

ATTITUDES TO POST-MORTEM EXAMINATIONS IN UGANDA: THE EFFECT OF PAST EXPERIENCE?

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When in December 1945 I was posted in the Colonial Medical Service of Uganda to be the pathologist at the University Teaching Hospital, Mulago Hospital in Kampala, I was surprised at how easy it was to obtain permission to carry out autopsies on the local population. Years earlier, round the turn of the century, the pioneer Christian missionaries and the scientists of the Royal Society's Sleeping Sickness Commissions had had the same experience. It was clear and surprising that, as far back as records went, the factors that limited the number of autopsies were the limitations of staff and time to perform them. This was in curious contrast to the public opposition to autopsy examinations reported from the Islamic fringes of the Sahara, and from the East African coast and Zanzibar, or from India or from the predominantly Roman Catholic peoples of South America. We had in Uganda a large Roman Catholic population, and a sizable Islamic population, and although some of the latter, especially the Moslem Nubians (then the most backward element in the population) objected strongly, the remainder were strikingly agreeable to granting autopsy permission.

Indeed, a post-mortem examination was often requested. On a number of occasions, this was to ascertain that death was due to natural causes and that there had been no neglect. These requests usually came from the elders of one or other of the Uganda clans who had placed some elderly or sick person in the care of some clan member, often a widow, and who wanted to audit the level of welfare.

It should be noted that this ready acceptance of autopsies came from a population prone to doubts and subjected to constant rumours. The 'Mumyami' movement, opposed to the taking of blood for diagnostic tests, and especially for transfusion, was at its height: it had indeed led to the spearing to death of a member of staff of the medical department as late as 1942. It was widely believed that the coal gas production plant at the Government Medical Laboratory was in fact run on the spirits of the dead autopsied at Mulago Hospital. Perhaps this concept should not be too readily discarded for when, years later, and following a gas explosion in another laboratory, the coal gas plant underwent a very delayed technical inspection, it was discovered that the sky could be seen through the top of the gas holder.¹

Never under any circumstances was I permitted by my African staff to carry away any specimen, no matter how interesting, from the morgue: only my paper records could be taken away. The morgue stood in the shade of the jacaranda and flame trees in the old part of Mulago Hospital surrounded by the carefully tended graves of members of

the hospital staff, including the morgue staff, who had died of plague. Any autopsy specimens we sought to retain were quietly brought round by the morgue staff after I had left openly with my papers. It was perhaps fortunate, though this was not realised at the time, that my figure was a full one, and that in my time at Mulago, no thin pathologist was appointed who rapidly gained weight!

The first and easiest explanation for the high autopsy rate lay in the fact that some 30% of bodies at Mulago Hospital were those of immigrants without close relatives from whom autopsy permission had to be sought. However, this did not explain the acquiescence of the local population. The next easy explanation was that it had resulted from the 'plague ordinances'. Plague had long been well established in Uganda. Textbooks and historical works might suggest to you that plague is easily diagnosed clinically, but in fact it is a very difficult diagnosis, and in many cases has to be made by a blood examination or an autopsy. The ordinances laid down that if plague was suspected, the authorities could insist on an autopsy. This, I was told, had been so impressed on the locals that they readily agreed to autopsies; it was equally acceptable to clinicians who could use it to secure consent for an autopsy when they desired one. But other communities had been the subject of similar ordinances, and they had been enforced without leading the community to accept autopsies readily. However, for some years I accepted this idea.

My interest in the remarkably advanced medical concepts and practices of the trained medical men in the old Kingdom of Bunyoro-Kitara² led me to speak of these at a medical meeting. This brought a reaction from some of my African medical colleagues who averred that the Nyoro surgeons of whom I had been speaking had an excellent knowledge of anatomy and this, they asserted, had been largely acquired by doing autopsies. To this a cynical Ganda physician, who had worked amongst the Gishu in Eastern Uganda, added that 'butchery also helped', a remark the significance of which escaped me for some time.

In 1884 R.W. Felkin, then a senior medical student, had witnessed a Caesarean section performed under comparative anaesthesia and comparative antisepsis in Bunyoro; an operation, as Felkin described, remarkable for the efficient use of local materials. It was a long-held practice both there and in Buganda to perform post-mortem Caesarean sections on the undelivered mother in the hope of obtaining a live child. Enquiry showed that this was only a single aspect of a much wider custom which Baumann in 1928 had noted as the Likundo culture.³ This culture was practiced over a large part of Africa from the Cameroons and the Niger delta, over the Mbomu and Welle-Bomokande riverine areas, to the Congo-Nile watershed and down East Central Africa to the area north of Lake Nyassa. The number of autopsies actually carried out varied from place to place but there seemed to be no

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shortage of material. In eastern areas it seems rather fewer autopsies were performed and the indications were more specific. Indeed what a modern experimentalist might call 'controls' were used, for individuals who fell under suspicion of practising witchcraft might be subjected to an ordeal test and, failing, be hanged and quickly autopsied, thus providing a subject whose death had not been due to disease.

The actual autopsy 'technique' varied from area to area, from a simple incision and determination based on some superstition in the local area, to a prolonged and detailed searching via an enormous incision in others. This was not a haruscopy i.e. prophecy by divination from the position of the entrails, but an investigational tool, for in the Likundu culture something had to be searched for in the dead body, a blemish or blood spot or clot, or a gallstone or a tumour. Thus in many areas of East Africa autopsies were frequently carried out in times long past and these could provide for the acquisition of the detailed knowledge of anatomy needed for successful surgery.

Did then this ready acceptance of autopsies in Kampala spring in part from the Likundu culture? Dr Wiggins recorded that the Kabaka Mutesa once vivisected a large number of Soga in various ways to determine which was the most important of the body organs, and concluded that this was the heart. No-one who assisted in this brutal mass experiment could have failed to learn some anatomy, but I came to discover that this was not what my cynical Ganda medical colleague meant. He was referring to the widespread habit of cannibalism in East Central Africa; he had worked amongst the Gishu who, as Hesketh Bell remarked,⁴ had no belief in sepulture. The family of a

dead person would give the body away in exchange for another from some other family, as Bell put it 'a cutlet for a cutlet'. No-one who engaged in cannibalism, especially the butchery side, could fail to gain some knowledge of human anatomy. Incidentally, having worked on protein malnutrition I do not share the usual abhorrence of cannibalism which seems to me a very sensible way of recycling available protein in a protein-starved area.

These factors could therefore have possibly contributed to the acceptance of autopsies on those dying in Kampala, but there was one other that I have not yet mentioned. In the medical laboratory where the histological sections of autopsied material were prepared, the process was under the charge of an elderly, very experienced, and very dignified Muganda named Mr Kasalwe. Naturally, I depended very much on him, and discussed why we needed more autopsies, for teaching, research and prevention of disease. Mr Kasalwe was not only a laboratory technician but he was also chief of the Lion Clan, one of the most important clans of Buganda, and as such his influence was immense. I suspect that our autopsy rates owed much to Mr Kasalwe having vouched for us and our scientific purposes.

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