CATHERINE'S GIFT

STORIES OF HOPE FROM THE HOSPITAL BY THE RIVER

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MONARCH
BOOKS
Oxford, UK & Grand Rapids, Michigan, USA

First published in the UK in 2010 by Monarch Books
(a publishing imprint of Lion Hudson plc),
Wilkinson House, Jordan Hill Road, Oxford OX2 8DR.
Tel: +44 (0)1865 302750 Fax: +44 (0)1865 302757
Email: monarch@lionhudson.com
www.lionhudson.com

ISBN: 978-1-85424-955-5

Distributed by:
UK: Marston Book Services Ltd, PO Box 269, Abingdon, Oxon OX14 4YN;
USA: Kregel Publications, PO Box 2607, Grand Rapids, Michigan 49501

This book has been printed on paper and board independently certified as having come from sustainable forests.

British Library Cataloguing Data
A catalogue record for this book is available from the British Library.

Printed and bound in England by J. F. Print Ltd.

PROLOGUE

It's the rainy season in Addis Ababa. The day begins with a promise. At the hospital by the river, patients who are not confined to bed throw off their woollen shawls and gather in the sun to gossip. The girls groom one another's hair, sew and bicker and joke. Some, perhaps speaking a rare tongue, sit by themselves on the low stone wall by the outpatients department, or squat on the ground watching the activity. In this self-contained little world, walled off from the chaos of the city, there's always something to see – new patients arriving, mud-stained, stinking and weary after travelling on foot over flooded tracks, vehicles bringing medical supplies, *ferenji* visitors from another planet, gardeners tending the lawns and flower beds, workers regularly hosing away the puddles which gather under the waiting patients.

These are peasant women. The seasons rule their lives. They savour the morning warmth, for they know that by midday black clouds will begin to form over the hills which ring the city and the thunder will grumble like a cranky old man leaving a warm bed. At two-thirty the rain begins – they could set their watches by it if they owned such things – and it does not stop until late at night.

In the highlands where many of these women come from, the rains can cut off villages for weeks on end. When doctors Reg and Catherine Hamlin first began treating the women half a century ago they could always count on some respite at this time of year. But for the past few years the rainy season seems to have made no difference. Is it because there are more cases than ever? Or just because the hospital has become so well known? Whatever the reason, every day up to half a dozen women arrive seeking help.

Sometimes they are alone – bewildered and frightened by the brutal indifference of the city. Sometimes a friend or relative has come with them. A few, with injuries so severe they are unable to walk, are carried in. They come from the desert, from remote highland villages, from the plains and the rainforest. They speak 80 different languages. They are Orthodox Christians, Muslims, Animists, or sometimes a mixture of faiths. They all have one thing in common – they are suffering from the medical condition known as obstetric fistula.

It is a cruel affliction. Ethiopia has its lepers and cripples, as does any poor African country. The diseased and the lame and the mad are on any street corner for all to see. But if there is a scale of human misery, the fistula women are up near the top. Imagine, if you will, how life would be as a woman whose bodily wastes leak out constantly through the vagina – a vile-smelling trickle which you were unable to control.

They believe they are cursed by God. And you have to wonder what God had in mind when he allowed a woman's most cherished act, childbirth, to produce this outcome. No matter where they live, 10 per cent of all women will experience some kind of problem, such as obstructed labour, during childbirth. In the west they simply go to hospital and have a caesarean section or a forceps delivery. For a peasant girl in a remote Ethiopian village it's not so easy. She will squat in her circular hut, or tukul,

sometimes for days, trying to force the baby out. After a couple of days the baby inevitably dies. The prolonged labour, with the baby stuck in the birth canal, may cut off the blood supply to parts of the mother's body. The tissue dies, leaving a hole, or fistula, in the bladder, and sometimes the rectum.

Because they are so offensive to be near, fistula sufferers are invariably divorced by their husbands and banished from their village. Theirs are lives of loneliness and despair, often in some ruined dwelling away from everyone else, or they may be forced to beg for a living in the town. We are not talking about some minor medical curiosity here. There are 200,000 fistula sufferers in Ethiopia; two million throughout the world.

Amid the comings and goings, some of the girls may notice a tall, slim, grey-haired woman wearing a white doctor's coat, passing through the outpatients department into the main ward. Dr Catherine Hamlin is 83 now. She was 35 when she and her husband, Reg, also an obstetrician/gynaecologist, first came to Ethiopia and saw the plight of the fistula women. 'Fistula pilgrims', Reg called them, on account of the formidable journeys they made to seek help. Since then the hospital has restored more than 32,000 from wretched despair to joyous new life.

Reg died in 1993 but Catherine carries on, and at an age when most women are content just to reflect upon their memories, she is working as hard as ever. She is intimately involved with every aspect of the hospital, still doing rounds, still operating.

At the nurses' station inside the ward she consults her colleagues about tomorrow's list. There are seven cases of varying degrees of difficulty. She pores over the notes, contained in green cardboard folders. They give a brief history of the patient – how many days she was in labour, where she came from, how she got here, how many previous children she has borne, any medical information

that will affect her management. The doctor who did the initial examination has drawn a diagram showing the location and size of the fistula. Catherine chooses her cases. Let us meet one of them.

Amina Mohamed is twenty, a heart-stopping beauty with glowing black skin, finely sculpted features, and wide, limpid eyes revealing an alert intelligence. Amina comes from the eastern part of Ethiopia, where the land rises in a series of jagged ridges from the Awash River to over 2000 metres. Impossible country, this, for motor vehicles. If you need to travel, you go on foot, ride a donkey, or if you fall ill, must be carried on a litter made of poles and goatskin. It will be many hours, maybe days, before you reach a road, never mind a hospital.

In a developed country Amina would have the world at her feet. But here her future is ordained from birth. Marriage. Children. Work. Death. Eternity. Motherhood is the most important thing to her. Without children she is nothing.

When she was ten her father arranged her marriage to a boy from a neighbouring village; her worth – two goats and a cow. When the deal was done her parents informed her that she was engaged, which was kind of them; often a bride does not even know she is to be married until her wedding day.

At fourteen she was judged old enough to become a wife. On her wedding day her husband's parents held a celebration at their home. *Injera* was served, a kind of rubbery pancake which is the staple of Ethiopia, and a special *wat* (stew) of goat in honour of the occasion. The men beat drums and danced. The women looked on, wailing an unearthly ululation that signified approval. Amina waited alone in her parent's *tukul*, nervous about what was shortly to happen.

After many hours the wedding party made their way to her

village. Her father led her outside to meet her new husband. Hesitantly, she mounted the donkey he had brought, then, glancing wistfully back now and again, set off for her new home.

Like many Ethiopian children Amina was stunted due to her poor diet. At fourteen she had not yet had her first period. Her husband obeyed his parents' instructions not to touch his bride until she was a woman. In the meantime she did her chores, fetching water and firewood, grinding the grain for *injera*. She learnt the ways of the household and got to know her husband a little better. She missed her family. She was sometimes frightened at the thought of being a proper wife and having children, but comforted herself with the knowledge that she would only be doing what millions of other women had done.

At fifteen her childhood ended. Three years later she fell pregnant.

The first labour pains came in the middle of the night. She did not wake her husband as he had to rise early to work the fields. This was women's business. By dawn the contractions were coming at regular intervals. Her mother-in-law helped her from the straw mattress on its earthen platform at one side of the *tukul*, onto the floor. Her mother arrived a couple of hours later to assist. With the two women supporting her, one on either side, Amina squatted all that day, pushing and pushing, wracked by regular waves of pain.

By the time night fell the baby had not yet been born. Amina was very tired. She lay down on the mattress; sleep was impossible.

The contractions continued all that night and into the following day without any sign of the baby emerging. The two older women encouraged Amina to continue pushing, but by now she was so exhausted that she could no longer keep squatting. She lay on the mattress whimpering with pain, occasionally steeling herself to get up and try again. *Please let the baby come. Why doesn't it come?*

Another night. As the sun stole into the valley next day with

still no change, Amina knew that something was terribly wrong. She had no idea what to do except to summon all of her will to push and push against the pain. All that day, for hour after weary hour, the contractions continued. The older women knew that the baby must be dead. It was the mother's life that they feared for now.

That night when her husband came home from the fields the family discussed what to do. At dawn the following day, the third after her labour had begun, two of Amina's cousins helped her to her feet and led her gently to the pathway out of the village. She staggered forwards, pausing for support each time the contractions struck. One hour passed. Two. Slowly they made their way up and down the steep hills, every step a trial of endurance. After more than three hours they reached the road which led to the regional capital, Harar.

The cousins flagged down a truck. While the driver revved his engine impatiently, they lifted Amina onto the tray. For an hour and a half they bumped along the gravel road. Amina, drifting in and out of consciousness, was delirious with pain.

There is a small hospital in Harar but there was no one there who was qualified to perform a caesarean section. The outpatients nurse told the cousins that they would have to take Amina to Nazareth, a further 60 kilometres away. This time they caught the bus, arriving at the hospital in the early evening. This hospital was set up for emergency obstetrics. Later that night Amina gave herself up to the heavenly oblivion of anaesthetic. The doctor made a swift incision. The baby, of course, was long dead.

When Amina woke in the morning she was tired and weak, and her abdomen hurt where she had been cut. She looked about her, taking in the other beds in the ward, some people leaning over a patient, a nurse writing on a clipboard. Gradually she became aware that something was not right. It took her a few moments to realise with dismay that the bed was saturated. She

rose and shakily made her way to the washroom. She cleaned herself as best she could, but what was this? Her bodily wastes continued to leak, trickling down her legs onto the floor. The odour was terrible.

The hospital could not wait to get rid of Amina. She was discharged that same day, to make her way back over rough roads and winding pathways to her home. As daylight faded she made excuses to remain outside the *tukul* for as long as she could. She only nibbled at a tiny bit of food, and drank as little as possible. Before finally going indoors to sleep, she washed herself once more. That night when she lay down beside her husband, she kept perfectly still with her legs closed tightly together. In the middle of the night she was woken by her husband shaking her. Her clothing and the mattress were dirty. The smell was overpowering. Roughly he pushed her off the platform and ordered her to sleep on the floor.

Amina did not want her husband to see her like this. The next day she returned to her parents, thinking that she would stay there until whatever had broken inside her had healed. She went to the village well once but the other women turned away holding their noses, and one or two taunted her cruelly. After a few days even her parents could not bear to have her in their living quarters. She moved into a broken-down little hut which had been used to house farming implements. There she passed her time, dejected and alone.

So far this had been a typical Ethiopian tale – one that usually ends with a lifetime of misery for the woman involved. But someone in the village had heard of a place in the capital, Addis Ababa, where it was said that women with Amina's complaint could be cured. And, as unbelievable as it might sound, the treatment was free.

At first Amina's husband visited her now and then, but his appearances became less and less frequent. Four months had

passed when, during one of these visits, Amina asked if he would give her the money to travel to the capital. He refused. He told Amina that she was of no use to him in this condition. He had wasted enough time on her and certainly wasn't going to waste more money. He was divorcing her.

Amina's parents loved their daughter. Although they were desperately poor, her father found the money for her bus fare to the capital. He did not feel he could take her himself as he knew nothing of cities and did not speak the language. A cousin was again called upon to help.

I can only guess at Amina's embarrassment at being in public in her state, or her dejection when bus drivers refused to allow her on board, or the undisguised disgust of the passengers who were eventually persuaded to endure her presence. I first met Amina when she arrived at the gate of the Fistula Hospital, humiliated and weeping. The guard directed her towards the outpatients department. As she made her way down the driveway and across the stone-flagged forecourt, she must have felt she had entered another world: of clean white buildings, well-kept lawns and flower gardens ablaze with colour. The admissions staff welcomed her kindly. She was examined by a doctor in a white coat who told her that they would help her. She was bathed, given a clean gown and a gaily coloured woollen shawl, and assigned a bed in one of the wards, along with dozens of other women who were awaiting surgery.

Now there is a third character to meet – the storyteller. In the year 2000 I came to the hospital to help Dr Catherine Hamlin write her biography. A biographer is a dilettante. You invade someone's life, questioning them, their friends and family, and sometimes their enemies. You peck out your few thousand words and you move on. Or sometimes not. The achievements

of some people are so remarkable that even after the book has been published, you feel you have barely begun to tell the story. Catherine Hamlin was one of these. She is a marvel. The *New York Times* said of her, 'Dr Hamlin is the new Mother Teresa of our age.' The institution which Catherine and Reg founded has spawned stories to fill several books. So here I am seven years later, living in the compound once more, observing Catherine at work, meeting the other doctors who are devoted to her cause, and hearing patients' stories – tales of heartbreak and triumph that make you weep and rejoice by turns. So many stories . . . so many transformed lives.

CHAPTER 1

At eight o'clock in the morning Amina is wheeled into the theatre. She is helped onto the operating table, where she sits with her legs dangling. Her gown is undone at the back and she is instructed to lean forward. A nurse standing in front of her cradles her head against her chest, murmuring words of reassurance. To the onlooker it's a strangely tender little tableau. Trust and compassion embodied in one poignant moment. The anaesthetist administers a spinal injection, an epidural, to make Amina numb from the waist down. The anaesthetic will last for about two hours. If the operation goes on longer and she begins to feel pain they can keep going with morphine for another fifteen minutes. After that there is another drug, Ketamine, they can use. Most operations take less than two hours.

Amina lies on her back and her feet are placed in stirrups. There are three tables in this big, open room, all within sight of each other. Another operation is already under way and Amina can see the green-gowned staff grouped around the patient, the flash of stainless-steel instruments. What must she be thinking, having come from a rural peasant existence to this? Amina's lower body is draped with green cloths until only her vagina is revealed. The

bed is tilted so that her head is pointing slightly downhill. When all is ready Catherine sits on a stool at the foot of the table.

Protocol dictates that she is never addressed as Catherine; it's always Dr Hamlin. The theatre nurse stands on her right side with the instrument tray, and an assistant surgeon stands at her left.

Catherine is feeling a little off colour today. She has spent the past few days in bed with amoebic dysentery. A doctor would advise her not to work, but here she *is* the doctor, and there is no question of her taking the day off. 'If I collapse, Dr Haile can take over,' she says brightly. Dr Hailegiorgis is one of the senior surgeons.

Catherine has lost count of the number of fistula operations she has done. She and Reg together did about 6000 in the sixteen years they were at a government-run hospital; they probably did 500 a year in the first few years at the Fistula Hospital before other doctors arrived to take some of the load. She still loves surgery and she sees no reason to stop just because she's 83. 'It keeps me going,' she says.

She believes that most surgeons retire earlier than they need to. The only reason to stop is if your hands start shaking and hers are still as steady as a girl's. Her eyesight is excellent. She wears spectacles only for distance.

When the Hamlins first came to Ethiopia in 1959, they knew nothing about fistulas. Very few doctors in the developed world had ever seen one. Catherine and Reg had been hired by the Ethiopian government on a three-year contract to work in the Princess Tsehai teaching hospital in Addis Ababa. They were to practise obstetrics and gynaecology and found a school of midwifery.

They hadn't been there long before they noticed smelly,

wretched women being turned away from the hospital gate. When they enquired, they were told it was a waste of time even examining them, as their injuries were incurable. After seeing these women's pitiable state and hearing about the hardships they had endured to get there, the Hamlins were determined to try to help.

They began by seeking out whatever information they could about fistula surgery. The earliest recorded fistula had been discovered in the mummified remains of an Egyptian woman who lived around 2050 BC. Fistulas were mentioned in the writings of ancient Hindu medicine, the Vedas and the Upavedas, and the ancient Persians also wrote about them.

From about the seventeenth century, European physicians were recording attempts at repair. One of the difficulties was finding sutures that did not cause infection. A Dutch physician, Hendrick van Roonhuyze, described closing the denuded edges with 'stitching needles made of stiff swan's quills'. Although he recorded two successes, van Roonhuyze believed surgical cure was practically impossible. Over the following centuries gold wire was tried, as was lead. In the mid-1800s a surgeon called Wutzer, in Bonn, cured eleven of 35 cases. One of these, Lucy Stitch, underwent 35 operations until he was successful – and this was long before the discovery of anaesthetics.

In 1834 a British surgeon, Montague Gosset, wrote a letter to *The Lancet* describing the successful use of gold wire, instead of the normal silk or goose quill, for sutures. The advantage, he found, was that there was little ulceration or irritation, yet it had a great ability to keep the edges of the wound together indefinitely.

At about the same time a brilliant American surgeon, John Peter Mettauer of Virginia, operated successfully on at least half a dozen cases using wire sutures twisted together. The cut ends projected just beyond the vulval verge and were sheathed in oiled silk to help stop irritation. They were re-tightened at regular

intervals. While the patient was healing, Mettauer used a silver catheter to drain the bladder.

Difficulties included the inaccessible space of the operative area, and the tendency for urine to contaminate the wound while it was healing. Little by little the principles of fistula surgery were discovered. The use of various instruments to aid working in a confined space, catheters to drain the bladder during convalescence, and suture material of non-reactive metal were all important. The problem was that no one was yet able to produce consistent results. It needed someone with a special genius to pull these facets together. That man was an American, Dr James Marion Sims.

Sims was born in 1813 in Lancaster County, South Carolina. After gaining an MD from Jefferson Medical College, he moved to Mount Meigs, Alabama, to practise. The first fistula sufferer he encountered was a seventeen-year-old slave named Anarcha. How familiar her plight sounds today. When Sims saw her, Anarcha had been in labour for three days and her baby was already dead. He pulled out the little corpse with forceps and the girl seemed to be making a recovery. Then, after five days, there was a sudden loss of control of both her bladder and rectum. Sims told Anarcha's employer that her condition was incurable and that he should take care of her for as long as she lived.

Within two months, two more slaves, Betsy and Lucy, had come to him with fistulas, but after examining them he concluded that these too were hopeless. He sent Betsy back to her master and gave Lucy a bed in a little hospital attached to his house while she waited for the next train to take her home.

Like many surgeons before him and many since, Sims became obsessed with the challenge of fistula surgery. One of the most vexing problems was the lack of access to the injured area. Fistula surgery has been described as like operating inside the toe of a shoe. One day Sims had an idea. He bought a pewter spoon then

ordered two medical students who were working with him to prepare Lucy for an examination.

Telling her to kneel with her head in her hands, he instructed the students to part the nates (buttocks) and introduced the bent spoon handle into the vagina. Then, as he wrote in his autobiography, *The Story of My Life*, 'I saw everything as no man had ever seen before. The fistula was as plain as the nose on a man's face. The edges were clear and well defined and distinct . . . I said at once, "Why can not these things be cured?"'

Sims immediately began designing instruments for the operation. The bent spoon was refined to become the Sims speculum – an instrument still used in modified form. He wrote to the owners of Anarcha and Betsy and asked them to send the girls back, and scoured the country for other cases.

When all was ready he operated on Lucy. The procedure failed. Nevertheless, he persevered with his long-suffering and ever-hopeful patients. Gradually, he eliminated one technical problem after another, but still he kept failing. One obstacle remained – he needed some way of tying sutures high up in the body where he could not reach. At three o'clock one morning, lying sleepless in bed, he hit upon the idea of using perforated lead shot which he would slide up the suture and compress with forceps when drawn tight.

In great excitement he again performed the operation on Lucy. He waited a week to see the result. When he examined her it was, as usual, a complete failure.

Sims would not admit defeat. He had improved his operation until it was as near perfect as he could make it, yet still there was something wrong. He wondered if it could be the silk thread he used for sutures. He had heard of earlier surgeons using metal and had tried a leaden suture himself without success. Musing on the problem one day as he was walking from his house to his office, in the yard he picked up a little piece of fine brass wire, which

had probably been used as a spring for suspenders. It was as fine as horsehair. He took it to his jeweller and asked him to make some silver wire of the same diameter.

Anarcha was chosen for the experiment. It was the thirtieth time he had operated on her. Stoically she mounted the operating table and prepared to endure once more the probing and cutting without anaesthetic. Sims brought the fistula together with four of his fine silver wires and fixed them with lead shot. As she had done so many times before, Anarcha went to bed to allow the healing process to take place. He waited out the next week in a fever of impatience, then, with a palpitating heart he turned Anarcha on her side, introduced the speculum, 'and there lay the suture apparatus exactly as I had placed it. There was no inflammation, nothing unnatural, and a very perfect union of the fistula.'

Over the next few weeks Lucy and Betsy and all the other patients were cured. Sims was in no doubt about the importance of what he had done. 'I realised the fact that, at last, my efforts had been blessed with success, and that I had made, perhaps, one of the most important discoveries of the age for the relief of suffering humanity.'

Catherine and Reg got a copy of Sims's autobiography from England and sat up late at night avidly reading about his techniques. In 1855 Sims had founded the world's first fistula hospital in New York. Before many years had passed they would build the second.

About a year after Catherine and Reg had arrived in Ethiopia they were ready for their first attempt at fistula surgery. Many of the techniques had improved since Sims's day. For instance, with modern sutures it was no longer necessary to use wire, and