

Insurance Medicine

By Philip A. Baer, MDCM, FRCPC, FACP

When I trained in Internal Medicine at the Montreal General Hospital, one of the most impressive clinicians I encountered as a resident was Dr. Doug Kinnear.¹ He was a gastroenterologist who was also the team physician for the Montreal Canadiens. That seemed odd, but when I moved to Toronto for my rheumatology fellowship, the Maple Leafs' team physician was a rheumatologist, Dr. Murray Urowitz, who had succeeded another rheumatologist, Dr. Hugh Smythe,² in that capacity. I certainly didn't mind meeting players from both teams as a result.

I remember Dr. Kinnear always cautioning the medical team not to prematurely label patients with a diagnosis that might not ultimately prove correct. Definite inflammatory bowel disease (IBD) was one thing, but someone who might have an infectious colitis should not be listed on their discharge summary as having IBD, lest it affect their ability to buy insurance down the line. If the patient in fact truly did have IBD, it would declare itself over time. The same concept could apply to a mild undifferentiated arthritis, which might resolve spontaneously or progress to definite RA. Very good advice, which Dr. Kinnear highlighted because of his other part-time work as a medical consultant to several life insurance companies based in Montreal.

Later, in parallel with my rheumatology practice, I began working part-time as a Medical Director at a variety of insurance companies and continue to do so. The initial training involved learning about underwriting, medical risk selection and the broad field of insurance medicine. The core textbook was "Medical Selection of Life Risks", edited and largely written by Dr. Robert D.C. Brackenridge, the Consulting Medical Officer at The Mercantile and General Reinsurance Company (M&G) in London, England. Since my first insurance position was at M&G, I was gifted an autographed copy of the 3rd edition of this textbook. I also had the pleasure of meeting Dr. Brack, as he was known, on a visit to London and sitting in with him as he reviewed cases.

Of course, as time went on and I gained experience and confidence in insurance medicine, I referred to the textbook less and less. It was available for reference and reassurance, but I also had company-specific insurance manuals and the entire medical literature to consult as well. Eventually, the wordstem Brack brought to mind first Inspector Thomas Brackenreid, a character on CBC's *Murdoch Mysteries*, rather than Dr. Brackenridge.

The fifth edition of Brack's textbook was published in 2006.³ You can still buy a used copy for \$437 online.⁴ In late 2024, that fact surfaced when I received an email from an insurance medicine colleague in the US. After close to two decades, a 6th edition of Brack was finally in the works. Chapter authors were needed, and as there were apparently only three rheumatologists in North America working in the insurance industry, we were all invited to consider this opportunity. Two of us accepted the challenge, so I am currently writing a textbook chapter for the first time.

Fortunately, I have written chapters on rheumatology topics for the training manuals of the Academy of Life Underwriters, so I have some source materials to draw upon.

I currently work for two insurance companies. I approached my main company to review my authorship contract, thinking they would be pleased to have my affiliation with the company mentioned in the new textbook. Incorrect. They were happy for me to be an author as long as the company's name was not mentioned. Apparently, they assessed that risk as too high, and after all their core business is risk assessment.

My next move was to review the Rheumatic Disorders chapter from Brack 2006 to see if I could use it as a springboard for our update. The first section covered Classification. Reactive arthritis and certain forms of vasculitis still carried their discarded eponyms, and juvenile chronic arthritis was listed as the preferred terminology. Moving along, the chapter included soft tissue rheumatism, nerve entrapment syndromes, intervertebral disc lesions and arthrogryposis multiplex congenita, none of which we plan to include. Also heading for the circular files: "Few of the rheumatic diseases have an early mortality ... Rheumatic diseases not being fatal, statistics are scarce." Regarding RA, we will update the 1987 criteria to those of 2010, and we won't be saying that "The monoclonal antibody treatment of RA is feasible but in the early stages of development; as yet the possible beneficial or long-term side effects of this treatment have not been established."

Interestingly, comorbidities were already recognized as being important markers of increased mortality, although cardiovascular diseases were not specifically mentioned, even if they are the leading cause of death in RA and many other inflammatory arthritides, and even though the assessment of cardiovascular risk is a bread-and-butter topic in insurance medicine.

The chapter submission deadline is sometime in 2025, so my co-author and I have work to do. As at *CRAJ*, I have been reminded that brevity and succinctness are important aspects of textbook writing. Thus, this editorial has reached its natural conclusion. Stay tuned for a possible sequel if I have more to report.

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