ASPECTS OF PRACTICE

Life assurance medicine

C. R. W. GILL
Joint Honorary Secretary of the Assurance Medical Society

General practitioners spend a considerable amount of time completing forms or examining proposers either for life assurance or for permanent health assurance (PHI). The Assurance Medical Society is the only society in the UK that brings the medical profession into contact with the life offices. I present some personal views in the hope that doctors will gain insight into what is required of them and at the same time might become interested enough to join the society, which was founded in 1893.

Medical attendant's report (MAR)

Doctors are frequently requested to fill in these forms about their patients. Few will know whether their patient is applying for life or disability assurance (PHI) or both, so it is advisable to have a uniform approach to completing them. Also the generous nonmedical limits on life assurance cover available these days mean that only after certain financial limits have been exceeded, or PHI cover is being requested, is it necessary to obtain a medical examination.

The MAR forms are needed to verify or amplify what has been disclosed on the proposal form. It is crucial that the doctor filling in one of these forms has the concept of relevance in mind at all times, particularly if there are copious notes and hospital reports. This is important because life offices are interested only in conditions that are likely to shorten expectation of life (mainly chronic progressive disorders in various body systems) or in self-destructive lifestyles such as overindulgence in alcohol and tobacco. Similarly, disorders that are likely to lead to premature disability or retirement, in particular chronic or potentially chronic orthopaedic disorders, are most relevant. Disorders that are self-limiting or cured completely such as influenza, childhood fevers, routine appendicectomy or tonsillectomy are not relevant.

Occasionally I am telephoned by doctors enquiring about highly confidential information such as therapeutic abortions, and one has to decide in each individual case whether or not this is relevant. Clearly an unwanted pregnancy without sequelae is irrelevant but if associated with a suicide attempt it may well be relevant.

For PHI purposes some idea of an individual's robustness is of great help, because the person who is always 'off sick' with minor ailments poses problems for the life office in correctly assessing the risks in order to be fair to the other policyholders who would otherwise be subsidising someone who is 'sick' but should really be at work.

The insurance medical examination

This has been well described (MacDonald, 1981). An idea why a proposer requires medical examination is very useful to the examiner. The main reasons are either a health problem that needs up-to-date evaluation, or the sum involved being large enough to warrant an examination or because there are no previous medical records available. The filling in of the history by the proposer and the rest by the examiner is not acceptable as important information can be missed such as the elucidation of the symptoms of neurological illness that turns out to be multiple sclerosis.

Asking a few extra questions such as 'What sport or exercise do you do?' is very helpful in ascertaining physical fitness and cardiopulmonary reserve. The testing of hearing by whispered voice in each ear, and visual acuity in each eye is extremely important for disability insurance—looking at ear drums and pupils is not enough as function as well as structure needs to be noted. Chronic orthopaedic problems should be sought and noted, as these are important for disability insurance but not necessarily relevant for life assurance. This usually means having a medical examination which is standard for both types of insurance.

Potentially serious disorders discovered by chance, such as grossly elevated blood pressure or diabetes, should be referred immediately to the general practitioner and a note made on the insurance form to this effect.

Advice to the medical officer of a company to refer a proposer to a cardiologist or a neurologist for clarification of signs found on examination should be resisted as this advice is not usually financially viable. It should be possible for the chief medical officer of the company to make a fairly accurate assessment of the risk by evaluating the data on the form from the examiner, if the information is reasonably detailed.

Disability claim forms

These have to be completed by general practitioners for patients who have disability insurance (PHI). They take two or three minutes to do and the important issue here is that the patient must be *totally* unable to perform his job, that is must be disabled. If he can do part of it he is not disabled. For this reason the doctor must think clearly before writing on the form and it is worthwhile giving enough detail for the claim to be assessed without further clarification by the chief medical officer of the life office.

Patients' reactions

On the whole doctors carry out these functions well. The MAR is required to confirm what is already on a proposal form and to prevent fraud. At the same time it may spare the proposer a medical examination and lowers the cost and inconvenience of taking out the required cover. Some doctors refuse to fill in forms in the mistaken belief that they are helping their patients. This really means that the patients have to be examined, and sometimes cover may have to be restricted because of the lack of verifiable information at the medical examination.

Occasionally patients are understandably upset if they

are rated, that is charged a temporary or permanent extra because of some impairment. The general practitioner should tell his patients why this is likely and can obtain this information by writing to the chief medical officer of the life office at head office. Difficulties also can arise when a hospital says that a proposer is cured of a particular form of cancer after say five years, and the life office only considers cures after 10 years.

The Assurance Medical Society

There are various areas of common interest between the medical and insurance worlds. The Assurance Medical Society provides a meeting place where topics, usually medical, are presented and discussed from an underwriting point of view. The Society does not distribute work and doctors who are interested in increasing the content of life assurance medicine in the practices should write to the chief medical officers of the offices that they have been doing business with and request that they be included in their list of examiners.

The Society has three evening meetings a year on the first Wednesday of February, May and November at the House of the Medical Society of London, 11 Chandos Street, London W1. Recently it has introduced an all-day meeting held once a year in a different part of the country. This year we are meeting in Edinburgh at the Royal College of Physicians on Friday 14 October.

Further details about the meeting and the Society can be obtained from Dr C. R. W. Gill, Blossoms Inn, 23 Lawrence Lane, London EC2V 8DA. (Tel: 01 606-6159).

Reference

MacDonald I D (1981). *Practitioner,* **225,** 659-664.

LETTERS

Healthier Children—Thinking Prevention

Sir,

We are pleased that Professor Bain and his colleagues should have given detailed attention to our report[1] (January *Journal,* p. 55) and we welcome constructive debate about child care in general practice.

We appreciate that they would like further research on the value of screening in general practice. We considered this argument carefully, and unanimously concluded that the greatest good could be done to the greatest number of children by starting our programme immediately. The programme which we identified especially in paragraph 7.26 is already well validated. Can Professor Bain or his colleagues challenge any one of the 20 suggested interventions?

It is not true that screening is presented as an activity that ceases at the age of five years. Our working party emphasized the importance of care throughout childhood, and indeed paragraphs 8.29 and 8.30 specifically recommended a new check-up for children in early adolescence. We agree that health visitors should continue to play a very large role and acknowledged this in paragraphs 5.2, 5.3 and 5.5.

Of course we accept that there are many systems for examining children, including both the Denver and Woodside methods. We were deliberately selective as our report was already longer than its four predecessors.

The responsibilities that we outlined will involve general practitioners as independent contractors in additional postage, paper, staff and duplicating costs and we believe that it is only fair that doctors who do this work should be reimbursed for it. We unanimously felt that this was an appropriate extension of the payments for public service which already exist for preventive medicine in general practice such as immunization, contraception and clinical cytology. Professor Bain and his colleagues may disagree, but we believe that most of the profession will see this as fair and appropriate. Suggestions from the United States about the fee for service approach are not relevant because those fees are paid by patients and not by the Government as in the UK.

Professor Bain and his colleagues may not fully appreciate the implications of our chapter on training. In fact it warmly endorses training, recommends its widespread introduction but does not believe that this should be used as an excuse for delaying the implementation of the service. The arguments against their proposals for general practitioner paediatricians are reproduced in Appendix 18. Our chapter on training certainly does not duck the challenge of the Court report.

We agree that most handicapped children will require the benefit of consultant care and we welcome shared care arrangements for them. We also agree that most consultant paediatricians do have a great interest in the physical, psychological and social factors of child care but they do not normally have as much knowledge of the health care of the other members of the family or of the home.

The Livingstone Primary Care Scheme is an interesting experiment. It has not however been reproduced in other parts of the UK and the essential message of our report was to propose a system that could be introduced in England, Scotland, Wales and Northern Ireland immediately.

We have been encouraged by the growing number of general practitioners who are now getting on and doing this work. We still think that this is one of the highest priorities for the future development of clinical work in general practice.

DENIS PEREIRA GRAY
Joint Convenor, Working Party on Child Care.

Reference

1. Royal College of General Practitioners. *Healthier Children—Thinking Prevention. Report from General Practice 22.* London: RCGP, 1982.

Attitudes to Audit

Sir,

According to the authors of the recent article (May *Journal,* p. 263) the results of an exercise among general practitioners in the Doncaster area point to a bleak outlook for audit in general practice. To the authors' evident disappointment, only 28 per cent of those approached took part.

However, the prospects for audit in general practice may not be as gloomy as they suggest for a variety of reasons. A similar exercise conducted in five districts in Greater Manchester produced a better response. Of the 522 doctors invited to take part in a study of their practice patterns, 44 per cent agreed in principle to do so and 40 per