answer yes or no"), is a world apart from the same questions asked in the following fashion: Did you ever have palpitation? ("Yes or no"). Did you ever have high blood pressure? ("Yes or no"). Did you ever have rheumatic fever? ("Yes or no"). Did you ever have a heart murmur? ("Yes or no"). Did you ever have a heart attack? ("Yes or no"). Did you ever have any other disorder of your heart? ("Yes or no"). And Did you ever have any disorder of your blood vessels? ("Yes or no"). This world of difference becomes vastly wider when, by the inherent magic of branched logic, it is quickly possible to add specific questions to any positive response, while quickly passing on by any negative response.

This vast difference is immediately apparent to even the most casual observation. Yet, because of apparently insurmountable psychologic or other barrier, the superiority of standardized detailed branched logic questioning has been almost totally overlooked and is rarely, if ever used for insurance applications.

An attempt to develop a branched logic questionnaire produced about 126 primary questions, and required a 13 page pamphlet. Single copies of this questionnaire (TST Health Statement) are available on request. This sheer number of questions - and pages - were perceived as such a shock by marketing people, executives, agents, and very few applicants that the attempt was rejected out of hand - and given no further chance for attempted pilot trial or application.

Yet, limited experience demonstrates that the branched logic progression of moving from one positive response to the next pertinent question, while making no move from a negative response, makes it possible, in a healthy "standard" applicant, to complete the TST statement in about twenty minutes, while even a highly impaired applicant can usually complete it in forty-five minutes.

There is very little psychologic shock in one single question at a time, easily answerable by "yes or no", with no further questions apparent till each one is answered.

There is very little psychologic shock in a well trained person presenting to the applicant one single question at a time. (It is vital that the interviewer avoid any dynamic bias in presenting the question or in suggesting a desired answer.) As noted earlier, a trained interviewer can be a nurse, a doctor, a highly selected "non-medical" agent, a paramedical technician or even a completely impersonal computer console. Properly developed and applied, such a health statement could permit very high limits of insurance to be issued on a contact with a single highly select physician, select agent, nurse or paramedical agency. All that is required is to use a completely standarized, branched logic series of single questions, without bias, irritation,
haste or suggestion of desired response - and to record answers in simple, legible accurate form, with adequate details when they are appropriate.

This should not be difficult, once the time honored, heavily encrusted opposition is fully recognized and discarded.

Some exploration, highly tentative, is already under way. A few years ago Equitable Assurance made some steps in this direction. Some paramedical agencies, notably Bodimetric, have made some exploratory steps. More recently a number of companies, notably General American, are experimenting with detailed telephone health statement interviews. A number of mini computer companies, notably Keltron Corporation, have made highly important moves in this direction, even though so far primarily oriented to clinical history of current illness.

The potential saving of money, irritation, and time is tremendous, and justifies a maximum effort of the entire insurance industry.

To this end the development of an influential task force of ALIMDA, which can work closely with a similar task force of underwriters, from such a sister organization as HOLUA, is urgently needed now.

Such a task force has been promised by Paul Entmacher. Its potential is enormous, and should command the best supportive efforts of us all.

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Seminars on Mortality Methodology and Analysis

by Richard B. Singer, M.D.
Program Director

By the time this issue of the Journal of Insurance Medicine is distributed, the 6th Seminar, held at the Republic National Life Insurance Company in Dallas, Texas, March 25-27, will have come and gone. My thanks to Charles Lodowski for his excellent work as Arrangements Chairman for the 6th Seminar, on which I expect to report in a subsequent issue. The rest of this announcement will be devoted to the two forthcoming mortality seminars to be held in the Fall of 1980.

Both seminars will start on a Tuesday, and participants will be assigned to Section A starting no later than 9 A.M. Tuesday or Section B, starting the same time on Wednesday. The two sections will overlap for lecture material on Wednesday, 9 A.M.-2:30 P.M. and workshops with a maximum limit of 10 registrants, will be held before and after, so that I can handle them separately. The time for each participant at the seminar will therefore be a little more than one and a half days, and the seminars are accredited by Ferris Siber, our Director of Continuing Medical Education, for 11 AMA Category I credits. However, as many participants have emphasized, you should commit enough time, probably 20 hours of advance preparation work or more, and enough time for the assigned reading (reading twice, before and after the homework is very helpful, I have been told by more than one). I have called these "learning by doing" seminars. What you will be doing is a set of life table calculations, an attempt to set up mortality tables from data in an assigned article, and an attempt to understand how to apply these principles in underwriting work.

The 7th Seminar will be held at Toronto, Canada, September 23-25, 1980. If you plan to attend, please write or call as soon as possible, preferably before the end of June, confirming your reservation with a check for $100 made out to the Association of Life Insurance Medical Directors of America for the registration fee. Do this with the Arrangements Chairman, David J. Breithaupt, M.D., Medical Vice-President, the Manufacturers Life Insurance Co., 200 Bloor Street, East, Toronto, Ontario, Canada M4W 1E5 (phone 416-928-4252). Get your registration in early - if you wait for the seminar you may find yourself without sufficient time to do the advance preparation work.

The 8th Seminar will be held at Philadelphia, November 4-6, 1980. Information can be obtained from registration as above carried out with the Arrangements Chairman, D. Ernest Bulluck, M.D., Medical Director, The Penn Mutual Life Insurance Co., Independence Square, PA. 19172 (phone 215-629-0600). Again, you are urged to get your homework package early by sending in your check as soon as possible.