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LETTER TO THE EDITOR

Ethics; the Main License to Do Spinal Surgeries

Dear Editor

If we are honest in our profession, we might ask ourselves how many percent of patients with spinal surgery are satisfied with our treatments: 50%, 70%, or 90%. How many percent of our spinal surgeries can restore normal anatomy to the patient? Is it enough to have academic credentials for carrying out spinal surgeries? Does having a gun means having the right to shoot at everyone freely? "Conflict of interest" is a term commonly used in scientific articles. This phrase implies the simultaneous existence of two or more benefits from a research activity that one of these benefits may not be oriented in a same direction of others. This secondary interest may interfere with the primary interest of an honest professional activity and should be clearly explained before the manuscript could be published and put into the widespread use (1, 2).

Indeed, it's proposed that conflict of interest is not limited to research activities. In the field of spine surgery, especially in the lumbar spine area, due to the existence of numerous innocent bystanders commonly seen in paraclinical assessments (plain radiography, computed tomography, and magnetic resonance imaging) conflict of interest may affect the surgeon's decision to undertake surgery. The lack of coordination between imaging and clinical findings is one of the proven facts in the field of spinal surgery that must be carefully assessed before beginning the treatment (3). For example, in the issue of lumbar disc herniation, there is no proven evidence to consider the size of herniation seen in MRI as a criterion for surgery and almost all surgical criteria are based on clinical findings. This is true in many other diseases of the spine, such as spinal stenosis, spondylolysis, spondylolisthesis, trauma, tumor, coccygodynia, and etcetera. And, it is us who know that any observed pathologic finding in para-clinics may not be the cause of the clinical illness of the patient. As in legal cases, the crime of the guilty party must first be proven and then be penalized. In many cases, preservative treatment is initially effective and then, in severe or refractory cases, surgery may be recommended (4).

This recommendation does not mean to lessen the significance of surgical treatment. In fact, when necessary, no treatment can override surgical intervention. But, if I can offer any advice to colleagues, and especially younger ones, it is to view every single case empathetically and do not let inhuman interests affect their ethical considerations in making decisions or surgical planning (5). We should not forget that the ultimate decision for spinal surgery should be based on both scientific knowledge and ethical standards. Regardless of any religion or creed, ethical principles should govern our conduct in medicine and life. The next time we may be the patient of an unscrupulous physician.

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