

# The complications seen from the treatment by traditional bonesetters.

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## Summary

Traditional bone setters are rampant in the West African subregion but the atrocities committed by them have never been reported hence the need for this article that deals with the menace caused by them.

All patients referred to the University College Hospital between 1996 and 2001 were included in this study.

Only a few number of the patients have been selected just to illustrate the menace caused by the traditional bonesetters in so many African societies. The deformities, financial loss and amputations resulting from the management by traditional bonesetters have been highlighted.

Suggestions are made on how to improve awareness in the way of adequate communications through televisions, radio and the press. Much need to be done in the society as it was found in the study that poverty or lack of education alone is not the major cause of the society seeking the help of the traditional healers, but probably the culture and traditional beliefs of the society.

**Keywords:** *Traditional bonesetters, Fracture complications*

## Résumé

Les cas des réductions traditionnelles sont endémiques dans la sous région de l'Afrique de l'Ouest, mais on n'avait jamais fait un rapport sur les atrocités qu'ils ont commis, en conséquence cet article éprouve le besoin de traiter les menaces causées par elles.

Tous les patients qui ont été envoyés au Collège hospitalier universitaire entre 1996 et 200, ont fait la plus grande partie de cette étude.

On avait choisi tout simplement quelques patients afin d'illustrer les menaces causées par les réductions traditionnelles dans beaucoup de sociétés africaines. Les difformités, la perte financière et des amputations conséquences de la gestion par les réductions traditionnelles ont été contrastés.

On avait fait des propositions sur comment améliorer la sensibilisation à travers des communications adéquates telles que la télévision, la radio et la presse. Il y a beaucoup de choses à faire dans la société comme on l'avait noté dans cette étude que la pauvreté ou la manque d'éducation ne sont pas seulement les causes majeures responsables pour les membres de la société de chercher l'assistance auprès des guérisseurs traditionnels, mais la culture et la croyance traditionnelles de la société sont peut-être responsables.

## Introduction

Bone healing occurs naturally but anatomical union is usually advocated by traumatologist and orthopaedic surgeons worldwide. The first orthodox hospital in Nigeria was built in Lagos in 1873<sup>(1)</sup>, before then the early form of health care available to the people of Nigeria was traditional medicine. While there has been a lot of literature on traditional medicine and midwifery<sup>(2)</sup>, there has not been much about the orthodox orthopaedic practice as regards trauma and the traditional bonesetters.

The existence of traditional bonesetters has merely been mentioned by some authors with little or no information about their practice<sup>(3,4,5,6,7)</sup>. Such is the fame some of these bonesetters have acquired in this environment to the extent that people take voluntary discharge from our hospitals to seek treatment from traditional bonesetters.

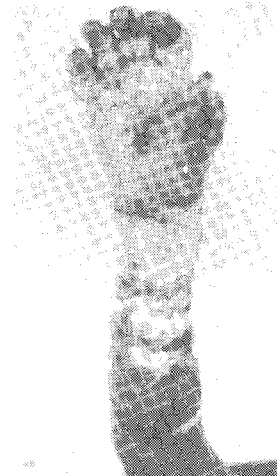


Fig. 1 5 year old boy with simple green stick fracture of radius that ended up with an amputation

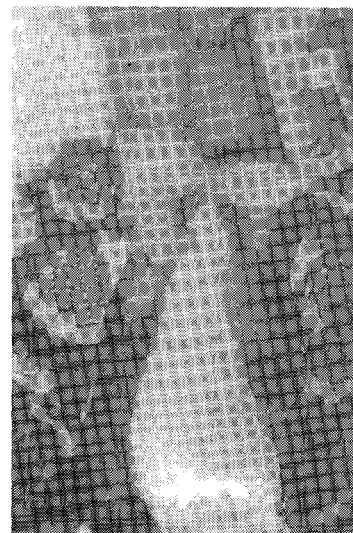


Fig. 2 An 8 years old boy with bilateral genu varum deformity but ended up with bilateral amputation following gangrene from traditional bone setter

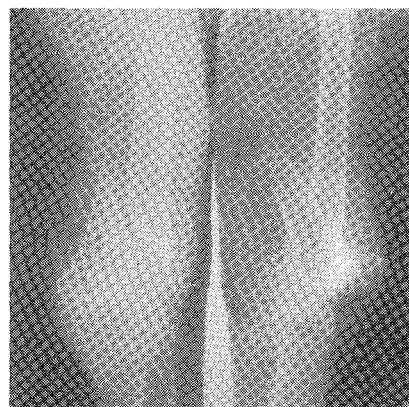


Fig. 3 80 year old mother of an x-ray radiographer with 2 year history of non union of the distal right femur.

Our experience in Ibadan with the prevalence of atrophic non-union of fractures, and devitalized limbs previously treated by traditional bone healers is presented so as to highlight some of the problems encountered in this environment.

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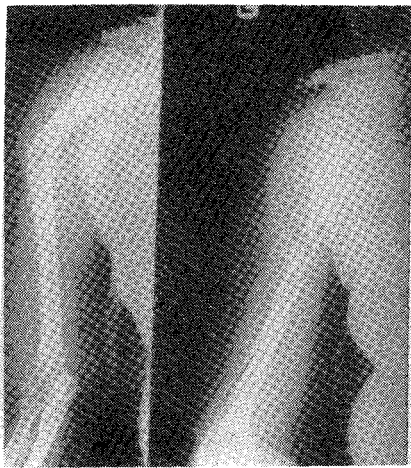


Fig. 4 47 year old chief executive of a government parastatal with 2 year history of non union of left humerus from a traditional bonesetter

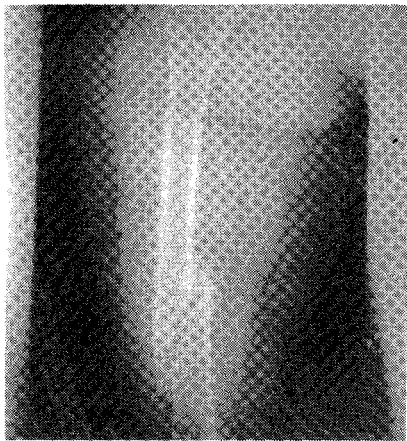


Fig. 5 85 year old mother of a retired school principal with atrophic non union of the femur

### Illustrative cases

These five cases were initially treated by the traditional bone healers, and were referred to us after the complications have occurred.

- I. 5-year-old boy with simple greenstick fracture of radius that ended up with amputation. Fig. 1.
- II. 8-year-old student with simple bilateral genu vara that ended up with bilateral amputations. Fig. 2
- III. 80-year-old aunt of first author and mum of a radiographer with atrophic non union of the right distal femur Fig. 3.
- IV. 47-year-old executive in a government parastatal with atrophic non-union of the humerus. Fig. 4.
- V. 85-year-old mother of a retired school principal with atrophic non-union of the femur. Fig. 5.

### Discussion

The above cases illustrate the magnitude of the problem encountered by orthopaedic practitioners in this community. The traditional healers catchment population have no boundaries as both educated and enlightened individuals seek the help of the traditional bonesetters. This may be attributed to the impoverished state of the nation or more importantly to lack of proper health education and ignorance on the part of the community.

However, considering the calibre of people involved, one cannot but assume that our culture or traditional beliefs must have

a great role to play. The importance of adequate management of fractures as they occur cannot be over-emphasised if one considers the fact that the estimated cost of managing a child forearm fracture is about (\$35 dollars) for sound union in about six to eight weeks. However, the cost of losing an arm in this environment cannot be quantified in terms of money, physical disability, emotional disturbance, and social stigma associated with it.

Moreover, the child has no actual say in his or her own management which is dictated by the beliefs of the parents who later on in life would not be around to suffer the consequences of the amputee. In the same vein, majority of the patients used as illustrative cases have suffered for over two years both in terms of financial losses, emotional, physical and the unquantifiable psychological trauma to their immediate families and the nation as a whole.

It is pertinent to reiterate the fact that in this millennium, when trauma is being regarded as a diseases entity, every nation in the world is spending a lot of her resources to reduce the loss of earnings and lives of her active work force i.e. adolescents and adults who are the ones mostly involved in accidents. We should also remind ourselves that traditional bonesetters were rampant in the Western world some 200 years ago; in fact one of the founding fathers of orthopaedics in the United Kingdom was born to a traditional bone setter<sup>4</sup>.

However, technological advancement and civilization have taken over in most places so that mal-union or complications of an inadequately managed fracture is usually considered as medical negligence which is liable to some punishment.

The first illustration Fig. 1 of the young boy ending up with an amputation reaffirms some of the risk of the traditional bonesetters using hot fomentation with herbal concoction for simple uncomplicated forearm fracture. The second illustrative case in Fig. 2 only had what the general public refers to as bowlegs but was unfortunately taken to a traditional bonesetter where bamboos and concoctions were applied until the limbs became gangrenous.

Majority of the patients treated by the traditional bonesetters especially when the fractures are displaced usually end with deformities and limb shortening as documented by some authors<sup>(8)</sup>.

Similar practices of traditional bone setting without any analgesic or anaesthetics have been reported in East Africa<sup>(9)</sup>. The use of raffia splints to immobilize the limb parallels the use of plaster of Paris in modern orthopaedic practice; however, the removal of the splint daily to allow hot fomentation; a practice similar to that of the Mano tribe in Liberia<sup>(10)</sup> has so parallel in modern practice. The atrophic non-union created by these traditional bone setters is never recognised by them as they do not have any scientific evidence in form of x-rays to know whether there is fracture union or not.

The fact that the patient can mobilize without much pain does not depict solid fracture union as most of the patients end up with pseudoarthrosis as demonstrated by the cases in Figs. 3 and 4. Traditional treatment of fractures is also practiced in modern China; but only uncomplicated fractures are treated by them while complicated fractures are sent to the district hospitals where orthodox treatment is used<sup>(11)</sup>.

In this millennium and in Nigeria especially, it would be difficult to make a case for traditional bonesetters if one evaluates their results as compared with the standards obtained today by Western medicine in the management of fractures. The illustrative cases in Figs. 1 and 2 where there have been loss of limbs, and the other cases where financial loss and useful manpower time have been lost can only be seen as a retrogressive dark age practice which should not be allowed to happen in any civilised society. The fact remains that only medically qualified personnel should be allowed to practise any aspect of medicine.

Efforts should be made to educate the general public as shown with the illustrated cases, poverty alone cannot be blamed for

patients going to seek traditional bonesetters. The belief by many people especially those far away from cities that once a person is referred to a Teaching Hospital, amputation is imminent should be erased from their minds.

### **Conclusion**

There should be more in the way of health education as to the management of fractures, and complications of mismanaged fractures.

The unhealthy propaganda by radio and TV stations about traditional healers bonesetters should be discouraged. In any civilized society, no one with a fracture should be made to go through the menace caused by these unorthodox traditional bonesetters.

The government should promulgate a law as it is done in most civilized societies against quack doctors advertising on radio, TV and newspapers.

### **References**

1. Schram J A.: In a history of Nigerian Health Services, Ibadan University Press; 1971; pg. 10-15.
2. Madean C: Traditional medicine and its practitioners in Ibadan. Nig. J. Trop. Med. Hyg. 1965; 168:237-44.
3. Onabamiro SD: In why our children die. London, Methuen and Co. 1949; pg 6-8.
4. Hugh Owen Thomas: Seven generations of bone setters: In A dictionary of the history of Medicine. Anton Sebastian. Parthenon Publishing Group, 1999-711.
5. Odebiyi O O.: Chemical and Biochemical studies on some traditional virilising preparations in use in Nigeria. Ph. D. Thesis, UI, 1972.
6. Osuntokun B O: The traditional bias of neuropsychiatric practice among the Yorubas of Nigeria. Trop. Geog. Med. 1975; 27: 422-430.
7. Soyawo B: Some aspects of traditional therapy in Yorubaland. DOKITA 362(3) 21-31.
8. Oyebola D D O: Yoruba traditional bonesetters: The practice of orthopaedics in a primitive setting in Nigeria. Journal of Trauma 1980; 20: 313 - 322.
9. Roles NC: Tribal surgery in East Africa during the 19th century. Part 2. Therapeutic Surgery. East Afr. Med. J. 1967; 44:17-30.
10. Harley GW: In native African Medicine with special reference to its practice in the Mano Tribe of Liberia. London, Frank Cass Ltd. 1941; pg 69-70.
11. Smith J. A.: Best of the old and the new. Br. Med. J. 1974; 2: 367-370.