SA Heart Education Committee

Members:
Dr Martin Mpe (Chairman), Prof Anthony Becker, Dr Farouk Mamdoo, Dr Mamotabo Matsheha, Dr Tom Mabin and Prof Johan Brink. Late Prof A. Okreglicki served on this committee. The education committee has decided to co-opt a member of SA Heart in his place and the chairperson is busy consulting regarding this process.

Subcommittee – All heads of cardiology departments
Prof P. Commerford, Prof M. R. Essop, Prof A. Doubell, Prof P. Mntla, Prof P. Manga, Prof D. Marx, Prof D. Naidoo, Prof A. Sarkin and Dr J. Lawrenson

1. Meetings
The Education Committee (EC) now holds regular teleconference to expedite attention to issues. These are held once every two months to allow time for committee members to attend to other competing interests.

2. Membership

Heads of departments
The heads of training institutions are now members of the EC and attend all meetings of the EC. This is a very positive step forwards since this consolidates a vital link with the statutory bodies. This eliminates conflict, defines boundaries in terms of roles and further merges programmes to allow adequate representation of the interest of the SA Heart members.

Dr M Matsheha
Dr Matsheha, a member of the EC, is now on scholarship training in Echocardiography at the Mayo Clinic. She requested to retain her membership of the committee.
The EC accepted her request but she remains a silent member for now and only receives all correspondence on the EC matters. She will resume full participation once back in the country.

Industry membership
Dr Luigi Zampieri (Business Manager | CRDM | Medtronic Africa) had requested membership of the EC. The committee felt that this would constitute conflict of interest. Participation of industry at this level needs review by SA Heart as it is constitutional matter. The request was therefore turned down.

3. Supervision and co-ordination of conferences, symposia and workshops
It remains a challenge to have the SA Heart event calendar efficiently managed. The intension is not to try and police or ban meetings. The hope is the EC stamp of approval will add credibility to meetings and further enhance the image of the association. The extent of involvement would not interfere with organization, however timeous declaration of intent will minimize or avoid parallel meetings where the intended audience is the same.
This issue was raised in the past and adherence to policy is still very low.

4. Training of Cardiologists: Examination for the Certificate in Cardiology
Prof P J Commerford has been appointed a national co-ordinator of examinations to serve for a three year term to advise and liaise with College regarding the examination.
This followed a proposal in a workshop involving members of the Council of the College of Physicians and the conveners of the subspecialty certificate examinations. This is intended to eliminate the perception lack of consistency in our cardiology examination as in some of the other subspecialties.
The workshop discussed the regulations and guidelines for examinations and the need for regular curriculum revision and updated lists of recommended texts. It was felt that it also necessary for logbook requirements to be updated.
It is therefore opportune for all to make input on the training requirements and standards in order to make the curriculum relevant to the evolution in the field.

5. CASSA’s proposal on Survey in Cardiology training institutions
CASSA is planning a formal survey of ECG, arrhythmia, device and EP teaching at the cardiology training units around SA. A request for approval of this intention was presented to the EC. The EC unanimously accepted this proposal. The EC will await the report once this venture is concluded.

6. The CASSA ICD Practitioner Accreditation proposal
The Education Committee (EC) concurs with the education and training objectives of CASSA. This intent is relevant towards the promotion of a better and quality health care. There is also consensus on the need for continuing medical education and encouragement of members to source training on new technologies where there is interest to broaden the scope of practice.
SA Heart association (SA Heart) and its affiliated bodies do not however, have the powers to limit the scope of practice or the mandate to monitor the practices of any practising health professional registered with the Health Professions Council of South Africa (HPCSA).

The HPCSA regulations compel registered practitioners to demonstrate competencies in procedures performed without much emphasis on the “registered field of practice”.

The EC is of the opinion that extra examinations and accreditation for registered cardiologists in any area is not recommended. As in line with the HPCSA, the responsibility and discretion on confines of scope of practice still lie with the individual.

SA Heart and its affiliates are not statutory bodies and can therefore not accredit specific procedures. The SIGs are however encouraged to advice members on the need for training and to offer support in this venture as well as assist towards definition of the course content.

The use of proctorium is recommended and encouraged since most of the new technologies are skills based.

Industry sponsored training is not ideal; however it serves an important role at present. This is a short term avenue that the profession has pursued but needs to be revisited going forward. The training should take place in the accredited training centres.

The EC also encourages participation of SIGs in the review of the curriculum for cardiology training. This would ensure that the training program remains current and relevant to new technologies.

7. The South African Heart Association Research Scholarship

This scholarship is available to full and associate members of the SA Heart Association living in South Africa. It is primarily intended to assist colleagues involved in much-needed research to enhance their research programmes. Applicants need to be fully paid up members/associate members in good standing for at least one year.

The advertisement for this scholarship has been modified to indicate the minimum requirements, especially ethics approval prior to application submissions by candidates.

Dr Vachiat was awarded the R50 000.00 SA Heart Research Scholarship for 2011.

8. Pan African Society of Cardiology (PASCAR) Fellowships in Cardiac Pacing:

The purpose of this fellowship is to support the training of African physicians and their supporting non-physician clinicians/nurses in cardiac pacing and clinical cardiology at recognised cardiology training units in South Africa.

This seeks to address the human resource barrier through the establishment of Fellowships in Cardiac Pacing and Clinical Cardiology through the Pan African Society of Cardiology (PASCAR) for the training of cardiac pacemaker implanters to work in public training institutions on the continent of Africa.

A pilot phase of three years was proposed for the development and establishment of this Fellowship Programme. In the first year, two Fellows will be trained at the University of Cape Town. In the second year, four Fellows will be trained at the University of Cape Town and a second Training Centre that will be invited and selected by the Selection Committee on the basis of a proven record of training cardiologists. In the third year, 8 Fellows will be trained in four Training Centres, for a total of 14 Fellows, 14 non-physician clinicians/nurses from 14 countries/institutions in this pilot period phase.

The selection panel constitutes of; Prof Bongani Mayosi, Prof Rob Scott Millar (CASSA), Prof Oluwole Adebo (PASCAR) and Dr Martin Mpe (Chair: EC, SA Heart).

9. SA Heart Annual Congresses

The SA Heart EXCO held a meeting on the 9th – 10th June 2012, in Midrand, where following points were raised and adopted:

- There must only be one annual SA Heart Congress which SA Heart organises itself as from 2014 and keeps 100% of the profit. The SA Heart has changed and grown in the past few years and needs more income to fulfil all its duties.
- A core group must be the centre of the organising committee and co-opt for content and programme on a rotational basis.

The core should be the SA Heart president, vice president, secretary, treasurer and SA Heart office administrator. There always needs to be one representative for surgeons and paediatricians. As according to our constitution the education committee is responsible for the SA Heart congress, either the chair of the Education Committee or a nominated representative from that committee must serve on the core Congress committee.

Dr Martin Mpe, Chairman of the Education Committee of SA Heart
Ethics and Guidelines Committee

The members of the Ethics and Guidelines Committee are:
Dr Ronnie Jardine (Chairman), Dr Cobus Badenhorst, Dr James Fulton, Dr Mpiko Ntsekhe, Dr Les Osrin, Dr Somalingum Ponnusamy

These include representation from the Special Interest Groups CASSA, SACSI and Cardio-Thoracic Surgery, but it is desirable that it include representation from HEFSSA and PCSSA also, in the future.

During the term of this committee, 2 new guidelines have been published by the European Society of Cardiology, viz. “Acute and chronic heart failure” and “Cardiovascular disease prevention in clinical practice”. As is policy, these have been automatically adopted by SA Heart Association, but they are being reviewed, the former by HEFSSA and the latter by the Ethics and Guidelines Committee itself.

Upon request from a number of role players, the Committee convened a Consensus Development Conference on high-sensitivity troponin assays. The 29 delegates included a number of cardiologists, chemical pathologists, emergency room physicians and industry representatives. The resultant Consensus Statement has been published in the current issue of the SA Heart Journal (SA Heart 2011; 9: 205-10) and calls for the widespread adoption of the high sensitivity troponin assays for the triage of chest pain and the diagnosis of myocardial infarction, and the abandoning of former assays, CKMB and myoglobin.

Currently the Committee is examining a proposed Consensus Statement on Renal Denervation for the treatment of resistant hypertension, and there has also been a request for a position statement on external balloon counter-pulsation as a therapy for ischaemic heart disease.

Ethical issues referred to the committee have included the question of mobile cardiac catheterisation laboratories, and a patient’s complaint regarding unprofessional conduct. The latter is not within the mandate of this committee and such matters must be directed to the Health Professionals Council of SA.

The Committee continues to meet by regular teleconference to deal with the issues.

Dr RM Jardine, Chairman Ethics and Guidelines Committee

Full Time Practice Committee

Members: Prof Andrew Sarkin (chair), Dr Sajidah Kahn, Dr Riaz Dawood, Dr Johan Jordaan, Dr Paul Adams

Brainstorming and development of plans by members of the committee revolved around the following issues:

- **Strengthening the Full-time academic departments** with regards to research, retention of staff, service delivery and resource availability.
- **Training**: Training of cardiac professionals remains a challenge in the country, with too few cardiac resources (including staff, equipment and skills shortages) to cover patient care in the country. The country needs to look at ways to increase training of cardiac practitioners and keep them in the academic/public hospital system. SA Heart could play a significant role in this. A review of our current training practices is needed and hopefully now that a representative at the College (Prof Commerford) has been elected, this will pave the way. Areas of training that could do with special attention include Arrhythmology/EP. The committee also feels that many departments have the capacity to train significantly more cardiac practitioners which would be a first step to increasing desperately needed cardiac staff in SA’s public sector.
- **More support is needed for the Academic/Public departments** from all role players including the state, the private sector and industry. SA Heart, as the representative body, could lead the way on this.
- **Public Private Partnerships** - this co-operation between the Public sector/University/Private Specialists and Industry is growing in most departments with overall benefits to all stakeholders. Industry and hospital groups seem to also be realising the positive role and necessity of these interactions to maintain cardiovascular care and training in the country.
- **NHI** has been discussed and a policy document from SA Heart is being prepared. This is an opportunity for everyone to play a greater role in our profession in a positive way.

Commitment and active involvement by all cardiac role players, with SA Heart’s leadership, will be extremely important in the next few years in order to ensure that academic departments are strengthened as much as possible to maintain the full scope of training, the existing high levels of cardiac skills, research and offering South Africans access to proper cardiac care. With SA Heart’s leadership and an open and honest approach, we should be able to significantly improve all of these aspects of our profession.

Prof Andrew Sarkin, Chairman of the Full Time Practice Committee of SA Heart
Private Practice Committee

Members of the Private Practice Committee and the SA Heart Association Special Interest Groups they represent:

Dr Darryl Smith  
HeFSSA and CISSA

Dr J Botha  
SCSSA

Dr Len Steingo  
SASCI

Dr Mark Abelson  
SASCI

Dr Harrisberg  
PCSSA

Dr Razen Gopal  
CASSA

Dr Makoali Makotoko  
Chairperson

The Private Practice Committee took a few months to get members as the SIGs were requested to nominate representatives. Those SIGs that still do not have representation are welcome to nominate even at this stage.

We have had three teleconferences to date and I have attended an SA Heart EXCO Strategic Meeting and a National Advisory Council Meeting and a brainstorming meeting on NHI.

There are many important issues facing Cardiac Practitioners in private practice:

Many of our cardiology colleagues had funds either withheld or withdrawn from their accounts at the end of 2011 and early in 2012 by Discovery Health for having billed patients for follow-up care after a variety of procedures. Discovery Health was of the opinion that there should be no charge for follow-up because of “Rule G” in the CPT manual. A careful study of the CPT manual showed that most percutaneous cardiac procedures are not governed by Rule G except for the implantation of various pacemakers. The fund withdrawals were therefore erroneous.

To attempt to resolve this issue, a meeting was held at the offices of Discovery Health in Sandton which was attended by Dr Maurice Goodman, Mr Darren Sweidan, Dr Claude Ndlovu, Ms Stephanie Fourie, Ms Inez Naidu representing Discovery Health. SA Heart was represented by Dr David Jankelow, Dr Andrew Thornton, Dr Len Steingo, Dr Kenny Govendrageloo and myself. Ms Sanette Zietsman represented SASCI.

An agreement was reached that both Discovery Health and SA Heart would follow the CPT manual adopted by SAMA for billing. The Discovery Health representatives undertook to check which procedures were affected by Rule G and they promised to reimburse those doctors whose funds were erroneously withheld or deducted. WE also indicated that Discovery Health should apologise to these same doctors. To date that has not happened.

It came to our attention later that a very large sum of money had been withdrawn from another colleague by Discovery Health in February 2012 for reportedly having a disproportionately large number of ICU patients (codes 1205 and 1206). A comparison of this colleague’s billing pattern, compared to the “average” cardiologist’s billing pattern was, according to Discovery Health, skewed to more ICU than ordinary ward care. Dr David Jankelow, representing SA Heart met with Discovery Health. An agreement was reached that Dr Jankelow and Dr Steingo will review the patient records that are being disputed and decide if ICU treatment was justified or not. Discovery Health has agreed to abide by the findings of the two doctors.

I would like to thank Drs Steingo, Jankelow and Govendrageloo for their assistance in meeting with Discovery Health.

Other important matters regarding coding:

I have requested and am requesting all SIGs to submit the list of procedures that are currently not in the SAMA Doctors’ Billing Manual to the PPC so that we can complete application forms to SAMA for inclusion in their 2013 manual. There are many procedures that are not coded for and for which billing is therefore problematic. Every doctor is using what he/she feels is the most approximate code. This raises the problem that the funders might reject such a code. The procedure for introducing new codes to be included in the DBM is very straightforward and fair. We have missed the deadline for this year’s edition, but we should aim to have the presentations ready for 2013. We have had a lot of support from the SAMA Coding Specialist, Mrs Leonie Maritz, and for that I am very grateful.

Chronic Medicine Forms

Most of the patients seen by us have chronic conditions. We feel that the current requirement by funders that doctors must complete application forms is not our obligation, it does not enhance patient care, it is tedious and unnecessary. At the same meeting with Discovery Health on the 2nd of April, we put it to them that a prescription from a Specialist showing the ICD 10 code for a patient’s condition and stating that the prescribed medicine is
chronic, should suffice. Discovery Health has accepted this proposal and will need three pieces of information on the prescription:

a) The ICD 10 code  
b) The date when the condition was diagnosed  
c) The patient’s consent that this information can be shared with the pharmacy.

It seems like a reasonable request.

We still need to have a similar discussion with other funders: GEMS, Bonitas, Polmed, Medshield, etc.

**NHI**

Another very important matter facing not only Cardiac Practitioners but all doctors in South Africa is the National Health Insurance. Several pilot NHI sites have started operating but we are still in the dark as to where and how specialists fit in. The SA Heart EXCO feels that the best way forward is to be proactive and to formulate a proposal to discuss with the Department of Health.

Cardiovascular disease is the second commonest cause of death in South Africa and is projected to be the leading cause by 2025. Cardiac Practitioners are therefore a very important component of any health plan, whether they be in the private or public sector. Several facts must be taken into account: a) There are far too few Cardiologists and Cardiothoracic surgeons in South Africa and we are producing too few to ever catch up with the country’s needs. B) The majority of the current centre cardiac practitioners are over 50 years of age. c) There are three provinces without any cardiac services in the public sector: Limpopo, Mpumalanga and the North West Province. We all have to be prepared to be involved in the improvement of cardiac services for the people of South Africa. Cardiac Practitioners need to be prepared to assist in the three service areas:

1. **Education and training of the younger colleagues: Cardiologists, Cardiothoracic Surgeons, Perfusionists and Clinical Technologists.**
   
   Private-Public Partnerships need to be put in place so that trainees can also be trained in the private Hospitals, especially in technology that is scarce in the public sector.

2. **Cardiology and Cardiothoracic Surgery Clinical services.**

   It needs to be recognised that we cannot hope, in the near future, to have enough cardiologists and cardiothoracic Surgeons for the country’s needs. We feel that there should be a national shift in the approach to cardiac, and general health services. There is a need for training of Nurses into Nurse-Physicians, who have diagnostic skills and who can identify and treat common ailments in the communities. High risk individuals would be recognised and referred to District facilities for more monitoring and interventions. At District level General Practitioners and Medical Officers should be trained, by members of SA Heart, in emergency cardiac procedures like tapping of pericardial effusions, insertion of temporary pacemaker leads, the recognition of ST-elevation myocardial infarction and administration of thrombolytics. Follow up of patients that have had cardiac surgery like CABG, valve replacement surgery, can be done at District level for stable patients. There are a lot of patients in the public sector who are followed up at Tertiary hospitals only because of the unavailability of medication at district hospitals. This makes queues at the tertiary hospitals to be very long and waiting periods for appointments unacceptably long. Cardiac Practitioners from the private sector could then come in at Provincial Hospitals and do fortnightly clinics and surgery as required.

3. **Research**

   Statistics about cardiovascular disease patterns in South Africa is scarce, and yet we need accurate figures for health services planning and to measure outcomes of our interventions. The public and private sectors need to have the same registries to capture information on similar conditions. SA Heart, as a body to which most cardiac practitioners belong, should work to make this a reality. Such registries can then be used to generate much academic work and publication for the betterment of all in this country. The SHARE Registry is an example of just such a registry initiated by SA Heart. It has taken a lot of work, money and dedication to get it going, but it is an example of what is needed for cardiac research and data capturing in this country and a collaboration between the private and public sectors.

   Professors Andrew Sarkin, Francis Smit and I are working on a document on the envisaged role of all cardiac practitioners in the NHI which we will present to the members of SA Heart for comment and input before presenting it to the Minister of Health. We also feel we need to align ourselves with a bigger doctors’ association like the South African Medical Association when discussing NHI with government. We feel that we have a better chance to be heard when we stand together and have a stronger voice.

*Makoali Makotoko’ Chairperson Private Practice Committee, SA Heart*
SA Heart Journal

The Summer 2012 issue (Volume 9, number 1) focused on transcatheter aortic valve implantation (TAVI) in Africa and included 3 invited reviews as well as the publication of the first South African experience with TAVI by Hellmuth Weich and his colleagues from Stellenbosch University and the Medi Clinic hospital group. In addition it featured an important consensus statement on TAVI by the SA Heart Association and its special interest groups SASCi and SCTSSA.

The Autumn 2012 issue (Volume 9, number 2) included an editorial addressing the role of the SA Heart cathlab registry, SHARE and another important consensus statement, this time on the management of dyslipidaemia, a joint statement by SA Heart and its special interest group LASSA. Other topics featured were cardiac MRI, patient selection for TAVI, balloon aortic valvuloplasty and the long QT syndrome.

The Winter 2012 issue (volume 9, number 3) features the abstracts accepted for the SA Heart Congress 2012. The editorial of this issue deserves mention as it raises important issues regarding accreditation in echocardiography including points of view from emergency medicine specialists and anaesthetists. The third important consensus statement for the year featured in this issue deals with high sensitivity cardiac troponins. This issue also features the regular ECG quiz, a feature that has become synonymous with SA Heart, prepared for the Journal by AO Okreglicki. This, the 28th ECG quiz prepared by AO, turns out to be his last contribution to the Journal. His untimely death is an immense loss and I would like to take this opportunity to pay tribute to the vast contribution he has made to SA Heart, as he has made in so many other areas.

An important initiative taken this year is an application to the US National Library of Medicine (NLm) of the NIH for MEDLINE listing. The Journal is already electronically published and is regularly accessed via standard electronic searches. The application to be indexed by the NLM will result in the Journal being accessed via PubMed searches, increasing its impact.

Anton Doubell, Editor, SA Heart Journal

SHARE Status Review (July 2012)

1. **10,000 cases captured on SHARE database** – This milestone has been achieved in 4 years.
2. The database is growing at average of 600 cases per month
3. **“Concept Proven”**: SHARE has 65 individual databases @ 14 hospitals in both the State and Private sectors with access to the program, of which 39 practices are regularly entering data.
4. YTD 2012 3,100 cases captured vs 4,040 in full year 2011. We are on track to once again double the year on year number of cases captured!
5. **Close working relationship with Netcare** (including funding, management and IT support) has proven crucial in the successful roll out of SHARE within the Netcare Gauteng hospitals.
6. **Since January 2012 the focus has been on Gauteng Academic** units with Charlotte Maxeke (Johannesburg General), Steve Biko Academic and Chris Hani Baragwaneth now operational.
7. **Financial “Break-even achieved”** - For the first time SHARE has been self-sustaining. SA Heart would like to thank the following sponsors: Netcare, Medtronic, AstraZeneca, Discovery, Cordis and Biotronik.
8. In the immediate future
   a. **Reporting and Research** – SHARE is currently developing and testing the mechanism to send individual practices encrypted and secure quarterly reports of their own data, shown in a comparative analysis to the national aggregated numbers. This will assist practitioners to self-review their own practice in comparison to the national statistics, and will also allow academic units to access the data for their own research projects more easily. The **10 000 SHARE cases captured to date, and the 4 000 cases captured in the first version of a SA Heart registry, will** be further analysed and a research paper will be submitted to an international journal, possibly to the European Heart Journal (with new SHARE committee member Karen Sliwa as project leader).
   b. Continue to raise **funding** under Research banner but expand focus to include international as well as local medical research institutions, with greater collaboration with other international registries such as the ACC and BCIS.

Prepared by George Nel and Elizabeth Schaafsma, SHARE project