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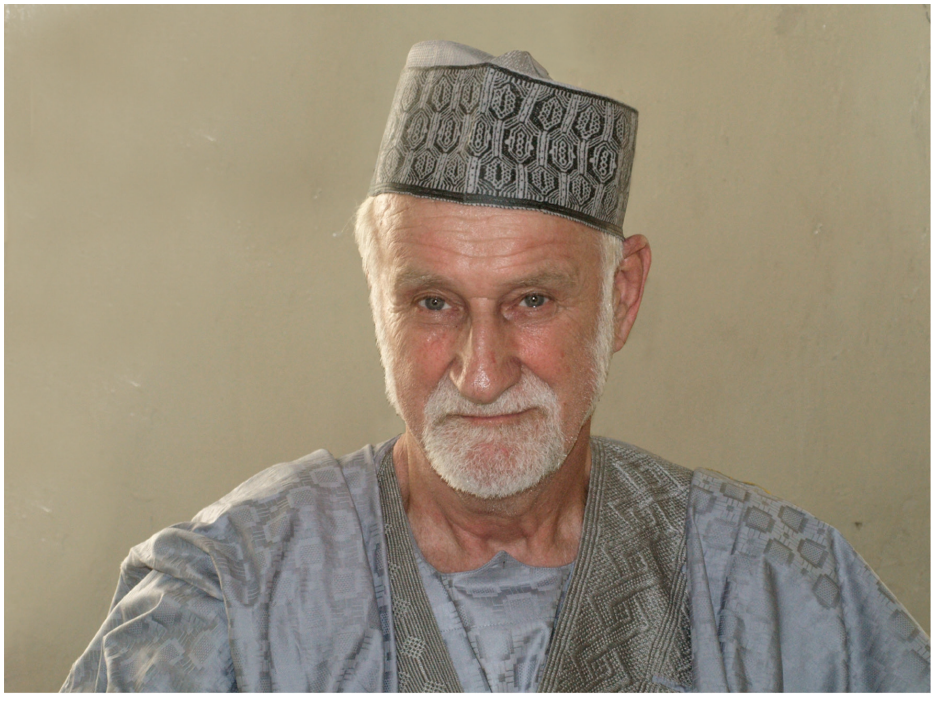
This section in Pelviperineology Journal, aims to interview the outstanding clinicians and scientists that had a special impact on the profession of Pelviperineology over the years.

Dr. Kees Waaldijk

Interviewers: Jacob Bornstein, Darren M. Gold, Pelviperineology

Dr. Kees Waaldijk is MD, PhD. He is one of the heroes in the fight against obstetric fistula. He is considered to be one of the most experienced fistula surgeons in the world. He has performed tens of thousands of repair surgeries throughout his career.

Dr. Waaldijk is also a master trainer in the International Federation of Gynecology and Obstetrics (FIGO) surgeon training program, and has trained hundreds of doctors, nurses, and midwives in obstetric fistula treatment. Dr. Waaldijk is committed to evidence-based practices and documentation of results. In the present issue of Pelviperineology he publishes his terminology of obstetric fistulas.



Dr. Kees Waaldijk wearing the traditional Hausa dress. After working for 25 years in Hausa land, one of his friends told him that he had to dress like the natives

• Dr. Kees Waaldijk, what is your background?

I was born in Amsterdam where I grew up, was schooled, and studied medicine. Having finished my medical education, I joined the army on a compulsory basis. Having served my time, I prepared myself to work in Africa with a postgraduate course in tropical medicine and further training in surgery and obstetrics and gynecology as required. Then, after further training in leprosy in Ethiopia, I moved to Kenya where I worked in a coastal district hospital as the only medical officer of health, with nine highly trained medical assistants for a population of some 250,000 persons, for 2.5 years, for all health aspects, with a special assignment on leprosy and tuberculosis. During these 2.5 years, I performed quite a number of surgical, but especially obstetric and gynecologic procedures. Returning to Holland for the secondary schooling of my children, I started a residency

training in obstetrics/gynecology which I resigned as I did not want to concentrate on that specialty alone for the rest of my life. I then moved to Germany to complete my training in surgery and traumatology and worked as senior physician in surgery for some eight years, where I obtained ample experience in all kinds of surgery and traumatology, including colorectal, thyroid, breast and some vascular procedures, including implantation of dual chamber cardiac pacemakers, all types of osteosynthesis and intensive care with parenteral nutrition. During this period, I spent six months as a military surgeon in the largest Cambodian refugee camp in Thailand where I witnessed the direct and long-term effects of conventional warfare. Eventually, I went to northern Nigeria for a leprosy control and care project where I met my destiny.

• How did you end up taking care of obstetric fistulas?

Actually, we found each other. Since there was no specialist obstetrician and gynecologist available in the whole of Katsina province, I went three times a day - morning, afternoon, and late night, to help in the maternity unit in Katsina town, in addition to working with leprosy patients. The worst cases I saw there were ten maternal deaths, 40 stillborn children and 15 internal version and podalic extractions because of a delayed labor with an arm prolapse for one week. I was approached by the staff to see if I could care for obstetric fistula patients. Although I had never performed a fistula repair, I had lots of surgical experience. I successfully operated on one fistula and then it continued. In the small leprosy hospital, I did my repairs in the morning and my leprosy field work in the afternoon, visiting 175 leprosy clinics where we asked if there were any obstetric fistulas as these should come to the hospital. The first 500 patients operated on, were treated in the same female ward and beds as the female leprosy patients, until we were able to construct a postoperative ward.

• What motivated you to continue your work with fistula patients?

From the time I was 12 years old there was only one thing in my mind: I wanted to become a surgeon and to help people in a developing country. Life is suffering, but some do suffer more than others. My drive was, is and will always be, to lessen the suffering within my possibilities in a professional way, out of compassion since we all have to die, but all of us do not have to suffer.

• What is your main achievement?

The immediate management of a fistula by inserting a urinary catheter and/or early closure instead of the previous approach

A 15-year-old girl supporting herself with home made crunches. She presented with a fistula and could not stand or walk due to the enormous obstetric trauma resulting from a prolonged obstructed labour. Dr. Kees Waaldijk had to wait for two months before she could be operated upon. Following surgery, she recovered completely, became dry and could walk normally. (The patient gave consent for publication of her photograph)

of laissez-faire, of doing nothing for 3 months; The active immediate management is highly effective and will prevent the woman from becoming an outcast.

• What prepared you to become top notch in your field?

Honestly, nothing, I never thought I would write a scientific article not to mention geting a PhD degree; it just evolved over time along with an accumulation of enormous experience with

The damage to that metal bed is due the uncontrollable leaking of urine by the patients who have been sleeping on it; this depicts the aggressiveness of the urine

the management of obstetric trauma, including the obstetric fistulas in all its forms.

• How did you proceed to determine what was the scientific truth?

I am still in a learning process, since the scientific truth of yesterday is not the scientific truth of today, which will not be the scientific truth of tomorrow.

• What did you first notice that alerted you that our current understanding of the subject was incorrect?

At an early state I noticed that the fistula was part of a far greater extensive obstetric trauma and that it could only be solved by a holistic reconstruction of the functional pelvic anatomy instead of concentrating on only closing the fistula.

• How did you know that you were right with your new approach?

I am a documentation freak; even though for years I did not have electricity, I hammered out on an old typewriter all the data including operation reports and follow up by an oil lamp and then later on, evaluating if what I was doing was OK or not; the high numbers were a curse since there was no time to think, but also a blessing, as they gave me a quick answer.

• Looking backwards would you have done anything differently?

I feel privileged that I am allowed to do all these positive reconstructive works, that I found in life what I was looking for - though I never knew what I was looking for… and that my work became my hobby. I achieved far more than I ever thought. However, I discovered everything myself the hard way; yes, the life of an obstetric fistula surgeon is not easy.

• Can you quote the main publications that reflect your achievements?

All my annual evaluation reports and my series “obstetric trauma surgery; art and science”. It includes so far 30 books, where I try to explain the obstetric trauma in relation to the functional pelvis anatomy, the characteristics of the enormous variety of trauma, the mechanism of action, and a step-by-step approach how to deal with these defects, in a systematic way. I directed it for a greater public in order to contribute, to lessen the suffering of the unfortunate women.

• Any advice to new physicians in the field?

Do your best to get your own insight and your own experience. Be honest to yourself about your own performance. This is how I performed in the most complicated challenge I ever encountered with obstetric trauma/fistula reconstructive surgery.