INSURING THE OLDER PATIENT AND DRIVER SOME IMPORTANT PERSPECTIVES

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"Age is important only if you are wine or cheese."
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"We don't crave immortality, but we must reach out to the limits of what is possible for mankind."
Pindar (500 B.C.)

When a thing ceases to be a subject of controversy, it ceases to be a subject of interest.
Anonymous

The Insurance industry is quite aware of the demographic fact that "senior citizens" represent the fastest growing segment of the United States population. To cite a single statistic, over 12 percent of the population is now 65 and over; it probably will exceed 17 percent by 2020. In a sense, this article could have been titled, "The Challenge of threescore and Ten For the Insurance Industry."

Accordingly, its medical directors and underwriters must attempt to recognize and remedy undue bias pertaining to persons over 65 who seek affordable health and driving insurance.

An Overview of Related Considerations

Many practical reasons underscore the necessity for such sensitivity. A few are listed.

- Agism has been rampant in this industry. It will prove self-defeating, however, as the ranks of the "young old" (or perhaps more accurately the "old young") and the "middle old" swell, and as competition for their insurance becomes international.
- Business organizations and the professions alike increasingly depend upon the skills and maturity of older persons. They currently confront the combined consequences of mediocrity in education and training, our birth dearth, deficiencies in attitudes relative to discipline and commitment, and the greater number of poorly skilled immigrants in the labor pool. In many instances, corporate survival itself depends upon such cadres of older employees.
- The nation's fiscal stability will be impacted negatively by a disproportionate reduction of its employable elders as several "hassle factors" — notably confiscatory income taxes and the prohibitive costs of medical and driver insurance — become unacceptable. A case in point is the outflow of Social Security "trust funds" when active persons elect to retire at 65 rather than at 67 or older.
- A driver's license often constitutes the principle basis for the economic and social independence of persons over 65. This is poignantly evident in "retirement communities" that have poor or nonexistent public transportation systems, as in my area. Arbitrary hurdles by the insurance industry therefore should be discouraged.
- Prejudice by underwriters toward certain diagnoses (see below) may be unreasonable. This is especially true when older persons not only are receiving competent medical care, but also evidence responsibility in terms of compliance and adhering to preventive personal habits.
- Primary-care and specialty physicians alike have been intimidated by the medicolegal risks inherent in provid-

ing too much *or* too little information in insurance forms. This anxiety is illustrated by the prospect of suit by a third party who claims to have suffered injury at the hands of a patient "who shouldn't have been driving in the first place." Indeed, refusal of a treating physician to complete a driver's insurance form could be logically regarded as "practicing defensive medicine."

The Author's Background

Before discussing several facets of this overview, some of which may be novel to the reader, brief reference to my background seems in order.

- I have been certified and recertified by the American Board of Internal Medicine.
- I am a member or fellow of several prestigious medical and scientific organizations (e.g., the American College of Physicians, the American College of Chest Physicians, the Endocrine Society, the American federation of Clinical Research, Sigma Xi).
- I have practiced in the trenches of clinical medicine as both a primary-care physician and a consultant for four decades.
- I was honored by peers (without my knowledge) for inclusion in *The Best Doctors in the U.S.*
- I have authored over 200 original articles and letters, and six texts — including *Difficult Diagnosis: A Guide to the Interpretation of Obscure Illness*[1], and *The Causes, Ecology and Prevention of Traffic Accidents.*[2]
- I was asked to represent the United States at a 1972 meeting convened in Paris by the Council of Europe relative to establishing international driver standards.
- I have selectively served as an expert witness for both plaintiffs and defendant insurance carriers in cases deemed to be meritorious. Some involved issues herein considered.

More on Agism

The frequent loose use of the defeatist term "aging" — as in "aging driver, "aging pilot," "aging football player," "the aging process," and even "aging and cognitive function" — indicates the infra-geriatric extent of such prejudice. It equates aging with disability, disease, or "the downslope of living." In a similar vein, Dr. Theodore B. Schwartz[3] challenged "the specter of decrepitude" held by many physicians in what ought to be viewed as "the harvest years."

Unreasonable discriminatory decisions by insurance medical directors and underwriters that are based primarily on chronologic age are as deplorable — and possibly unethical — as when they occur in patient care. An example of the latter is failure to adequately pursue the diagnosis and treatment of an "elderly" patient with a so-called living will, who then developed an acute life-threatening illness.[4]

The Older Driver

The insurance industry must not reinforce the broad brush of agism aimed at "getting older drivers off the road" being wielded by well-intentioned citizens and legislators. Examples include such practices as (a) mandatory annual physical examinations, (b) the completion of forms by physicians who may be given only one or two lines for pertinent comments (e.g., a highly cooperative and conscientious patient), and (c) subjecting older drivers to testing that is not required of younger persons (e.g., parallel parking.)

Exasperation over the perception of impaired vision or hearing, slow driving, delayed responses to signals, and apparent confusion at busy intersections or highways by older drivers is understandable. Such vexation, however, must be balanced against the *self-imposed* restrictions by many experienced drivers who value their licenses.[3] Some examples:

- Avoiding rush hours
- Avoiding roads with heavy traffic
- Avoiding driving at dusk or night
- Avoiding driving when fatigued
- Avoiding drugs that may cause fatigue or drowsiness...and inquiring about these side effects
- Avoiding alcohol
- Limiting the amount of driving
- Driving "defensively"
- Minimizing potential obstacles when selecting a car (e.g., the avoidance of vehicles with large blind spots, excessive window tinting, glare from chrome, the close proximity of pedals, and poor visibility of the instrument panel, controls or gear position)
- The acceptance of driver limitations imposed by departments of motor vehicles
- *Voluntary* relinquishing of one's license because of poor health

Individual physiologic ability and motivation are paramount in this sphere, and must be recognized by medical directors. For example, Harold W. Bowman[5] wrote in response to his state representative's proposal for mandatory testing of drivers 80 and older:

> I am 87, have an enviable driving record and a "safe driver" license. I recently took a course (voluntarily) in driving safety, designed specifically for the aging. I learned a lot and, upon graduation, received a reduction in my insurance. I am willing to be tested every two years. The proposed law would contribute not only to my safety, but also to that of those who let wishful thinking interfere with their good sense.

These and related factors deserve specific inquiry, careful study, and compassionate consideration by insurance physicians and underwriters if a win-win accommodation is to be achieved. The American Medical Association made the following pertinent statement concerning older drivers in *Medical Conditions Affecting Drivers.*[6]

> Tending to reduce the risk of crashes of the elderly is the fact that many retired persons, acting either on their

own or under advice from their physicians, alter the amount and the type of driving they do...Because there is such wide variation in individual capability among the adults of any age group and especially among the elderly, recommendations are not given here relating age *per se* to the driver's medical qualifications and the class of vehicle that he or she is medically qualified to drive. Rather, the decision about the elderly persons's driving should be based on the findings in that person and on the associated fuctional limitations.

Selected Diagnostic Prejudices

In dealing with senior citizens, physicians in the industry must practice "insurance medicine" rather than "life insurance medicine" for reasons previously summarized. Recent advances in medicine, nutrition, technology, and other fields have radically changed some actuarial statistics. These insights obviously ought to be made operational in determining both insurability and costs.

The readers of this journal are aware of these generalities. They also have ready access to major texts and other published guidelines dealing with disability risk or evaluation.

My further comments address a few of the important nuances that require judgement in the pursuit of enlightened underwriting. Some that seem controversial are based on prolonged observation and personal research. In effect, I hope to challenge and stimulate optimal inputting in the computerized "expert system" used by experience medical directors.

- I have been unable to find actuarial data indicating an increased risk of "sudden death at the wheel" in persons with *controlled hypertension* who have no other major risk factors.
- I believe an increase of premiums for older persons based solely on an *"elevated cholesterol level"* is unwarranted and discriminatory. I have repeatedly emphasized that "cholesterol has to be understood rather than lowered."[7] Conversely, I am not familiar with actuarial data indicating that protracted reduction of the cholesterol concentration *per se* lowers the mortality of persons over 65.
- The activity and longevity of older patients with *coronary (ischemic heart disease* have been dramatically extended by contemporary medical and surgical treatment. It is inappropriate to deny affordable driver insurance to such individuals, especially when they remain symptom-free for relatively prolonged periods.
- *Diabetic patients* who adhere to a sound medical and dietetic regimen, and who have either no or only mild neuropathic symptoms or "background retinopathy," deserve sympathetic consideration. I also place considerable emphasis upon the avoidance of insulin reactions and "hypoglycemic" attacks through proper dosing and snacks — especially for drivers. In my experience, blind insistence upon "strict control" has harmed many older patients by the aggravation or precipitation of diabetic and cardiovascular complications.[2,8–11]
- Moderate degrees of *osteoarthritis* or *obesity* in active older persons do not justify rejection for insurance.
- *Narcolepsy* (pathologic drowsiness) in persons of *any* age poses a unique challenge to insurance physicians because (a) it is a common cause of unexplained "fatigue," (b) this diagnosis is based largely on obtaining an accurate history of the narcoleptic complex, (c) it is *frequently* overlooked by physicians, (d) patients resort to a variety of compensatory mechanisms (viz., caffeine, frequent naps, and avoidance of heavy meals and alcohol), (e) drivers and pilots often deny such an affliction for fear of losing their jobs and licenses, and (f) the disorder is usually readily treated with analeptic drugs such as methylphenidate hydrochloride (Ritalin) and supportive measures. I have reviewed these issues in many publications.[2,12–16]
- The insurance industry still must address the problem of equitably insuring patients with controlled narcolepsy, as stressed in my text on traffic accidents.[2] Refusal to insure such persons who are under medical supervision solely on the grounds they require an analeptic agent risks greater accident-proneness through the phenomenon of denial.[2,15,16]
- *Reversible confusion* that has been resolved by accurate diagnosis and treatment should not carry the prolonged stigma of "Alzheimer's disease" or an "organic brain syndrome." Examples include reactive hypoglycemia[2,12,13,17], hypothyroidism, the side effects of many commonly prescribed or over-the-counter drugs (e.g., beta blockers, eye drops, pills or patches for seasickness), and reactions to products containing aspartame (NutraSweet)[18–22], The latter can increase proneness to accidents even among pilots.[19,21,11]

The Evolution of "Insurance Gerontology"

My focus on the older driver is patently arbitrary. It does serve, however, to underscore "The Challenge of Threescore and Ten For the Insurance Industry" for reasons summarized in the introductory Overview.

Practicing physicians cannot ignore the ongoing momentum of "universal access to health care" in the United States. Similarly, the insurance industry must subject itself to the proverbial agonizing reappraisal in the matter of insuring older persons who function in an acceptable manner relative to their daily activities. This cannot be properly determined solely by an armchair consideration of formal diagnoses. For example, many octogenarians with a long "problem list" of ailments pursue vigorous professional, community and political careers. The proposed simple and standardized screening parameters for evaluating function in older individuals[23] should be seriously considered for adoption by insurance physicians and underwriters. Otherwise they risk the same criticism leveled by Thomas Jefferson at laws and institutions that failed to evolve with progress of the human mind: "We might as well require a man to wear still the coat which fitted when a boy as civilized society to remain ever under the regimen of their barbarous ancestors."[24]

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