INSURABILITY AND EMPLOYABILITY/Engle

Congenital Heart Disease and Innocent Murmurs

“CAN I GET A JOB when they see this scar on my chest?”
“I feel OK now. How’s it going to help me to have this septal defect closed?” “Doctor, if you say my child has an innocent murmur, will that be bad for his record later on when he applies for a job or wants to get insurance?”

Every day some physician hears a question such as this. Each year about 20,000 Americans born with a cardiac defect enter the adult world. Over half of the rest of the population becoming adults have had an innocent or functional murmur, since such a murmur is so prevalent in childhood. While these people have been growing up, so have the fields of pediatric cardiology and cardiovascular surgery. Medical students have been trained to listen carefully as physicians and to record heart sounds and murmurs. At the same time that the natural history of the common kinds of congenital heart diseases is being documented,1, 2 it is being rewritten by the continuing advances in diagnostic capabilities as well as in medical and surgical treatment. Analyses of long-term results of that treatment are appearing each month in some journal devoted to cardiology or to cardiovascular surgery, and modifications of previous recommendations are being advised. Meanwhile, amid these changing circumstances, insurance companies find themselves with little actuarial data on congenital heart disease, unlike their experience with hypertension, coronary artery disease and rheumatic heart disease where such data are fairly abundant.3

How does the physician interested in his patient’s long-term well-being and productivity as an adult guide the child with a congenital cardiac defect to be competitive in the job pool and to assume the other responsibilities of the adult in today’s society, including insurance for himself and his family? An even more common question, because of the larger numbers involved, is what will be the effect on later insurability and employability of faithfully recording on the normal child’s report that there is a midprecordial, mid-systolic, vibratory murmur, grade II out of VI in intensity, with physiologic splitting of the second heart sound?

Insurability is an overt expression of acceptance by society of the prospect of a relatively normal life pattern.4, 5 As such, it is important to many normal individuals, and it has particular meaning to those with a cardiac defect that may or may not have required surgery in the past, and that may or may not need cardiac surgery in the future.

In order to gain an understanding of the problems of clinical cardiology and of insurance medicine in evaluating patients with congenital cardiac defects or with innocent murmurs and to modify opinions as experience and additional information become available,6 the American Heart Association together with the Association of Life Insurance Medical Directors of America arranged a series of conferences. The first was in May of 1963,6, 7 the second in May of 1965,6 and the third in June of 1972. The deliberations of that last meeting, which included representatives of the Industrial Medicine Association as well, have since been reviewed, updated and approved by the physicians representing the Life Insurance Medical Directors and Industrial Medicine and by the Council on Cardiovascular Disease in the Young of the American Heart Association. The names of the participants, who concurred in the final version of the report which appears in the News from the American Heart Association section in this issue of Circulation are as follows:

References

Third Conference on Insurability and Employability of Young Cardiacs (June 1972, with revisions and updating March 1976)

Co-Chairmen: James A. Manning, M.D., University of Rochester; John J. Hutchinson, M.D., New York Life Insurance Company.

Doctors S. Gilbert Blount, Jr., Mary Allen Engle, Donald C. Fyler, Mary Jane Jesse, William C. Roberts, Francis F. Rosenbaum and William H. Weidman represented the American Heart Association.


Although the opinions and comments expressed have no official status, they certainly can serve as a general guideline and point of departure for those concerned with specific problems in these fields.

While both clinical cardiology and insurance medicine are concerned with questions of insurability, certain key differences exist between the two. The clinician sees, listens to, and examines actual patients, often on many occasions over a period of years, and he may change his diagnosis as conditions change. In a lifetime he might see a few thousand patients. The insurance company, in contrast, deals with groups of patients and may see papers on several thousand applicants in a single day. These records are often "long on diagnosis but short on history and details," the medical director of one company remarked. The life insurance company makes a decision on prognosis, not just for the next few weeks of an illness, but for a lifetime. From the information submitted, which is often sketchy and obtained in less than ideal examining conditions, the individual applicant is placed in one of several broad rating groups, one of which is rejection.

The function of life insurance is to provide an equal sharing of the risk of dying. The purpose of premium setting and of underwriting is to assure that the risk is reasonably equal between the persons is any particular rating group. The fortunate members of a group help pay for those less fortunate; hence, rating groups must be broad enough to include cases probably better than, as well as worse than, the median experience of that group. In insurance examining, the majority of examinations are made by physicians who have not had special training in cardiology and therefore may have some difficulty in both hearing and describing murmurs.

Congenital Heart Disease

Applications involving cardiovascular disease usually go to the medical director of the company. The size of the policy applied for is one factor in deciding about the need for additional information, such as electrocardiogram and chest roentgenogram, sometimes cardiac catheterization, in order to rate the application. After cardiac surgery, a waiting period of one to three years is usually required before an application is considered. Reparative surgery performed in the childhood years is considered to provide the individual with a better insurance risk and chance of more complete recovery of cardiovascular function than that undertaken later in adult life.

In the deliberations of the conference, children with an innocent murmur were judged to be insurable and employable, just as any other normal person. Specific recommendations were made for the common congenital cardiac anomalies in mild form, without need for surgery, and in the postoperative state for those operated upon. Concerning employability, the physicians attending the conference reiterated the importance of appropriate counseling and diligent preparation for a job that the young cardiac will be able to do without penalizing himself or his employer. Industry evaluates what the person can contribute and judges whether he or she is worth the risk.

Innocent Murmur (Functional Heart Murmur)

Insurance companies have traditionally been wary about granting life insurance to children reported to be normal but described as having functional heart murmurs. Actuarial data were presented on approximately 9000 individuals with apical systolic murmurs which were judged to be organic if they radiated into the axilla and functional if they were soft and did not radiate. Compared with an expected mortality of normal people, considered as a figure of 100%, the group classified as organic had a mortality figure of 160%, but those called functional had the standard mortality.

The cardiologists discussed the fact that some murmurs previously considered as functional might actually be found to be organic, and gave as an example the late systolic murmur at the apex of mitral valve prolapse, the so-called systolic click syndrome. In such patients, development of clinical mitral insufficiency, arrhythmias, and sudden death have been documented.

Summary

The conference ended with a sense of improved understanding by the cardiologists, medical directors of life insurance companies and physicians in industrial medicine of the shared problems and of the opportunities to liberalize the restrictions on insurance and on employment of the adult with congenital heart disease and to remove them altogether for the individual with a bona fide innocent murmur. Like clinical cardiology, insurance medicine is an ever changing field, and medical directors of insurance companies are willing to consider that they can insure many conditions they had previously declined.

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References


Insurability and employability. Congenital heart disease and innocent murmurs.
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Circulation. 1977;56:143-145
doi: 10.1161/01.CIR.56.2.143

Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/56/2/143.citation

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