

The Association of Life Insurance Medical Directors of America 100 Years of Progress

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Author's Preface

It has been a pleasure to read through the history of the Association of Life Insurance Medical Directors of America (ALIMDA) and a privilege to record it. Certainly in this 100 year history there are many stories.

There is the growth of this organization from 34 Medical Directors representing 27 companies in the United States to 776 Medical Directors representing 265 companies, many with multiple branches, as of 1987 Medical Directors were from 51 foreign companies in 26 countries outside of the United States and Canada.

There is the story of the relationship between the Executive Department, and the insurance business in general, and the Medical Director.

There is the story of the productive joint efforts of some members of the Society of Actuaries and some members of the Association and the close relationship of the two organizations themselves.

There is the story of two medical research funds: the Life Insurance Medical Research Fund, which existed from 1945 to 1970, and the Life and Health Insurance Medical Research Fund from 1983 to the present.

There is the story of the Medical Information Bureau: its origins, its changes, its growth, its legal separation from the Association and the excellent job it has performed.

There is the story of the many diseases particularly the infectious diseases, in the pre-antibiotic era and then the different diseases in the post-antibiotic era and the mortality therefrom. Embedded in this story of disease is, of course, the story of the heart diseases and blood pressure, the metabolic diseases (particularly diabetes mellitus), laboratory testing, and the associated instruments including the sphygmomanometer.

And, of course, there is the story of the Medical Director himself, his concerns, his interests, and his own growth.

All these stories are simply threads that go to make up the strong fabric that is the Association of Life Insurance Medical Directors of America.

The following is a brief abstract of a portion of this history.

The Beginnings

On May 29, 1889 "at the suggestion of Dr. John M. Keating, Medical Director of the Penn Mutual Life Insurance Company, an informal meeting of the Medical Directors of Life Insurance Companies of the United States was held at the Union League Club in New York City". So begins the 'Abstract of the Proceedings of the Association of Life Insurance Medical Directors of America from Organization to and Including the Sixteenth Annual Meeting' as written by Dr. Frank Wells of the John Hancock in the first volume dated 1889-1906. This group, meeting in May 1889, consisted of 28 physicians representing 21 companies.

Apparently there was "clearly demonstrated the necessity for the formation of a permanent organization." Even at this meeting it was unanimously voted that the companies represented should "exchange a list of those examiners whose appointments should be canceled for cause" and also a list of "those physicians making applications for the position of examiner who by reason of incompetency should not be considered eligible." A five-member committee was appointed; it was also empowered to consider the advisability of an immediate exchange of the names of rejected or declined applicants for life insurance.

On December 6, 1889, 18 physicians representing 14 companies met at 'The Cambridge' in New York City. The Special Committee appointed on May 29, 1889 reported that it had met on June 20, 1889 and voted to form "a permanent organization of the Chief Medical Directors of the Life Insurance Companies of the United States and Canada and that the membership should be limited to those companies which unite in the Mutual Exchange of Rejections". Indeed at the June meeting 2 men, namely, Dr. Tuck of the New York Life Insurance Company and Dr. Wells of the John Hancock Mutual Life Insurance Company, were requested to frame the Constitution and By-Laws.

At the December 6, 1889 meeting the Constitution with its 13 articles was submitted and adopted. (The admission fee was \$2; the annual assessment was \$1.) The name was the "Association of Life Insurance Medical Directors".

In the Constitution adopted originally, the stated objective of the Association was "the promotion of medical science as applied to life insurance by personal intercourse of its members, presentation of papers, discussions and such other methods as may be found desirable, and also the encouragement

of social and friendly relations between its members, and the advancement of the general interests of life insurance". Although later revisions of the Constitution stated the objective more succinctly the mission today remains essentially the same.

It was also at this meeting that a vote was passed to submit plans for the 'Exchange of Rejected Risks' to the Executive Committee, which would then put these plans into a definite form to be considered at the 1st Annual Meeting. At this same meeting the use of the Library Card Index System for Rejected Risks was proposed and discussed at some length. Thirteen companies approved; others were in doubt. It was voted to proceed in 30 days if two-thirds of the companies agreed. So it eventually carried. Yet it is obvious that this principle of sharing information on rejections, even in those days, was of concern to many. Indeed, soon quite a few companies decided not to be a party to this concept.

In these early years much time was spent on the organization of the Association and on papers relating to specific problems of the day. Influenced by some work done in Germany, Dr. Bernacki of the Germania gave the one and only paper at the 1st Annual Meeting concerning the 'Influence on Longevity of the Use of Large Quantities of Beer'. "The moderate use of wine or whiskey was not deleterious, but beer - on account of the large quantities consumed and its mechanical effect - was the most injurious of all alcoholic beverages."

Albuminuria was discussed at the 2nd Annual Meeting and at many more meetings over the years. Indeed the discussion of organic vs. functional (orthostatic) albuminuria at the 1891 meeting in many respects could take place today. From an investigative point of view much work in the early years revolved around the examination of the urine, and this continued as the major thrust into the early 1900s and beyond. Perhaps Dr. Dwight of the New England Mutual led the way here reporting that 785 cases had been accepted with an expected mortality of '6.8%', but he reported that only one had died, "and he was blown up by an automobile." Dr. Muhlberg of the Union Central later did much good work. Then outstanding results of investigation came from the Metropolitan first by Dr. Ogden in 1915 continuing through the consultations of Prof. Otto Folin and Prof. Blatherwick of Harvard and Prof. Benedict in the late 1920s and early 1930s.

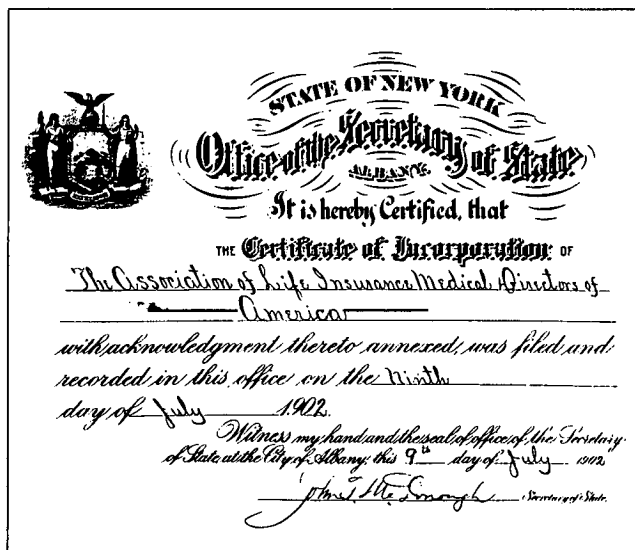
Out of the urinalysis came papers on the many types of casts; from the urine sugars came blood sugars and the glucose tolerance tests to which Dr. McCrudden of the New England Mutual contributed so much — again with Drs. Benedict and Folin contributing considerably.

Nevertheless, in spite of the interest exhibited and reported in the many current problems of the day the major impetus was on the organization and its structure.

Even "a uniform medical examiner's blank" was discussed in the halcyon days when the Sherman Anti-Trust Act lacked the teeth of government enforcement which did not come until 1901 when Theodore Roosevelt entered the picture. Again, this uniform blank was seriously proposed in 1921, but it was

not until the late 1950s that a uniform form was accomplished - however not an examination form, rather an attending physician's statement approved by the industry and the American Medical Association.

Since 'consumption' was accounting for approximately 17% of the deaths, there were always many company reports on tuberculosis, and these reports continued for many years. Indeed since 1953 when the government began reporting nationwide health statistics the incidence of tuberculosis continued to decline approximately 6% each year. However in the past several years, i.e., the late 1980s, more than 25 major cities in the U.S. with populations over 250,000 have reported a rise in the incidence of tuberculosis. For example in the first 10 months of 1988 in N.Y.C. there will be 407 more cases of TB than in the corresponding period in 1987. In these same 10 months in 1988, 21 states and the District of Columbia have reported higher TB statistics than in 1987. It seems clear that immunosuppressed people, especially those with, or at risk to, the human immunodeficiency virus (HIV) are adding to the tuberculosis problem: the risk is 100-200 times greater than in the population at large. In addition there are the homeless and others, including the elderly, with poor nutrition and crowded living conditions. A sputum culture originally took 2 to 4 months to grow out TB bacilli. With a DNA probe this is converted to 1-4 weeks and soon this probe will be possible directly on the sputum. In other areas companies were requested by the Association to have all applicants for insurance show evidence of vaccination, and reports appeared on influenza.



Over the centuries there had been other epidemics as the Black Death (the bubonic plague) of the mid 14th century - preceded by a significant drop in the mean temperature of Europe and resulting widespread crop failures, famine, the move of rural population to cities, severe poverty, crowding and poor sanitation, increase in black rat population, death of rats, and transfer of the host of the rat fleas to the humans. Then in 1812 there was Napoleon's army of 500,000 men with a remaining 3000; the vast majority of the losses were due to typhus and dysentery. The largest cholera epidemic was in 1832; the city

of New Orleans had 5000 cases. To understand the Acquired Immune Deficiency Syndrome (AIDS) today one might review not only the various epidemics but the responses of society in the early 1900s to syphilis and gonorrhea. All these epidemics occurred in part either because the diseases at the time were not understood or new diseases had arisen.

They all affect nations, politics and even the course of history. During all epidemics there are political and social responses which are already occurring during the present AIDS outbreak. Since AIDS is a sexually transmitted disease (STD) society's response to this aspect is also illuminating. Our advanced biotechnology has permitted us to attempt sophisticated solutions to the biologic problems of AIDS, but our human responses are essentially the same today as in previous epidemics. Social and behavioral problems a part of the AIDS epidemic, are thereby dealt with ineffectively. (Surgeon General, Dr. Koop, has been a help in this area.)

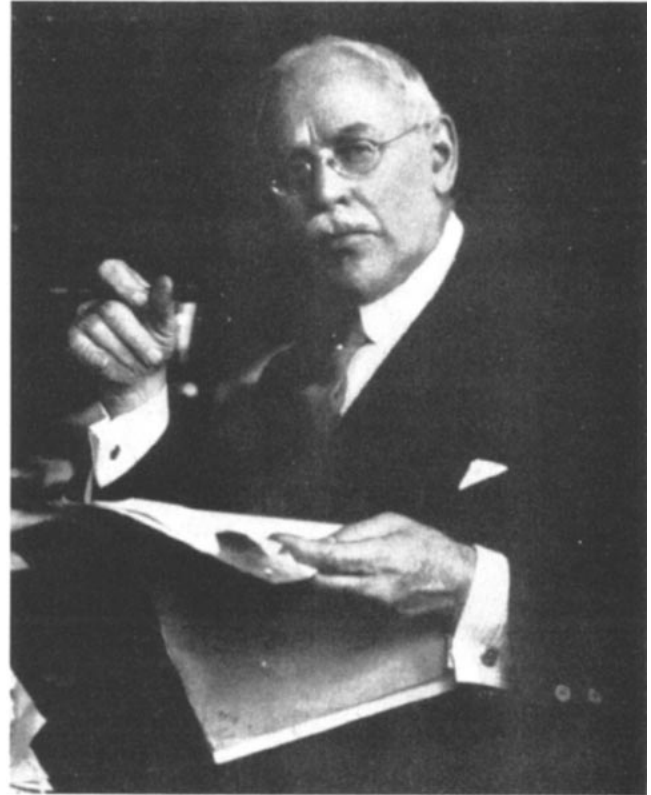
Actually, the greatest single disaster in the history of the life insurance industry was the influenza A epidemic of 1918-1919. At the 1921 Annual Meeting Dr. M.J. Rosenau of Harvard described the epidemic as it broke out in the confusion and overcrowding of World War I Naval recruits received at Boston's Commonwealth Pier and in the city of Boston. He noted that "There was never such an explosion of any disease in the history of the world." (World-wide there were about 22 million deaths with 12 million in India alone.) By the spring of 1919, an estimated 550,000 Americans had fallen victims - five times the number who died in combat in France. In Philadelphia in one week the mortality rate reached 261 per 100,000 of population. For the country in general this epidemic raised the mortality rate by 35-40%. About 500,000 death claims ascribable directly to influenza, were paid. In the pandemic of 1891-1893 87% of the claims of the Mutual of New York had been on policyholders over the age of 40. In 1918-1919 it was reported that 75% of the Mutual of New York deaths were in ages 20-40 "taking the strong and robust and particularly the pregnant women." This influenza epidemic compelled the Medical Directors to take a more active interest in public health measures. In many respects the epidemic itself and the effect on the Medical Directors are a prelude to the AIDS problems of 65-70 years later.

Scientific Underwriting

At the 3rd Annual Meeting in 1892 the principle of 'Collective Investigation' of certain cases was discussed and pursued. Then in 1895 Dr. Edgar Holden, of the Mutual Benefit, stated "It should be our aim to contribute such new matter as to give our decisions the weight of mathematical accuracy."

However, it was Dr. Oscar H. Rogers of the New York Life, who developed the numerical rating system — beginning in 1890 with extensive studies of business from 1880 to 1899. By 1896 Dr. Rogers was able to evaluate a wide range of borderline and substandard risks, and at this time New York Life cautiously began to insure impaired risks.

After much long and arduous labor, in 1913 Dr. Rogers and



Oscar H. Rogers, M.D., Sc.D.

his friend and actuary, Mr. Arthur Hunter also of New York Life (an Honorary member of ALIMDA after 1923 and later with an honorary degree from Scotland) Dr. Hunter submitted a summary of the findings to the officers of New York Life in a paper, "The Scientific Valuation of Human Lives for Insurance". This material was formally presented to the Association in 1907 in Dr. Rogers' landmark presidential address, 'Medical Selection and Substandard Business'.

It is fortunate that at that time it seems that there was a moderate number of medical directors good at and interested in mathematics and statistics. It was also at this time that the Society of Actuaries, organized in 1889, began (in 1900) large scale intercompany statistics. But for some years it was Dr. Rogers who was the most effective advocate of substandard underwriting. In 1907 in his presidential address he stated "I look forward with confidence to the time when all life companies will, for the first time, be fulfilling their true mission". With the vigor and logic of his argument, the numerical rating system soon became universal.

Perhaps it was Dr. Van Wagner of the Mutual Benefit who best expressed the impressions of this 'golden era' and of previous eras when in October 1924 at the annual dinner he spoke, "Reminiscences and After Dinner Talk". Dr. George Van Wagner (1845-1940) was one of the 28 'good fellows' who attended the preliminary meeting in May 1889 and on the Executive Committee through 1931. He speaks of talking to an actuary friend concerning his own life expectancy; his friend quoted the well-known rule that it was "2/3 of the difference between your age and 80." Dr. Van Wagner commented "Gen-

tlemen, I ask you, what comfort is there in an equation of that sort for a fellow who has already celebrated his 79th birthday!" He commented on Dr. Shepherd's work in 1905 and the resulting height and weight tables of 1907; "the 'combined Medico-Actuarial Mortality investigation' begun in 1909 and published in 1912-1914 — a stupendous and magnificent work —". Five volumes based on 2 million insured lives. He recalls Dr. John Fisher, Dr. Rogers, and Dr. Hunter, but also Drs. Russell (Aetna), Frank Wells (John Hancock), Tabb (Virginia Life), Edgar Holden (Mutual Benefit), and others. He ended with the last nine lines of 'Bryant's Thanatopsis' - never a President but a long-term active member: scientific, sympathetic, and philosophical.

The Medical Information Bureau (MIB)

In the early 1900s the Rejection Exchange came to an end. The Library Bureau, forerunner of the Recording and Statistical Company, had 30 companies including 2 Canadian ones in the Exchange by 1891. Medical Directors and company executives began to feel that this Exchange created more trouble than it was worth. So in 1902 at the 13th Annual Meeting of the Association a study committee submitted a new plan, "Resolved, that the present Rejection Exchange be discontinued and be replaced by an Exchange known as the Medical Information Bureau, which shall be carried on in the same way as the present Rejection Exchange. To this Bureau shall be notified all applicants for insurance whose examination discloses any of the impairments named in the sub-joined list." The impairments were reported in code, and the Bureau did not have access to this code. The administrator of this new Bureau was placed under the direction of a committee of the Association headed by the remarkable Dr. Rogers from 1902 until his retirement in 1932. This was a span of time that covered almost the entire period during which the Association administered the Bureau. Dr. Rogers kept meticulous records revealing the numbers and percentages of contributions, inquiries, delays, etc. by company number, and gave an annual report to the Executive Committee and the Association.

There was only one significant problem. In 1903 the rule was adopted to have all member companies "absolutely refuse all information regarding risks to all insurance companies outside of the Association". At that time, to be a member a medical director had to represent a company doing business on the level premium plan for at least 10 years and of a certain amount. As a result many of the new smaller companies could not qualify. The Medical Section of the ALC was organized in 1910, and now because of this rule there were hard feelings and a schism developed. The ALC developed an exchange of its own. It was not until 1922 that this was resolved by forming an Associate Membership in MIB.

This MIB then continued to operate in this fashion through World War II at which time 222 companies were members.

In 1946 the Bureau was reorganized into a company membership association independent of any other industry association. Originally there was an Executive Committee of 9 executives from member companies, 4 of whom were medical

directors elected annually by the Association. (This committee has now become a Board along with many other changes.) Mr. Joseph Wilberding, a lawyer, was the administrator and Executive Secretary of this newly organized MIB, and he performed a grand job. He remained close to the Association and its members. Fundamentally he was a pragmatist, but he also was a visionary. Mr. Wilberding organized the MIB well, got it functioning smoothly; then with the help of A.D. Little Inc. and ALIMDA and actuary members converted it from a manual to a computerized system. It was in 1969 that Mr. Wilberding (MIB) and Dr. Brown (automation) discussed this conversion, and others including Dr. Dorman, President-Elect of the AMA, Dr. P. Robinson of the Metropolitan, Drs. Larson, Pepper, and Sodeman discussed other insurance aspects - all at the Section of Public Health, Preventive and Industrial Medicine at the College of Physicians of Philadelphia in "Life and Health Insurance Today A Survey for the Practicing Physician", arranged by Dr. Vaughan Simmons.

Mr. Wilberding's vision related to the need for the MIB to perform 'other' matters for the public good. In October of 1975 he talked to ALIMDA for the last time. Mr. Neil Day, also a lawyer and one whom Mr. Wilberding brought into the MIB, has done much since 1975. He has been most involved in legislation, including confidentiality, the tax-exempt status, etc., in physically moving MIB to new quarters outside of Boston, setting up a Center for Medico-Actuarial statistics (CMAS) first established in 1972, working with the actuarial group on many studies including the medical impairment study, the ALIMDA group on Medical Risks, and on and on. The MIB is today an incorporated, active, thriving, self-sufficient industry association protecting the insurance industry from fraud and withholding problems.

The Research Funds

Although originally discussed in 1929, the Life Insurance Medical Research Fund (LIMRF), because of the depression and war years, did not come into existence until 1945. Prior to its liquidation in 1970 it had contributed \$26.5 million to basic research in cardiovascular/renal disease (and, later, other areas) and to the subsidizing of scholars seeking both an M.D. and Ph.D. The names of the scientific directors of this Fund are well known: Dr. Francis Dieuaide, Dr. William Jeffers, who in 1965 died in a tragic and untimely fashion, and Dr. William Sodeman, who continued with the Insurance Medical Scientist Scholarship Fund (IMSSF) and then the later Fund - always with an administrative expense of less than 7%.

After the 25 years of much work and the great contributions of the LIMRF, Dr. Sexton and the Massachusetts Mutual started the IMSSF. Under Dr. Nay's guidance this fund grew in dollars and number of involved companies.

Finally, in 1983, with the ACLI and the CEOs involved, a new Fund was founded, the "Life and Health Insurance Medical Research Fund." It would seem that because of those involved this might be a more permanent Fund, both for basic research and M.D. / Ph.D. scholarships.

This and That

It was in 1897 that Dr. Shepherd of the Connecticut Mutual first presented his new table to the Association, a table finally published in 1906. Based on 75,000 lives from 24 companies this was the first table of heights and weights to take into account age. This was used until it was supplanted by the tables resulting from the Medico-Actuarial Investigation of 1912-1914.

In 1901 Dr. Rogers had given a paper on "Build as a Factor Influencing Longevity", and in 1908 Dr. Faneuil Weisse of the Mutual of New York presented his table of standard weights for women based on 60,000 insured lives. In 1910 Dr. Rogers presented a build table for women based on 104,000 lives (he had supplied over one-half of the lives in Dr. Weisse's tables). It was in 1906 that Dr. Rogers commented relative to Dr. Shepherd's work: "Should the question ever be asked, 'What has the Association done to justify the time and earnest works its members have put into it?' an answer could easily be found in a single one of its achievements — the work on a standard table of heights and weights."

Beginning in 1907 a committee headed by Dr. Dwight began working on plans and techniques for an investigation. (It was at the 3rd Annual Meeting that a committee began to carry out 'a collective investigation' of certain classes of applications in which applicants had either been accepted with flaws in their personal record or family history, or postponed for temporary ailments, or declined.) In mid 1909 a joint investigation with the Actuarial Society began. Five volumes were published in 1912-1914.

One of the Medical directors quite involved in many of these early actuarial matters was Dr. Brandeth Symonds of the Mutual of New York. It was he who in 1899 gave a paper, "A Plea for Undergraduate Instruction in Making Life Insurance Examinations" and pursued the concept of medical schools giving insurance courses in their regular curriculum. A few schools showed interest, but after 1905 this subject was dropped.

Again in the early 1900s (1905 and then 1911) bubonic plague on the West coast caused a committee of the Association to contact and talk with the federal government. In these same years there was much discussion about medical examiners and fees — a never-ending story.

Again in 1905 and later there was much discussion relative to the sphygmomanometer and blood pressure. Dr. Root of the Aetna and Dr. Porter of the Mutual of New York were involved, but the leader in blood pressure was certainly Dr. John Fisher of the Northwestern Mutual, who over many years reported on blood pressure mortality. Early on there was much discussion not only relative to the methods of obtaining blood pressure but the value of the diastolic reading. In this area Dr. Rogers again made an outstanding contribution by devising an aneroid sphygmomanometer and the sleeve saying "I have transferred all my rights, title, and interests in it to the young man who assisted me in developing it, and so my interest is entirely sentimental and scientific." He later regretted this because out of his work devel-

oped the Tycos sphygmomanometer. It was the 'excessive cost' of the Tycos to which he objected.

Through all of this Dr. Fisher continued to report annually the mortality relative to blood pressure and to suggest the blood pressure be taken under age 40 as well as at ages 40-60 as was then the custom. It was in 1918 that the blood pressure became a standard part of the insurance examination in all companies. It was not until 1925 that the first joint Medico-Actuarial Intercompany blood pressure study was published (covering 700,000 lives and establishing average ranges for sex and ages).

1928 there was a joint Medico-Actuarial study of 176 occupation classes covering 1,300,000 lives and also a generalized study of medical impairments on 2,100,000 lives in 39 companies.

In 1920 the chest x-ray began to enter the scene particularly for tuberculosis, a still very common problem. It was in 1938 that tables of predicted normal transverse cardiac diameters as determined by x-ray for various heights and weights were prepared by Drs. Clark and Ungerleider (a giant in the field of mortality and electrocardiography). Meanwhile after 1935 the use of the electrocardiogram became more frequent, and an increasing number of articles on this subject appeared. The present day literature still contains many such articles.

A major joint Medico-Actuarial Intercompany study of medical impairments was done in 1951, and resulting from this investigation, there appeared in 1959 a detailed study of the build and blood pressure. It was at this time that the insurance industry published the figures on the increase in death claims in groups with mild to moderate increase in build and blood pressure.

Also at this time there began in the Association Meetings an increasing trend toward the discussion of selecting suitable cases for insurance among the diseases formerly rejected — now insuring individuals with tuberculosis, diabetes, hypertension, ulcerative colitis, and the like and even experimenting with cases of coronary artery disease and of cancer.

Similarly there developed a vast accident and sickness coverage with many companies applying substandard ratings to appropriate cases in this area as well as in life insurance.

The Last Quarter Century

It was in 1960 that the Medical Section of the ALC gave its endorsement to the 'Board of Life Insurance Medicine', the beginnings of which were in 1950 and over which there were much discussion. In 1983 it became the 'Board of Insurance Medicine'. It was in this same year that Dr. Bradley, Prof. and Chairman of the Department of Internal Medicine at Columbia, talked of the prestige of the LIMRF.

In the early 1960s and later there, was an ever-increasing attention paid to 'preventive medicine' by both the medical directors and their CEOs. There had been the vaccines, the chest x-ray screening, the Salk vaccine, and now the hepatitis B vaccine along with attempts to work out malaria and AIDS vaccines. Auto-immune diseases were discussed - actually in

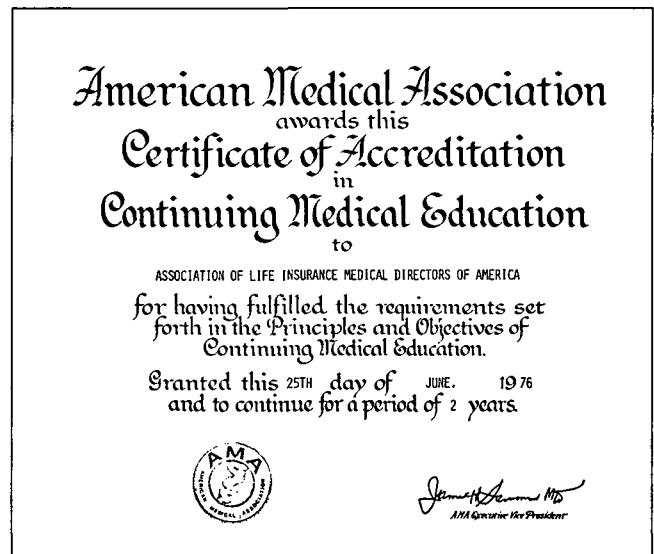
1965 at the Annual Meeting a Professor at the University of California talked of 14 such diseases including "pernicious anemia, myocardial infarction, chronic active hepatitis" and others.

It was in the mid and later 1960s that more relationships with other medical organizations took shape, for example, the American Society of Internal Medicine (in 1957), the AMA, American Heart Association, American Diabetes Association, American Cancer Society, and others. In 1968, in addition to a 'Congress on Medicine and Insurance' sponsored by the AMA and ALIMDA at the AMA's Annual Meeting, a liaison committee with the Society of Actuaries was formed under the urging of Dr. Singer. In the late 1960s Dr. Purdy revealed his imaginative thinking by suggesting "an informational letter", a 'Newsletter', later under the able hands of Drs. Plucinski and Elder to be the respected Journal of Insurance Medicine. It also was Dr. Purdy who was empowered to appoint a historian. It was in 1969 that the first osteopath was brought into membership.

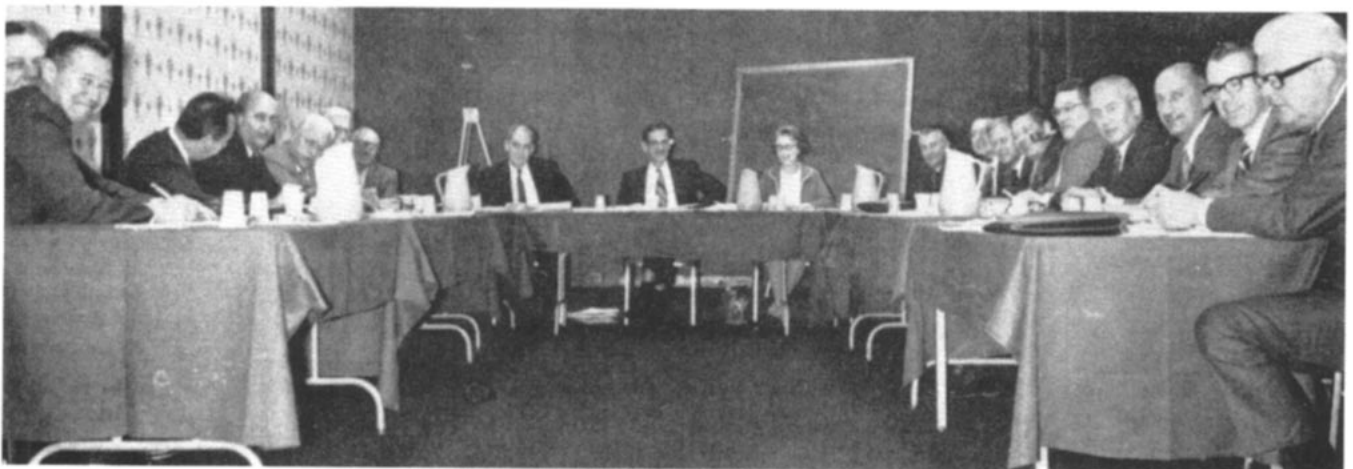
It would appear that each decade thereafter became more crowded with 'happenings'. It was in 1970 that Dr. Brown, Secretary of ALIMDA and member of the MIB Operations Conversion Committee for some years and Chairman of the MIB Executive Committee that year, announced that the 700th company had gone on-line. In that same year the Liaison Committee (with the Society of Actuaries) reported on the "Feasibility Study of the Center for Medical-Actuarial Studies" (CMAS) and it was in 1970 that Dr. Sexton, President of ALIMDA and a true 'corporate executive', announced, to his sorrow, the liquidation of the LIMRF.

In the early 1970s 'confidentiality' became a large issue; Dr. Simmons' Newsletter expanded; Ed Lew, the helpful actuary, became an honorary member of ALIMDA. Mr. Wilberding of the MIB introduced his new associate, a lawyer, Neil Day. Dr. William Bolt of New York Life died; Dr. Bolt had been President of ALIMDA during the World War II years when no annual meetings were held for two years, 1943 and 1944.

In 1976, with the approval of the Executive Council and the efforts of Drs. Siber and Brown, ALIMDA received AMA category I accreditation for continuing medical education (CME). Dr. Singer and his panel with Dr. Entmacher reported on "The Mortality Monograph: A Medical Milestone." - Also in 1976 ALIMDA had an observer on the AMA Interspeciality Advisory Board. In 1977 the MIB Executive Committee became the MIB Board of Directors, and MIB itself was incorporated in 1978. A year later MIB took on the servicing unit and acquired land in the Boston area.



It was in the 1970s and early 1980s that underwriting underwent a marked change. In 1979 the CEO of General Reinsurance spoke at the Annual Meeting on facultative shopping programs. His company did not participate; he felt it "emasculates the underwriting and medical functions." He was philosophically against it and felt it uneconomical; he was dedicated to 'underwriting profit'. Indeed in 1984 Dr. Haskins spoke on this subject 'The future of Underwriting' (not the



Executive Council, Chicago, April, 1971. L to R: Moore, Cook, Rougraff, Hunzicker, Sexton, Pepper, Pearson, Brown, Cochran, Miss Andrews, Nelson, Wheatley, Simmons, Ward, Wood, Peck, Vaughan, Alden, Larson

underwriting of the future). He spoke of aggressive re-insurers and shopping programs and particularly of the re-entry term product, the very 'permissive underwriting'.

It was in 1980 that the AMA eliminated its Interspecialty Board and in 1982 that ALIMDA was in its first year of membership in the AMA as a specialty group with its seat in the House of Delegates. Dr. Paul Metzger had contributed much to this effort.

By 1985 the MIB Board expanded from 9 to 14 and ALIMDA passed a resolution suggesting that the number of medical members on this Board be designated at 6 rather than the previous 4. Mr. Futia, retired CEO of Guardian Life and a former Chairman of the MIB Board, talked to ALIMDA and in 1985 noted that "The current trend to broader financial services is not revolution but evolution, merely the latest phase of the evolutionary trend; i.e., the accumulation of wealth for ones own use and for retirement in a tax-efficient manner. Ethical values have eroded. — In this context I think of the importance of sound underwriting and a competent medical director who is a leader." (He was referring to Dr. William Herbert.)

In these several years before the 100th anniversary two events particularly stand out. The first is the problem of AIDS and the related legislation in various states, the education of the public, and the research being conducted nationally. The sec-

ond item is all the work, the planning, and development of the proposed 'Mortality Center'. Related to the first, the Society of Actuaries and ALIMDA are also involved in mortality. It is with education and legislation (both federal and state), that the Medical Section should be and has been so very involved. With respect to the Mortality Center there seemed to be some concern relative to the loss of identity of ALIMDA, but under Drs. Robinson and Kost's guidance it has progressed to near fruition.

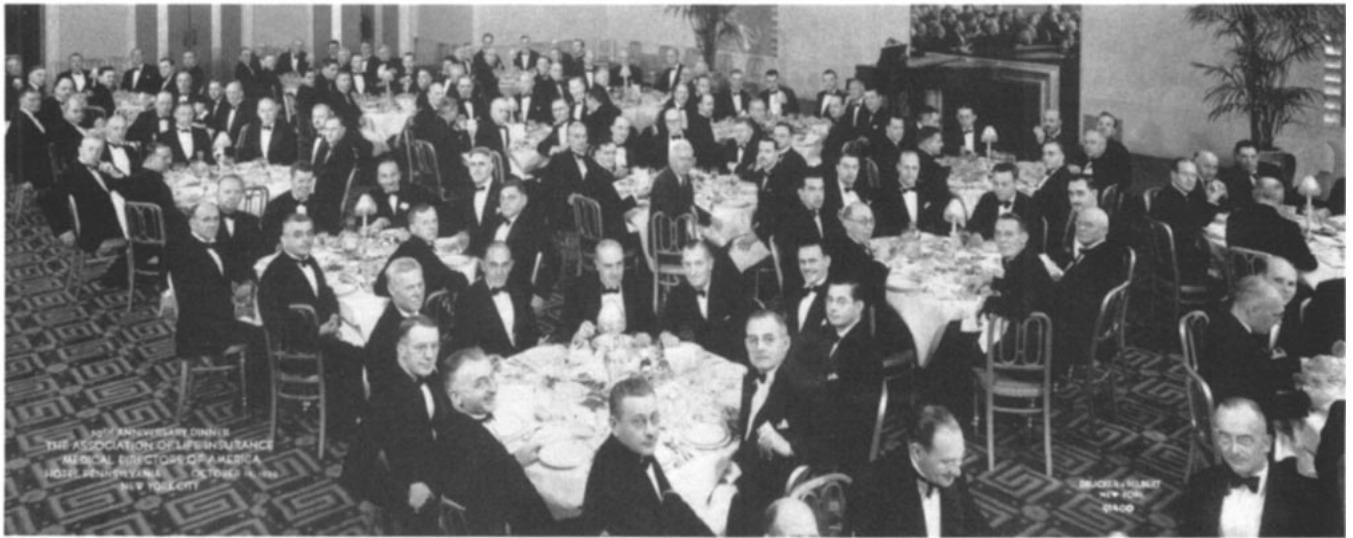
Certainly, in the 100 years of ALIMDA's existence, the organization has changed, but the Constitution and mission and dedication of a few people (not ever enough) have remained constant. There have been many threads that have gone into the weaving of this sturdy fabric called ALIMDA, but the main thread throughout its long history has been the thread of mortality as exemplified by men such as Dr. Rogers and others and now Dr. Singer with more to follow. The other threads are many, but the fact remains that the Medical Director is many people with differing talents from mathematical and statistical to clinical to administrative, managerial and policy-making — a 'corporate executive.' The Medical Director must chose that direction where his talents and interests lead him.

Acknowledgements

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47th Annual ALIMDA Dinner, Hotel Pennsylvania, New York City, October 22, 1936



50th Annual ALIMDA Dinner, Hotel Pennsylvania, New York City, October 10, 1939



Dinner to Mr. Alva J. McAndless, Starlight Roof, The Waldorf Astoria, New York City, December 10, 1941



59th Annual ALIMDA Dinner, Hotel Statler, New York City, October 19, 1950