Monospecialist Section

of Surgery

1963 - 1988

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Introduction.

This year 1988, the Monospecialist section of Surgery of the European Union of Medical specialists commemorates its foundation, 25 years ago, on the 2th of March 1963. This time-span does not make any impression, not in relation to the history of Europe, nor to the history of Surgery.

But in this period a basic change has been forced in Europe. The Treatise of Rome opened the possibility to all physicians and to all specialists to set up practice in anyone of the E.C. member-states, a rather revolutionary consequence.

With different historical roots and different training programs the final product ("le produit final") of specialist training had to be different. Moreover the need of specialists and therefore the degree of sub-specialisation differed widely. The task to give advices on the indispensable harmonisation covered a great many fields, which had to be studied first.

When one tries to describe the "faits et gestes" of the members of the section there are many arguments to do this. And it is not difficult to avoid the suspicion of being pretentious.

- The work goes on. We can learn a lot from the successes of our predecessors and also from their failures. But only if we are informed about the ideas and the meanings behind their activities.

- The task of the Monospecialist section and the limitations thereof, the organisation of the U.E.M.S. and the relation of the Management Council to the Standing Committee of Doctors is a complicated one.

When one has become a member of a monospecialist section by appointment as a delegate of the Responsible Authority in his Country, it is important to be introduced in the new task as soon as possible, and not to be impatient. The chain of advising institutions is a long one.

- A great number of our predecessors have a right to lasting respect and gratitude. More then has been expressed in the valedictory address (if any). Their contributions have to be known, at least by the active members.

In writing history the author has the duty to be objective. But the reader has to keep in mind that this is nearly impossible. This historiography is composed as a selection from hundreds of pages, already selected reports and minutes. My conviction that I tried to select honestly, does not give guarantee against omissions and misinterpretations.

Amsterdam March 1988 Dr. J. T. H. Grond.
Chapter I  The Organisation of the
Union Européenne des Médecins Spécialistes.

The U.E.M.S. has been founded among the national professional medical organisations of the member countries of the European Community, the 20th of July 1958 in Brussels. The objects are:
- to defend at international level the title of the specialist and his professional status in society,
- to study, promote and defend the quality of a comparable high level of specialist care given to patients,
- to establish tighter bonds between the national professional organisations, grouping together specialists in all fields, to support and coordinate their actions,
- to contribute to the creation or maintenance of solidarity between European specialists, particularly between specialists in the same field,
- to study, promote and defend before the international authorities the free movement and the moral and material interest of European specialists,
- to collaborate within the European medical community, particularly with the Standing Committee of Doctors and with the U.E.M.O.,
- to organise exchanges of information by whatever means are adequate on professional subjects concerning specialists.

Every member state of the E.E.C. is represented in the U.E.M.S. by one national member organisation, nominated by the Competent Authority, representing the medical specialists. Each member organisation is represented in the Management Council of the U.E.M.S. by one or two delegates. The U.E.M.S. is administered by the Management Council (conseil de Direction). The Management Council elects an Executive (Bureau), including a President, four Vice-presidents, a general Secretary, a Treasurer and a Liaison Officer with the Standing Committee of Doctors of the European Community, (Comité Permanent).

The U.E.M.S. may create, within its association, study sections at the level of each specialty, at the rate of one section per specialty. These sections are named: Mono-specialist Sections of the U.E.M.S.
The monospecialist section is responsible to the Management Council, and exclusively to the latter, and must report regularly on all its activities. It does not enjoy, therefore, any autonomy whatsoever.

The task of the monospecialist section is:

to study the problems raised by the Treaty of Rome concerning the definition, training, qualification and the exercise of the profession in that particular specialty.

"Le Comité Consultatif pour la Formation des Médecins" has been instituted the 16th of July 1975, also by the European Community. The advice to the Competent Authorities in the member states are published by this organ. The relation between the Comité Consultatif and the Standing Committee of Doctors is not clear. The President of the Comité Consultatif is chosen out of the members of the Management Council U.E.M.S. The Secretary General has to be invited to every hearing the Comité Consultatif wants to organise with one of the monospecialist sections.

A working group out of the Comité Consultatif has published two reports on the formation of specialists:

The report III/D/732/2/78 adopted 21 March 1978
The report III/D/1074/82 adopted 9 March 1983

After many years of preparation the free exchange of specialists in Europe started the 16th of December 1976.
Chapter 2 The start of the Monospecialist Section of Surgery.

The historiography of the section has to begin with the first sentence out of the first minutes, written by Dr. Willy Smets, "qui avait assuré le secrétariat provisoire de la section":

"À l'initiative de la délégation Belge, la section monospecialisée de Chirurgie a tenu sa réunion constitutive le 2 Mars 1963, à dix heures au Siège du groupement Belge des Médecins Spécialistes à Bruxelles".

From the six Countrties eleven delegates are present. They start by appointing Nuboer to the presidency. With Dr. Joris as Treasurer and Dr. Smets as Secretary and liaison-officer they form the executive, "le Bureau". Everybody reports about the legal regulations and the organisation of surgical training in his country, on the basis of a list of questions, drawn up by Dr. Smets.

After that, ideas about the harmonization of surgical education are discussed and measures, deemed necessary to reach equivalence between the European surgeons are proposed.

The bureau is charged with the redaction of the draft of the final report and the delegates are convocated to the next meeting, 18 and 19 April 1963 in Munich.

All twelve delegates are present at that time. They decide unanimously a great number of questions. The first is:

Definition de la Spécialité

"La dénomination de chirurgien s'applique aussi bien à celui qui pratique toute la chirurgie qu'à celui qui s'intéresse particulièrement à une de ses branches. Le champ d'action de la chirurgie ne peut supporter de limites, un chirurgien peut pratiquer tous les actes chirurgicaux sans exceptions. Il va de soi que tout chirurgien peut procéder aux actes techniques inhérents à la branche de la chirurgie dans laquelle il est spécialisé".

At the end of the two days meeting the final report is sent to the Management Council. It contains the list of propositions necessary to achieve equivalence. The importance of this document induces me to cite all of it. With the list goes a remarkable complete "Tableau comparatif des modes de formation et de qualification des chirurgiens".
Propositions d'équivalence de formation et de qualification des chirurgiens sur le plan Européen :

Conditions Préalminaires

- Nécessité d'une disposition légale créant l'enseignement de la chirurgie, formation du chirurgien,
- Nécessité d'une disposition légale créant un diplôme ou un certificat de chirurgien, à décerner après examen en fin d'études ; un examen au début et en cours d'études est souhaitable ; un travail en cours d'études est souhaité, qualification du chirurgien,
- Pour les chirurgiens déjà qualifiés par leur organisation nationale lors de l'entrée en vigueur du Traité de Rome, reconnaissance sur le plan Européen de cette qualification nationale,
- Pour tout chirurgien qui s'installe dans un pays qui n'est pas celui où il a conquis son diplôme de médecin ou de Docteur en médecine, il est nécessaire de prévoir une période d'adaptation pour permettre l'acquisition de la connaissance de la langue, des lois sociales et l'éthique médicale de ce pays.

Formation du chirurgien:

I Formation Théorique:

- Enseignement théorique, pendant les 2 ou 3 premières années de la formation. Il est suggeré de choisir les matières à enseigner parmi les suivantes : anatomie topographique et des régions, anatomie pathologique, physiologie et chimie biologique, bactériologie, travaux pratiques dans les disciplines ci-dessus :
- physio pathologie chirurgicale, y compris réanimation
- indications thérapeutiques
- techniques chirurgicales y compris notion d'anaesthésiologie clinique chirurgicale y compris notions de radiographie.

2 Formation Pratique :

- Examen de maladie, assistance opératoire, exécutions d'opérations dont la liste sera fournie à des époques à déterminer, gardes chirurgicales, consultations externes, comme assistant, à temps plein, pendant 6 ans, dans toutes les sections de la chirurgie.
Il est loisible au candidat chirurgien de passer au minimum un an, à temps plein, pendant sa formation, dans une discipline connexe à la chirurgie, par exemple anatomie pathologique.

3 Travaux Cliniques ou Expérimentaux :

- Au moins une publication est souhaitable en cours d'études
Qualification de Chirurgien!
- Diplôme ou Certificat de Chirurgien, attribué après la réussite d'un examen à la fin des Études.

La création d'Ecoles de Chirurgie est souhaitable pour faciliter l'enseignement
Agrégation des Services de Chirurgie:
cliniques Universitaires - de droit
services non universitaires - agréées par un organisme médical compétent.

Comment
Although the demand for a six years training period was unanimous, the situation in the six countries was quite different at that time.
Registration as a surgeon was possible after a training of 4,5 years in Luxemburg, 5 years in Germany and in Italy, 5 years in Belgium with the stipulation 6 years after the Academic Doctor degree; in France 5 years after training in a University, 6 years after training in a non-university clinic. Only in the Netherlands the period of 6 years was obligatory, without exception.

Comment
The definition of the specialism given by the section, gave rise to a fundamental discussion with the Management Council. Limitation of the field of action of a specialist will stay a point of discussion until today. Discussions on this subject get extensive attention in Chapter 4.

Comment
This important piece of work, completed within five weeks, gives an interesting historical picture of the expectations of a group of leading surgeons and of the demands they deemed indispensable to achieve harmonization in the training of the "European Surgeon"
It is clear this result would have been impossible without the pushing power of a very motivated man. Undoubtedly this man has been Dr. Smets.

It is striking to note that, nevertheless, the next meeting only took place in June 1969. After such an explosive activity at the start, this asks for an explanation, which is not found in the papers at hand.
I consider the probability that the executive held the opinion that nothing could be done, after the task the section had completed. They had given all information asked for. They had done much more by giving unanimous advice about changes, deemed indispensable to harmonization. Now the section had to wait and look out to the effects.
As far as we can see two developments gave rise to the convocation of the third meeting.
- The government in Belgium, in Germany, in France and in Italy were preparing new laws. The standing training programs were in discussion. It appeared important to know whether the imminent changes were in accordance with the ideas living in the section of surgery.
- The unanimous advice: a period of six years is indispensable to the training of a surgeon, had been rejected.

The 21st of June 1969 the section met again in Brussels.
The secretary, in the mean time, Prof. Smets reported his interventions in 1967 and 1968. With the support of the Management Council and of the Liaison-Officer to the Standing Committee he had defended the uniformly accepted six years period. But in vain. The "Commission de formation personelle du Comité Permanent des Médecins de la C.E.E." had decided to a period of 5 years.

The new developments in four of the countries were presented:
In France: the new training program provided for a training in two phases
   basic (fundamental) training in surgery for 2 or 3 years, higher training either in surgery or in one of the surgical specialties 3 or 2 years. Together with the obligatory one year during the "Internat" the total amounted to 6 years.
In Germany: Surgical training will last 6 years in the near future, 4 years general surgery, followed by two years, either in general surgery or in one of the "Chirurgischen Teildgebieten" traumatic- and pediatric surgery. A number of theoretical courses are obligatory as well as a number of 370 operations, to be performed under full responsibility of the trainee. These operations are specified in different classes and not interchangeable. Orthopedics, Urology and Neurosurgery have their own training programs from the start (5.5 and 6 years). Plastic surgery is not a recognized specialty.
In Italy: After one year "Internat", half medical half surgical clinical stage, the Academic "Ecole de Specialisation" offers a five years course. After examination in 22 disciplines the candidate can obtain his certification. The new law intends to impose:
- Uniformity in the programs of the specialty schools,
- Clinical stages at the University clinics, with the obligation to reserve sufficient places to the students of the specialist schools,
- Full payment of the trainee during a full time training of 5 years.
In Belgium: Notwithstanding strong pressure from the surgical Associations two drafts of law were rejected. Flemish-French controversy makes every decision difficult.

The scheme in the Netherlands stands model in the way the masters of training have to be selected and controlled by visiting-committees.

After this exposé the section, unanimously decided to renew its decision on the necessity of:

A salaried, full time training period of six years, both theoretical and practical, in a clinical stage.

But also new opinions were formulated, as for instance those regarding the stage master; his training program and facilities have to be tested by the responsible authority or a competent institution and his training permit has to be limited in time and only renewed after visitation.

The last point gets emphasis in the advice: A l'unanimité les délégations estiment que la formation doit être contrôlée par un organisme, tel qu'un Concilium Chirurgicum ou un Comité Central. Ce contrôle doit s'exercer pendant toute la durée des études....

Accordingly the preference to a final examination has disappeared. After all only in France and in Italy examinations were conditional to registration. "A l'unanimité les délégations estiment qu'un examen en fin de formation n'est pas opportun, mais que la formation dans son ensemble doit être l'objet d'une appréciation général. Par contre des examens, eventuellement éliminaires, paraissent indiqués à la fin de première et de la deuxième année".

The proposals about new training programs in France and in Germany meet appraisal. Most delegates expect the list of obligatory operations in Germany will turn out to be exaggerated.

The meeting in Utrecht in 1971 starts with a survey of the situation in the different countries.

In Belgium a "Commission d'agrégation" and a "Commission d'appel" have been instituted. The system they are working out resembles the model of the Netherlands: training permit, granted to the chief of the department, after inspection and with regular visitations.

Training program: 6 years, full time, salaried, no final examination. The expectation this system will be accepted, is justified.
In France the law did not become operational this year. The delay is due to troubles in the Universities in 1968.

In Germany the new law has been accepted in the "Länder". Only the urologists rejected the proposed two years of basic surgical training. An obligatory final examination, proposed by the Bundes-Ärzte Kammer has been prevented. (thank goodness)

In Italy: no information is available as the delegates were unable to come. In Luxemburg and in the Netherlands no changes have occurred.

In preparing the meeting the secretary asked, and received from the U.E.M.S. information about the phase deliberations have come into.

"Les propositions de directives sont actuellement... soumises au Conseil de Ministres qui doit trancher dans les prochains mois..."

Most of the proposals coming from the section are accepted by the Management Council with one exception. The minimal period of training is fixed to the period of five years and only with regard to the specialisations: surgery, neurosurgery and internal medicine.

The U.E.M.S. is preparing a questionnaire on a number of important aspects as the contents of training programs, measures to guarantee quality, selection of training departments a.s.o.

The section decides to base advices on a six years schedule. This being the real situation in nearly all countries.

The last question is a principle one:
"faut-il maintenir la notion de chirurgie générale ou bien s'orienter résolument vers des spécialisations chirurgicales complémentaires?"

In a first reaction the members stress the importance of concentration and warn to the dangers of fragmentation.

After some discussion it became apparent that the problem is lying just between the two extremes.

As it is to late to answer this question now, the delegates decide to study the question at home and agree to a meeting within half a year.

The following meeting has been convoked in Paris, the 21th of September 1974. There is no explanation or argument known to account for this delay.
Chapter 3 Conclusions and Recommendations.

The decisions of the Board of Ministers resulted in advices to the member-states. Accompanied by extensive motivation these advices are published by the "Comité Consultatif pour la formation des Médecins" in the:
"Rapport et Recommandations sur les problèmes généraux de la formation des Médecins Spécialistes no: III/D/732/2/78".

This report, indispensable to every delegate, member of a monospecialist section contains in an appendix a:"Aperçu des Régimes de formation des Médecins dans la Communauté Economique Européenne".

The situation in the nine member-states, Denmark, Ireland and the U.K., entered meanwhile, is described there completely, 13 pages in all.

I decided not to copy these pages but to refer readers to this, official text.

The following amplifications make the given information up-to-date.

Belgium: The acceptance and publication of the law in the Moniteur Belge is dated 29 June and 1 July 1978. The 7th of August 1979 also the surgical training program, criteria to be fulfilled by the stage master, a.s.o. have been published. Stage master and trainee are bound to report every year to the Commission d'Agrégation. The institution of visiting committees is not mentioned.

Denmark: The educational program, accepted 1981 says: The trainee is registered without examination, after a training of 5.5 years. Another 2 years are stipulated to become eligible to the post of chief of a department.

If one chooses to practice in a rural hospital, one had to complete the training by one year of orthopedics, if the practice encloses traumatology and one year of obstetrics if the practice encloses obstetry.

In the draft salaried tutors were provided for. As the payment of these tutors has been refused by the parliament, now the National Health Board is looking for unpaid tutors to take supervision during the first three years of the training.

Germany: Also vascular surgery, plastic and cardiac surgery are incorporated in the specialism surgery as "Teilgebieten".

The final examination, rejected in 1969, has been introduced in 1977.

Italy: The salaried, full-time training, for five years, with obligatory clinical stages, mentioned since 1969, finally has been accepted in 1984.

The training in the common truc of surgery has been accepted by all surgical specialties.
France: the situation described in the report of the Comité Consultatif has been changed fundamentally in the year 1982. In that year the Government abolished all existing Laws and regulations, without any consultation. The consequences are described in Chapter IO.

Duration of surgical training
In this report the Comité Consultatif gives no indication at all on the desirable duration. The advice of the U.E.M.S.: a minimum of five years for surgery and the surgical specialties, is not mentioned.
In the course of 1979 the six years training has been accepted in Belgium and in Luxenbourg. So in 1982 surgical training everywhere in the member-states amounted to six years, with the exception of Italy.
In December 1982 the Comité Consultatif published a second report. There the advice is given to bring the training period to six years for the specialisms surgery and the surgical specialties, III/D/107/4/82.

Examination during or at the end of the training.
In the first report the Comité Consultatif asked for a competent institution in every country, with the task: .
..d) d'accomplir toutes les tâches qui se rattachent à la délivrance des diplômes, certificats et autres titres officiels, .
In the second report the recommendation is more explicit: .
..c) L'autorité compétente assure la qualité de la formation dispensée à chaque stagiaire par des mesures telles que: .
des examens ou des évaluations adéquates.

After the year 1994 a final examination only exists in Germany and in Italy.

The report of the Comité Consultatif ended the phase of inventory of the surgical training in the E.E.C.
As most advices the Comité had published in connection with harmonization, were correspondent with the ideas living in the surgical section, they no longer offered subjects for the agenda.
In the years to come more and more the ideas and meanings, behind the facts, came to the fore; and the collision of meanings and (supposed) interests.
Alas, also between monospecialist sections. Often the section had to discuss the same subject in many successive meetings.
By continuing the way I started, viz. a short report of each meeting, the historiography was in danger to grow into a rather tedious and unreadable paper. So I decided to change the design and to continue with surveys of items which kept us busy during the years.

Here of course lies the danger of a subjective selection. I invite every reader to amplify the text, wherever desired.

Two short accounts to begin with:

Finance, the annual Treasurers report.
The principal decision to spend subscriptions only to cover the cost of the administration never has been changed.

In 1963 the representatives decided to contribute yearly, 1000 Belgian Francs per member. This subscription had to be doubled in 1979. This led to a cash-surplus which made it possible to pass over the collection in 1983 and 1984. This sober line of conduct has been made good by the generosity which fell to the sections share, from the surgical Associations and Colleges in the Host countries.

Heavy medical Equipment D 7926.
In 1979 Dr. Buisseret had been charged by the Management Council to study the needs, cost, distribution and limiting measures, regarding this equipment, and to report on the situation inside the E.E.C.

To complete his information he sent a questionnaire to the section of surgery concerning coronary and open heart surgery, scanners and hemodialysis.

In 1982 he received extensive information on the situation in Ireland, Luxembourg, the Netherlands and the U.K. Apparently it was impossible to gather information from Germany and Italy. The situation existing in France, see Chapter 10, prevented participation in this inquiry.

Incited by the dominant attention to this, undoubtedly important, item and by the enormous sums involved, the section decided to a motion:

"General surgery is the basis of surgical care for the community and plays a big role in the training of surgeons in all specialties. The monospecialist section of surgery considers it necessary, at this time, to re-emphasise the need to ensure adequate allocation of resources to this end.

In particular the financing of expensive equipment for use in the surgical specialties must be balanced by the provision for general surgical services."
Chapter 4 Limitations in the practice of the Specialist.

The 26th of July 1963 already, Dr. Godin Secretary General of the U.E.M.S. informed Dr. Smets that the definition, given by the section in its first meeting, had raised objections inside the Management Council.

An amplification to the last sentence appeared to be indispensable. One of the members of the French delegation, Dr. H. Lafitte, that one way or the other, the Maxim: "ne faire qu' on sait faire" had to be expressed.

The Council had proposed: "dans la limite de sa compétence".

At the instance of Dr. Lafitte the Council now proposed the last sentence to be read:

"le champ d'action de la chirurgie ne peut supporter de limites, un chirurgien peut pratiquer tous les actes chirurgicaux sans exception dans la limite de ses connaissances".

Smets and Nuboer corresponded about these redactions. Smets objected to both.

"Who is able to judge a specialists knowledge or competence?" only the specialist himself. So the criterion has to be found in the conscience of the surgeon. Ther is only one acceptable text: "un chirurgien peut pratiquer tous les actes chirurgicaux sans exception dans la mesure où, en conscience, il s'en estime capable."

Dated 28 August 1963 all members received a letter from Nuboer and Smets containing ample information and the text of preference. All members agreed, except the Germans who proposed: "die in den Grenzen der ihm erteilten Anerkennung liegen". It appeared impossible to persuade them this restriction had no sense. Nowhere in Europe qualifications, officially, were bound to limitations.

It was impossible to trace the boundaries of the always extending specialties. Nevertheless, the German delegates refused to accept the proposed, as well as the other texts.

Smets wrote, unofficially, to Godin 16 Januar 1964, that unanimity had proved to be beyond reach in the section of surgery. "C'est pourquoi je me demande: s'il ne serait pas plus sage de s'en tenir à la définition qui a paru dans "le Médecin Spécialiste", sans aucun addition. Cette formule avait rencontré l'unanimité".

There is no reply to be found to this letter of Smets. Not in the archives of the section, nor in the archives of the Secretary General.

So this discussion ended without a conclusion. A most unfortunate event.

This problem, not solved this time, has reappeared regularly, in different forms, ever since.
Frequently this problem became apparent in attempts to find general rules regarding the relation of general surgery and the surgical specialisms. Up to now the policy of the Management Council and of the section has been identical. Therefore an expose of the arguments is indicated, in this paper. Two starting points are out of contention:

1. General surgery is indispensable in Europe, now and in the future as far as we can see. At this moment the standard of medical care implicates the obligation to bring general medicine, general surgery and obstetrics within reach of every citizen. In many places this demand is the utmost.

The facilities, common and indispensable in University clinics and in great centers are unattainable in small towns: 60% of the European countries are thinly populated.

2. Progression of specialisation is a consequence of development in science and technics. Increasing specialisation stands for progress; desirable and beneficial to a growing number of patients.

But not all patients are in need for high-specialised care. Even there where facilities are present, patients are consigned to the general surgeon. When is the "generalist" obliged to consult the surgical specialist?

The necessity to maintain both forms of specialist care has two consequences which often are not realised sufficiently.

1. The subspecialist has to accept that he can not claim every part of the discipline which is covered by his subspeciality. The general specialist has practised a notable part of the subspecialty before it was recognised as such. If general surgery should abandon the practice of all parts of the (former) specialty, which now has become (or is going to develop into) a subspecialty, general surgery will not exist anymore in a very short time.

2. Continuing Medical Education is an ethical obligation to every specialist. The consequences lead to the origin of an ever increasing number of subspecialisations. The general surgeon has to incorporate in his own practice diagnostic and therapeutic innovations, resulting out of the efforts of subspecialists. Only by doing so he can bear his responsibility to his patients. But he has to be aware of the limits; his competence, his knowledge and the intercollegial situation he is working in.

And also it must be clear that, thanks to further subspecialisation the limits are gradually shifting. The development of every specialty is due to the contributions of many scientists. Inside, but even outside the Medical discipline, we have to respect each other, reciprocal.
It is the task of the hospital staff to find solutions in difficulties arising in the cooperation of individual specialists.

As far as cooperation goes the U.E.M.S. formulated its task in point 4 of the subjects, noted at page I: "maintenance of solidarity".

So the Management Council had to reject regularly motions of monospecialist sections, claiming exclusive practice. Often these were motions of sub-specialists claiming exclusive practice of cases which for many decades had been treated by generations of specialists in the mother-specialty. The Management Council sticks to the rule never to adopt a motion, aiming at a "Chasse Privée". But if, unfortunately, a wrong decision is taken, the mother-specialists section has to spend a lot of time and energy to correct an impossible situation. The most time consuming case is reported in Chapter 9.

Also the second consequence often caused problems. The first one in July 1963 has been described already. "Ne faire que ce qu'on sait faire". Afterwards this this Maxim came out frequently. Every time monospecialist sections attempted to enlarge the field of action of their specialty, maxillo-facial surgery, E.N.T. and cervical surgery, dermatosurgery a.s.o.

What are the restraints every specialist is bound to respect in his own daily practice?

Legally every physician is qualified to the practice of medicine, surgery and obstetrics. The member states will not change their laws in this respect. And they are right.

It is impossible to describe the content and the limits of the specialisms, in principle engaged to enlarge their field of action.

The Comité Consultatif declared in the report 1962, page 2:

"Toute liste énumérant le continu d'une spécialité ne peut avoir qu'une valeur indicative. Elle ne peut en aucun cas être considérée comme limitative ou exhaustive."

And so the words, already mentioned at the beginning of this Chapter come out again: dans les limites de ses connaissances, ... de sa compétence... dans la mesure où, en conscience, il s'en estime capable.

In an attempt to find a new wording for the moral standard the U.E.M.S. wants to impress upon every European specialist, the following text has been composed at a meeting in Brussels, the 15th of June 1985.
"Les sections monospécialisées de Chirurgie et d’Orthopédie réunies à Bruxelles, le 15 Juin 1985,
- se rattachent sans réserve
1) à la doctrine de l’U.E.M.S. qui rejette toute notion de chasse gardée ou de monopole,
2) à la définition du rôle des sections monospécialisées telle que reprise à l’article 28-I du Règlement d’Ordre Intérieur : "l’étude des problèmes soulevés par le Traité de Rome, concernant la définition, la formation, la qualification et l’exercice de la profession ; sion dans la spécialité envisagée ;" acceptent en conséquence de ne pas s’immiscer dans le champ d’activité d’une autre section monospécialisée et à fortiori de ne pas lui imposer de limites dans la pratique de sa discipline déclarent que, dans l’état actuel de l’évolution de la science médicale, la pratique habituelle de tout type de chirurgie requiert la formation adéquate, nécessaire à sa pratique, affirment que tout praticien de l’art de guérir doit, dans l’exercice de son art, respecter scrupuleusement les limites définies à la fois par sa formation et sa compétence, le maintien de celle-ci impliquant une pratique habituelle."}

This motion D 8525, has been adopted by the two sections and by the Management Council. From the start of the discussion in Brussels the discussion partners aimed to do more than just make an end to the tedious discussion about the motion D 8205-bis. (see Chapter 9)
The text of D 8525, wittingly has a general scope and is ment to express the conviction of all monospécialist sections. Once this text generally known and accepted, a number of discussions would become superfluous. As for instance the discussion of the motion D 8747 of the section of Pediatric Surgery. It is striking to notice that the solution of the sections first problem has reappeared in 1985. The three criteria out of 1963 now are used together Connaissances ...... result of adequate training Compétence ...... result of continued study and practice Conscience ...... doit respecter scrupuleusement les limites.
Chapter 5

The Common Trunc of Surgery.

Already in the last decades of the 19th century a growing number of surgeons chose to restrain their practice to a field of preference. The fast development of surgical science and technics made sub-specialisation desirable and necessary. And sub-specialisation led to further developments, a sound and beneficial course of events.

The free choice to start a practice exclusively in orthopedic- or neuro-surgery or in urology was open to, fully trained, (general) surgeons. As general surgery also was growing very fast, the surgeons training necessitated gradually more than 2 or 3 years. At the same time a training in the chosen sub-specialty became desirable, in some countries already made a rule. For a long time the necessity of a complete training in surgery stayed undisputed. To both groups the common problems stayed predominate. The discussion started the moment the total period of training increased and then mainly the proportion between the years in the mother-specialty and in the sub-specialty became the point of concern.

The reflection of this historical process is apparent in the advises the surgical sections gave in the first years.

- In 1963: que se généralise aux six pays l’obligation de donner à tout chirurgien spécialisé une formation de base préalable, de chirurgie générale.

- In 1969: A l’unanimité les délégations estiment indispensable une formation de base en chirurgie fondamentale de 2 à 3 ans; pour tous les chirurgiens qu’ils s’orientent ensuite vers la chirurgie générale ou vers une chirurgie spécialisée.

At the meeting in 1971 the secretary communicated the information he had received from the Management Council: the sections’ advises, adopted by the U.E.M.S. were in discussion at the Board of Ministers.

Denmark, Ireland and the U.K. were present for the first time. There, as well as in France, Germany and the Netherlands common trunc training was the adopted practice. So the, now enlarged, section repeated its advice.

The report and advice of the "Comité Consultatif pour la Formation des Médecins" dated 13 February 1979 formulated accordingly:

6) "Il est nécessaire de former des spécialistes dans les disciplines médicales et chirurgicales ayant une formation générale étendue avec des qualifications particulières dans des domaines particuliers et dans la mesure du possible. La formation devrait en partant d’un trunc commun aller du général au plus spécialisé."

In the second report the Comité Consultatif stresses the importance of repressing further fragmentation of specialisation and gives full attention to the interdependence of specialties arising out of the same mother-specialty. The many consequences are worked out. Not only in the aspects of science, technics and cooperation in daily practice, but also with a view to the training programs. These have to be organized with a maximum of efficiency at the minimum of costs and human effort. The comparison with a tree, branching off at different levels, illustrates these consequences.

Common trunk training is a necessity. I quote two statements:

"Il n'en est pas moins souhaitable que la spécialisation dans les différentes branches de la chirurgie commence par l'acquisition d'une expérience en chirurgie générale et dans d'autres spécialités et que la formation chirurgicale générale comporte des sièges dans les services spécialisés".

And the recommendation no 7:

"la formation de spécialiste "vrait comprendre un tronc commun dans les spécialités apparentées, tronc commun dont la durée et le continu effectifs peuvent être modulés en fonction de l'orientation final."

This report of the "COMITE CONSULTATIF pour la Formation des Médecins, instituted auprès de la C.E.E." has been adopted 3 March 1983.

So one would expect it has to be respected, at least by the monospecialist sections. But apparently it is difficult to leave a solved problem alone. There are always new ways to create new difficulties.

In 1978 the section of Orthopedic surgery had presented the motion D 7808, in which was stated (among other things)

...refuse l'hypothèse d'être à la remorque de la spécialité chirurgicale sous forme d'un tronc commun...

...revient sur ses résolutions de 1974 et propose deux arrêts de chirurgie en général, tout en soulignant la signification du mot en ...

In preparation of the second report the Comité Consultatif had invited the monospecialist sections to a hearing. Therefore Dr. Pouyaud, President of the U.E.M.S. had convoked the "Commission polyspecialisée des disciplines chirurgicales" in Brussels the 20th of Sept 1980, the 11th of March and the 1st of April 1981. The principle of common trunk training in general surgery had been accepted unanimously during those meetings.

So there appeared to be no need to comment the rather peevish statements of the motion D 7808.
The first of September 1984 the Commission Polyşpecialisée met again in Brussels. During the meeting several deputees used the expression: surgery-in-general and chirurgie-en-general. In response to Prof. Lacquet's question what the meaning could be of this indication this was the answer: the urologist, the orthopedic surgeon a.s.o. are as capable as the general surgeon claims to be, to instruct the general principles of surgery to the future urologists and orthopedic surgeons.

The answer of Prof. Lacquet: general surgery is a fast developing specialty, how can you claim to be a teacher in your specialty and at the same time a teacher in the general science? Why did you opt for a specialty as you are obliged to stay well up in general surgery? seemed to settle the discussion.

But the same expression: surgery-in-general reappeared in the motions D 852I and D 8522, presented by the section of Plastic surgery. A discussion initiated by Prof. Gruwez, in the Assembly of the U.E.M.S. in 1966 did not result in a better understanding.

So the section of surgery put this topic at the agenda of the meeting in 1966. A survey of the arguments:
- General surgery is not the remainder, left after the specialties have cut off their part,
- General surgery is a specialty in his own right, concentrating on the human being, suffering from surgical disease,
- Upon the reactions of the whole body to severe illness and surgical trauma,
- Dedication to a sub-specialty is not compatible with the competence, indispensable to supervise common trunk training,
- What is the use of multiplying courses which are concentrated now?
- The programs of common trunk training are known, supervised and approved.
  In many countries control of the effects by examination is the rule,
- Common trunk training only is possible in a clinical department where general problems are concentrated.

Nevertheless, the stubbornness in the demand for common trunk training in "surgery-in-general" is indication of an immense irritation.

There is no point in ignoring this by stating, for instance:

Only the general surgeon has the competence to supervise common trunk training, indispensable to all surgical specialists.

So the section concluded to send a motion, describing the contents of the common trunk training program and the facilities, indispensable to the realization.
This motion, adopted by the Management Council on April 1957, has been published with the number 873I and says:

La section de chirurgie exprime son avis unanime sur le fait que la formation chirurgicale de base est une partie essentielle de la formation de tout spécialiste pratiquant la chirurgie opératoire.

La formation chirurgicale de base doit principalement consister en la formation dans un département ou un service clinique qui offre la possibilité de soigner un grand nombre de patients sur le plan chirurgical. Il doit aussi consister en cours d’anatomie, de physiologie et de pathologie concernant toute pratique chirurgicale.

Le programme de cours doit englober la connaissance de sujets communs à toutes les spécialités chirurgicales tels que les soins de blessures, le choc, la réanimation, le metabolisme et la nutrition, ainsi que les diagnostics concernant le traitement de patients souffrant de maladies pouvant atteindre tous les systèmes du corps, en particulier le système cardio-respiratoire, le système du centre nerveux, le système gastro-intestinal, le système vasculaire et le système musculo-squelettique.

Un élément essentiel de la formation de base est aussi celui de la responsabilité de toutes les différentes étapes de soins administrés au patient blessé comprenant également les soins administrés en urgence et dans les services de soins intensifs.

It is not to be expected this is the definite end of discussions about surgery-in-general. There are problems that are not solved by arguments alone. We should keep in mind the recommandation of the Comité Consultatif out of the second report, (no 10 page 14):

"Chaque spécialité doit avoir son propre organisme responsable de la formation, mais il est nécessaire qu’un processus de coordination et de collaboration s’établisssse entre les autorités des spécialités apparentées, notamment pour la réalisation du concept du tronc commun et l’acquisition d’une expérience dans les spécialités voisines,..."

France has been the first to introduce common trunk training in 1969. She has also been the first to abolish it by the revolutionary changes the Government forced in 1982, contrary to the wishes of the French surgeons, contrary to the striving of the U.F.M.S. and contrary to the advices of the Comité Consultatif.
Chapter 6 Spécialisation de formation—Spécialisation de réputation.

Training in the common trunk of surgery attended to the broad base of surgical knowledge and experience to all surgeons, general as well as specialized. This was the rule adopted in the U.E.M.S. and the practice in the countries of the E.E.U. (the situation in France after 1982 is described in Chapter 10). In the report of the Comité Consultatif 1978, a sound argumentation is given which concluded to the proposition no 7:

"Il ne semble pas y avoir intérêt à augmenter le nombre des spécialités médicales, sauf bien entendu quand un même besoin se fait sentir dans différents États. Les subdivisions les plus poussées devraient être considérées plutôt comme des champs particuliers d'application de la spécialité de base que comme des spécialités autonomes".

In correspondence with this article the Rules of Procedure of the U.E.M.S. were formulated in Article 24-II:

"Une section monospécialisée peut être créée pour une spécialité reconnue dans au moins la moitié des pays membres effectifs lorsque sa création est demandée par une majorité des membres effectives tels que définis à l'article 3 des Statuts."

Soon it became apparent that fragmentation of the Mother-specialisation could not be prevented by this article, which offered ample opportunities to create new sections, there being only one criterion: number.

The historical process, described in the last chapter did not stop. It never will stop as long as surgeons, general or specialized, will stay intelligent, active and inventive.

So in every country we find, to begin with in Academic clinics and in big centres, surgeons who, registered as general surgeons, practice only as oncologic-, vascular-, pediatric-, hepato biliary-, proctologic-, or etc. surgeons. And also there are orthopedists who restrain their practice to the abnormalities of the vertebral column, plastic surgeons who concentrate on hand surgery and urologists who have an exclusive pediatric practice.

All those specialists have in common that they restrained their practice after the completion of their specialisation: training, their "Specialisation de Formation".

And they all started the exploration of the field of special interest as a "hobby". Whether this stays only a part time function, or whether this hobby develops into a full time function, is dependent on many factors.

The most important is the reputation which they know to establish in this "Spécialisation de Réputation".
Every specialisation started as a specialty of notoriety (de réputation) and many of them developed, after a short time or after many years, into a specialisation of training (de formation).

It is one of the many merits of Prof. Lacquet to have described this distinction and this evolution in a brilliant paper in 1978. Also there he drew the attention of the Management Council to the practical consequences.

It is not the task of the U.E.M.S. to stimulate the scientific activities of specialists, but to study the consequences of the Treaty of Rome in its practical aspects.

So the foundation of a monospecialist section is not a reward for important scientific innovations but a necessity arising from the wide application of a new development in many countries. Only when the practice apparently has grown into a "spécialisation de formation" the Treaty of Rome has, or may have consequences for the group of new specialists.

Prof. Lacquet also formulated the three criteria, deciding the distinction between the two types of specialisation. These criteria met the approval of the Management Council in May 1978 and of the section of surgery, assembled in Francfort 21 October 1978. The section sent the following motion:

"La section estime donc qu'une section monospecialisée d'une nouvelle spécialité ne pourrait être créée au sein de l'U.E.M.S. que lorsque cette nouvelle spécialité répond aux trois critères essentiels qui sont:

1. La pratique exclusive de cette spécialité existe réellement dans la majorité des pays membres de la C.E.E.,

2. Le nombre de ses praticiens spécialisés est suffisant pour constituer parmi eux des jurys d'examen ou des commissions de reconnaissance de jeunes spécialistes,

3. Il existe suffisamment de services hospitaliers de cette spécialité, dirigés par des spécialistes compétents, pouvant être qualifiés réciproquement comme services de stage et de maîtres de stage, pour la formation de futurs spécialistes de cette discipline."

By adopting this motion the Management Council declared explicitly to be competent to verify the considerations which had lead to the recognition of a new specialty in the member states. In future the foundation of a new monospecialist section could not be decided solely by counting votes.
whether the Management Council ever applied these criteria in the years after 1979, we do not know. Surely they were not mentioned in the following cases.

- The foundation of the monospecialist section of Pediatric surgery has been decided, solely on the argument that pediatric surgeons were practicing in the majority of the member states. At the protests of Prof. Junghanss, the sections delegate to the Commission polyspécialisée in Brussels the 10th of April 1981, this was the only answer.

Even in 1982 Mr Brearly, member of the Management Council and President of the Comité Consultatif, motivated the correctness of the decision in a letter to Prof. Bevan with the argument: "as the exclusive practice of the specialty really existed in the majority of the member-countries." The answer of the section of surgery that the three criteria together formed one, indispensable condition, did not result in further arguments.

- During the meeting of the Assemblée in Frankfurt 1987, the creation of a section of Endocrinology has been accepted, the creation of a section Vascular surgery rejected. Both decisions solely on ground of the number of votes. The minutes contain one extra argument: L’U.E.M.S. doit tenir compte des progrès de la médecine !

The new redaction of the Statutes and Rules of Procedure came in discussion during the same meeting in 1987 in Frankfurt.

- The text proposed to the Assemblée of the article 24-II, was the same I quoted in the beginning of this Chapter. The adoption of the criteria, formulated by the section of surgery, in 1979, clearly had been forgotten.

In his letter dated 12 August 1997, Secretary Dean stimulated the members of the section to make their vision known to the Delegation of their Country to the Assemblée in Lisbon 2-3 October 1987.

There (thanks to our intervention?) the redaction of the article 24-II has been changed fundamentally. Not only the number of proposers has been raised to 75% of the countries. The more important result is the explicit mention of the adoption 3 Nov 1979 and the text of the three criteria.

The obligation to ask the advice of the interested monospecialist sections also is formulated, the advice of the Mother-specialty has a special importance. Is this also a result of our intervention?
Chapter 7 The Supervisor of Surgical Training.

The advice the section gave after the first meetings said: six years of training at the university or the surgical school, gives access to the surgical practice in every one of the member states of the E.E.C., after a final examination. In all probability the deputes had not paid much attention to the question of supervision.

Already in 1969 this advice had changed completely.

Now the advice asked for supervision by the Competent Authority and stressed the place and responsibility of the chief of the training department, not to the hospital but to the chief in person, the training permit had to be conferred, for a limited period. And also in university clinics, with prolongation only after judgment of the training activities. The visiting committees of the (Dutch) Concilium Chirurgicum were explicitly mentioned.

In this unanimous advice the voice of Nuboer still can be heard.

The Belgian delegates had reported the intention of their government and of the Belgian Surgical Associations to copy the Dutch example. But the advised practice only existed in the Netherlands.

In France: University clinics had the specialist training permit "de droit". Non-University clinics were selected on the basis of a questionnaire. Results of the training were tested by the final examination.

In Germany: Specialist training at the University always had been taken for granted. Training permits to non-University clinics were dependent on the reputation of the hospital as a whole. The training programs had been recorded in extenso. After 1977 also the final examination functioned as a quality test.

In Italy: A very great number of examinations were obligatory at the surgical schools which were affiliated to the Universities. During the examinations candidates also were interrogated about their experiences during the theoretical training and the clinical stage (if any).

In Luxemburg: "Le Collège Médical" yearly published the list of hospitals, all abroad, where a completed training entitle to registration in the Grand Duchy.

As the sections advices out of 1969 had been approved by the Management Council the first report of the Comité Consultatif contained accordingly:
Recommendation I:

"Il convient de créer dans chaque État-membre un ou des organes compétents pour la formation des spécialistes qui auraient pour mission, A) de fixer normes et matières de formation et d'en contrôler la bonne application par des visites régulières dans les centres de formation..."

After the entry of Denmark, Ireland and the U.K. the procedures of supervision again came in discussion in the years 1978 and 1979. In the mean time also the Law in Belgium had become operative.

In Denmark: Training permit is granted after information about the reputation of the hospital. Visitations are not known.

In Ireland and in the U.K.: Every 5 years "Inspecting teams" of the Royal Colleges visit all hospitals and report about the activities of trainees, registrars and of the training staff. Log books are not in use (only as an experiment in two centres in the U.K.). The Colleges are authorized to withdraw training permits.

Candidates have to report about their training during the F.R.C.S. examinations. The nomination sessions of registrars and consultants also give insight in the training programs and experiences.

In Belgium: The Ministry decides about permission, according to the advice of "médecins inspecteurs". The Conseil Supérieur has published the list of criteria, to be fulfilled by stage masters and by hospitals. Regular visitations are not prescribed.

In 1981 Prof. Bevan presented a paper on the various entries, open to make supervision effective:

Authority: examinations before, during or at the end of the training

Regular visitations and/or frequent reports.

Hospital: Number of beds, specialists, training departments, admissions
Facilities e.g. O.K.s, Library, central archive, photography, film a.s.o.
Activities e.g. Affiliation, staff, medical audit, attention to costs a.s.o.
Surg Department: Out patients, emergency and program surgery, total workload, workload of trainees, experimental surgery, day hospital a.s.o.

Surg staff: routine meeting regarding indications, complications, near accidents, necrology, capita selecta, demonstrations, instruction courses a.s.o.

Staff members: reputation, scientific activities apparent in publications, congresses and symposia, examination Boards; activities in staff committees and participation in Surgical Associations and Colleges.
The Comité Consultatif has had hearings with the monospecialist sections in the years 1980 and 1981. Therefore it is not strange to find in the second report of this Comité in the list of official recommendations:

8) Toute formation doit être contrôlée par un Authorité Compétente habilitée à homologuer des centres de formation ou au contraire à leur retirer l’homologation, en se basant sur des inspections périodiques et en tenant compte de
a) l’infrastructure hospitalière : bibliothèques, réunions, équipement et plateau techniques tels que radiologie, pathologie, archives,

b) l’activité de l’unité : l’éventail et le volume de travail (nombre de malades traités, nombre des lits, niveau technique du travail)

c) les qualifications et l’expérience des formateurs et de leur collaborateurs,

d) le travail accompli par le candidat spécialiste, ses progrès et son expérience.

9) L’autorité compétente assure la qualité de la formation dispensée à chaque stagiaire par des mesures telles que:
- l’approbation préalable du programme de formation, ou la publication de programmes approuvés et de listes des centres de formation agréés pour la mise en œuvre de programmes complets ou de parties déterminées de ceux-ci,
- la supervision de l’accomplissement du programme par le stagiaire, par exemple au moyen d’un carnet de stage. Ce carnet donne au candidat et au formateur une idée claire du programme à couvrir et de la progression du stagiaire,
- des examens ou des évaluations adéquates,
- des échanges de rapports avec les autorités compétentes des autres États membres où le candidat a reçu une partie de sa formation.

All surgical specialties have a common interest in the many problems which have to be solved to make surgery safe to the patient and effective in healing. In principle, the stage master bears full responsibility for the work the trainees are doing. They have to assist to many operations in order to develop the dexterity, the knowledge and the competence to perform the operation alone, with full responsibility. The delegation of responsibility is the most difficult task of the stage master.

During the meetings this aspect of the training received much attention. As also this, the practical experience, is an aspect of supervision, these discussions are reported here.
Chapter 7  B Operative Experience during the Training.

In 1969 the German delegates presented the draft of the regulations in preparation in the B.R.D. Apart from an extensive program of theoretical studies the minimum number of operations, indispensable to registration, had been laid down in the proposed Law:

Operations on traumatological cases
- on the extremities 100
- head and neck surgery 30
- thoracic surgery 20
- abdominal surgery 170 among which 70 major ones
- hand and plastic surgery 20
- vessels and nerves 10

Every trainee had to operate upon, independently, with full responsibility, at least these 370 operations. Deficiencies in one group could not be compensated by abundance in other groups.

This presentation aroused many commentaries.

In Luxembourg the trainee had to produce a log-book before registration, the average number of operations was smaller.

In the Netherlands the visiting commissions took notice of operation lists during visitations. The inquests had the impression that the number of operations were much smaller.

In France only the total workload of the surgical department was subject to controle. The number of operations of the trainees explicitly were not registered.

Most of the delegates were of the opinion that the obligations of the program could not be met by the trainees in Germany.

Until now Germany stayed the only country where kind and number of operations is one of the conditions to registration.

In 1975 the Concilium Chirurgicum in the Netherlands started a computer-program on the operative experience of trainees (Op-er-A) in the three classes of training services: U (University clinics 6 years), A (non-University clinics 6 years) and B (common trunk training 2-3 years) Operations were classified in 5 groupes, according to difficulty and risk. Registration included the three types of participation: assistance to a more experienced surgeon, performance of the operation with full responsibility and assistance to a younger colleague, in the function of instructor.

As every trainee and every member of the staff had his own registration number the activity of all participants were registered.
Yearly the stage master received the results from his own clinic, with the overall averages. So he was in the position to correct devoations himself. The Concilium, receiving the total output, after a few years got a clear picture of the situation in every training department. After six years of registration the standard experience was known. The average trainee in the A clinic, during his total training had assisted one of the experienced staff members 1200 times, he had performed 1000 operations on his own responsibility and he had functionned as an instructor to a younger colleague 200 times.

In the B clinics the results were proportionally the same and in the U clinics the average experience mounted to 50% of the A clinics.

Much more impressive were the data showing the wide dispersion of the figures gathered from the individual clinics.

The average number of independently performed operation yearly were:
- In the U clinic 93 with a dispersion between 50 to 141
- In the A clinic 182 with a dispersion between 116 to 289
- In the B clinic 108 with a dispersion between 45 to 234

The lessons learned by this program were obvious but totally unexpected: the average experience appeared to be much greater than expected, in a few U and B clinics the experience was small and hardly sufficient. But in many more clinics, specially in the A category, the trainees had to work so many hours in the operation theatres, that their scientific and clinical training was jeopardized.

The Dutch delegates reported yearly about the development and the results of this program in the years 1975 to 1982.

And it was no surprise to hear about the experiences in Germany, where most of the trainees had no problem to operate upon twice the number of operations they were obliged to.

During discussions on supervision, gradually the central and decisive role of the training staff appeared to be in the foreground.

Many times the subject "supervision" led to reflections on the need of continued training.

As this subject at the moment is already firmly embedded in the Anglo-American literature, "I will report about the activities of the section on this subject, using the official title: Continuing Medical Education."
Chapter 7 C Continuing Medical Education (C.M.E.)

At the first discussion in 1978, members agreed that continued training was a moral duty of every specialist. As such, self-education should be an activity out of free choice.

Active participation in a training program and in the tasks of the hospital staff were deemed most important stimulants. The section concluded:

Le stimulant le plus efficace à la formation continue est de se savoir jugé par ses pairs.

Prof. Olivier commented a study in France on this subject in 1960.

Prof Bevan reported experiences in the U.K. where the Royal Colleges were very active to stimulate continued training. Thirty days study allowances had been granted to candidates preparing the F.R.C.S. examinations.

So the full trained surgeon should at least spend a week every year, solely to self-study.

In 1982, after another exposé of Mr. Bevan, the section sent a motion, again worded by Mr. Brady, "our motion-maker"

"During the meeting in Dublin on the 19th of June 1982 the section of surgery discussed the necessity of continued education for every surgical specialist and came to the following conclusions:

- C.M.E. is the responsibility of every surgeon, so a program only can be developed on a voluntary basis,

- C.M.E. mainly is realized by three activities
  - instruction of pregraduate and postgraduate students
  - full cooperation of the specialist in the hospital staff
  - open communication with specialists of the same discipline

- C.M.E. should continue until the day of retirement from active practice

- To realize a program of C.M.E., statutory study leave and due allowance of time for intra- and interdisciplinary meetings are indispensable."

The Standing Committee of Doctors of the E.C. published the "Dublin Declaration" in 1982. There the conclusion is formulated:

"Continued Medical Education is an ethical obligation which every fully qualified doctor must himself discharge".

The Committee stresses the importance of Medical Quality Assessment by the group of doctors of the hospital, referred to as "a peer group".
Chapter 8 Manpower Planning

Initially, and for many years, the Authorities were mainly concerned with the number of training posts. So we read in the Report of the Comité Consultatif of 1978: "Le nombre des candidats spécialistes doit correspondre au nombre auquel peut être offerte une formation de qualité dans le cadre des installations disponibles."

And also in 1969 the major problem had been: "résoudre les difficultés qui naissent de la pénurie d'hôpitaux de stage."

During the meeting in Rome in 1979, the discussion led to one of the recommendations published in the Report of the Comité Consultatif of 1978: "Il faut et reconnaître et encourager les périodes d'études à l'étranger."

The Dutch representatives drew attention to a consequence of this practice viz. enlargement of the existing training capacity.

In the Netherlands studies in 1978-1979 had shown that the yearly "production" of surgeons mounted to 60. The need being only 35, the training capacity had to be reduced, enlargement was out of question.

In 1980 Dr. Grond presented a report about the measures which, after long discussions, had been accepted in the Netherlands. The number of training posts had been reduced to 58%, as a first step.

The repercussions in the training departments were expected to be very hard as the same daily task had to be fulfilled. All training staffs had given consent, but everybody now feared the Treaty of Rome becoming a threat to the effect. Every trainee, rejected in the Netherlands easily could find a place in one of the surrounding countries.

The section adopted a resolution urging the U.E.M.S. to investigate the overproduction of specialists in the E.E.C. and to ensure that the training capacity in the countries should be balanced to the need of specialists.

Apparently overproduction existed in all countries, and not only in the training of surgeons. And so manpower planning has been a major concern until today.

I only mention a selection of remarkable studies and statements.


constaté que dans tous les pays du Marché Commun le nombre de médecins se spécialisant en chirurgie dépasse de loin le nombre de places qu'ils pourront trouver comme chirurgien dans leur patrie,"
- constate que dans certains pays des mesures sont prises (ou préparées) afin de limiter la capacité de formation aux besoins réels du pays,
- constate qu'une réduction de la capacité de formation risque de rester sans effet dans les pays dont les ressortissants peuvent trouver (et trouvent en effet) un stage de formation dans les pays voisins de la C.E.E.
- demande avec insistance au Conseil de Direction de l'U.F.M.E. de bien vouloir rechercher et mettre en œuvre tous les moyens possibles afin de réaliser dans le plus bref délai, au sein des pays de la C.E.E. un équilibre de marché concernant les chirurgiens (et autres spécialités médicaux)."

1982 The answer of the Secretary General of the 19th of July:
"En ce qui concerne le nombre de chirurgiens en formation, le Conseil de Direction a approuvé à l'unanimité la motion votée par votre section et a chargé son officier de liaison auprès du Comité Permanent de défendre votre point de vue et d'insister pour que tous les moyens possibles soient mis en œuvre afin de réaliser, dans le plus bref délai, au sein des pays de la C.E.E. un équilibre de marché concernant les chirurgiens et les autres spécialistes médicaux."

1983 Prof. Lacquet, president of the section, declared: with 1200 surgeons and a production of 50 instead of 21 yearly, the situation in Belgium is still worse than in the Netherlands. The attempt to reduce the number of training posts aroused enormous protests...

In Belgium 35 surgeons have no employment, many more perform only a few, minor operations in a month.

In the Netherlands the number of physicians, admitted to surgical training in the year 1983 has been reduced to "zero".

The section sent a motion declaring: ... the underemployed surgeon, who operates occasionally, is as disadvantageous to good surgical care as the overworked surgeon. Overproduction of surgeons encourages the proliferation of a excessive number of subspecialties..."

The Management Council again showed serious concern in the situation by the "Communiqué de Presse" they delivered in Brussels 14 December 1983
"Constatant que deux des dix États-membres de la C.E.E. n'ont toujours pris aucune mesure pour limiter l'accès aux études de médecine, adjoins les autori-tés responsables de ces États de mettre en œuvre sans délai cette limitation de façon que l'offre d'emploi médicale équilibre la demande réelle de soins de santé..."
The situation in Belgium and in Germany is unchanged. Without doubt this is not due to lack of efforts and pressure from many surgeons of authority. In the Netherlands 16 trainees are selected for surgical training after a psychotechnical test and a final selection by hearings with the most respected stage masters. Prof. den Otter presents a paper on this unusual procedure.

At the Assembly in Paris, 16-II May, Dr. Fanfani, president of the U.E.M.S. regrets to report that the Comité Permanent did not mention in the report of November 1984 the problems arising from the Plethora of specialists nor the Numerus Clausus.

The section of Surgery concludes that the Associations of Surgeons and the Colleges must organize the limitation of training posts in their own countries themselves and in cooperation.

The members of the section present figures of the population, the number of practicing surgeons and the number of trainees in their countries.

<table>
<thead>
<tr>
<th>Country</th>
<th>Population in millions</th>
<th>Number of surgeons</th>
<th>Number of trainees</th>
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<tbody>
<tr>
<td>Belgium</td>
<td>10.0</td>
<td>1200</td>
<td>300</td>
</tr>
<tr>
<td>Benmark</td>
<td>5.2</td>
<td>347</td>
<td>240</td>
</tr>
<tr>
<td>France</td>
<td>54.8</td>
<td>5947</td>
<td>800</td>
</tr>
<tr>
<td>W. Germany</td>
<td>61.6</td>
<td>2049</td>
<td>4358</td>
</tr>
<tr>
<td>Greece</td>
<td>10.0</td>
<td>1770</td>
<td>256</td>
</tr>
<tr>
<td>Ireland</td>
<td>3.5</td>
<td>95</td>
<td>75</td>
</tr>
<tr>
<td>Italy</td>
<td>55.0</td>
<td>4000</td>
<td>?</td>
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<tr>
<td>Luxenbourg</td>
<td>0.37</td>
<td>46</td>
<td>12</td>
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<tr>
<td>Netherlands</td>
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<td>775</td>
<td>123</td>
</tr>
<tr>
<td>U.K.</td>
<td>52.0</td>
<td>1200</td>
<td>236</td>
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</table>

The critical notes in the section are abundant and severe.

The figures are not complete and not exact. The enormous difference in the number of surgeons per 100,000 inhabitants indicates that a general surgeon is not the same person, with the same practice in the different countries.

In France, where the training for general surgeons does not function anymore, it is impossible to give a real number of trainees.

The task is to find a way to produce figures which are reliable and comparable.

During the meeting of the International Federation of Surgical Colleges in New Orleans Oct. 1987 also surgical manpower problems were discussed. Where the same problem became apparent, the definition of a surgeon in the U.K. is quite different from the definition on "the continent". In Greece many "surgeons" have no surgical practice at all.
In Ireland many trainees are coming from the undeveloped countries and will leave the E.E.C. after the training.

In the U.K. a great number of junior registrars will complete their training in one of the surgical specialties, so it is impossible to give more exact numbers. At the end of the discussion the members conclude they cannot draw conclusions from the collected information.

The conclusion has been too rash.

The advice given by our section and repeatedly reviewed by the U.E.M.S. has been: Fix the number of training posts to the number of vacancies, expected in the country. So the difference in composition of the group, called general surgeon, is not relevant. The number of specialists, indicated as surgeons has to be kept constant (or lowered).

Our data give a clear insight in the way this advice has been followed in the countries. This is one of the points of the agenda of the meeting in 1988.

During the meeting in 1987 members agreed to the supposition: the average period of activity of a trained surgeon in the E.E.C. is 30 years.

So every year one-thirtieth of the number of surgeons leaves practice and creates the vacancies.

As the training period for general surgery is 6 years, every year one-sixth of the number of trainees is ready to fill up the vacant places.

To keep a balanced situation the number of trainees has to be one fifth of the number of surgeons in (active) practice.

<table>
<thead>
<tr>
<th>Country</th>
<th>Number surgeons per 100,000 inh.</th>
<th>Ratio trainees: Pract surgeons</th>
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</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>12</td>
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<td>6.6</td>
<td>I to 1.4</td>
</tr>
<tr>
<td>France</td>
<td>10.8</td>
<td>I to 7.4</td>
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<td>Germany</td>
<td>3.3</td>
<td>I to 0.46</td>
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<td>I to 6.9</td>
</tr>
<tr>
<td>Ireland</td>
<td>2.7</td>
<td>I to 1.3</td>
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<td>Italy</td>
<td>7.1</td>
<td>?</td>
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<td>12.8</td>
<td>I to 3.8</td>
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<td>Netherlands</td>
<td>5.5</td>
<td>I to 6.3</td>
</tr>
<tr>
<td>U.K.</td>
<td>2.3</td>
<td>I to 5.1</td>
</tr>
</tbody>
</table>

Conclusions have to be left to the discussion at the meeting in Athens the 16th of April 1988.
Chapter 9 Surgery and Traumatology.

In its report to the U.E.M.S., presented after the first meetings, the section of surgery stated: "La section décide: l'unanimité que la traumatologie fait partie intégrante de la chirurgie."

In 1969 this statement was repeated, the situation in the six countries being correspondent. The vast majority of injured and of fracture patients were treated by general surgeons in daily practice.

In the years 1969 - 1975, the relation between the (general) surgeon and the surgical specialists regularly was in discussion, the principle of common trunk training gradually being accepted.

The conviction that basic surgical science and technics were indispensable to every "cutting doctor" was leading to the practice of a partially combined training in most of the countries.

The idea of marking out the field of surgical specialties never came up. It was abundantly clear that subspecialisation had resulted in more profound knowledge and better therapeutic possibilities. The advantages to a group of patients were out of discussion. The choice, which group of patients had to be treated by the surgical generalist, which group by the surgical specialist, clearly is a problem of conscience and intercollegial consultation. Not a problem to be decided by the sections of the U.E.M.S.

The fact that to the treatment of a large group of patients the surgical generalist is as competent as the surgical specialist (or even more) also remained undisussed; also the inevitable consequence that traumatic cases were treated by surgeons and by orthopedists, even in the same hospital. This all stayed out of discussion, being evident.

It was with surprise that the section at its meeting in 1981 had to take notice of motion D 8106 of the section of Orthopedic surgery, saying:

- That the treatment of traumatic lesions of the musculo-skeletal system should be made by surgeons with a full training in orthopedic surgery.

- That in hospitals in which traumatic lesions are admitted, there should be an orthopedic surgeon with full responsibility for the management of the musculo-skeletal injuries.

The discussion did not need much time. Anyone was aware of the rule of the Management Council never to adopt a motion aiming at a "Chasse Privee."

So the comment to this motion was short and plain:
"The monospecialist section of Surgery rejects the claims of the monospecialist section of Orthopedic surgery concerning the relationship of traumatology to orthopedic surgery and confirms its previous motions saying that traumatology, including the musculo-skeletal injuries, is an essential part of surgery."

In retrospect the answer has to be criticised. The better reaction should have been a declaration as, for instance: General surgery maintains a claim on Traumatology, not only because the origin of all surgical activities lies in the care of the injured patient, but also because most traumatic cases, all over Europe, are in fact treated by general surgeons. So an exclusive claim of Orthopedic surgeons in inadmissible. Local circumstances are decisive, respecting the free choice of the patient. In cost situations cooperation in the care and the cure of the badly wounded, is the better solution.

And so the story did not come to an end.

Coming home, 21 June from the meeting in Edinburgh, the secretary found a letter dated 6th of June 1982, containing the decisions the Council of Management had taken during their meeting in Amsterdam 7-8 May 1982.

Among other things the Secretary General reported the adoption of a motion of the section of Orthopedics, after correction of the last sentence by the Council. Only this last sentence being quoted, the secretaryread to his astonishment: "Il est recommandé qu'un chirurgien général qui pratique la chirurgie des lésions traumatiques du système musculo-squelettique possède une formation complémentaire adéquate en orthopédie".

After receipt of the text of the complete motion D 8205 astonishment rose to perplexity. This was the text adopted:

"Le but final est que le traitement des lésions traumatiques affectant le système musculo-squelettique devrait être confié à un chirurgien formé en chirurgie orthopédique. Pendant la période intermédiaire, il a été admis que de tels cas pourront être traités par un chirurgien possédant une formation dans d'autres disciplines chirurgicales, il est recommandé qu'un chirurgien général qui souhaite pratiquer, etc..."

Of course president and secretary immediately sent their critical notes to the secretary general and discussed their remarks with the members of the Deputation of their own country to the Assemblee. In Belgium and in the Netherlands the motion met strong resistance. This led to changes in the redaction. At first the last word "orthopédie" was changed into "chirurgie osseuse" after some time the last word of the first sentence has been changed in the same way.
And also a text circulated ending with the words "devrait compter au minimum de trois ans de spécialisation en orthopédie".

At one moment four different redactions were circulating.

One week before the meeting in Haarlem in 1983, the secretary asked for the official version and received the text of the motion, now D 8205 bis, with the word "orthopedique" at the end of the first sentence and the word "chirurgie osseuse" at the end of the last sentence.

This was the redaction discussed by the surgical section and indeed it met no sympathy at all!

In the first place, consultation of the sections concerned, had been omitted, and the decision of the Management Council must have been a mistake.

The imprtnence of a monospecialist section to dictate the concience of their collegues and force specialists to a retrain course is inadmissable.

But the main objection is the claim to a "Chasse Privée" No; immediately this time, but as a "but final" I prefer not to write down "verbatim" the extensive paper the section sent to the Management Council.

As there were more problems to discuss between the sections of the surgical specialists, the Council convocated the polyspecialist commission in Brussels the Ith of Sept 1984. The discussion on the motion D 8205 bis did not take much time. The Bureau of the U.E.M.S. and the representatives of all surgical sections advised the Orthopedic section to withdraw its motion. At that moment the discussions should have come to an end. But alas, they did not. The Orthopedic section refused to follow the unanimous advice.

As long as the orthopedic surgeons could maintain the motion D 8205 as being adopted by the U.E.M.S. (and so it was) it could be used official. Also in court. And it has been used officially, at least once in a case of arbitration in the Netherlands (Bergen op Zoom 1985).

So the surgical section required: either the orthopedic section had to withdraw its motion or the Management Council had to withdraw the adoption. To reach this goal the surgical section had to spend a lot of energy and much paper.

The rest of this disagreeable story has to be told in short.
The Secretary General of the U.E.M.S. invited the presidents of both sections to a conference in Brussels I5 June 1985.

There in a friendly sphere and in good understanding a new text has been composed: the motion D 8525. (see page I5)
During the discussion the partners intended to do more than just make an end to the tedious discussion about the motion D 8205 bis. So they tried to formulate the rules which have to be respected by every specialist on the ground of his responsibility towards his patient and at the same time on the ground of his respect to his colleagues. This motion is meant to be accepted by all monospecialist sections.

The discussion partners were convinced that the acceptance of the text D 8525 had the effect of eliminating the intentions which had guided the draft of the motion 8205 bis. But they also were convinced that an official withdrawal was imperative once the motion D 8205 had been adopted by the U.E.M.S. After the text of D 8525 had been adopted by both sections and by the Management Council none of the parties appeared eager to state the indispensable conclusion. After three years of continued pressure the section of surgery reached its goal, thanks to the help of the Secretary General. At the meeting in Frankfurt I - 2 May 1987 the Management council declared officially that the Motion D 8525 replaced and cancelled the Motion D 8205 bis.
Chapter 10 General Surgery in France.

The 6th of May 1982 Dr. Michael Verhaeghe sent copy of his letter to the President of the "Syndicat National des Chirurgiens Francais" to the sections secretary, in which he announced Prof. Olivieres and his own decision not to come to the meeting in Edinburgh 19 June. "En réalité la situation est telle, en France actuellement que nous n'avons plus aucun idée de la façon dont seront formés les chirurgiens. Les études de Médecine sont complètement bouleversées. Le concours de l'internat est supprimé. Les conditions de formation des spécialistes, et par conséquent en particulier des chirurgiens, sont totalement inconnues."

President Lacquet tried to change this decision, but in vain. During the meeting Dr. Faber confirmed the tumultuous situation in France, strikes at the Medical Faculties and in many training clinics. In a motion the section urged the Management Council to give its attention to this alarming situation.

Also at the next meeting the delegates of France were absent. In answer to the invitation they announced their resignation the 4th of April 1983. It was impossible to contradict their arguments: the classification of specialisations and of training programs has been changed fundamentally. In future only ten surgical subspecialties are recognized, general surgery does not exist anymore. So there is nothing left to represent in the section of surgery.

In the minutes of the meeting the statement has been recorded: the development in France goes on with a complete disregard of the advices of the Comité Consultatif, which stressed the interdependency of surgical specialties and the importance of the common trunk training in both its reports.

At the end of January 1984 two new French delegates were nominated. Ten days after his nomination, without any preparation, without information about the policy of the French Government, even without the (forwarded) agenda of the meeting Dr. Bellamy was present in Dublin the 11th of February 1984. After being informed by the president on the long history, Dr. Bellamy reported on the situation of the moment:

- Training programs at the University clinics recently had been started.
- The selection of the "Internes des Hôpitaux" took place at the Universities during the 5th and 6th year of the medical study program.
- Those who have qualified will start a clinical 4 years training program at the University,
- after one year as a "Chef de Clinique" registration follows, without examination
Dr. Bellamy confirmed the information the section had collected up to now. Also after his opinion all consequences of the new scheme had not been worked out yet. Everybody was convinced of the impossibility to staff the numerous hospitals in small towns in France without general surgeons.

The following motion also was signed by Dr. Bellamy, delegate of France, after consultation with the Syndicat de Chirurgie:

"Les nouvelles propositions des Autorités Françaises pour le développement des spécialités chirurgicales mènent le statut de la chirurgie générale et du tronc commun de formation chirurgicale.

Ceci met en lumière la nécessité de continuer à enseigner les principes de base de la chirurgie et de former des chirurgiens généralistes de haut niveau."

Preparatory to the 1985 meeting Dr. Bellamy and Prof. Garbay presented the official document of Dr. Pouyard, describing the Law of 23 Dec. 1982, accompagnied by their personnal comment.

The consequences of the law and its applications are far from obvious. Common trunc training has been abolished. The trainee starts and finishes his training in the chosen subspeciality. He also is free to select a sequence of stages in different, highly specialized, programs. If a trainee chooses to make himself eligible to a post of "general surgeon", he can choose the programs of intestinal surgery with traumatic- or vascular surgery, a.s.o.

Both French delegates were not optimistic. Dr. Bellamy wrote: "on a fait disparaître le corps des internes des hôpitaux, qui a fourni pendant cent quatre vingt ans l'élite de la Médecine Française."

Prof. Garbay: "bref, l'ancien système est détruit, le nouveau ne fonctionne pas encore et tous les médecins hospitaliers parisiens sont très inquiets devant ce changement brusque et non préparé."

In this connection readers have to recall the referendum of the 80th French surgical Congress in 1978. 740 surgeons responded the questionnaire. Continuation of the "concours de l'internat" scored 96%, common trunc training 88% of the votes.

During the discussion it became clear that disorder is inevitable when the Government makes regulations in the field where only the profession is competent. One of the many disadvantages of the new situation: it is impossible to know how many (general) surgeons will claim the vacant posts of general surgeons in the future. Manpower planning is made impossible.
Umanimously the deputees adopted the text of a motion, drawn up by the French members:

"Tout en reconnaissant le droit d'un Gouvernement élu démocratiquement, à déterminer les meilleurs méthodes pour la dispensation des soins de santé pour la population, la préservation du niveau de la qualité des praticiens est une responsabilité professionnelle. L'élaboration des programmes d'études, l'organisation des examens et des concours pour une spécialisation plus poussée incompent aux organisations scientifiques et professionnelles, et ne devraient pas être soumises à une influence politique quelconque. Pour cette raison la Section Monospécialisée de Chirurgie Générale de l'U.E.M.S., ayant eu connaissance du rapport du délégué français sur les développements récents de l'internat, exprime son inquiétude profonde vis-à-vis de cet événement. La section est unanime à faire part de son opposition aux actions arbitraires du Gouvernement Français, qui a imposé des changements radicaux dans le recrutement et la nomination des internes et ainsi dans les programmes de spécialisation."

After this masterly wording of the sections opinion and criticism there was no reason to repeat our concern during the following meetings.

In 1987 the French delegates reported the recent decision to reduce the number of acute beds by 10%.

As the introduction of the internat qualifiant had resulted in a reduction of the number of trainees, the problems in the day-to-day running of the services were heavily felt.
Delegates of the Member Countries in the monospecialist section of surgery:

**Austria**
- Prof. Dr. W. Smets
- Dr. J. Cahen
- Prof. Dr. A. Lacquet
- Dr. J. Buissereet
- Prof. Dr. J. Gruwez
- Dr. E. Ruhm

**Belgium**
- Dr. L. Bergouignan
- Dr. J. Busron
- Prof. Dr. C. Olivier
- Prof. Dr. M. Vormhege
- Dr. J. Bellamy

**France**
- Prof. Dr. M. Garbay

**Germany**
- Prof. Dr. H. Schwaiger
- Dr. K. Hempel
- Prof. Dr. A. Ruffo
- Prof. Dr. A. Cirenci
- Prof. Dr. B. Testauro
- Prof. L. Angelini

**Italy**
- Prof. Dr. H. Louisch
- Dr. J. Joris
- Dr. J. Schoentgen
- Dr. P. Faber

**Luxembourg**
- Prof. Dr. J. Nuboer
- Dr. J. de Jong
- Dr. H. Grond
- Prof. Dr. G. den Otter
- Prof. Dr. N. van der Heyde
- Dr. U. Starup

**Netherlands**
- Dr. F. Heurnberg
- Dr. C. Frimadler
- Dr. F. Formaggia

**M. B. Lagos, 1963**
- C. J. de Volde, 1963

**Denmark**
- Dr. Pederson
- Dr. E. Thing

**1963 u.a. 1985**
Ireland
Prof. M. Brady
Mr. W. Hedermann

United Kingdom
Prof. P. Gilroy Bevan
Prof. N. Michie
Mr. A. Dean
Prof. A. Marston

Portugal
Prof. A. de Almeida
Dr. R. Riquera

Greece
Dr. A. Yotis

Spain
Charly
Porous popcorn

Board of the Section

President: Prof. Dr. J. Nibber 1963 - 1974
Prof. Dr. W. Smets 1974 - 1981
Prof. Dr. A. Lacquet 1981 - 1985
Dr. J. Grond

Secretary: Prof. Dr. W. Smets 1963 - 1974
Prof. Dr. A. Lacquet 1974 - 1981
Dr. J. Grond 1981 - 1985
Mr. A. Dean

Treasurer: Dr. R. Joris 1963 - 1981
Dr. J. Schoentgen 1981 - 1984
Dr. P. Rutten 1984 -

Sweden: Prof U. Håglund 1954 (we note it?)

Finland 2 x 1956

Norway 1 x 1955
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<th>Year</th>
<th>Date</th>
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