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The SOS Surgeon

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Introduction

In a world already dominated by laparoscopy and robotics, and shortly by AI and ChatGPT, I would like to propose a new career option for hospitals to consider and for aging surgeons like me, the SOS Surgeon.

The Surgeon On Standby will be the in-house surgeon available for emergencies that the current generation of surgeons isn't yet prepared to handle or isn't prepared to handle by themselves. The SOS surgeon will be the "old timer" who remembers how to do open gallbladders when the robot isn't available or suitable for the case, how to do a subcostal incision, how to position the retractors, how to perform an open common bile duct exploration. The SOS surgeon will also know how to tie knots in Prolene and PDS sutures and not have to use a V-Loc, or Stratafix, or double looped PDS for closures of fasica. The SOS surgeon will know how to place IV's, central lines, and arterial lines without the use of an ultrasound probe. Knowing how to "clamp, cut, and tie" when dividing the mesentery of the colon or small bowel without the use of an Enseal or Ligasure will be their bread and butter, the pride and joy of their youth.

They will also be experienced through years of medical practice and attendance at the weekly M&M conferences and at least have some clue how to manage the most major complications. As a surgeon, or hospital administrator, you wouldn't want to be in a first-time situation with an EEA stapler misfire, a cut ureter, a trocar injury into a major arterial vessel, a stapler is fired across an NGT in a gastric bypass, or an air embolism at the start of a laparoscopic case. You want someone, "on the bench," who is ready to be called into the game, at a moment's notice. And, sadly, the SOS Surgeon may have experienced a malpractice case or two and might be familiar with the proper documentation to protect those involved (include the hospitals) in such unfortunate occurrences.

There comes a time when all surgeons have to face the fact that we don't have the physical endurance we once had. Our backs aren't the same and get sore by the end of the day. Our legs similarly have changed and now swelling in the ankles is common after long cases. Sitting down at the robot helps, but that comes with its own wear and tear on the surgeon's body. But, as the SOS surgeon, we still will have the priceless experience of our residency training, where we witnessed open surgeries that aren't very common anymore. Where we likely rotated onto other services such as Urology, Ortho, Plastics, and ENT so we are familiar with diseases and techniques outside of the typical general surgery armamentarium. The SOS Surgeon will still have the familiarity with how to do things that make a hospital run without technology, such as writing scripts by hand, orders by hand, writing notes without a EMR template or macro. The SOS surgeon is ready to help when help is needed. Every hospital and young attending will want a legendary relief pitcher available when it's the bottom of 9th inning of the world series and you are battling a gangrenous friable gallbladder in a septic diabetic patient when the operating attending's only assistant is a brand-new second year resident and the only reasonable maneuver is a retrograde/dome-down gallbladder with a subtotal cholecystectomy and suturing the cystic duct closed from inside the gallbladder lumen.

Many young attendings, when considering where to practice, ask about their support with regards to senior surgeons. No young surgeon wants to be in the situation in the middle of the night, trying to deal with a perforated ulcer and the sutures keep pulling through. Similarly, no young surgeon wants to be deep in the narrow male pelvis six hours into a low anterior resection only to see bubbles come from their leak test and not have a plan B. A hospital would likely have a better opportunity to attract young talent if they could offer an SOS surgeon available 24/7/365. Starting a brand-new bariatric program is lucrative for a hospital, but quite daunting as a young attending by yourself. However, it's not so bad if you know that you have talented backup ready to support you, if support is necessary, like when one of your early bypass patients shows up in the ED with an obstruction and an intussusception of the JJ. Furthermore, that same hospital is likely to see a slightly lower complication rate from that same young surgeon, who now has a mentor, in the form of the SOS surgeon. AI is great, but mentorship is often more important that knowledge in a young surgeon's career.

There have been tremendous advances in medicine and surgery I have been privileged to witness throughout my career. I suspect many more advances are still to come. But, when the technological aids aren't available, aren't suitable, when the power goes out, when it's a dire emergency and split-second decisions based upon years upon years of experience are necessary, we SOS surgeons will be ready to come and lend a helping hand. And, as I'm writing this, my long standing RNFA wants me to add, that she would happily apply for the job as the SOS RNFA-ready to help when an old-time assistant is needed.

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