

Foundations of the South African Heart Association: The South African Society of Cardiac Practitioners 1985 - 1999

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INTRODUCTION

In the early years, there were limited facilities for cardiologists and cardiac surgeons at institutions such as the Florence Nightingale Hospital, Hospital Hill, Johannesburg. Cardiologists in private practice often worked in close conjunction with academic and state institutions to obtain the more sophisticated aspects of care, such as echocardiography and cardiac catheterisation, for their patients. Cardiac surgery was almost the exclusive preserve of state hospitals at that time. However, it was in the late 1970s that the development of cardiology and cardiac surgery in private practice took a significant step forward with the establishment of Cardiac Catheterisation Laboratories and Coronary and Cardiothoracic Intensive Care Units at private hospitals. The opening of these new facilities encouraged cardiologists and cardiac surgeons to move from their posts in state facilities into private practices situated in or near these hospitals. Among the first units to open were Milpark Hospital in Johannesburg, City Park Hospital in Cape Town, and St Augustine's Hospital in Durban.

Cardiac practitioners in private practice soon appreciated that interactions with the medical aids, the Medical Association of South Africa (MASA), the South African Medical and Dental Council (SAMDC), and the state, were required to facilitate the coding of and allocation of tariffs to the new procedures being performed in private practice. The existing South African Cardiac Society (SACS), a long standing organisation predomi-

EDITOR'S COMMENT

The South African Heart Association (SA Heart®) was established in 1999. Prior to 1999, 2 professional societies represented the interests of cardiologists and cardiac surgeons in South Africa – the South African Cardiac Society and the South African Society of Cardiac Practitioners. The latter was formed in 1985 by cardiologists in private practice to serve the interests of private practitioners. At the time, the South African Cardiac Society was based mainly in the academic training institutions and the need arose to have a representative body addressing the needs of private practice.

In the late 1990s it became clear that the 2 societies were competing for the same support from industry and were diluting each other's influence. The realisation that strength lay in unity led to an amalgamation of the 2 societies in 1999 – to form the SA Heart® Association.

In this commentary, Dr Tony Dalby provides us with a personal reflection of the history of the South African Society of Cardiac Practitioners. In future issues of the SA Heart® Journal, we will feature similar personal reflections to document the history of the South African Cardiac Society and the South African Heart Association. SAHeart 2018;15:214-216

nantly based in academic institutions, had neither an interest in nor the capacity to develop the required communications between the professionals in private practice and the statutory bodies. This void necessitated the establishment of a representative organisation, which could give voice to the needs of private practice.

As a result, the South African Society of Cardiac Practitioners (SASCP) was founded and its constitution, approved by MASA, was ratified at the Society's first annual meeting held at the Royal Hotel, Durban, in November 1985. The first Executive Committee consisted of Dr MA Rogers (Chairman), Dr GA Cassel (Vice-Chairman), Dr CA Hammond (Secretary-Treasurer) and Drs J de Nobrega, EA Lloyd, and RM Matisonn. The Society's constitution was amended in 1988 to alter the designation of the Chairman and Vice-Chairman to President and Vice-President, and furthermore to separate the roles of the Honorary Secretary and Treasurer. The Presidents who followed Dr Rogers were Dr GA Cassel, Dr EA Lloyd, Dr RM Matisonn, and Dr AJ Dalby.

The SASCP's stated objectives were to promote the private practice of cardiology and cardiac surgery, to define and establish relationships among private cardiologists and private cardiac surgeons – and between those groups and hospitals, public and private institutions, government authorities and the medical profession in general. In addition, an objective was to promote the legitimate professional interests of private cardiologists and private cardiac surgeons.

Any registered medical practitioner confining his practice to cardiology or cardiac surgery, or with a special interest in either discipline and who was a member of the MASA, was eligible for membership. Around its peak in 1995, SASCP membership reached 170.

From its inception until 1998, the major sponsorship was provided by Bristol Mead Johnson (later called Bristol Myers Squibb) through the good offices of Mr Quintin Oswald and later Dr B Allmann, Mr P van Hoesselen, Mr B Scott and others. Through the generous sponsorship provided, SASCP was also able to fund the air travel of 1 or 2 of its members to attend congresses overseas each year.

ANNUAL MEETINGS

The SASCP held annual meetings from 1985. With the growth of the Society's annual meeting and with the assent of BMS, additional sponsorship was obtained from various pharmaceutical and medical device companies from 1991 that allowed for a greater number of international speakers to be invited. In addition to the annual meetings, courses in coronary intervention were organised from time to time, to which international experts were invited to demonstrate new techniques.

COMMUNICATION

In 1989 Prof AJ Brink independently established the Cardiovascular Journal of Southern Africa, which became the mouthpiece for the Southern African Cardiac Society, and the South African Society of Cardiac Practitioners. Two years later, the Society commenced the publication of an independent newsletter to update its members on the Society's activities.

CARDIAC BUSINESS UNIT

In November 1989, the Society organised a "Think Tank" under the auspices of Bristol Myers, enabling cardiologists and cardiac surgeons from around the country to interact directly with representatives of medical schemes, private hospitals and the pharmaceutical industry. Arising from this meeting, it was proposed that a business unit be developed to represent cardiac practitioners, and that a subcommittee to deal directly

with medical aids and a public relations subcommittee be established. Despite several attempts at establishing this "business unit", professionals investigating the option recognised the difficulties in gaining consensus from this group of highly individualistic doctors, as well as their poor appreciation of business skills. They appreciated that it would be necessary to create a "common need" or to enhance levels of awareness of a "potential crisis", in order to unify the disparate views of cardiac professionals.

MANAGED HEALTHCARE

In 1996, Anglo-American and United HealthCare of America combined to form Southern HealthCare JV, which intended to launch its initial managed healthcare programme in Gauteng. In effect, this company proposed a "top down" imposition of American-style managed healthcare. At the initial meeting held in Rosebank, Johannesburg, attending practitioners were provided with a rough outline of the organisation's ambitions and attendees were invited to pick up a contract which was ready to sign. However, subsequent attempts to obtain clarity from Southern HealthCare on numerous issues failed to elicit satisfactory responses. Members were urged to not sign the proffered contract; 98% of members agreed. The first portion of the Annual General Meeting that year was a symposium to discuss managed healthcare. Various presenters, including Mr John Wardle of Southern Healthcare and the Society's guest Dr Richard Pozen of Vivra Heart Services, Florida, USA, participated. Mr Wardle's brazen approach included him standing with his foot on the front desk of the meeting hall, while lecturing members. Following this performance, Dr Pozen remarked that he had then understood the meaning of the term "ugly American" for the first time.

With the emergence of managed healthcare in South Africa, "doctor companies" were formed to unite various groups of professionals in their response to the imposition of the proposed measures. In 1997, the development of a "Cardiologists' Company" was explored, eventuating in the formation of CARAPACE Co-operative, which attracted 126 members. However, by 1998 the initial proposals of managed healthcare companies to contract outright with medical practitioners began fading away, once it became apparent that the principle of "divide and rule" by offering preferred provider status would not succeed within a small, overworked medical community not seeking individual preferment with a view to increasing their patient numbers. Around this time, the author was treated to lunch by Dr J Jersey, an employee of Southern HealthCare JV. His message was brief: "You have beaten us this time, but it won't happen again". Not long after this the funders began

imposing mechanisms such as pre-authorisation and central drug lists upon their members, without entering into contracts with practitioners. The usefulness of CARAPACE fell away and the Co-operative was closed down in 2000. Remnant funds were transferred to the South African Heart Association.

RELATIONSHIPS WITH OTHER BODIES

The Society was in regular communication with MASA, the SAMDC, the Department of Health, the Heart Foundation of South Africa, the Alliance of Consulting Clinical Disciplines, and the Health Technology Policy Committee. Members of the Executive dealt with coding of procedures and tariffs such as Holter monitoring, coronary angiography, paediatric cardiology, post-operative care following cardiac surgery, and over-servicing. The Society gained increasing recognition as the mouth-piece for cardiology and cardiac surgery and was frequently consulted by the SAMDC (from 1997 called the Health Professionals Council of South Africa) and the MASA when contentious issues arose. After the SASCP and others protested at the lack of an increase in the scale of benefits for specialists in 1990, the MASA held a conference at Helderfontein in April to discuss the apportionment of tariffs, for instance between labour-intensive and capital-insensitive services, intra- and inter-disciplinary relativities, and the avoidance of over-servicing. Resulting from the Helderfontein Conference, the MASA Fees Committee was restructured as the Private Practice Committee (PPC) to which Dr J Benjamin and Dr CA Hammond were seconded. In 1991, PPC adjusted the cardiovascular tariff structure with the help of Dr J Benjamin.

Over the years, the Society was requested to comment on matters such as a proposed Social Health Insurance Scheme, undergraduate medical education and training, continued medical education, the registration for Continued Professional Development, health technology policy, the Tobacco Products Amendment Act, euthanasia and assisted suicide, and the Department of Health's threatened closure of heart transplant units.

The SASCP also made inputs into MASA's national guidelines on lipids, heart failure, cardiac rehabilitation, and conscious sedation.

TRAINING

In 1989, the SASCP proposed the establishment of satellite training units at both Milpark Hospital and the Morningside Clinic for cardiology and cardiac surgical registrars training through the University of the Witwatersrand. The university rejected these suggestions and nothing came of them.

CLINICAL TRIALS

From 1995, an informal sub-group of members began voluntary participation in international Phase 3 clinical trials in cardiology variously investigating fibrinolysis, antiplatelet therapies, dyslipidaemia, heart failure, and atrial fibrillation.

SUB-GROUP DEVELOPMENT

In the last decade of the century, the specific interests of paediatric cardiologists, electrophysiologists and interventional cardiologists led to the independent development of special interest groups, which were loosely allied to the SASCP.

AMALGAMATION

At the AGM in 1995, a proposal to amalgamate the SASCP and SACS was put forward, but rejected by a majority vote. By June 1997, the impracticality of having 2 societies within South Africa representing a community of cardiac professionals totalling less than 200 came to be recognised and a written proposal for a merger of the SASCP and SACS was put forward. Furthermore, despite still providing generous sponsorship of the SASCP, a broad spectrum of pharmaceutical and device companies were encountering increasing difficulty in funding both the SASCP and SACS. Furthermore, though separated by a thin line, it was realised that the influence of both Societies was being diluted by their joint existence. Once the Societies acknowledged the need for amalgamation, a constitution for the new body was devised under the direction of Prof P Manga and Prof O von Oppel of SACS and Dr AJ Dalby and Dr S Spilkin representing the SASCP. The proposed constitution was circulated to the members of both Societies. Written comment was received and incorporated before the final version was circulated and voted upon; 47% of SASCP members responded, returning a 95% vote in favour of amalgamation. Both Societies were dissolved and the South African Heart Association (SA Heart®) was established. The last Annual General Meeting of the SASCP was held in conjunction with the 1st Annual General Meeting of SA Heart® at Fancourt, near George, in September 1999. Eight invited overseas guests addressed the meeting, which was sponsored by 22 companies.

The new Association's constitution made provision for a National Executive, 4 Standing Committees (Education, Ethics and Guidelines, Private Practice, and Full-Time Service Practice), Regional Branches, Specialty Groups (Cardiothoracic Surgery, Paediatric Cardiology) and Special Interest Groups (e.g. the Cardiac Arrhythmia Society of South Africa [CASSA] and the South Africa Society for Cardiac Intervention [SASCI]). Prof AF Doubell was elected SA Heart®'s first President and Prof PJ Commerford as Vice-President.