AGENDA

1. Welcome and apologies
   Dr Adriaan Snyders opened the meeting and welcomed all present.
   Attendance as per attached attendance register
   Apologies were received from Dr Rob Girdwood and Prof Anton Doubell

2. Confirmation of minutes of AGM 2012
   The minutes were accepted as true
   Proposed: Dr Eric Klug Seconded: Prof Andrew Sarkin

3. Matters arising from the minutes (AGM 2012)
   No matters were discussed

4. President’s Report
   Dr Adrian Snyders asks those present to stand for a minute of silence in memory of Prof Andries Brink and Dr André van der Watt who have passed away since the previous AGM.
   The President’s report was circulated and read.
   No comments received

   Dr Snyders announced that Ms Erika Dau has been promoted to Executive Officer.

5. Treasurer’s Report
   Prof Francis Smit presented some slides on the finances. As we are in the same financial year as the previous AGM, no audited financial statements were available yet, but figures of the current financial year were displayed as well as expected expenditure in February which showed that SA Heart would have a loss of around R862 000.00 for the financial year, but still with positive cash flow.
   Prof Smit then presented the budget for the finance year 2014. He broke down the various SA Heart projects into possible cost and profit centres and presented these separately, showing where we could possibly save and which projects were already partially funded through targeted donations.
Speaking conservatively the expenses expected will leave us with a loss around R10500.00 but SA Heart Exco is positive to be able to generate more income or get targeted funding for projects.

The membership fees for 2013 will rise to R1000.00 for ordinary members and R150.00 for associate members. Prof Smit urged members to make use of the eLibrary which at R1500.00 per annum is a bargain as it give access to a multitude of Journals and textbooks.

6. Annual Reports from our Standing Committees
   a) Private Practice Committee
   b) Education Committee
   c) Ethics and Guidelines Committee
   d) Fulltime Salaried Committee

The reports were circulated and the highlights presented.

   a) Dr Makotoko spoke about coding and billing and the advances made and that CASSA still has a problem as ICD is currently listed as surgical procedure not cardiology procedure. While PCSSA has already submitted their new codes which have been accepted, other SIGs still need to work on these to be included in the 2014 billing manual. She highlighted working with Discovery and being able to solve a number of problems, also establishing direct links for queries and mediation, but still felt unhappy that Discovery tends to micro-dissect issues and takes the clinical judgment away from the treating doctor. She in particular pointed out to members to ensure that billing and codes for ICU or High Care patients matched that of the hospital.

Dr Makotoko reported on the meeting with Medscheme which was attended by a number of roleplayers like SAMA, SAPPF, and physicians’ forum. Items discussed included tiered consultations, equalizing the Rand conversion Factor between consulting and surgical disciplines, improving financial wastage within Medscheme and passing the saving to practitioners, Reducing the current administrative burden that is placed on doctors with chronic medicine forms and motivations for procedures and establishing direct lines of communication for specialists. The forum members will meet quarterly. The PCC is aiming to interact with more medical schemes to discuss the same problems. The committee is aware that there are other issues to be dealt with, but have decided to concentrate on these during their term to sort them out once and for all and future committees can then build on this and address other issues.

Dr Silivia Brenner (non-member) commented that it has come to his attention that certain doctors acting as advisors at Discovery Health also serve on SAMA representing our interests as far as private practice is concerned. He feels this is a conflict of interest and should be taken up by PPC. Secondly, currently Doctors are not allowed to be appointed by clinics, yet if we are dealing with the NHI, the next step the government will take is to pass legislation for doctors to be employed by clinics, which is a dangerous step. At the moment doctors who are contracted to medical aids, are basically ‘employed’ by medical aids. Under NHI doctors will be ‘employed’ by medical aids and employed by clinics, and the government will decide what doctors get paid. He warns strongly about signing contracts with medical aids and funders and the problems coming up with clinics and the NHI.

Dr Makotoko replies that she is not aware of doctors serving both on Discovery and SAMA boards and she invites Dr Brenner to come and see her and advise who these are. As far as she
understands the NHI document, there is still a lack of clarity around the engagement required from doctors currently in the private sector. Having read through the entire NHI document she has not come across any methodology that will be applied and that is the reason why it is so important to put out our recommendations. They will keep watching the process and react as is necessary.

Dr Snyders adds that Prof Stef van der Spuy who is now the chairman of SAMA is also an employed trustee of Discovery and he has taken it up with Dr Grootboom who said it had been discussed and found ethical.

b) Dr Mpe pointed out that the ICD coding issue had been updated since the report was written and the update will be on the website. The new wording:

   The CASSA ICD Practitioner Accreditation proposal
This issue was revisited following appeal for review by CASSA. The decision of the EC was rejection of the proposal for “accreditation” by a non-statutory SA Heart affiliation group. The principle of continuing medical education is encouraged and as such fully supported.
A subcommittee consisting of Profs P Commerford and A Doubell, Drs T Mabin and P Obel met and were in agreement that it would be satisfactory if the phrase "CASSA endorsement" of the educational process undergone by the cardiologist would replace the phrase "accreditation". (The latter implies some form of licensing function to CASSA).
A suggestion was made that an outside professional body be involved in setting and/or reviewing the exam questions. Approaches have been made with what is an initial favourable response from ECAS.
The CASSA process has been simplified and no longer includes CASSA monitoring the physical implantation or the facility where implantation is being done. It will include the exam and review of the indication for the ICD insertion once it has been implanted, plus programming and ICD interrogation in the follow up year.

Dr Mpe also pointed out that there are still some problems with the SA Heart events calendar in that there is competition with too many events too close together. He urges again that academic and other meetings are reported to the education committee in their planning phase before dates and venues are set in order to allow for better planning and spacing of all cardiac events. Dr Snyders adds that the webpage and with that the events calendar has changed and feedback is awaited from members and SIGs.

c) Dr Jardine refers to his short circulated report and adds that we are looking at drawing up SA Heart ethical guidelines for members on what is ethical and good practice when it comes to requests for sponsorship etc. from industry and to forward opinions on what should be permissible and not to the E&G committee.

d) Prof Sarkin highlighted that tertiary hospitals which were under provincial administration will move to national level with budgets ring fenced. He spoke to the NHI document he together with Prof Francis Smit and Dr Makoali Makotoko have prepared as working document which will be posted on the webpage for comment. We are awaiting input on what you can offer an how the document can be improved.

7. Report from Special Interest Groups / Regional branches
The reports were circulated. No comments

8. **SA HeArt REgistry (SHARE)**
Dr Thornton: The report has been circulated. We have entered 15 500 patients. We have identified deficiencies in terms of getting a publication into which Prof Sliwa has put a lot of work
The main shortcoming is that we do not have any outcomes data. Funding remains a challenge, while SHARE was donor funded for the previous financial year, for the current year with the economic climate we could not manage this target. The way forward is with a curtailed budget which can be achieved by simplifying the dataset and also the way/platform we enter the data, as eMD is costing a fortune. It will however be a complete disaster to stop it in its present form until we have something that can take over right away, as we will lose the goodwill and momentum.

Prof Sliwa comments that the database was initially developed for surveyance purposes and it was hoped that industry would be interested in this data and fund the project. Industry has supported the project for some years but this model is not sustainable if industry does not get direct benefit out of it. Industry has asked for data for surveyance for management in different region or what certain doctors are doing. The SHARE group has different opinions on this issue. The registry can be used for different purposes. The ESC for example has extensive registries and it is understood that societies should collect data that is not influenced by industry or medical aids but to help management of disease and outcome. For SA Heart to have such a registry some changes are necessary, the most important one is getting outcomes data and there are several methods how this can be collected and captured. Prof Sliwa mentions that she is not convinced that the registry needs to continue on the magnitude it is run at the moment, one could look at collecting data from rotating centres or alternative years or follow surveyance models from other registries, but add outcomes data. Her idea is that somebody who has an interest in the data, i.e interventionist should lead the SHARE group, preferably somebody in public service as that would bring with it a number of registrars who can support the registry without needing an additional salary. She has spoken to Prof Mpiko Ntsekhe who has recently taken over as department head of cardiology in Groote Schuur who has indicated strong interest. As this was only 3 days ago, no meeting has taken place yet and no further plan discussed.

Another idea was to approach the MRC who has now got a new very pro-active head which offers a chance that the MRC will support us, yet the MRC is also short on funding. Prof Sliwa also mentioned that she recently spoke to the Western Cape Minister of Health indicating that we have a shortage of and need for data, so following up on this avenue is an alternative, too. Prof Smit commented on the financial aspect of the registry: Apart of the moral obligation where we have to collect data, if we look at a number of databases in the public sector, they vary from provincial to national to WHF – and the quality is poor and not controlled, yet we use this data to plan for healthcare in the public sector and partially in the private sector. The NHI will impact greatly on medicine and healthcare in South Africa and somebody has to provide data in an interpreted and responsible way. If we don’t think this needs to be SA Heart, that is fine, but then we cannot complain about the decisions taken on our behalf. The NHI will also impact on the private practice.

The importance of a database is thus understood. If we look at funding mechanisms we have two subsets: We can have a public sector project which should focus on national health with the MRC, the burden of disease and statutory requirements in terms of reporting on activities in cardiovascular medicine. In the private sector, if we want make money we need to be able to sell a product, we thus need data that will be fundable or available to industry and hospital groups, this should be the second phase of the project. We can run the project on about R300 000 per year cost to SA Heart. As this is a cath lab based registry, with the head of SASCI, Dr Hellig being present he suggest adding outcomes and SASCI could take over some funding as an in-house gesture.
Dr Snyders concluded that there were lessons learned and new visions for the project and invited all members to partake and contribute through ideas and participation.

9. Changes in Exco
   President Elect – Prof Karen Sliwa
   Vice President – Dr David Jankelow
   Secretary – Dr Rob Kleinloog

10. Motions received / for discussion
    Though more than 25 ordinary members being a quorums signed the attendance register, by the time the meeting reached point 10 and with that motions presented, only 20 full members and one proxy were left. Nevertheless the motions were discussed.
    The first motion was on some technical changes and additions to the SA Heart constitution in order to comply with stipulations spelled out in the new tax law which require a new application for tax exempt status. Some further minor changes are made to make applying for PBO status easier. As there were no objections or discussions, this motion was passed.
    The second motion was on the SA Heart Journal and copyright issues and was debated with a variety of different views and as such the members present felt that no final decision could be taken at this AGM and forum.
    Although SA Heart Journal is recognized by the Department of Education, was not successful in its recent application to be listed with Pubmed and funding is not as generous when you publish in a not Pubmed listed journal.
    Prof Sliwa says she would like more information on the reason why SA Heart Journal is not Pubmed listed. Other Societies, even within Africa, normally manage to get their publication listed within three years. The SA Heart Journal is expensive and has not reached the stage where it should be and is to some extend in competition with the CVJA. Maybe a larger committee must be formed to look at the reasons why SA Heart Journal has not achieved the goal and at ways to modernize the approach for the SA Heart Journal to make it more visible and user friendly. This is fundamental as people don’t want to publish in a journal where your contribution is not found and you don’t get benefits like rating.
    Prof Smit gives some background as to the cost of running the SA Heart Journal which is quite high. It only appears on a quarterly basis which is negative from a pubmed perspective. At the last Exco meeting is was discussed and agreed to make the SA Heart Journal an electronic web-based Journal with only limited copies printed for copyright and medical libraries, editors and contributors. We also hoping to achieve higher circulation through electronic means, also use international contacts (ESC/EACTS) for distribution.
    The cardiac community needs to support it with publications, including subgroups like surgeons and paediatric cardiologists. Marketing to industry for funding will then also be easier and in this process raise the profile. He suggests accepting the motion temporarily and re-looking at the motion at the next AGM.
    Dr Klug we have supported the SA Heart Journal in various ways with publications and it has not achieved the status it should have and it is unfair of people who submit abstracts to be under the yoke of publishing in SA Heart because it is the society’s Journal rather
than in a publication that is pubmed listed. The same applies to the publication of the SA guidelines. You have to publish in SAMJ first that you get a wide readership, you get the pubmed listing, it has status for algorithms for the funder and in public health. We have to accept that the SA Heart Journal is not a success and it has had plenty of time. As we know the editor of the CVJA has passed away and they must have a new management plan. We need to ask ourselves, can we afford two cardiovascular journals. He urges not to accept the motion, even temporarily, as it will influence guidelines being published this year and maybe even abstracts. He suggests re-looking at working together with the CVJA and not to live in hope and promises. Prof Sarkin disagrees arguing that it is very important for a country to have a cardiovascular Journal as it is for the society to have a proper profile and if it is struggling we need to look at ways to support it more and tide it over, the same way we have taken acceptance for the SHARE registry. It is a high profile thing, Prof Doubell has worked hard on it for some years. We have discussed raising the profile and cutting costs at Exco level and if we don’t support it now it will be the death nail for the Journal. Certainly as academics we need to look at ways to support it and as Prof Sliwa indicated maybe re-look at the structure, but it would be a big calamity to collapse the Journal down. Dr Hellig says it is an important decision and there is not adequate representation at this meeting to take a final decision and we need to poll the membership. Dr Snyder summarizes that we agree that it is important to have Journal. It is a big decision to accept the motion and we should not hastily make that decision and need a proper quorum to do so. We have to investigate reasons why the Journal was not successful in getting listed so far and give support to get it listed in future. We will support the SA Heart but will not enforce abstracts or guidelines to be published in our journal because of the limitations. Dr Steingo says we don’t have the forum or the right to vote on the motion tonight and need to speak to Prof Doubell about the reasons for not getting listed while acknowledging his hard work. Prof Sliwa mentions that she has just received an email advertising the post of editor for the CVJA. That Journal is in Cape Town, our Journal is in Cape Town. The target audience and contributors are the same – why must we specialize on articles from South Africa and not Africa. She suggests she writes an email to Prof Doubell encouraging him to apply for the position.

11. General

Dr Snyders adjourns the meeting encouraging members to visit the SA Heart website and to encourage colleagues to attend the next AGM.