The opinions in this article are individual to the author and do not reflect the policies of the organisations mentioned.

The provision of surgical services to non-metropolitan areas has become an important issue politically both in Australia and New Zealand. It is important also for the College as there is a concern about our ability to train general surgeons with skills broad enough to equip them for practice outside of the subspecialties. There is also concern by on-call surgeons providing acute services that their increasingly narrow scopes of practice are making them uncomfortable at dealing with problems of a more general nature. This issue affects surgeons in both rural and metropolitan units.

The Divisional Group of Rural Surgery (DGRS) was established within the College thanks to the dogged efforts of individual rural surgeons who were able to convince their colleagues that rural surgeons and their issues were important. The importance of rural surgical representation is recognized in that the Chair of DGRS is a co-opted Councilor. In addition, there are projects that the College administers with Commonwealth funding through DoHA that are part of the DGRS portfolio.

However, the DGRS box sits awkwardly within the College Administrative structure which in the latest iteration has DGRS reporting to the Fellowship Services Committee as part of the Professional Standards and Development Board. In addition the DGRS chair is a member of the Board of Regional Chairs.

The Provincial Surgeons of Australia (PSA) meeting was first held in 1965 and has met every year since then. It was set up as a scientific and collegial forum for rural Australian surgeons, many of whom were not Australasian College fellows and who were not encouraged to take part in the College meetings at that time. Its theme was based on a “fair dinkum, no bullshit” and “no one-upmanship” philosophy. Participants were encouraged to bare their souls and talk about their failures as well as their successes in a supportive forum which acknowledged that surgery is a risky profession and we can all learn from each other. Over the past two or three years there has been a growing enthusiasm for aligning this rural forum more closely with the College.

DGRS and PSA were created out of the climate of their times and there has been a significant change since then, both in terms of political recognition, and in the way the College functions and relates to its Fellows and Specialties. The College is currently considering its future governance structure and looking at a lean and efficient Board to handle essentially what the Council Executive does now, with a widely representative Governance Council to set the policy parameters and strategic goals and meeting less frequently than the current 26 member Council. It is therefore timely for us to look to position rural surgeons for the future challenges as well.
Significant relationships have developed between the College and the Surgical Specialties in the Memoranda of Understanding and Service Agreements signed by the College and Specialist Societies. These define the functions of training and continuing education that the Societies have agreed to be responsible for.

General Surgeons Australia (GSA) after a shaky beginning has, this year, signed a service agreement with the College defining the training and education functions which it will be responsible for and bringing it into line with the agreement that the New Zealand Association of General Surgeons (NZAGS) ratified some years ago. Is GSA the forum of the future for Australian rural general surgeons?

When NZAGS was created, its constitution entrenched the principles of the importance of being representative of metropolitan and non-metropolitan surgeons by building a balance of executive members and officeholders to reflect their backgrounds and practice. There are misconceptions amongst the target surgeons about who GSA actually represents but these can be overcome so that it can be regarded as an advocate for the rural general surgical community.

The DGRS does not exclusively represent general surgeons as other larger specialties have rural members who already actively participate in both organisations. So should DGRS be retained as a “box” in the College structure or should the specialist societies ensure rural advocacy through their structures as NZAGS has done?

The PSA has provided an educational forum for rural surgeons and has acted as the meeting place for rural surgeons to discuss broader issues. It has not itself had a political function. Perhaps the administrative, political and surgical training needs of rural surgeons could be best represented under the GSA umbrella. As GSA now has its own scientific meeting, so PSA could retain its own so that the rural surgical flavor of the meeting is retained and participation by the other specialties would not be lost.

Finally, what of the co-opted rural Councilor? Over recent years the rural surgeons have shown their democratic maturity by electing rural nominees to Council as part of the College ballot. Assuming the next governing structure includes a widely representative group of surgeons including those nominated and voted in by their rural colleagues, then there seems little point in retaining a co-opted position.

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