

## ASSA presidential report



This edition of the *South African Journal of Surgery* coincides with the biennial joint meeting of the Association of Surgeons of South Africa (ASSA) and the South African Gastroenterology Society meeting in Durban. This meeting includes the 12 integrated societies and three interest groups within the Federation of South African Surgeons (FoSAS). How did this all begin?

ASSA held its first meeting when a group of surgeons, primarily in private practice, met in 1943 at Groote Schuur Hospital. A constitution was presented by Dr Toddy Schrire and agreed upon after circulation among all 73 general surgeons on the specialist register of the Medical Association of South Africa (MASA), whereafter ASSA became a registered constituent group within MASA. In 1945, ASSA was recognised by the International Association of Surgeons in New York. A historical point worth noting is that MASA was restructured and transformed into the South African Medical Association (SAMA) in 1998 after the fall of the apartheid government.

By 1948, meetings were attended by representatives of the Orthopaedic, Gynaecological, Urological, Otolaryngeal and Ophthalmic Societies and the membership fee was one guinea. The following fees for specialists were agreed upon: three guineas for a first consultation by a physician or neurologist and two guineas for a first consultation for surgical specialities.

So right from the start it would seem surgeons were valued below their physician colleagues! The cost of annual membership then was half the cost of a consultation, and successive ASSA treasurers have strived hard to keep membership fees to a minimum, which still represents outstanding value.

The minutes from those early meetings 60 years ago reflect many of the same issues as today, with attempts to build unifying structures in the face of natural divisions. An example was the formation of a College of Surgeons which ruffled a few feathers, but things were patched up and by 1952 a joint college was formed with physicians and general practitioners.

We have come a long way, and face some very different challenges today. Two of these, confronting all general surgical structures throughout the world, are managed healthcare and the development of subspecialisation. The perennial question asked is how a general surgical association stays relevant and finds common ground for all its subspecialty constituents. Both the president and past president of the Association of Surgeons of Great Britain and Ireland will be in Durban and will explain how their association has grappled with this issue far longer than we have. However, the difference between South Africa and the developed world is that most of our general surgeons remain just that – general surgeons. Nearly all of us will perform surgery across several subspecialties. As an example, in Oxford where I trained, there are six specialist colorectal surgeons in one hospital serving a population of under a million, and they never venture outside their specialty, even to drain a breast abscess on-call or to repair a hernia. That compares with South Africa, where we have approximately 10 accredited

colorectal specialists scattered around two or three centres. Thus the vast majority of the colorectal workload is performed by general surgeons, who are also performing endocrine, breast, biliary and vascular surgery.

Regardless of this generality of service provision, the subspecialty associations are well established and provide valuable academic activities for their members. The Vascular Society of South Africa and the South African Society of Endoscopic Surgeons (SASES) have large memberships and are very busy academically. Others, such as the South African Colorectal Society, are new and trying to establish their own administrative structures and grow their membership. Other groups emerge as the perceived need arises, such as the Breast Interest Group of South Africa (BIGOSA) and the Hernia Interest Group (HIG), the latter of which has allied itself to SASES for administrative purposes.

Out of these evolving subdivisions grew the recognition that we needed a new structure that would be inclusive, allow us to keep sight of each other and seek unity on matters of common interest. This structure is FoSAS, and its formation stimulated the appointment of a full-time secretariat at the Wits Donald Gordon Medical Centre, staffed by Alison McLean and Susan Parkes. FoSAS meets twice a year under a rotating chair from each constituent member society or association (these are all listed at the end of this editorial). Current controversies are discussed, such as Medical Protection Society and remuneration for work outside of public service (RWOPS), radiological investigations or procedures by surgeons, allowing each society to share and understand how the others are dealing with their issues.

The organisation of academic meetings grows more challenging each year, primarily because of the decline in financial support from the trade. Surgeons not only have to fund their own attendance but also suffer loss of income and vacation time. With the increasing number of competing subspecialty meetings, the general surgeon finds it harder to attend all the meetings of his or her choice. FoSAS supports ASSA's proposal that all societies combine in alternate years in an 'umbrella' or 'jamboree' meeting, which rotates between a few big centres in the country. The combined meeting would be spread over a longer period and accommodate a full academic programme for each society. In the alternate year, each subspecialty would hold its own stand-alone meeting, thus building its own identity. This makes sense for both the individual surgeon and the trade as it allows industry to better fund each meeting.

What about our members' private practice interests? Full-time private surgeons constitute 86% of ASSA membership, the other 14% being in the public service, where many have a limited private practice. SURGICOM is the private practice arm of ASSA and has been revitalised in the last year under new leadership. SURGICOM has recently allied to the South African Private Practitioners' Forum (SAPPF) which strengthens the bargaining opportunities with healthcare providers and funders. ASSA and SURGICOM have agreed upon a memorandum of understanding and this is expected

to receive the support of our AGM in Durban. The current SURGICOM project with Discovery is highly innovative and aims to improve payments to surgeons for no extra work. Participants need only agree to have their costs to the funder subjected to peer review. This project has proved very valuable with other users, such as the Paediatric Management Group. It will be presented in Durban at the private practice session.

What vision do we have for the future? We would like to have each and every member of ASSA as a member of SURGICOM. We would like to copy the example of our South African anaesthetic and gynaecology societies and generate enough income to employ a CEO who will have the time and skills to properly manage and advance the interests of all general surgical societies under the

FoSAS banner. To achieve this we need a bigger membership and a substantial increase in fees. This leap of faith will be a challenge we will ask of each general surgeon in the country.

What can you do for your association? First of all, please attend the AGM and select a strong committee. We are actively seeking nominations of energetic and committed surgeons to provide on-going leadership and carry forward the momentum that is steadily building. Your association needs you!

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ASSA	Association of Surgeons of South Africa	
CS of CMSA	College of Surgeons	
SABS	South African Burns Society	
SAAPS	South African Association of Paediatric Surgeons	
SACRS	South African Colorectal Society	
SASES	South African Society of Endoscopic Surgeons (incorporating Hernia Interest Group)	
SASSiT	South African Surgeons in Training	
SNSA	Society of Neurosurgeons of South Africa	
SRS	Surgical Research Society	
SURGICOM	Surgicom	
TSSA	Trauma Society of South Africa	
VASSA	Vascular Society of South Africa	