THE WORK CONTINUES

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Building Surgical Capacity Through Partnership, Education and Sustained Commitment

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The Flash

The day before I left for Ethiopia, I was driving to the hospital to pick up some surgical instruments for the upcoming workshop and then — a flash near Crammond Bridge in Edinburgh. A speed camera. That brief, flat, entirely unmistakable light in the peripheral vision, followed immediately by the mental arithmetic that everyone runs: was it me? Was I over? How much is over? Will I get points? Some questions are best answered by a week in Ethiopia first.

A Complete Circle -

India. The United Kingdom. Ethiopia.

I did not plan for these three countries to shape the arc of my surgical training, yet looking back they seem connected by a common question: how do we deliver good surgical care when resources are limited?

Ethiopia sits at the beginning of everything. The bones of Lucy, found in the Afar region nearly four million years old, make this the literal origin of our species. We all trace a line back here. That is not sentiment — it is palaeontology.

I had worked in India before this trip — one of the oldest civilisations on earth, a place of profound historical depth and profound healthcare inequity existing side by side. I arrived in Ethiopia expecting similarities. I found them. But I also found differences that mattered. Ambition and commitment of Ethiopia's medical workforce, often advancing faster than the systems available to support it.

Addis Ababa — Arrival

Addis Ababa surprised me. Customs at Bole International Airport were thorough — the kind of thoroughness that reminds you this is a serious undertaking, not a tourist visit. Letters from our Ethiopian colleagues proved invaluable. We were received by Ramzi and Fitsum, the Addis team with a warmth that immediately set the tone for everything that followed. We ate, talked, and then flew south to come back later that week.

Hawasa

Arrival and First Ward Round

The domestic flight south crosses the Rift Valley — the geological scar that runs the length of eastern Africa. Looking down from the window, it does not look like a landscape waiting to be developed. It looks like a landscape that has already seen everything.

Hawasa is a different world from Addis. The city wraps around its lake, and the Orthodox church bells drifting across the water at dusk carry a resonance the capital's noise does not. The contrast between the two cities, separated by less than an hour's flight, is a miniature version of the contrast that defines the whole country: the gap between what modernity has reached and what it has not yet touched.

We dropped our bags at the Oasis Hotel — welcomed properly, not perfunctorily — and went straight to the hospital for pre-operative ward rounds. Patients were selected, imaging reviewed, consent obtained, and checklists completed. The MDT dynamic between local and international clinicians was collegial from the outset. The corridors were busy with a particular kind of curiosity — patients and relatives watching this unusual combination of faces moving through with purpose. This was followed by a quick tour of Boot camp preparation for the following day. The day was not over, the work had simply changed the register.

The Boot Camp

There is a particular kind of attention in a room where the stakes are real. The Emergency Urology Boot Camp brought together general surgery resident doctors alongside local and UK faculty — and I was one of the faculty members. That distinction matters, not for the title but for what it demands: to be useful, to be honest about what you know and what you do not, and to meet the energy of a room that is bringing everything toward you.

The local team ran the sessions — standing at the front, leading the teaching, managing the room. Shekhar Biyani and Steve Payne guided from the side, offering their experience when needed and stepping back when it was not — a restraint that is itself a form of wisdom.
Will Finch, Matthew Trail, Sachinka Ranasinghe and myself were part of the faculty team to help them conduct boot camp.

What struck me first about the residents and faculty was not just their ability but their commitment to getting there. Doctors had not simply turned up from the local hospital. They had travelled — some flying in, some driving considerable distances, some arriving by public bus from neighbouring towns and cities.

Despite having fewer resources than any comparable setting in the UK, the session was meticulously organised. Everything that could be prepared had been prepared. The contrast between what was available and how professionally it was deployed was striking — a lesson, for those of us from better-resourced systems, in what motivation and organisation can achieve independently of budget.

These residents were not passive. They interrupted with good questions. They challenged assumptions. They worked through scenarios with the lateral thinking of people who have learned early that resourcefulness is a clinical skill. Their enthusiasm was not the enthusiasm of people who do not yet know the difficulty. It was the enthusiasm of people who know it exactly and have decided to show up anyway — some of them quite literally having boarded a bus to do so.

In the Operating Theatre

Percutaneous nephrolithotomy — PCNL — is a minimally invasive surgical procedure for removing kidney stones too large to pass or treat by other means. In a country where stone disease is common, access to clean water unreliable across large rural populations, and open surgery the only alternative in most centres, the ability to perform PCNL safely is not a technical refinement. It is a meaningful shift in what patients can expect from the healthcare system. What happened in the operating theatre on this visit deserves to be stated plainly: the Hawasa team led. Previous visits by the Urolink programme had invested in training these surgeons, and what we witnessed now was that investment made visible. Matthew Trail and William Finch were present — their experience and technical fluency an anchor for the room — but the PCNL cases were driven by the local team, supine position, methodical and assured.
Leading the operation were Tilaneh and Getch, whose confidence and precision demonstrated exactly what sustained training investment looks like when it finally stands on its own feet.

There is a particular satisfaction in that — not the satisfaction of performance, but of testimony. This was not a team being taught. This was a team demonstrating what they had already learned.

Between cases, in the space just outside the theatre, we gathered — residents, whoever could be spared from the next preparation — and sat on the floor. No chairs available, no adjoining seminar room, just a corridor of floor and the shared understanding that the teaching mattered more than the furniture.

A patient with a urethral stricture drew us into a longer consultation — one that moved between clinical history and social history, between what the body requires and what the life around it makes possible. Treatment decisions here cannot be made without understanding a patient's geography, their family structure, or their ability to return for follow-up. Medicine and context are inseparable. They always are, everywhere. Here it is simply more visible.

The Corridor

Outside the wards, a child was playing football with a ball made from paper and string. A few metres away, hand-painted wooden coffins stood stacked near the hospital entrance. Life and death existed side by side, with none of the separation modern hospitals often create.

Inside, patients sat in the corridor holding bags containing their medications. The sight was instantly familiar. I had seen the same thing in India: patients carrying the treatments they depended upon because they could not assume the system would do it for them. Different countries, different healthcare systems, but the same quiet dignity and self-reliance.

Hospitality and History

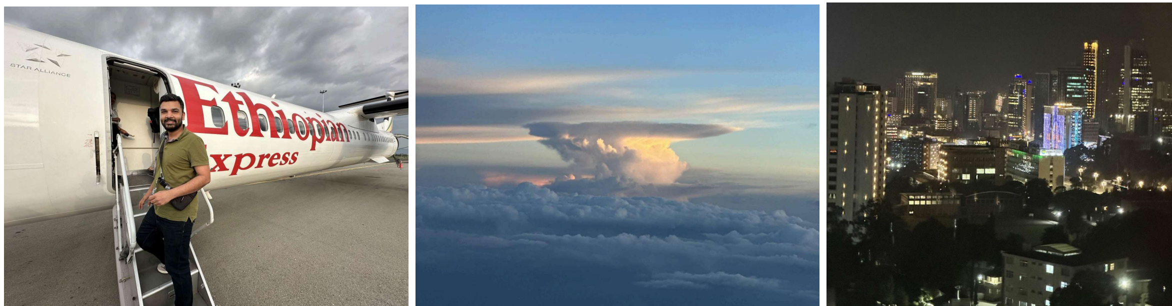
That evening, a local colleague hosted us for dinner. Traditional Ethiopian food, served with the kind of hospitality that makes you feel you have been added to a family rather than a guest list. Stories about the country's history — its extraordinary resistance to colonisation, its ancient church traditions, and its cautious present optimism. These conversations do not happen in conference rooms. They happen around food, late, when people have stopped performing and started talking. I left that dinner knowing more about Ethiopia than any briefing document could have told me.

The Long Day

The second PCNL day ran long, the Hawasa team again at the operating table, building on the previous day's momentum as cases accumulated complexity through the afternoon. Matthew and William watched, advising where needed, but never needing to take over — which was itself the measure of how far things had come. The kind of day that tests not just technique but temperament — the ability to stay methodical when the room is tired, to hold the atmosphere steady when it wants to fray.
The hospital's Managing Director joined us during the afternoon — a conversation about the future of the urology department that was neither vague nor bureaucratic. The infrastructure around the programme is being built. The will is not the question; the resources are still catching up. But will, sustained over time, has a way of solving resource problems that resources alone cannot.

Addis -
The Return : City Seen Differently

We flew back to Addis in the early evening, an anvil-shaped cumulonimbus standing over the Hawasa valley behind us — enormous, perfectly formed, lit from beneath by the last of the sun. It did not feel threatening. It felt like punctuation. The week made its mark on the sky before it ended.



Addis is a genuinely modern city — wide boulevards, high-rise construction reaching skyward, with the energy of a capital mid-transformation. The modernity of the capital felt neither superior nor irrelevant. It felt like a destination the country is moving toward, and a reminder of how far some parts of it still have to travel. Both things at once.

Boot Camp

Back in the capital, the same pattern held: the local team led the sessions, with Shekhar and Steve alongside — guiding, prompting, sharing experience without crowding the space the local faculty had earned. The same framework, a different medical community — one shaped by the capital's different pressures and possibilities. Where Hawasa had the intensity of a place accustomed to working without margin, Addis had the energy of a system that can sense what it is becoming.

The session required anatomical specimens, and some were missing. This required a different kind of initiative: we went to the local butcher. And that is how I ended up in the old part of Addis — navigating a market that the modern city does not advertise. Narrow lanes, open stalls, the smell of spice and livestock, the texture of a city that has been a city for a very long time. The butcher was found. The specimens were sourced. The session proceeded.

But what stayed with me was the walk. Because I have walked streets that feel exactly like that before — in India, the lanes around Old Delhi or as we call it " Purani Dilli" , where the city presses close and a mosque rises above the roofline just as one did here, above old Addis. It was, again, a homecoming I had not expected.

A Glimpse of What Is Coming

The team visited the site near Bishoftu, forty kilometres outside Addis, where Ethiopia's new international airport is rising. You feel the ambition of this country in a very specific and physical way. Ethiopia is not waiting to be noticed. It is building.

We had lunch there — the kind of unhurried meal that becomes a debrief without anyone deciding it should be. The week laid out across the table in conversation, each person finding different words for the same accumulation of experience.

Coffee and Souvenirs

No departure from Ethiopia is complete without coffee. This is, after all, where coffee originates — the word itself traces back to the Kaffa region. We found time before the airport to buy proper Ethiopian coffee and a few souvenirs: small objects that will sit on shelves in Edinburgh and occasionally prompt the question, where did that come from? The answer will open the conversation that needs to be had.

On Shoulders — The Urolink Legacy and the TUF Fellowship

Nothing about this week happened from a standing start. Any international medical collaboration is not a visit — it is a relationship. Relationships require showing up repeatedly, absorbing the friction of logistics and distance and institutional inertia, and not stopping when the enthusiasm of the first trip fades. The Urolink team demonstrated what that looks like across years. This week was built on what they built. The Hawasa team leading their own PCNL cases is not a footnote — it is the entire point. It is what sustained commitment, revisited year after year, actually produces.

This visit was made possible by The Urology Foundation Fellowship, which I applied for and was awarded in 2024 — at a moment, as it happened, when I was in transition myself, moving from Edinburgh to Dundee and not entirely certain where that step would lead. I did not know then that the fellowship would mark the beginning of a global journey in surgical education. Looking back, that feels less like coincidence and more like the same pattern the report has been tracing all along: you take a step without knowing it is a transition, and the destination only becomes clear from the other side. TUF's investment is not in a single visit. It is in the chain of transmission a visit sets in motion — the resident who learns a technique, the patient who benefits, the department that becomes a centre of regional excellence. That chain starts with someone deciding the investment is worth making. TUF made that decision, and the week in Ethiopia is the evidence of what it enables.

Reflections — India, Ethiopia, and the Space Between

I arrived in Ethiopia carrying India as a frame of reference, and the frame fit — partially. The similarities are real: the civilisational depth, the gap between aspiration and resource, the ingenuity of clinicians working in constrained environments, the patients who have learned to carry their own safety nets.

But frames only show you what fits inside them. What this trip revealed around the edges was equally important. Ethiopia's medical training infrastructure is at a different stage of development. The pressures on its healthcare system are distinct. That gap, between the people and the quality of the system supporting them, is precisely where programmes like this one do their work.

What connects India, Ethiopia, and the UK is not the similarity. It is the same underlying question, asked in different accents: how do you build surgical capacity that outlasts the people who taught it? How do you make a visit into a legacy? The answer, as the Urolink team demonstrated, is time, and return, and the refusal to treat international medical education as a one-off expedition.

Conclusions and Recommendations

This was among the most professionally and personally formative visits of my career to date. The headline finding is clinical: the Hawasa team led their own PCNL cases, supervised but not dependent, and did so with a confidence that is the direct product of the Urolink programme's sustained investment. Matthew and William's presence provided the safety net; the fact that it was rarely needed was the point. Shekhar and Steve's teaching gave residents tools they will carry for decades, and Sachnika reminded everyone that the best learning happens in a room that genuinely wants to be there.

The human dimensions of the week were equally instructive: the doctors who boarded buses to attend a boot camp, the teaching session on a corridor floor between cases, the patient with a bag of medications, the child's paper football, the coffins stacked at the entrance, the old city lane that sent me back to Delhi without warning, the dinner table history lesson.

With sustained commitment — with the consistency that Urolink has modelled and that the TUF Fellowship makes possible — the urology department at Hawasa University Comprehensive Specialised Hospital has every capacity to become a centre of regional excellence. The foundation is not being laid. It is already there. It needs time, presence, and the refusal to stop. The programme has proved its model. The next step is to build on that proof.

The Post Arrives

Two weeks after I left Edinburgh for Hawasa, I checked the post. Nothing. No speed camera fine. No notice of intended prosecution. No fixed penalty. The flash in the peripheral vision that had lodged itself in the back of my mind before departure had come to nothing. I arrived in Ethiopia with a suitcase full of equipment and medications. I returned with a lighter bag. In its place were conversations, experiences, and lessons that weigh nothing but remain long after the journey ends.

The United Kingdom, Ethiopia, India. A speed camera that came to nothing. An Arsenal win that brought a week's memories flooding back. A Delhi memory at exactly the right moment. Transitions, all of them — most of them unrecognisable as such until you are already on the other side.

Ethiopia. Goodbye — or as the brief Italian occupation left its one lasting word in the language: Ciao. I am still working out what it means - on a shelf in Edinburgh, next to a bag of Ethiopian coffee that smells, every time I open it, for a week I am not finished understanding.

The work continues. That is enough.

"The measure of success is not what visitors do, but what remains when they leave."