Memories

Dr C.C. Leibbrandt

from inside and outside the profession

Abridged version, with photographs 2020
Professional years
(medical study - retirement, 1956-2002)

Autobiography
Cees Leibbrandt
Born October 20, 1935 in Groesbeek (near Arnhem, Holland)

Motivation:

This little booklet is not an autobiography, but a compilation of the many experiences (or adventures?) in my career as medical professional. Perhaps these anecdotes are giving a better inside view on my live than any more formal autobiography.
I started writing in 2017 because my wife was suffering from dementia. She died last year. For me her loss of memory was a very painful experience. It could happen to me as well; so I started to write something down about my earliest remembrances, just for myself. That covered the Second World War and also the painful recovery of our country in the years following. After a few aborted trials this booklet became quite a big project, and it ended up covering my professional life as well.

The earlier more complete version (there also the period 1940-1956) was in Dutch language and was distributed rather widely to my close colleagues in the Netherlands and also to Dutch medical institutions and libraries. There was quite a lot of response from all sources.

This little English language booklet, covering only the years of my professional life, is an excerpt of the Dutch version. My active medical practice in Otolaryngology covered the period 1963-1996. Most of these years I was member of the board of national medical organizations. From 1986-2002 I was member of the Management Council of the UEMS, from 1996-2002 of the executive committee, the last 3 years as secretary-general.

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Cees Leibbrandt
Graadt van Roggenstraat 33
NL - 6522 AW Nijmegen
tel: +3124-360.7236
cc@leibbrandt.net

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Dr C.C. Leibbrandt, born. October 20, 1935 in Groesbeek
Otolaryngologist in Utrecht and Amersfoort, NL

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1- The years 1956-1965

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Second part of the medical study, clinical years

After 3 years of basic medical training and the candidate-examination in 1956 I moved into a ‘’student home’’ in Utrecht, together with a group of friends, several in medicine, but also in pharmacy, chemistry, dentistry and veterinary medicine. This was a marvelous time. We learned a lot from each other and the study went without effort.

However, there was a hurdle. That was social medicine. There were some lectures in that subject, but not many educational tools. It was not part of the main examination, but one did have to pass the examination (orally and written). The oral examination was about health insurances and related subjects. That was not too difficult, but the written examination was about statistics, relevance of outcome, size of required samples etc. That was a big hurdle.

The oral examination came first. I had to report some morning to the professor at his home address, a large old building on one of the canals in Utrecht city. I was ushered into a small room with just a table and a few chairs. It took a long time. Then I heard a bathtub being filled upstairs. Later on it was being drained. In the meantime I had ample time to inspect the waiting room extensively. There was not much to see, but there was a waste-paper basket. There were scraps of paper inside. I did put them into my pocket.

At home we medical students pieced together the pieces. They turned out to be examination questions. It was good material for exercise and we spent a lot of time on them.

Later, when we had to take the written examination, we got exactly the same examination paper. Unnecessary to say that we all passed the examination with distinction.

In that summer 1956 there was also the Lustrum of our “Utrecht Student Corps’’, our student organization. Part of the festivities was the ‘’Masquerade Xerxes”, based on the Persian invasion of Greece (480–479 BC). I was part of the event in the ‘’technical committee’’ that had been building the war chariots. I was also riding in the tail of the parade through the city as an ‘’AA/RAC patrol’’ in a war chariot equipped with the necessary technical equipment. And there were emergency repair jobs on the way! That was a lot of fun.


Els, 1970

My lustrum companion those days was Els Nikkels, a fellow medical student, who had attracted my attention shortly before. She became my wife in 1961.

This 2-years ‘’doctoral’ period (1956-1958) of the study was patient-related, not only pathology, bacteriology etc., but it also covered the bulk of the clinical subjects. Every morning, also on Saturday at 8.15 a.m. there were clinical lectures, where you could be called forwards to intriguing questions by the professor about the patient in question. Your behavior was recorded and validated.

The summer of 1957 was occupied for the second time by military service, this time in a training facility for medical

students in a special outdoor encampment. We did all kinds of military duties, even shooting. At the end we qualified as an infantry platoon and we were all promoted to the distinguished rank of sergeant.

In the years 1956-1958 I also had a function as assistant in the Laboratory of Physiology in the practical training of second year students in basic skills in physiology. The director was Prof. Jongbloed, a First World War fighter pilot veteran. We will meet him again.

One afternoon each week the younger medical students were counseled during their practical activities and assessed by us together with the permanent staff
That was stimulating work, also for ourselves. Later on the experience proved to be very fruitful in my further career.

My own medical study now centered on the clinical disciplines. The examinations in the ‘’smaller’’ disciplines took place during the 5th year, but for the examination in the 4 major disciplines there was a special interesting procedure.

This (Doctoral) Examination, which would be qualifying for the title “Drs/Dra’’ (doctorandus/a), which is the final

qualification of all university studies in the Netherlands, was at that time (1958) an oral examination.
It took place in 4 small rooms on the upper floor of the Clinic for Neurology-Psychiatry. In each room a professor was present for the examination The 4 divisions were resp. internal medicine, surgery, neur/psych. and gynaec/obstetrics. Each interrogation lasted 15 minutes, then a bell rang, and the 4 candidates had to change rooms. In this way 3 times a group of 4 candidates were interrogated.
After the last group, there was a short time for the professors to make up their mind, and then the results were announced. In this way there came the end to our university study. In this stage nearly everyone passed the examination. So did I.
But we still had to do 2 years of study/work in the hospital and pass a tough examination at the end before we could become real medical doctors.
In that period we had the rank of ‘’co-resident’’, which is as low as you can get in clinical medicine.

Co-residencies, clinical training

After the Doctoral Examination came the clinical training with the ‘’semi-medical doctor examination’’ and finally the medical doctor examination. That was the final examination, which gave at that time (1960) entrance to independent practice of the whole medical profession.
In this period it became very real and serious. We were busy the whole day and often during the evenings and nights as well. Especially in surgery, internal medicine and obstetrics the days (and nights) were long. And there were queer demands. One day I was stationed for hours under a leaking operation table. My job was to keep the patient awake. Above the professor was doing something in local anesthesia in the interior of the skull. That was in 1959. 10 years later I have been operating on that same operating table together with a younger neuro-surgeon and with proper general anesthesia and micro-instrumentation.

The arrangement of the co-residencies was a tricky matter. Els, my future wife, was at that time also in that stage of her study.

She got problems, because she had done something outside the protocol in the clinic of professor X. No harm was done, but the penalty was extension of her clinical period with 2 weeks. That threatened to disrupt her next stages. In the worst case this could cause considerable delay of her graduation as medical doctor. She went to professor Y, where she had to start her next stage.
She told him her problem. His reaction was: ‘’child, you have a problem with prof. X. What can I do for you?” That was the start of that next stage 2 weeks later. It was arranged immediately.
Apart from this incident the clinical stages went very well for both of us. I graduated as medical doctor on December 2, 1960, Els on July 7, 1961.

Application for postgraduate training in Otolaryngology

During this last year of my medical study I had chosen to become an Otolaryngologist. The reason was the up to date practice of this specialty with a lot of high-tech. I was fascinated by the combination of real patient-care and the micro-surgical techniques, but also in the physics of audiology and its application in the treatment of hearing loss. I had also seen that the Otolaryngology department in Utrecht had a high standard. Its head Prof. Gerlings was only a short time in function, but he had managed to obtain funding for a competent staff and modern equipment. As we shall see later, this was not an automatism in all cases.
For audiology there was already Prof. Groen, who was heading the physics department connected with our clinic, which was in charge of further development of audiology and also with the application and further development of hearing aids.
My application in 1960 after graduation went well; my earlier connection in the years 1956-1958 with the Laboratory of Physiology proved to be an advantage. And I was put on the waiting list. The Clinic did not have a vacancy in the next 3 years. I had to wait, but Prof. Gerlings advised me to apply for a place as assistant in Physiology in those years. This proved to be very good advice, as we shall see later.

Another point was that I still had to fulfil my 2 years of military service. I was already sergeant, and the training for medical officer and actual service as such followed shortly after my graduation.

Els graduated in that period as medical doctor as well. She applied for training in anesthesiology, also in the University Hospital in Utrecht with Dr. Pearce. He was an anesthesiologist from the UK, at that time working in Utrecht. Later he became professor of anesthesiology in Amsterdam. We both remember him with kindliness.
She graduated as anesthesiologist on March 1, 1965.

Military Service

Military service with training as medical officer followed shortly after my graduation. The army needed doctors!
But in the meantime I managed to do some substitution for general practitioners, including in Groesbeek, in the old practice of my father in the late thirties, and in Amsterdam, where my father was born.
Meanwhile I was at work to obtain a function in the Dutch Air Force as flight-surgeon. My relation with Prof. Jongbloed did the trick
My Air Force time was an exciting period. I worked on 3 airbases. I was also some time air-transport doctor, flying out to France or Germany, repatriating sick or injured Dutch service-men from training facilities in France or from our standing army at the border with the iron curtain in Germany.
It was a queer feeling, walking around on a German Airbase in a uniform, identical with the Royal Air Force uniform, with the Second World War still fresh in our memory.

Marriage

Our marriage took place on July 29, 1961 in Tubbergen, a small village close to the German border. Her father was there the veterinary surgeon. That was the start of a new phase in our lives. We had bought a very modest apartment in Utrecht, at

that time for € 11.000 with a down payment of € 900 (from our parents). We had some money from my substitutions for general practitioners and my modest military salary. Furniture was very basic, but we were happy. Later in that same apartment both our children were born, in 1965 and 1966.

Physiology in Utrecht

After military service there was still a year to go before I could start my Otolaryngology training. I had already applied for a place as an assistant physiology with Prof. Jongbloed, and after my demobilization in August 1962 I could start there right away.

The focus of this laboratory was in the field of sport and exertion. I was put to work on the measurements of the amount of energy swimmers were producing with different styles of swimming. For this purpose there was a small indoor swimming pool. The swimmers were strapped in a tackle. So they stayed stationary, and the amount of forward energy they produced with different styles of swimming was recorded. The electro-cardiogram and probably their oxygen consumption were recorded as well.

The purpose was the determination of the most efficient style of swimming. The whole staff of the laboratory was involved in this type of measurements. But there were other fields.

After a view weeks of introduction I was asked by the professor if I had a special field of research in mind. This was a tricky question. I had auditory physiology in mind, but I knew that the laboratory did not have a history in this field. The same was true for equipment. Only much later I realized how much backlog we had in Europe due to the Second World War, even 15 years later.

But I had done my homework, and I had seen that electro-physiology of hearing was a blank spot Europe-wide. I had done a lot of reading in mostly American literature, and over there electrophysiology of hearing was very present.

I took my chance and mentioned electrophysiology of the ear in guinea pigs. I also displayed some (very recent)

knowledge in this field from the well-supplied reading room of the laboratory.
The only link of the laboratory with electrophysiology in Utrecht was the Physiologist Einthoven end 19's century. He was the discoverer of the electrocardiogram (1901), but that was later in his life in the city of Leiden. In 1924 he was honored with the Nobel Price.

My own field of research in the laboratory

Looking behind, it is very special that I got the green light for a project in this field. It was new for the laboratory and it involved new techniques in several fields. Most of it I had to invent myself. At that time I had no surgical experience at all.
The guinea pig was the obvious experimental animal for this purpose. It has a lot of characteristics of the human inner ear, but it was smaller. However, following literature I found the surgical entrance to the guinea pig ear. General anesthesia was required, and so I went to the laboratory workshop, which was always a pleasure. A very basic but reliable ventilation device was developed in short time, working by way of a tracheotomy.
The next problem was the guinea pig ear itself. Therefore I needed magnification like I had seen in the hospital operating theater. I had already toyed with it a little bit during my co-residency in the hospital. But no smaller and cheaper alternate microscopes for this type of work were available. In the hospital the beautiful new Zeiss operation microscope had been introduced only recently for ear surgery.
I started looking around and I found an obscure company that imported an even newer East-German copy of the West-German original (Zeiss in Wetzlar). Remember, it was in the year 1962, in the cold war (the year of the Cuba-crisis) and I came right out of military service in our Air Force. This eastern copy was remarkably well done; it was much cheaper but also too expensive for the laboratory. So I started negotiating about purchase of only the optical part with the internal light source. This did the trick. I bargained for a price within the laboratory budget, and I knew our staff in the laboratory workshop would

welcome the challenge to produce the necessary unipod, even on short notice. So it happened.
For the electronics I had the support of my friend and senior staff member Peter Hans Kylstra, who had designed a simple amplifier for the practicum of the medical students, which they used to record the action potentials in the hind leg of frogs. That was the only electrophysiology that was done in the laboratory at that time.
I built a 2-channel balanced copy, which promised to give more stable recordings. And it did the trick.
Very quickly I was able to record the microphonic potential of the cochlea as well as the action potential from the acoustic nerve. This was done as everywhere with continuous sound or by clicks. The problem is to separate the 2 electrical phenomena in the inner ear and acoustic nerve. Here I was lucky again. I saw by chance that a very high-tone tone burst has the same effect as a click, but that the 2 electrical effects can now be separated in the recording. That was a break-through, and it offered entrance to all kinds of further research.
Following that, my attention was drawn by the phenomenon of adaptation, which now could be seen in the action potentials of the acoustic nerve when stimulating with a short series of such tone bursts. Adaptation did not appear in the cochlear microphonic potential. This proved that the action potential I was seeing was really an effect of neural origin. And it also appeared that the adaptation of this burst of action potentials disappeared when the acoustic nerve was blocked by a local anesthetic.
This again showed that the well-known adaptation in psycho-acoustical adaptation to noise is at least partially produced by suppression from inside the brain.
I was looking for that effect, because shortly before (1960) the anatomist Rasmussen had discovered a nerve bundle from the brain towards the inner ear.

Doctoral Thesis

My experiment generated a lot of discussion in the laboratory. Of course, I had to reproduce the experiments.

Sometime later I was invited by Prof. Jongbloed for some further discussion. He had a shocking story. He told that it was time to put my observation on paper. I already had expected that. But he said that it was worth a doctoral degree. That was very unexpected for me, but it was the way it went.
I bought myself a typewriter (a mayor investment in those days), and I started to get some information how something like writing a doctoral thesis should be handled.
The promotion was a year later, on March 24, 1964.
The actual thesis was a very small booklet, but later on it was already a predecessor of my later work on the Cochlear Implants 20 years later.

Residency Otolaryngology in Utrecht

Until the end of September 1963 I worked in the Laboratory of Physiology in Utrecht. The start of my Otolaryngology training was October 1 of that year.

But there was a catch. Normally one starts working in the outpatients department with the treatment of patients with epistaxis, otitis media etc. But my case was different. I was sent immediately to the department of Prof. Groen, the chief of Audiology, both scientific as well as practical in the field of hearing revalidation. For a long time he had wanted to set up a line of research in electrophysiology. But it had never materialized.

Halfway the training for otolaryngology a stage of half a year was foreseen with a scientific project. But he grabbed me right at the start of my period in Otolaryngology with the task to set up a line of research in electrophysiology.

I had no voice in it, and I was delegated to the audiology department right away.

This caused another problem. The residents in this stage of their training had to participate in the schedule of on-call-service in the out-of-office hours for emergency patients, who came to the hospital, day and night. If I was exempted from this service, they had to do more on-call services. So they took me under their wings for a couple of weeks and prepared me for these services as well. This went smoothly without incidents.

In this half year I have done some interesting things with small publications. But my main task was to set up and supervise a new line of electrophysiological research. That has been fruitful in the following years. I also built up a network of colleagues in other universities where they also wanted to work in this field. That provided me with a considerable network.

Underneath building 4 of the University Hospital, where the Otolarygology was located (photo taken from the ‘’Domtower’’ part of the old mediaeval church in the city center)

March 1964 was the start of my actual clinical training. That was a good feeling. And for me there was a special privilege. Due to my record in physiology, I was the only resident who had unlimited access to the audiological equipment in the clinic, which for that time was very advanced. It belonged to the domain of Prof. Groen, the audiologist. I could play with it as much as I wanted. I also developed good relations with both his clinical and scientific staff.

I also continued some experimental work myself, but that was limited to the Saturday mornings. On Saturday morning Prof. Gerlings made his ‘’big’’ clinical rounds through the wards.

Everybody had to be present on time, but I was exempted to do my experiments in the laboratory.
If I started early I could have finished, and then I was able

to participate in the ‘’coffee’’ in the office of the senior nurse zr. Hamelink with the professor and whole staff. There you heard all the ins and outs of the profession, which turned out to be an essential part of our training.

Anesthesiology training Els

In the meantime the specialist training of my wife also progressed. She had good relations with the chief of training Dr. Pearce (an Englishman, no professor at that time, later to become professor in Amsterdam) and Prof. Nuboer, the generally feared head of the department of surgery.
But he knew his profession! In January 1962 the railway disaster in Harmelen, close to Utrecht, took place. The intercity to The Hague pierced itself into the left turning train local train to Amsterdam. 93 passengers were killed, 53 severely wounded. Most of the wounded were brought to our University Clinic in Utrecht. There it was pandemonium all over the place until Prof. Nuboer positioned himself in the waiting room at the entrance of the clinic and personally took the triage in hand. Then there came order in the chaos and the wounded were directed to the right department in the clinic. Personally we

were not involved in it. Els was working in another hospital in Utrecht and I was still in military service. There I also learned the basics of triage. It was not part of the medical curriculum.

It should be mentioned here that Prof. Gerlings, the chief of our hospital department, had a secretary, Loes Oosterdijk. I saw her quite regularly. If I as a resident had something to discuss with the professor, she had to arrange it. She was in charge of the correspondence of the professor and also the typing of the draft of the new Dutch textbook otolaryngology. Prof. Gerlings was the chief editor.

She also did the typing of a small booklet with the essentials of Otolaryngology. Students at that time had some difficulties with textbooks, and they had pressed for a shorter booklet. Nobody in the department volunteered to spend time on it. It does not have a place in any scientific personal record. But I took up the challenge and volunteered to do the writing, initially still as a resident. The first edition came 1967, but there have been several reprints. Loes did the typing for this project. We still have some copies at home.

That was the end of my acquaintance with Loes. She was doing an advanced training at that time and she qualified as speech therapist. Subsequently she left the hospital and practiced as speech therapist in elementary schools.
Many years later we will meet her again in this story. At that time she was school speech therapist in Wychen, a place near the city of Nijmegen. That is where the Radboud University is situated. There around 1987 a Cochlear Implant program was being developed, just as we had done some time earlier in Utrecht.

I visited the otolaryngology department on several occasions over there, and so I met Loes again. But that story comes later.

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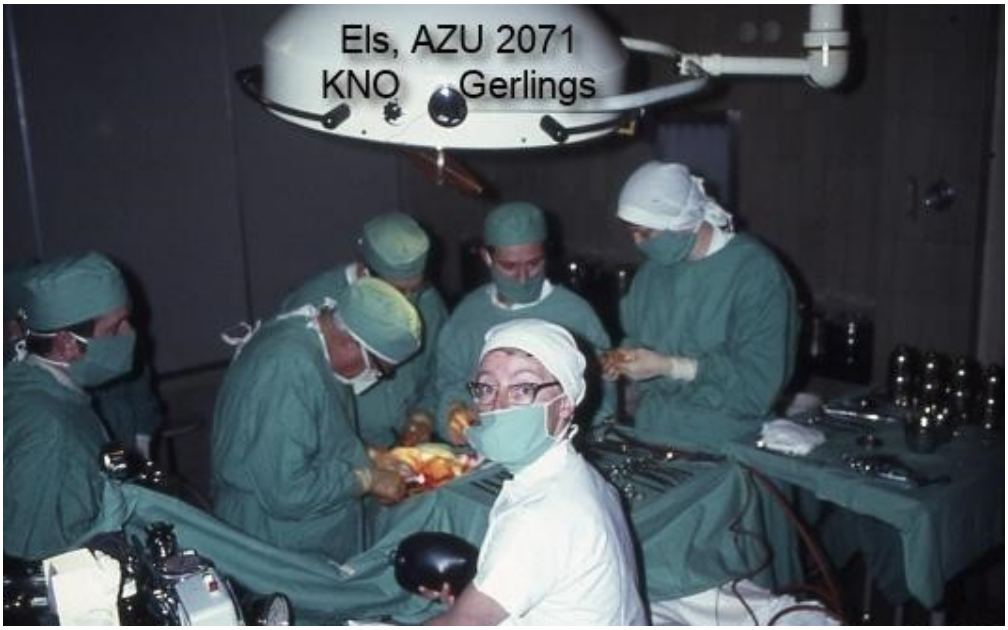
2 The years 1963-1973

My fulltime years in the Otolaryngology Clinic in Utrecht, addition to the family.

Addition to the family

The start of these years were stormy. Els was pregnant and we were both busy in more than full-time jobs. I was in the second half of my training, and this was the period with the focus on surgery. Els qualified on March 1, 1965 as anesthesiologist and carried on as staff member in our hospital, initially full-time, but after the birth of our son 3 days in the week plus on-call-service in out-of-office hours.



And there was the childbirth itself. We had a difference of opinion. I had the obstetrical department of our own hospital in mind. We both knew this facility well and we had our contacts there. But Els had another idea. She wanted it in our own home. That was usual in those days for deliveries by a midwife, but I preferred a real doctor instead. I really did not know how to arrange that. But Els had the solution to this problem; she wanted me as the doctor in charge. That was a bridge too far, and I refused. But I have not been able to change her mind.

This is certainly not the usual way, but looking back it was not irresponsible. We both were well trained in obstetrics in the Utrecht curriculum and I got during my recent substitution for general practitioners quite a lot of experience. Previously she was seen by a gynecologist, and he did not foresee any problem.
There was one problem however, but we had solved that already ourselves. That was high blood pressure in the second half of the pregnancy. The treatment of choice is ‘’no salt’’ at all. So we have banished all salt and salt containing foodstuffs from our home completely. That worked perfectly.
One get used to it in daily life quickly. Besides, we already knew it. In the hospital there were always patients on a salt-free diet and the remainders of the slices of bread were served to the medical staff during the coffee break.
The delivery on July 20, 1965 went undisturbed. The mother was on her feet again quickly, but it took Christian more than a year. Anke came 1½ year later, on December 22, 1966.
Els resumed her work quite soon, 3 days in the week. We had a nanny for those (often long) days. We knew her already and we could hand over the children without worry. Later on her younger sister took over the job until we moved to Amersfoort.
Worth mentioning were the financial consequences. We had both a salary from the hospital. These were added together, and the internal revenue tax was calculated according to our combined income. The tax-rate over the top was 72%. That meant that the remainder of the second salary was hardly enough to pay the nanny. But we were happy with it.

Training in Otolaryngology

The second part of my training went all right. Even before my registration I was already scheduled for laryngectomies without supervision. Els, who had been registered as anesthesiologist already, was not easy with that, when we were working together. That happened often. After our second child she worked mainly in the Otolaryngology department.

A real challenge were the on-call duties. We could not be on-call at the same time because of our young children at home. For anesthesiology there were more colleagues on-call, and for otolaryngology there was always a resident in the hospital.

Only once it went wrong. There was a child with a guilder in the esophagus, and that required intervention in general anesthesia. Therefore we both had to come to the hospital. It was a quiet Sunday afternoon. So we went to the hospital and we took both our children with us. The children (around 6-7 years old) were stationed in the office of the head nurse, and Els went to the operation theater to put the child to sleep. Then I got a signal and followed. Shortly after that the children managed to escape the head nurse and followed the corridor, where they had seen us disappear. In those days there was no lock at the entrance of the operating theater and they walked in, hand in hand, right into the place where the action was, which was the actual operating theater. They said that they were curious to see how we got the guilder out of that child.

In that time I also substituted, usually for only a day, in other hospitals in the region. One of them was the military hospital in Utrecht. 20 years later I met myself there. The military had moved to another building, and the old building had been converted into an office building. At that time in a part of that building the general administration of the Dutch Protestant Church was located. I returned there as I was later secretary of the Protestant Church in the city of Nijmegen, where I still live at the moment.

International experiences

During the period 1967-1973 we were both staff member of the University Hospital in Utrecht. In the autumn of 1967 I made a grand tour through the USA, with visits to an extensive series of hospitals and scientific institutions. It covered the Mayo Clinics in Rochester, Minnesota, the ‘’House’’ Clinics in Los Angeles, Stanford University (close to San Francisco), Chicago (Shambough), the laboratories in Ann Arbor and subsequently Boston (Schuknecht, Nelson Kiang). At the end Els came over to Boston, where she spent some time in the anesthesiology department of the Massachusetts General Hospital.

The children stayed that period with grandmamma Nikkels in Tubbergen, a small village where she lived.

In the USA we only visited top institutions. Here again, but now with more emphasis, I saw the backlog we had in Europe due to the Second World War, even 17 years later. It was a strong reminder for us. It showed the way ahead.

I also brought some medical equipment home from the US. They had an adapter that prevented the Zeiss operating microscope to get out of focus during the operation. That was a huge success. Prof Gerlings immediately ordered the purchase of another one for the second operating theater. We did not have that in Europe. I also brought suction-irrigators with me.

But I was interested also in cochlear implants. We knew that William House in Los Angeles was working on the topic, but he did not say anything when I asked him. But Blair Simmons in

the Stanford University in Loma Linda, near San Francisco showed me later in 1969 already his prototype.

Finally we spent a couple of days together in New York City privately. Travel was special, certainly in hindsight.
NYC is not far from Boston, but we had open flight tickets. These were accepted by all airlines. There was a financial clearing house, way back founded by Plesman, the director and founder of the KLM. So I tried to get reservations. This was not possible. We were advised to go the Boston airport and report to the NYC gate of the Eastern Airlines flights. There was no checking at all. The gate was opened, and we walked with our luggage to the waiting aircraft. At the back there was a small elevator, where we handed in our luggage. That disappeared into the aircraft, and we boarded through the regular entrance. We could sit here we wanted. During the flight the stewardess came around with coffee and for the collection of the tickets. Our open KLM tickets were OK. People without tickets could pay cash (it was before the time of the credit cards).
That was flying in the USA in the year 1967. If there were too many travelers, another plane an hour later was provided.
It was the only time I ever flew in a Constellation.

It was Saturday and we were early in NYC. We had reservations in a hotel near Columbus Circle. After checking in we walked to the nearby Metropolitan Opera. There were still tickets for the matinee and 30 minutes later a performance of the Marriage of Figaro was scheduled! We went in! That was our first experience with this famous institution. Many would follow.

Development of clinical work

At home the real job waited. I had seen a lot of news in our specialty and many ideas were suggested to me. Surgery of the parotid gland was one of them. The mixed tumors of the parotid glad were not very malignant, but they did come back after operation. And during the operation the facial nerve was very much at risk. So in Europe irradiation was the treatment of

choice. That was good for a couple of years, but recurrence was frequent.
Later in NYC I saw Conley operating these tumors. It was a pleasure to see him operating these tumors. He was a leading surgeon in this field in the USA. But he did it with the naked eye. So I thought ‘’I can do that as well as Conley, but not without the operating microscope’’. Later I mentioned that possibility to him, but he thought it was too difficult.
But I had already nearly a decade of experience with the operating microscope, and for me operating without microscope was more difficult than with it. So that is what I started doing in Utrecht with startling success.
Another innovation in this type of surgery was the use of a nerve-stimulator to search for the facial nerve in the parotid gland. Initially I used my self-build nerve stimulator from my physiology time for this purpose. But that one was rejected by the hospital and very quickly I got a new professional one.
Together with the pathology we also developed the ‘’thin needle’’ biopsies, which provided us pre-operatively with an accurate diagnosis. The ‘’open’’ biopsy often caused un-necessary spreading of the tumor.

Another new development in these years was the use of the microscope at the laryngoscopy. That is a much more accurate approach of laryngeal pathology than with the conventional direct laryngoscope, especially in the treatment of benign processes. At some time we received a box with the necessary instrumentation. Prof. Gerlings entrusted me with this procedure. We did some trials without patient. And then we had to find a suitable patient. That appeared to be the chairman of one of the student associations. Conventional laryngoscopy had already failed repeatedly to remove his vocal cords polyps without recurrence. With general anesthesia and the operating microscope this could be done more cleanly. Together with good counseling, and speech therapy he was cured at last.

Another point of attention was the cooperation with the neurosurgery. There Prof. Verbiest (neurosurgery) had developed together with Prof. Gerlings the transnasal approach to tumors of the hypophysis. I had already joined them. After

the retirement of Prof. Gerlings in 1972 I took over that job. We also introduced the operating microscope in that type of surgery.

My own activities in this period were focused upon training of residents and clinical work in otology and oncology. This is an unusual combination in a big department, but that is the way it went.

Later I got offers for senior university positions in both fields. But that was much later.

Building a new out-patient department, extension activities

In this period an important investment took place. It was the building of a completely new out-patients department, next to our main building. In the basement an acceleration rink was projected. But Prof. Groen never saw it finished. It was intended for basic research of the organ of balance, but funding was only provided for direct patient related research.

But very early we did get our first computer. It was an ‘’Evoked Response Computer’’. This computer used averaging to display the auditory response in the Electro-Encephalogram in humans.

Move to a new home in Vleuten in 1970

In the mean time we were looking for a new home. Our apartment in Utrecht was too small with 2 children; kitchen and shower were filled to capacity, there was no central heating and the location on the third floor became an obstacle. So we started looking for a new home. We found it in Vleuten, a small village, 10 km west of Utrecht. It had not been built yet. So we had to wait, and we were able to arrange for an extension. There was a garage, which we converted into an extra room. And we added a large garage, which could be built aside this extension. But it was 1970 before we could move.

That home was perfect.

Retirement Prof. Gerlings 1972

Prof. Gerlings left our Otolaryngology department in 1972. The consequences were negative. The university had to

economize at that time and the occasion was used to obtain a reduction in the staff.

The result was reduction and no investments for new developments. And that was a problem for the succession.

It was also the case in the audiology. Prof. Groen died in 1973, and that department was reduced as well.

The retirement of Prof. Gerlings had consequences for both of us. For me the future of the department was an open question. I could expect increasing workload, without the pleasure of renovation and new developments.

Els had also been working in our department with pleasure, but for her the strain was increasing as well. For instance: she wanted routine Electrocardiographic monitoring during

operations. Some years earlier she had seen that in Boston. In our hospitals at home this was not available anywhere. She wanted that in her operating theaters, but it was refused.
Eventually she obtained equipment paid by the Otolaryngology budget and Otolaryngology was the only operating theater with continuous ECG monitoring anywhere in the university hospital.

We both expected a difficult time ahead, and we started to make up our mind.
There was another hospital in Utrecht, where I was welcome, but I started to look around. It appeared that the regional hospital in nearby Amersfoort, where I already had my contacts and friends, had an opening for me.
We both have been struggling with the problem. The end result was movement to Amersfoort. I started there in Otolaryngology, Els was happy with a period of less strain and more time with the children.

Amersfoort: altogether this led to another move, already in 1973, to Amersfoort and to a new practice in the regional hospital ‘’de Lichtenberg’’ in Amersfoort.

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3 - The years 1973-1985

Otolaryngology practice in Amersfoort, part time in Utrecht
LSV (national organization of medical specialists)

Amersfoort

The move to Amersfoort in 1973 came quite natural. We had decided to leave the university in Utrecht. The next step was: what now? There were more possibilities, but I knew the regional hospital in Amersfoort already; I had already been working there from time to time. And I had been living in Amersfoort until my 18's year. My friend and former colleague in Utrecht Hans Venker was already working there. Later Gerrit Pluimers, also from Utrecht, would follow.
The hospital in Amersfoort was distinguished by good internal relations between direction and all other people, who were working there.

The other point was that my wife fully supported this move. She lost her part-time function in anesthesiology, but working in Utrecht had become less engaging for her. A couple of years later, when the children were somewhat older, she has been working as teacher in the local training institution for nurses, and she enjoyed that job very much.

Looking behind, the move to Amersfoort has been a very wise decision.

There was a warm reception in ''de Lichtenberg''. My background in Utrecht pushed me quite soon into the multidisciplinary ''oncology team'', with weekly meetings. After a while these were attended by Prof. van Peperzeel, who became professor of radiotherapy in Utrecht in 1972. This fitted very well and patients from Amersfoort could be treated in Utrecht directly with the specialists in Amersfoort as part of the medical team.

There was also membership of the executive committee of the Dutch Society of Audiology.
But most of my administrative work that time was my function as secretary of the medical staff of the Lichtenberg 1975-1978.

There was a new project, which was the drafting of the (first) policy plan of the medical staff. That task fell into my lap. It was subsequently approved by the medical staff and became the forerunner of later policy plans by my successors.
Ultimately it played a part in the fusion of the 2 hospitals in Amersfoort. But that was 20 years later.
It was a pleasure to work in de Lichtenberg.

Part-time in Utrecht

In Utrecht my decision to move to Amersfoort came unexpectedly, and was not very opportune. That led to the offer/request to continue coming to Utrecht, one day each week. This was especially meant for the oncological surgery.
I was not free to accept this request; I had to get the green light from the hospital board and from my colleagues in our practice in Amersfoort. But they complied with the request and it was granted.
Another point was that I wanted to see my patients in Utrecht some time before the operation, both for counseling of the patient, and for myself for the planning of the operation.
That required some arrangements, but it has been functioning very well.
This part-time function in Utrecht has lasted from 1973-1988.

Part-time in Utrecht 1973-1980

As suggested before, the succession of Prof. Gerlings by the faculty in 1972 did not deserve a prize for beauty. Staff and budget were reduced and Prof. Groen had died. Unfortunately there was stress in the training of residents, and I got a mayor responsibility with my 25% contract. That included the oncological surgery and some function in the training of residents. Luckily I was treated very kindly, but it was quite a challenge.
There were worries about the continuation of the license for training of medical specialists. The faculty responded by hiring Prof. Struben, the emeritus professor in Rotterdam, but he did not involve himself in patient care and training. His function was external relations.

Another worry was the availability of sufficient support for the otolaryngology by the department of anesthesiology. Els had left the anesthesiology department at the same time, and the anesthesiologists were split up between the 4 operating theaters in the Hospital.

Dr. Pearce, the head of the anesthesiology department had left Utrecht in 1969 to become professor of anesthesiology in Amsterdam. His successor wanted more centralization of the anesthesiology in the hospital. This was understandable, but that required centralization of operating theaters. And that is difficult in a hospital with 4 main buildings. Far reaching changes for post-operative care in otolaryngology were proposed, with relocation of the patients after operation away from our department, where we had the trained medical and nursing staff. It threatened to damage the quality of our work. My opinion was not asked, but it was obvious that I did not like it.

Then there was an incident with involvement of myself, and also anesthesiology. From the side of anesthesiology the word ‘’disciplinary council’’ was mentioned. However, thanks friends in the hospital, I got an advantage in knowledge, which led to a favorable outcome for our department with in the following years good anesthesiology service. So that was one problem solved.

Part-time in Utrecht 1980-1988

Everything changed with the appointment of Egbert Huizing as professor in otolaryngology in 1980. With him there also came funding for investments in staff, new development in our specialty and for an update of our building.

In the following years we could welcome new staff members, Kees Graamans, Adriaan van Olphen, Herman Lubsen and later John de Groot.

In 1982 Gert Jan Hordijk was appointed as professor with the special task the oncology.

In this constellation the department prospered again.

For me everything changed as well. The daily activities in the Clinic were no longer my concern. And the otolaryngology department was firmly anchored in the faculty again. I could

Prof. E.H.Huizing

have taken my leave, but I was asked to continue my staff membership. Special projects became my focus of attention. I still played a part in the training of residents, but the focus was on the cooperation with the neurosurgery, the surgery of the parotid gland and the project ‘’Cochlear Implant’’.

In the mean time together with my colleague Kupperman, I was busy writing a booklet about ear surgery. It was part of a long series of booklets about special topics in medicine for general practitioners and others outside specialized clinical medicine.
This booklet was published as nº 118 in that series in 1978.
Years later I found in a second hand bookstore a whole pile of these booklets as special offers. I bought the whole pile, and distributed them among our residents in training, but also to the nursing and the operation theater staff in Utrecht and Amersfoort. It was very much appreciated.

Renovation of the operation theaters in Utrecht

Another point was the renovation of the 2 operating theaters in our hospital department in Utrecht. The update was long overdue. There was some extra space available because the small X-ray facility in the original planning (1960) was not in use anymore.
The construction department of the hospital informed itself ‘’thoroughly’’. Out came a beautiful concept. It arrived during absence of the professor, head of our department. They were in a hurry, and they needed our approval quickly. I was next in line and I happened to be around at that time. So the secretary showed the papers to me. The renovation was very well designed, but to my horror I saw that there was something missing. That was the coffee-room within the Operating Theater.
And that happens to be a vital point in the day-to-day running of a surgical department. That is the place for information exchange, planning the next day etc. It is also an important place in the training of residents. And it is always nice to have a cup of coffee between two operations.
So I copied the drawings of the construction department on graph paper, and took the whole lot with me home the same day.
During evening (and night) I went to work out an alternative with coffee room. That implied a lot of changes, but without moving supporting walls and the main machinery.

Initially when I presented the next morning my alternative in the construction office there was skepticism all over the place. But I persisted and at last they had a good look at my drawings. The conclusion was that they would take my modifications seriously. Feedback was not given. But in the subsequent drawings from the construction office my changes appeared to be taken over completely.
And that was the case in the final construction as well.

Hip-fracture Els

For us personally there was a tragic event in 1983. Els broke her hip in rather small incident with her bicycle. Recovery was slow and not to normal function. Problem was a Südeck dystrophy. The revalidation was also slow and painful. In retrospect it was the harbinger of more trouble in the years to come.

LSV- National Association of Medical Specialists 1982-1991

After my function as secretary of the medical staff in Amersfoort I was asked to be candidate for membership in the Central Counsel of the National Association of Medical Specialists (LSV), presently Federation of Medical Specialists and I was subsequently elected.
That was a completely different story.
This organization had two permanent committees, the Committee for professional interests, and the Committee medical staffs. I became member of the second one.

One of the first topics I had to deal with was day-treatment. As an Otolaryngology specialist I was expected to have a good view at this. Day-treatment was advocated by patient associations and insurances, but for completely different reasons. There was generally no support for this within the profession and in the hospital boards. So policy had to be developed. It was now up to the LSV to draw up a position statement that could lead to consensus. The starting points were quality and safety in day treatment. Progress in this file is only justified when these are guaranteed. And many variants

are possible there. If someone has an operation on his leg, you cannot let him go home in the evening if he lives 4-high in an apartment without an elevator, but you can if it has an elevator. Co-morbidity also plays a role. I have been able to use these and similar points later in national negotiations with insurers successfully. Their original approach was that every code for a procedure or a disease had a fixed label for clinical or day treatment. That was not good, and it never happened.
In my report I have put our point of view in a penetrating way.

Another project that I started working on my own initiative was a model policy plan for medical staffs nationwide. I already had written something like that for our hospital in Amersfoort and I then drew up a draft Model Policy Plan for Medical Staffs for the LSV. That has been improved and supplemented from all sides and has led to an initial "final" release.
As in Amersfoort, it was the first in a series.

Disappointing in those years was that most of the energy in the LSV was aimed at defending our work against the constant attacks by mainly the government, through tariff measures and budgeting. It was disappointing because these measures did make headlines for the government, but did little to curb the rising costs of public health as a whole.
The government has missed opportunities there at that time. The conflicts with the specialists were a cover for failing government policies on the issues that really mattered. I am thinking of the bureaucracy that was already increasing at that time, the stiff relationships with the pharmaceutical industry and the often inefficient use of capacity.
The only means the government used here was budgeting. This led to waiting lists and vacancy in the month of December. In January this had to be made up again from the budget for the following year. And so on.
This could have turned out differently in close cooperation with the medical organizations, but politicians preferred the conflict and the headlines.

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4e period, 1985-1995

Disease Els, Practice in Amersfoort
Part time practice in Utrecht until end of 1988,
Membership professional organizations.

Els

In 1983 she had broken her hip, followed by a Südeck dystrophy, which meant that recovery and rehabilitation took years. Gradually it went into the right direction. But in 1989 during a holiday in Austria I noticed that she was a bit insecure, as befits a beginning ataxia. This was reason for neurological consultation. It was indeed a neurological condition, but a cause could not be found, let alone a therapy. There was not even a name for it at the time.
At first she was extensively examined in the Lichtenberg, later in the Academic Hospital in Utrecht. But it actually didn't yield anything.
It was a sad situation for all of us.
In the meantime she became increasingly disabled. A walker came, but once it was there, there was already so much progression that a wheelchair was needed.
We had good domestic help. In addition, there was a lot of professional aid and assistance from different disciplines coming to our home.
Earlier we decided to look for a new housing, smaller and with everything on the ground floor. We had bought that house on Zandbergenlaan 39 in Amersfoort on drawing and therefore it could be adjusted a bit. It was an extremely comfortable home. We moved there in September 1991. Unfortunately Els has been upstairs in that new house only once.
It was a very difficult time. I had quite a lot to do, both in Utrecht and Amersfoort. Apart from a complete termination of the practice, I might have been able to reject something, but that would not have made much difference. At least it was also clear to me that there would be a natural ending. And therefore I did not want to cut lines to future professional practice.
Els did indeed deteriorate further in a few years and finally died in her sleep at home on March 25, 1995.

My part-time job in Utrecht

Everything changed from 1980 with Huizing as professor. For the time being I still had something to do in oncology, but in 1982 Gert Jan Hordijk was appointed professor with a special focus on oncology.
Everything changed for me too. The day-to-day affairs were no longer my concern and the Otolaryngology was now firmly anchored in the faculty. In fact I could have said goodbye, but I was asked to continue my position. Subprojects then became my focal points. Apart from contributions to resident training this was especially the case in the field of parotid gland surgery and the Cochlear Implant project.
Later in this booklet there is a separate chapter about this latter subject.
Another story concerned the relationship with neurosurgery. Here Prof. Verbiest was succeeded in 1981 by prof. Tulleken.
With him the operation microscope also entered neurosurgery. In previous years, Gerlings and Verbiest had introduced trans-nasal hypophysectomy. I was now invited to take that over. I had seen some of that before, but it was really new to me.
Later, the translabyrinthary approach to acoustic neuromas with microsurgery was also introduced, as developed by William House in Los Angeles. We will meet him again at the Cochlear Implants in Utrecht in the second half of the 1980's.
At the end of 1988 I said goodbye to the Clinic in Utrecht. My functions were taken over without ripple by the younger staff members Kees Graamans, Adriaan van Olphen (cochlear implants), Herman Lubsen and John de Groot.
Gert Jan Hordijk had already taken over the oncology in 1982.

Practice in Amersfoort

That was the core of my work, especially in this decade. I felt very much at home in the Lichtenberg and working there was a pleasure. We had an excellent partnership together with Hans Venker and Gerrit Pluimers.

However, changes came on the horizon. Our building was from the 1950's and the St. Elisabeth Hospital (EZ) from the 1960's.

We already worked together a lot at the level of the medical staff, but the hospital boards could not pass together through one door, and the other employees were also reluctant to cooperate. So it was up to the medical staff to work towards a future merger. Fusion was inevitable. The buildings were outdated and there were no means and no need to build 2 new hospitals in Amersfoort. By the way, it would take until 2013 before a jointly new building could be taken into use.
As medical staff, we already had several umbrella partnerships, and more followed in the late 1980's. The EZ board had the condition that I would actually practice in the EZ. That was a bit of extra stress in the beginning, but after some adjustments it worked very well. The hospitals were also only 5 km apart and we ourselves lived halfway. Among other things, I contributed myself by taking policlinic outpatient's assistants back and forth. That was a good idea, because it created already some familiarity in this area and it was discussed on the shop floor widely.

Representation in professional organizations

My board participation in the LSV (National Specialists Association) from 1982-1991, with which the previous chapter ends, meant that I was asked to represent the LSV in four other organizations. These were 2 advisory bodies of our national government, the NRV and CVZ. These advisory bodies work with expert committees that report to the plenary. The final advice is then formulated here.
The other two were professional medical organizations. They were the SPMS, our professional pension fund and the UEMS, the European Union of Medical Specialists in Brussels, the umbrella organization of the national specialist associations in Europe.

1 - The NRV (National Public Health Council)

I was involved from 1986-1990. This was a very broad body, that could provide solicited and unsolicited advice on all kinds of matters. Usually it was about matters outside our field of activity, but I nevertheless took action once. It was geriatrics.

That was an emerging specialty at the time. In the draft advice, the NRV judged that all old people's homes were entitled to geriatric expertise, but with moderation. It was therefore proposed to appoint one geriatrician for each region, who would then be available for geriatric care in the dozens of old people's homes in the region. That was reason for me to intervene. Geriatrics was already emerging as a clinical specialty, and the work of the geriatrics is patient care. I have asked how people imagine the work of this one geriatrician. If he wants to show himself in all institutions in this area, he is a peddler for at least a month. How does this compare with patient treatment? They had no answer to that. The advice was then expanded with a few sentences, but I did not hear about it anymore. The rapid development of clinical geriatrics has made all of his obsolete.

2 - The CVZ (College Hospital Facilities).

I was involved from 1985-1990. This is a completely different story. This College advises the Ministry on personnel, new construction, expansion and equipment in the hospital sector.

- Swimming pool:

A draft opinion of the relevant committee on a swimming pool at the Dutch Asthma Center in Davos in the Swiss mountains was presented to the plenary board. Originally this was a tuberculosis sanatorium. They had received a swimming pool as a gift from a sponsor, or rather a promise of financing for construction and furnishing. The Dutch government should decide whether to accept this. The committee's advice was not to accept this. The reason was that it would increase the running costs of the Center, and the need for this was not recognized. The reasoning was that if those asthmatics had to

swim for therapeutic reasons, it might as well take place in the pool in Davos village. And just that was the sponsor's reason. He wanted to offer asthmatics the opportunity to use a chlorine-free swimming pool. That chlorine was the bottleneck at the time. A chlorine pool is not compatible with the treatment of asthma patients. I raised that point in vivid terms in plenary. The plenary was initially deaf, until at some point the representatives of the patient associations in the College woke up. When they entered the debate, the draft opinion was withdrawn for further consideration. I do not know exactly how this continued. But I do know that there is a nice swimming pool in the recent new building of the asthma center in Davos, without chlorine!

- **Children's wards:** the next point was much more important.

It concerned children's wards in general hospitals. These had been targeted by governmental bodies as a possibility for increased efficiency – meaning cost reduction. A committee had been formed to draft a concept advice. This committee consisted of ministry officials and retired professors in pediatrics. They were asked to describe their view of an ideal children's ward and draft a pre-advice.
They fell into the trap and described a children's ward with high-medium- and low-care departments, all necessary facilities and specialized professional staff. That was well-done, but the committee was of the opinion that there was only room for a limited number of these children's wards in our country. But they had to be larger than the usual children's wards. That was no problem, for in this case the children's wards in all other general hospitals could close.
That would be a huge economy measure.
When I asked in the plenary meeting where the children with a broken leg, with a stuffy nose, with congenital orthopedic abnormalities should go, the answer was: they can also go to the department for the adult patients. That was the opportunity for me to outline in the meeting how a children's ward functions in a general hospital. There is a playroom, education can be given to children with a long-term hospitalization, etc. I turned

out to be the only person present who regularly worked in a children's ward in a general hospital. The representatives of the patient associations woke up at that time. Later they told me they understood that the pre-advice was about intensive care units.
But their eyes opened now anyway. There was some upheaval in the meeting and the chairman took back the pre-advice and promised on my advice that the preparatory committee with the retired professors of pediatrics would be expanded to include representatives of the surgical specialties. That would go through the scientific associations in those specialties. Within the LSV, it was then urgently ensured that these associations would take care that representatives in this committee were well informed and well-cut. The aim, of course, had to be to destroy the project. This is how it happened and we still have children's wards in general hospitals.
This story has been published in Medical Contact no 35, 31 August 2012, page 1936.

3 - the SPMS
(Foundation Pension Fund Medical Specialists)

This is an independent foundation within the framework of the pension legislation of the national government for the liberal professions. The board consists of medical specialists, who are elected by the professional group as a whole. The links with the profession are only informal, but close. This has been formalized by a position on the board of the Pension Fund for a representative of the LSV. From 1988-1991 I was able to fulfill that function. I had no expertise in the pension field. My function was the mutual relationship between SPMS and the LSV. In the latter I was member of the Management Council during that period. My main task was to exchange information and coordinate policy.
I was struck by the high level of expertise and commitment of our colleagues, as well as staff and external advisers. In hindsight, the SPMS was also very successful. During the recent pension crisis earlier in the 21’s century my SPMS pension has even increased (25% in the last 8 years!)

4 - the UEMS (European Union of Medical Specialists).

From 1986 to 1996 I was a representative of the LSV in this European professional organization and a member of the Executive Committee of the UEMS from 1996 to the end of 2002. In the last chapter of this booklet, the reader will find a personal report of my fascinating experiences in this organization under the title: "personal notes". I wrote that article in early 2017 at the request of the UEMS board as a piece of history documentation. It has been the final phase of my professional career, and not the least exciting.

Here I was struck by the high level of expertise and commitment of our colleagues and staff in this organization.

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We also had fun in the family (with Loes, 2004)

The Cochlear Implant, early years 1982-1990

The Cochlear Implant program in Utrecht,
E.H.Huizing-C.C.Leibbrandt

N.B .: This text regarding the development of the Cochlear Implant Program in Utrecht 1982-1988 is a shortened and somewhat edited form of the article by Huizing and myself in the Dutch Magazine for Throat Nose Ear Care, 16th volume no 4, October 2010, p. 192-197.

The hesitant start in Utrecht

In Utrecht, cochlear implants came into view of the then newly appointed professor, Egbert Huizing, as early as in 1980. Many projects were going on in this field worldwide, but always by collaboration between an Otological clinic and a Technical College. The latter did build the implants, but these were experimental and beyond our reach.

However, Huizing and Leibbrandt (then a part-time senior staff member of our department) had been in contact with several of these groups for some time and the item was put on the agenda of the department staff meeting on Friday September 1, 1982 as a future spearhead. At that time, resources in our clinic were available for starting a Cochlear Implant Program and putting together a multidisciplinary team with the necessary expertise. There was skepticism in the meeting, but it was decided to further investigate the feasibility.

However, no equipment was commercially available at that time. But in the early 1980's, the patent of the House-Urban group (Los Angeles) was transferred to the 3M Company and commercial production was started. At a symposium attended by us (CCL) in Erlangen at the end of September 1982, a representative of the 3M Company was present and the first contact about delivery was made. We chose the House-3M prosthesis without hesitation, because by far the most experience existed with this implant. At that time, all other equipment was still experimental and was only privately

available. Therefore, in August 1984, the 3M Company headquarters in Minneapolis was visited (CCL), where delivery was discussed in more detail. The production facilities were also visited. However, it seemed prudent to wait until the House-3M prosthesis was registered by the Federal Drug Administration (FDA) because it would reduce the likelihood of legal consequences in the event of failure.
In November 1984, the FDA finally granted approval, but only for domestic use in the USA. For export, an import license from the relevant country was required.
I then asked the Dutch Ministry of Health for an import license. The answer was that import licenses for medical technical equipment were not required in the Netherlands and were therefore not issued. Several contacts followed, but no import license. In the end, I myself drew up an import permit in English and sent it to my contact person in the Ministry of Health in the Hague, together with a stamped reply envelope, that was addressed to me on my private address. Finally, there was the question to be kind enough to copy this import license on stationery from the Ministry. And sure enough, after a few weeks my reply envelope came back with my text on the official stationery and a somewhat misty signature.
The document was immediately faxed to the 3M Company in Minneapolis!

In the same year, a core team was formed and preparations started. Over the next two years, work was done on patient selection, information, preoperative tests to measure sensitivity of the auditory nerve, selection criteria, surgical technique, postoperative training of implanted patients, and the social aspects of treatment. The team was expanded with this purpose and ultimately consisted of: A. Clemens, audiologist; Mrs. J.F.M. Dorjee-Albersen, social work; E.H.Huizing, chairman and coordination; C.C.Leibbrandt, otology, clinical selection, surgical aspects; A.F. van Olphen, otology, preoperative tests; Mrs. H.H.M.del Prado, rehabilitation; G.F. Smoorenburg, audiology and equipment for preoperative tests of the auditory nerve.

The first candidates and the first equipment

In the start-up phase, patient selection was the most important and most critical concern. As elsewhere in Europe (Vienna, London, Paris), it was initially decided to focus on adults, who had become deaf after their post-lingual hearing and speech development. Large numbers of patients were seen. However, only 26 of the first series of 136 applications met the primary selection criteria.

Who pays?

Finally, there was the problem of financing, because the price of a House-3M prosthesis was at that time (1985) between ƒ 40.000,- and ƒ 45.000,- (€ 18.000,- and € 20.500,-).
When starting a project like this, appeal to a health insurance company in the first instance is not productive usually, nor to a public-law advisory body such as the Health Insurance Council. Of course we did, but that soon turned out to be a dead end. Fortunately, the AZU board (medical director Mrs Els Borst) was sensitive to our ideas. It was not successful to have the project registered with the Development Medicine Fund, but the Direction of the Hospital promised to make prostheses available from its policy reserve in the run-up period. This was effected for three implants annually.

The first implantations

Finally, on February 12, 1985, the first implantation (CCL) with a single-channel House-3M prosthesis took place in a 28-year-old married woman who was completely deaf post-lingually without any other disabilities. Two other patients were implanted a few weeks later. No complications occurred and the results were encouraging. We were able to see progress on three fronts:
1. abolishing of the acoustic isolation,
2. support of the speech reading and
3. improved voice and speech control.

Thanks to the financial commitment, a second series of three patients could be implanted in early 1986. The main reason for choosing small series was that the postoperative care, the adjustment of the device and in particular also the rehabilitation had to take place in groups.
At the time, attention was also drawn to this new development through a number of publications in professional magazines. At the end of 1986, a report for the Dutch Audiology Association was subsequently written, in which the first experiences were recorded.
In 1988, the switch was made to the Nucleus 22-channel implant. During this transition, we received support from the Otolaryngology University Clinic in Hanover (Dr. Ronald Laszig and Prof. Lehnhardt). With this prosthesis a considerable improvement was achieved, especially of speech understanding. In May 1990, a patient with this prosthesis was demonstrated at the Otolaryngology meeting in Utrecht, where the operator van Olphen had a telephone conversation with the person involved from the lecture hall. The significance of the CI was then also proven in our country.

The Utrecht-Nijmegen collaboration

A few years later the Otolaryngology department in Nijmegen under the direction of Prof. van den Broek also started a cochlear implant program. There the first implantation was carried out in 1987, with a four-channel 3M-Vienna prosthesis. In contrast to the hospital management in Utrecht, Nijmegen chose to register a project with the Development Medicine Fund. At that time, in 1988, Nijmegen did receive the means to provide a series of adults with an implant in a three-year project, and later in collaboration with the Institute for the Deaf in St-Michielsgestel a second project with children.
It was very loyal of the Nijmegen group to involve the Utrecht team in a subsequent adult project in 1991. Indeed, moving together in a difficult conquest is wise.

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Some more personal comments

As mentioned above, patient selection was a difficult task, especially in the initial phase. I took care of the first intake, after which a process followed along with the other team members.
But prior to that, there was the question "how do we reach potential patients". Cochlear Implants were not known in the Netherlands and the traditional procedure with referral by otolaryngologists did not work. So some publicity was needed. Nobody was enthusiastic about that, but eventually an interview with a reporter from de Telegraaf came into the picture. I had to give that interview, so it took place in Amersfoort in the Lichtenberg Hospital. It has become a very nuanced and good report in de Telegraaf. And it has indeed worked; we now saw many patients with this type of hearing problem.

Before the interview I called my daughter Anke with the message that if she could come to the hospital immediately, she would feature with the device attached in the newspaper. She was there within fifteen minutes. I had a dummy of the external equipment of our implant available. We equipped her with the external transducer behind her ear. Her picture with external part of the device in place has featured prominently in de Telegraaf, on the front page.

At the end of 1988 I myself said goodbye to the 25% appointment at the Utrecht clinic and with that to my active role in the Cochlear Implant project. My functions have been taken over by Adriaan van Olphen, who has done a lot of work for years and brought the project to maturity. The scope of the work soon required someone who could take over my position full time, and Adriaan did an excellent job. I myself, but primarily patients and clinic are indebted to him for this.

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5- The years 1995-2005

Farewell to the Otolaryngology practice end 1996
Marriage with Loes October 1996
Liason officer and later Secretary-General of the UEMS.
Epilogue

Els' death was not unexpected. Yet it is very drastic. It has put a damper on my life for at least ½ years. Later I heard from fellow sufferers that they had experienced it the same way. Suddenly it is a very empty feeling.
Fortunately, the children have supported me enormously in this. Coincidentally, Christian would play a part in this in the very short term. He would come with me for a short trip to London. I was invited there by the Royal College of Physicians to speak about medical training in a European context. They were already Eurosceptic back then. Dates and tickets were set long in advance and Anke would help out at home those days. The departure date was the day following the funeral. I initially wanted to cancel, but eventually it went through. Christian has visited all kinds of technical matters in London and we attended 2 musicals. Details of that meeting can be found in the last chapter of this booklet, which deals with the UEMS.
On departure from London we were extensively examined at the airport. They mistook us for a mafia boss with a bodyguard. But that could be cleared up.

What now?

For the longer term, the question was "how to proceed now". I had practice in the 2 Amersfoort hospitals and also intensive involvement at the background with the UEMS in Brussels, the European Union of Medical Specialist. I had my neck sticking out quite a bit there and it was to be expected that I would be elected to the Executive Committee. That is difficult to reconcile with a practice in the Netherlands. Then I decided to stop in Amersfoort and aim for Brussels.
So we were looking for a successor in Amersfoort, but unfortunately that did not work, at least not in the short term.

Fortunately after 2 years a successor was found, and I was happy with her, but my colleagues in our Otolaryngology period did have a difficult interim period.

Loes Oosterdijk

Another point was that Loes Oosterdijk had reappeared in my life. We already know her as secretary to Prof. Gerlings in the Utrecht clinic, where I started my Otolaryngology training in the late 1960's. She became a speech therapist and left Utrecht in the early 1970's and also disappeared out of my field of vision. In the 1980's, when I got in touch with the Otolaryngology clinic in Nijmegen in connection with the Cochlear Implants, I met her again in Nijmegen. She was a speech therapist there.

We kept in touch after that. Initially, after 60 years of independence, she did not feel much about it; I was a widower, but in the end it was the run-up to our marriage. And we had a great time together.
The marriage ceremony was performed on October 19, 1996 on the Nijmegen Pancake boat during a cruise on the river Waal with a large group of friends and relatives.
In the meantime I had moved to Nijmegen, to a comfortable and beautifully situated apartment in the Belvoir complex on Trajanusplein, 33 Graadt van Roggenstraat.

Election in Daily Board UEMS

The honeymoon went to Oslo the day after the wedding. There was the semi-annual meeting of the UEMS. I had already discussed setting up a website there. I was able to fill that in when I was elected as a liaison officer on the Daily Board. The majority of the meeting was opposed against an own UEMS website because of the alleged high costs (it was 1996!). That is also true if you outsource it. They also doubted whether it made sense. The rest is history.
So I got the green light, provided it didn't cost any money. However, I already had a private internet connection thanks to the support of my brother Hans and our professional institution, which already had prepared this for its members. I thought I could use that website in the initial phase. However, that was not so easy. For example, we did not yet have a program to convert Word-Perfect texts into HTML. So that had to be done manually. My brother Hans has removed these and similar obstacles.
Ultimately, the website was a great success, and with minimal costs. We were miles ahead of the medical professional associations at European level.
In the following years I traveled alone or together with Loes for the UEMS. Every year there was a meeting in one of the European capitals and there were many invitations for lectures on various European matters for national medical organizations.
We also made a holiday trip around the world in 1999. When we returned, I was elected Secretary General of the UEMS. The years following that were especially labor-intensive years. The

reader will find a more detailed description of this in the last chapter of this booklet.

In Europe, conditions had changed radically as a result of the fall of the Berlin Wall in 1989. Medical organizations in the east had to be built from scratch there.

Quality policy had always been the spearhead of UEMS policy. In the past, this had focused on the content of European legislation and especially on the mutual recognition of diplomas. This was effected in 1975 and the European Union did not want to deal with further details through European regulations.

So it was now up to the profession. And there was desperate need to support the eastern countries with models and support for their necessary rebuilding of the structure of health care!

The UEMS picked these issues up and was able to incorporate the fledgling medical organizations in very short time, against considerable internal resistance.

I then resumed that quality policy, but in a completely different way. I aimed at professional national organizations and started lobbying to bring more European cohesion between national training programs. The time turned out to be ripe and it worked out wonderfully. It was done by collecting national data about training in the countries of Europe, and making them visible to the separate countries. With these data in hand discussions could start about bringing content of training closer together. Consensus was then codified in European Charters, concerning quality of specialist training and continuing education.

If there was consensus on this, national organizations were asked to implement elements of this in their own national regulations. This has also gradually happened.

Continuing training

Training is an important tool in quality development and I have addressed this separately. The European Union distanced itself from this and it was therefore on our plate. This mainly concerned the quality assurance of international refresher courses and the international recognition of refresher credits. When I started talking about these things in the late 80’s, they were hardly negotiable. Ten years later we managed to reach a

consensus on this. I already had contact with the American Medical Association, which manages the credit system for the training there. Mutual recognition of European and American in-service training credits was established in 2000 through this contact.
More information can be found in the last chapter of this booklet, which was written for the UEMS earlier in 2017.

Farewell to the profession

In 2002 I no longer stood for election. The main objectives had been achieved or were on track. The work was too heavy for me.
The UEMS had no funds for a permanent home in Brussels. I did as well as possible with 1 to 2 trips to Brussels each week in addition to the many trips to places elsewhere in Europe and the world. Furthermore, there was daily extensive telephone contact with the ladies of the Office Staff. My homework came by e-mail. My special thanks go to Mrs. Bénédicte Reychler, our chef du bureau. We worked very well together.
But then it was enough and from the end of 2002 I withdrew completely from my profession. It had been nice.
A more detailed report under the title "personal notes" of my experiences in Brussels can be found in the last chapter of this booklet.


Loes 2005, Venetia

Epilogue

We really retired in 2002. But we have not been idle in those years.
After leaving professional-related functions, I was a commissioner close to home for 10 years in our apartment complex annex hotel Belvoir. There one will learn other skills as well. For example, I made a booklet for our complex with a detailed overview of most of the general technical facilities with photos, information about maintenance, supplier and other relevant facts.
Furthermore, I was secretary of the Church Council of the Protestant Church in Nijmegen from 2005-2014. That gave a completely different view of the world.
All in all a busy existence.

That period from 2002 to 2015 has been a wonderful time. We traveled a lot. Hawaii and Tahiti enjoyed our interest with even two Pacific cruises around French Polynesia. We also visited less hurriedly many regions of the USA that I already knew, especially in the far west and California. Elsewhere in the world, we have been to Canada and Hong Kong. Closer to home it was mainly Austria and Rhodes, where we went.

From 2015 our action radius has become a bit more limited. Loes had broken her wrist, but also started to struggle with her health. Since 2008 I have also been required to visit the hospital as a patient myself regularly, including the operating theater. That was a nice experience thanks to the lumbar anesthesia and the viewing equipment. The 24 hours after that are less pleasant, but in daily life I have had no real problems.
With many thanks to my wife Loes Oosterdijk[1], my children[2] and everyone else who assisted me.

February 2018

[1] Loes died in peace in a nursing home in August 2019. I was with her. She had been hospitalized there since December 2018.
[2] My son Christian died in April 2020 in the Intensive Care Department of the University Hospital in Leiden with a Covid-19 infection. His wife Shari was with him. See also page 63.

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DEN EUROPEISKE FORENING FOR LEGESPESIALISTER
EUROPEISKA SPECIALISTLÄKARORGANIZATIONEN

Secretariat-Siège:
BE-1040-BRUSSELS
Rue de l'industrie, 24
e-mail: info@uems.eu

Tél: +32-2-649.5164
Fax: +32-2-640-3730
www.uems.eu

History of the UEMS-EACCME®, personal notes

European Union of Medical Specialists
European Accreditation Council for Continuing Medical Education.

Dr C.C.Leibbrandt[3], UEMS Secretary-general 1999-2002

Accreditation of postgraduate and continuing medical education

Professional, national and European levels in the field of medical specialists

Historical notes 1986-2002

February 2017

[3] Dr. C.C. Leibbrandt
Graadt van Roggenstraat 33
tel: +31-24-360.7236
NL - 6522 AW Nijmegen, Netherlands
e-mail: cc@leibbrandt.net

History of the UEMS[4]-EACCME®, personal notes

European Union of Medical Specialists – European Accreditation Council for Continuing Medical Education.

Dr C.C.Leibbrandt, UEMS Secretary-general 1999-2002

Accreditation of postgraduate and continuing education

Professional, national and European levels in the field of medical specialists

Historical notes 1986-2002

1 - Early start of professional quality policy; the Charter on Postgraduate training 1993

When I became delegate on behalf of the Dutch association of medical specialists in the eighties, the prevailing mood in the UEMS Management Council was that quality of postgraduate training Europe-wide could be and should be accomplished by European Union legislation. This was a continuation of UEMS policy in the sixties and early seventies. In that period the UEMS and its specialist sections had been successfully providing the European Union the materials for the drafting of the ''doctor's Directive''. In this directive minimum requirements for the quality of postgraduate training were laid down. This was a condition for the required Europe-wide recognition of national diplomas of medical specialists.
The latter was part of the introduction of the common market by the EU, providing free exchange of goods, capital, people and services[5], including medical services.
Therefore the care of this directive was task of the EU Directorate Internal Market. Its focus in the medical sector is free exchange of diplomas and free movement of doctors. This became effective in 1975 with the Doctor's Directive[6] and its later updates (presently Directive 2005/36/EC). After that time quality of medical care became a side issue (and a nuisance) for the EU. Updating of the directive was limited to administrative details. The profession was expected to take care of quality policy by itself.

However, at that time the UEMS Management Council pursued its policy of producing motions, some concerning very trivial issues. These were sent by way of the Standing Committee of European Doctors and the European Union ACMT (Advisory Committee on Medical Training) to the

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[4] UEMS, European Union of Medical Specialists, www.uems.eu info@uems.eu
BE 2040 Brussels, Belgium, Rue de l'industrie, 24

[5] Free exchange of goods, capital, people and services: the four freedoms as formulated by the EEC (European Economic Community), the predecessor of the European Union.

[6] This was the only reference to health care in the original Treaty of the European Union. However, the Treaty of Maastricht (1992) put Public Health on the agenda of the EU. This was incorporated in the Directorate of Social Affairs of the EU. It is outside the field of curative medicine.

Directorate of Internal Market. The idea was that these motions would be incorporated in later updates of the Directive.
I did some research into the effectiveness of this approach, and came to the conclusion that this was a dead end[7].
In the plenary UEMS Council meeting in Athens October 1986 there was some concern about this matter, but the discussion was confused and the president (dr M.Fanfani) broke off the discussion without conclusion and adjourned for coffee break.
Subsequently during a chance meeting in the lavatory of the Athens Conference Palace I ventilated my concern to Jacques Gruwez[8]. He shared my feelings and we decided to do something about it.
We gathered some younger colleagues in the UEMS Management Council and together we started the preliminary UEMS ‘’Harmonisation Committee”, initially rather informal. Formal establishment of this committee by the Management Council took place in 1988. Jacques Gruwez became president, I was secretary.
Under the auspices of this committee I gathered the requirements of postgraduate training separately for each member state and for all specialties. This was a huge and time consuming task. At last the data were laid down in the UEMS Compendium (1992).
This compendium brought to light that the medical profession really had a problem in Europe, due to the wide diversity of postgraduate training content.
But at the same time there was a growing feeling nationally that existence of some sort of European standard might be helpful for national organizations to improve their level of postgraduate training and facilities.
Bringing up the requirements for state of the art postgraduate training Europe-wide needed independent action by the profession itself. Therefore I started working on the first UEMS Charter in this field (postgraduate training). The subsequent draft evoked a lot of criticism in the Harmonisation Committee, which was endured by Jacques Gruwez with grace.
I evaluated all criticism and we did some networking. Half a year later we presented the draft with the required improvements. To our surprise it was adopted without much discussion in the Harmonisation Committee. It took some effort to convince the Management Council of the UEMS, but the Harmonisation Committee provided the necessary drive, and the UEMS Charter on Training of Medical Specialists in the EU was adopted with a

[7] The ACMT (Advisory Committee Medical Training) is an institution of the Directorate Internal Market, set up in 1975, with the task to establish contact between the Directorate and representatives of organizations in the field. Its advices are only rarely taken over in the updates of the Doctor’s Directive. Furthermore, the ACMT had in fact been powerless most of the time due to lack of funding.
[8] Jacques Gruwez, head of the Belgian delegation in the UEMS, professor of surgery in Leuven.

substantial majority by the Management Council (president dr A.Kuttner) in its Berlin meeting October 1993.
For the following Charters the same procedure was followed. That went much easier.

2 - Continuing Medical Education and Professional Development[9], Charter 1994

In the mean time I had been thinking about CME. Traditionally Continuing Medical Education had been free of obligations and rules in the countries of the European Union. But in the early nineties awareness was growing that this could not be continued. And it was clear also that the profession should take the lead in developing quality control, both in postgraduate and in continuing medical education.
In my own country (the Netherlands) there was already a functioning system of accreditation of CME and awarding of credits in my own specialty Otolaryngology. But I had also seen a lot of practice in this matter during my frequent travels to the USA. In those days I was heavily involved in the development of ear surgery and head and neck surgery (that could be done together in those days) in the university hospital in Utrecht.

So in the UEMS I focused on CME as well. This was more difficult. The prevailing mood in the European countries was that CME was an individual responsibility. Very evident deviations should be taken care of by disciplinary measures. But the mood was changing. So I started again in the UEMS Harmonisation Committee to lobby to get CME on the agenda. It was an uphill struggle with initially not much support. But due to the efforts of Robert Peiffer, at that time secretary-general of the UEMS, as a first step agreement on a UEMS position paper on CME was achieved with the support of the UEMS specialist sections (June 1994).
In the mean time I was a step further. I had been working on a Charter on CME using bits and pieces from several countries and associations. It was a hell of a job to get some form of consensus for this document, again starting in the Harmonisation Committee. But it was approved in the UEMS Management Council meeting in October 1994 in London (president Mr L.Harvey) with not too many abstentions and just one vote of the delegates against (without any explanation).

Just as in postgraduate training there was a growing feeling nationally that existence of some sort of European umbrella organization for CME

[9] CME, also more accurately called ‘’CPD, Continuing Professional Development’’. For easy reference in this document the acronym ‘’CME’’ is used exclusively.

outside commercial interests would be desirable. Most doctors were already familiar with this phenomenon in the US. So there was work to do. But it went slowly.
We did not have actual plans for a follow-up at that time. In the years afterwards our first task was to gather support from national organizations of medical specialists in Europe. This also was an uphill struggle and involved a lot of traveling and usually a lukewarm reception.
Among others I was invited by the Royal College of Physicians in London to present the case for a European approach in March 1995. I was not in the best mood at that time (my wife had died a week earlier) and I was treated in the discussion rather roughly. Just as in 2016 the UK was weary of European structures. But after the meeting the president came to me and said ‘’you are on the right track, please go on’’.
Another accidental meeting during that meeting is worth mentioning. As I mentioned before, in the October 1994 meeting there was one vote against the CME Charter. The delegate concerned explained to me afterwards that he considered any ruling of CME unethical. But in London the president of that particular national association happened to be present. I sat down with him during lunch and told him what had happened in Brussels and asked for an explanation. He exploded, stressed that the vote was against policy of his organization and promised to do some homework. The result was that we never saw that particular delegate again in Brussels.

3 - EACCME®, establishment and early history

Progress was slow in putting together the elements of a working European structure. It was envisaged as a clearing house for CME credits, but it soon became a structure that we called the European Accreditation Council for CME (EACCME®). Basic principles had to be defined, as well as principles of operation including a financial paragraph. In comparison with other CME organizations the UEMS was operating on a shoestring and there were predators around.
At some time I was invited to join a meeting of executives of a large European Association in a particular specialty. It was held in a small castle outside Brussels. I arrived there by train (second class). I just saw the president of the meeting arrive in the biggest Mercedes I have ever seen. Snacks and drinks were excellent. In their meeting a European Accreditation *Committee* on CME (EACCME) to organize CME in their specialty was presented. My contribution was that establishment of a European CME structure by specialty seemed to me unwise. There was need for cooperation. Back in Brussels my first job next day was the setting in motion of European registration of the acronym EACCME and its meaning. We just beat them.

A lot of thought was given in those years to defining principles and quality requirements for the accreditation system for CME credits. This process and its outcomes are described in the UEMS papers[10] extensively and do not need to be repeated here.

A very positive point was our relation with the AMA (American Medical Association). One of our section members reported to the UEMS office in Brussels, that he had met an AMA representative during a European scientific meeting who was there as observer. His task was to evaluate a request by that particular society for AMA CME credits. His report was not taken very seriously at first, but it crossed my desk and I contacted the AMA. There my letter reached the desk of Dennis Wentz, who appeared to be looking for some form of structured awarding of American credits to European CME activities. Therefore he needed contact with a European umbrella organization of European national professional associations, and the UEMS was just what he was looking for.

Loes with Dennis Wentz in Munich (2003)

[10] A summary is given in the 2008 document ''A history of the UEMS-EACCME on the occasion of the UEMS 50th anniversary symposium in 2008.

Dennis Wentz together with his right hand man Mike Gannon came to Brussels in November 1997. There the executive committee of the UEMS (of which I became member in 1996) met with them. We quickly discovered that our organizations were very different but our goals and background very similar. So it was decided to proceed to cooperation. A Letter of Intent was drawn up and approved. Furthermore they offered assistance where ever it was useful.

In June 1998 I went to Chicago to present the case to the Council of Education of the AMA. My presentation was favorably received and the green light was given for cooperation of the AMA and UEMS / EACCME in the field of reciprocal recognition of European and American CME credits. However, I was mandated by the UEMS, but the Council of Education of the AMA was not. That needed the approval of the Chief Executive Officer of the AMA (past Surgeon General of the US Air Force), and he was not available due to the pressures of the AMA General Assembly taking place at that time (which is a huge affair with more than 1000 delegates).
However, quite accidentally I met him under 4 eyes in the revolving door of the hotel where the meeting took place. He saw my tie, which was (quite accidentally) a tie of the Dutch Air Force. He pointed to the tie and asked: “what is that”. I saw the opportunity and explained that I had been a medical officer in the Dutch Air Force long ago. He asked then, in which airbase. This was Soesterberg Airbase, and he said ‘’that is where I have served as well’’ (there was an American squadron on that very airbase in those days). His next question was ‘’what are you doing here?’’ I explained (all in the revolving door) that I was representing the UEMS and was discussing with the AMA Council on Medical Education the possibility of exchanging CME credits between the European Union and the USA, but that we had not been able to make an appointment with him. He said ‘’this mutual recognition is a great idea; let my people prepare the papers and I will sign them as soon as they reach my desk’’. And that is what happened.

In its October 1999 meeting in Vienna (president Mr L. Harvey) the Management Council of the UEMS formally established the EACCME® and also enacted the quality document D 9908. On the first of January 2000 the EACCME became operational. At that time the agreement with the AMA also became operational as a pilot project. In 2002 it became a formal agreement, which was extended every 4 years ever since.

4 – Conclusion

In hindsight the year 1986 mentioned above marked the shift of European medical specialist policy in the UEMS from lobbying European legislation towards independent European professional policy in our field. We did not know it at that time, but it was an opportune moment. 1989 saw the collapse of the Soviet empire and the start of the gradual integration of the former European Soviet satellite states into the free world and the European Union. The UEMS was able to provide models for independent medical organizations in those countries. I remember that there was pressure in those days from the colleagues in these countries to provide Charters and other material when the ink was still wet.

Still it took the UEMS nearly a decade to reach consensus and to formulate its European policy in the crucial fields of medical specialist training, continuing education and medical practice.

Its conclusions were taken up by national authorities, both medical and non-medical. This shows the principle of subsidiarity, which is anchored in the EU treaty. Contrary to general perception the EU does not show a trace of meddlesome EU policy in the medical field. The ‘’doctor’s’’ Directive 2005/36/EC in its article 25 states only minimum requirements for medical specialist training and the minimum periods of training are very short indeed (annex V-1-3). Further filling-in is left to national or in our case professional European organizations in accordance with the subsidiarity principle.

Life-long learning is specifically excluded from EU legislation in the Directive (preamble point 39). Member States should adopt the legal arrangements in this matter.

Unfortunately the medical profession is increasingly constrained by national organizations (for instance health insurance funds) and authorities in the member states, while on the other hand commercial multinational organizations are free to follow their own policy without hardly any limitations by European legislation.

There is no easy approach to these difficulties. Strengthening of the position of the medical profession itself in Europe is part of the answer. This what we should keep doing.

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Cees Leibbrandt

Curriculum vitae of Dr. C.C.Leibbrandt
cc@leibbrandt.net

Cees Leibbrandt, born 1935, is a Dutch otolaryngologist with training at the university hospital in Utrecht. His practice focused on oncological surgery and otology. He introduced the cochlear implants in the Netherlands.
He practiced otolaryngology in the University Hospital in Utrecht and in the regional Hospital ‘’de Lichtenberg’’ in nearby Amersfoort.
During his professional career he was member of the boards of several medical organisations in his country, both on local and on national level.
In 1986 the Dutch Order of Medical Specialists delegated him to the UEMS, the European Union of Medical Specialists, the umbrella organisation of the associations of medical specialists in the European Union.

Under his guidance the UEMS set up a program to harmonize and improve the quality of training and practice in the countries of the European Union. As secretary of this program he was instrumental in the codification of European requirements for postgraduate and continuing training of medical specialists. In the early nineties this resulted in the UEMS Charters for Postgraduate Training and Continuing Medical Education, still valid today.

In 1996 he retired from his private and university practice and became member of the Executive Committee of the UEMS, in which he served in several functions.
From 1999 till 2002 he was Secretary-General of the UEMS. In this period he founded the EACCME, the European Accreditation Council for Continuing Medical Education, which became operational in 2000. In this function he negotiated the agreement with the American Medical Association concerning reciprocal recognition of AMA and EACCME continuing education awards.
He is honorary member of the UEMS and bearer of the Hippocrates Award of the Global Alliance for Medical Education.

September 2016

Abbreviations:

AMA	American Medical Association
AZU	Academic Hospital Utrecht, presently: UMCU, University Medical Center Utrecht
C.I.	Cochlear Implant
CME	Continuing Medical Education
CVZ	Council Health Care Institutions (till 2000)
EACCME®	European Accreditation Council for Continuing Medical Education®
ECG	Electrocardiogram
EEG	Electroencephalogram
EU	European Union
EZ	Elisabeth Hospital (Amersfoort)
FDA	Federal Drug Administration (USA)
FMS	Federation Medical Specialists (earlier: LSV)
HBO	High School
KNMG	Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst: Royal Netherlands Medical Association
KNO	Keel-Neus-Oorheelkunde, Otolarygology
LSV	National Association of Medical Specialists Presently: Federation Medical Specialists
NRV	National Health Council (government)
NSB	National Socialist Movement (until May 5, 1945)
OK	Operation Theater
SPMS	Pension Fund Medical Specialists
UEMS	European Union of Medical Specialist Union Européenne des Médecins Spécialistes
UMCU	University Medical Center Utrecht
USC	Utrecht Student Corporation
UVSV	Utrecht Female Student Association

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Final note:

This extra page has been inserted at the last moment in commemoration of my son Christian, born 1965, also mentioned on page 18-20 and 47. He died in April 2020 as a victim of the world-wide Covid-19 epidemic.

He was a senior I.C.T. engineer at a Dutch Computer Company. Here he is shown at work during his week-end ‘’hobby’’ as technician in the Regional Broadcasting Studio in the province of Utrecht.
His other ‘’hobby’’ was curling. He was member of the World Umpire Team, and traveled widely to the Olympic Games and to many regional tournaments in the northern hemisphere.
He and his younger sister Anke (page 46) were the joy of my life. But Anke is still here. I count my blessings.
We all miss him, Shari, his Canadian wife, his family, his colleagues, his many friends.

Cees Leibbrandt, April 2020