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Editorial

Has History Taking Become a "History"?

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Having practiced spinal surgery, having seen tears and laughter from many of my own patients and from others' experience, I would like to add on to a genuine concern Prof. NJ Mani expressed in his editorial "Whither to?" [1].

We all know that these days, many spinal surgeries are done for back pain or sometimes spinal fusions are done following spinal canal decompression. We also know that back pain is very common in the general population. We also are aware that the common causes of back pain are anxiety, stress, worry, depression, muscle spasm, flabby muscles, bad posture, referred pain from sacroiliac joint pain, piriformis syndrome, retro peritoneal pathologies, facet joints etc. In addition we all know that MRI is done at the drop of a hat for patients with back pain. We also know that MRI most often shows disc bulges, ligamentum flavum hypertrophy, facet hypertrophy and canal compromise. We also know that these findings are common in many asymptomatic people and are part of a normal aging process. We all seem to know everything, aware of everything and are knowledgeable about everything. But what we don't know or fail to know is that when we face a patient with back pain in our clinic, we forget all that we know! We tend to get influenced by the MRI findings or report and totally ignore a significant part of clinical evaluation. And that significant part is History taking. In no other aspect of medicine does history play such an unequivocal role in decision making as in spine surgery. But this is where most of us stumble, and we see history as a thing of the past. Why bother to waste time on history when we have all the modern gadgets for investigation and treatment at our disposal?

Many spine surgeons, especially the younger ones and new entrants into this exciting specialty get carried away by the advances in technology such as endoscopes, fixation devices, bone substitutes, fusion enhancers etc. They also get mesmerized by the beautiful post-operative images showing multiple screws, rods and hooks perfectly aligned in the spine - from the front, back and sides. Sometimes it makes me wonder whether the English phrase "screwed up" has been made after witnessing the umpteen numbers of such spinal fixations!

It is common knowledge that 80% of the decision to perform a spinal surgery comes from a detailed history - history of the patient's symptoms, his personality, his life style, his family and social background, his job description, his expectations of the outcome of surgery etc. but the moment we see an "abnormality" in a spine MRI, we throw common sense into thin air and rush to sharpen our scalpels, polish our endoscopes and unpack our fixation devices with a sort of vengeance unheard of

even in the most brutal wars. Notwithstanding the best interest of the surgeon to help the patient, the final result is most often an excellent looking post-operative X-ray and a miserable looking patient. Spinal surgery has become more of a cosmetic surgery with the main aim to enhance the beauty of an ugly looking spine in an MRI scan to that of a presentable spine. And how do we do it? We do it by decorating the spine with all the latest screws, rods, nuts and bolts. And we all say Bravo to this dressed up spine which reminds one of the shiny armors the ancient Roman soldiers decorate themselves with to show off their supremacy and success.

I would like to emphasize that I don't intent to undermine the utility or effectiveness of spinal surgery. In fact I believe in the relevance for spinal decompression or/ and fixation. Yes spinal surgery is here to stay - but with the correct indications. All that I am trying to emphasize is that the mere possession of an endoscope or implants and an ugly looking MRI or even our own supreme technical expertise should not be an indication for spine surgery. In other words we should refrain from proving the relevant age old adage "*A man equipped only with a hammer will find everything else as a nail head*". Focus on the basics. We are treating a patient, not an MRI. Technological advances and expertise is NOT a substitute for a detailed history in decision making in spinal surgery.

I dedicate this editorial to Prof: N.J.Mani - a most respectable professional, who has spent his life in total commitment to patient care and education. I would like to end my views by emulating the question Prof: NJ Mani asked: Spinal Surgery - Quo Vadis?

Reference

1. NJ Mani. Whither to? BMH Medical Journal 2016;3(4):83-84.