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Private Practice in Cardiology Much to offer, much to lose

All the contributions to this edition of SA Heart were invited from authors with connections to private practice. It is therefore noteworthy that two of the six articles include co-authors from the respective academic units in which the invited authors work. Such collaboration illustrates the close links that exist between the private and academic sectors in South Africa. Not only do private practitioners participate in the activities of the teaching units, but, in turn, many of their senior academic staff have ongoing interests also in their own private practices.

Sadly, private practice in South Africa finds itself under increasing pressure at this time. The Health Minister has initiated legislation which, if promulgated, will severely restrict the incomes of private practitioners. According to the results of a recent survey, this will provoke the emigration of substantial numbers of specialists to other countries, as well as their migration away from private practice into alternative non-clinical occupations. It is thus clear that the Minister's jackboot methods will result in severe attrition amongst the specialists who work within the most progressive and successful sector of this country's health care.

Despite the inherent incidental ugliness that may accompany free enterprise and capitalism, it is precisely the latter elements that have produced a South African private health care system that has been at the forefront of innovation and the font of medical progress within the country for the last two decades. The private sector boasts modern, sanitary facilities offering high quality care that complies with the strictest international standards. Contrast this with the debilitation evident within the public hospital sector, affecting as it does almost every aspect of its service delivery, and that has turned public hospitals into a last refuge for the desperate and the destitute. Despite these glaring disparities, the Minister sees fit to rail against the costs of private medicine, as if curtailing what in the developed world passes for tolerably good quality medicine will miraculously redistribute funding into the sector over which she has presided for the last eight years, and rescue it from the ruin into which it has been allowed to descend.

It is abundantly clear that healthcare reform is needed both locally and internationally. We are all acutely aware that the cost of healthcare has increased disproportionately over the last two decades, driven inter alia by the escalating costs of technology and an expanding knowledge base that has broadened and deepened the indications for treatment. This cost escalation has brought with it the ability to rapidly diagnose conditions that were previously inaccessible and to treat them effectively to sometimes save and oftentimes prolong life. The Health Minister needs to take cognizance of the benefits of modern medicine, to recognise that anti-retroviral agents are superior to the African potato and to abandon her political agenda in favour of a policy of consultation and collaboration with those who know more than she does and who have done more than she has done to heal this nation. I doubt that there are any in private practice who would turn away from offering assistance if asked.

Although cost containment must feature within our future plans, cutting off the life blood of the private sector will not result in its transfusion into the terminal patient that the public sector has become.

Many years ago, when William Osler contemplated the difficulties of partnership between the private and public hospital sectors in Canada, he concluded that both sides would be required to temper their egos to conclude an amicable agreement to work together. As in so many things, he was correct. All the participants in South Africa's

healthcare need to take his advice to heart right now. The Department of Health (DOH) needs to stop dragging its feet, to stop fearing business initiatives and to drop its outdated adherence to good-hearted social policies that it cannot support financially. Private practice and private hospitals need to become willingly engaged in sharing their successful solutions to healthcare with those who so far have failed to find them.

Most of us in private practice are unable to run our practices on the current Recommended Price List tariffs. The recently completed HealthMan survey has recommended tariff increases in excess of 100% based on current practice running costs. In this issue, the Chair of the Private Practice Committee, Dr Anthony Stanley, shares his views and experience regarding the development of an equitable tariff structure. Clearly, our profession has a long way to go before the Minister and the DOH can be convinced of these requirements!

Drs Rapeport, Schamroth and Patel, and Dr Abelson report on their respective experiences with two novel interventional techniques. In the first instance, a series of percutaneous patent foramen ovale closures is reported from Milpark Hospital. Their group of patients was, on average, older than previously reported series and the large majority was submitted to closure only after the demonstration of a systemic embolus. In their hands, the technique has proved to be safe. Dr Abelson's report of his experience with percutaneous reperfusion of the cerebral vessels in the acute phase of stroke also shows promise, apparently with an immediately discernible improvement in short-term outcome. However, in both of these procedures, broader experience and longer follow-up has yet to satisfactorily prove the utility of these techniques.

Dr Libhaber reviews the uses of radioisotopic myocardial perfusion imaging in detail. Locally, the relatively scant use of this and other techniques that detect ischemia, such as exercise stress echocardiography and estimation of the fractional flow reserve (FFR), highlights our frequent reliance upon "oculostenotic reflexes" when it comes to deciding upon the appropriateness of revascularization. Simply estimating the diameter stenosis of a coronary vessel can be misleading and needs to be supported by objective evidence of the functional significance of the lesion. An example of the inaccuracy of measuring the stenosis was shown at the recent Euro PCR meeting in Barcelona. In the study quoted, the discordance between the results of quantitative coronary angiography (QCA) and FFR exceeded 50%. We need to reconsider the need for objectively demonstrating ischemia and expand the use of techniques that enable us to do so.

Dr Kleinloog and his group present their experience with intracardiac tumors, discussing their clinical presentation, detection and management in an interesting and richly illustrated article.

Finally, Dr Klug discusses the cardiorenal syndrome, an increasingly frequent problem encountered in the management of heart failure, a product inter alia of the initial success of managing these patients with contemporary pharmacotherapy and the consequent aging of this patient group. Although no specific treatment exists to manage such patients, Klug sounds clear warnings on how to avoid the pitfalls that exacerbate this syndrome.

Private practitioners in Cardiology in South Africa have much to offer by way of their expertise and experience. In many instances, it has been the private practitioner who has pioneered innovations in our country. These qualities should not become lost to our profession by the thoughtless intrusion of political dogmatists.