

MANAGING PUBLIC AND PRIVATE HEART DISEASE

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David Kettles obtained his MB ChB at the University of Cape Town in 1989 and the FCP (SA) in 1996. After initial cardiology training at Groote Schuur Hospital, he furthered his training in clinical research and coronary intervention in Brighton, UK. His

MMed (Int Med) dissertation (2000) related to the complications of thrombolytic therapy. In 2000 he returned to East London to pioneer a cardiology service in the private sector.

When I was a third-year student it seemed that 'clinical methods' meant learning cardiology. The accurate distinction of a systolic ejection murmur from a diastolic rumble represented, for a time, the pinnacle of good doctoring. Later I was a junior doctor when the thrombolytic therapy of acute myocardial infarction (AMI) became widespread. Having been described as early as 1958, interest in this novel treatment was reawakened in the seventies, and it became one of the most widely studied areas of clinical medicine ever. ISIS and TIMI researchers and others delivered evidence-based recommendations that impacted on our daily practice. The treatment of AMI was revolutionised: previously we accepted coronary occlusion and dealt with its consequences, now we adopted aggressive strategies to secure reperfusion of the threatened myocardium.

Management strategies continue to evolve. Interventional cardiologists have recently seen compelling evidence emerging for percutaneous coronary intervention (PCI) as reperfusion strategy of choice in AMI. Facilitated PCI (drugs then a stent) is the new frontier.

The articles in this issue of *CME* will assist you in staying abreast of current developments in cardiology. You will gain practical knowledge from local experts covering common clinical scenarios. My concern is how effectively you will be able to use your clinical expertise to the benefit of your patients. In both the private and public sectors we currently face constraints to the practice of clinical judgement that at times seem overwhelming. Is it unreasonable to expect that the demonstrable benefits of cost-effective modern therapies should be extended to all South Africans?

In the private sector it seems doctors have been reduced to 'service providers' trapped between faceless insurance companies and desperate patients. Burdensome bureaucracy guarantees less and less productive use of time. Can a medical system survive long term by co-opting doctors as involuntary, unhappy administrative clerks? Is it sensible that an insurer insist on a motivation form before providing clopidogrel to a patient with a coronary stent or statins to a diabetic with coronary disease? Who benefits when a complex antihypertensive drug regimen changes to match a new formulary? Or when medications are discontinued without a patient being informed of Prescribed Minimum Benefit legislation and their right to receive medications throughout the year!

Of course demanding motivation letters from doctors may constitute a useful business practice, ensuring less money is paid out because of poor compliance. But how should we react

when a patient is informed that carvedilol is unnecessary for his cardiomyopathy, or is telephonically advised that aspirin alone is safe and that clopidogrel is not required after stented AMI?

Many patients contribute from a meagre income to an insurance fund that they believe covers all medical eventualities. Later they will discover that a R6 000 prosthesis limit effectively means that they cannot receive essential treatment for an acute infarct or receive a basic pacemaker for heart block. Would you pay for insurance if you understood that it would not cover you in common medical emergency situations, but placed you in a private hospital where you were unable to receive or afford appropriate therapy?

I believe that the sort of practices noted above will, if left unchecked, rob this country of some of its finest minds. Highly skilled national resources will vote with their feet – just tired and disillusioned!

There must be a better way for insurers to ensure that they are paying for appropriate management regimens. Can patients ever be prioritised where profit is supreme? A relationship of trust between insurers and physicians has to be pursued, because our patients suffer every day from the current combative environment. A visit to the doctor is no longer a time for reflection on symptoms, discussion of management issues, and an opportunity to build therapeutic relationships. Instead we see a quiet desperation on our clients' faces: 'What will my medical aid pay; can I get it on "chronic"; I cannot have an echo!'

Obstacles to good clinical practice are different but no less intimidating in the state sector. In the Eastern Cape, the entire population is served by one catheterisation laboratory, which recently has been out of commission for months! How many of our smaller hospitals have drugs available to administer thrombolysis? How widespread is access to echo for the diagnosis of heart failure, or ambulatory ECG recording for the diagnosis of paroxysmal atrial fibrillation?

There are solutions. And they must start with attaching value to people – to clinicians, and to their patients. When doctors are valued as responsible professionals by insurers and state employers alike, we will be on the beginning of a new path. And when patients are recognised as having legitimate needs which are our responsibility to fulfil, and we are willing to extend ourselves creatively to meet those needs – then we will be amazed at the vastness of the resources at our disposal!