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# -Worksheets-

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Worksheets

VGIS-7  
GROUP 743

Aalborg University

# Problem Statement

## Motivation

Robot assisted minimally invasive surgery (RAMIS) is used for many medical procedures. It allows for more precise surgery and lowers the risk of injury while reducing recovery time for patients [History of minimally invasive surgery]. Traditionally, the surgical performance has been measured in terms of surgeons' visuo-motor skills and dexterity, however a shift in the conceptualization of competencies is emerging in new literature (Safer Surgery book p 83). One of these competencies is teamwork in the operating theatre (source Hayley et al). A study concluded that 80% of incidents in anaesthesia related errors were preventable (Reported significant observations during anaesthesia: a prospective analysis over an 18-month period). Of these, 75% of these were due to human error.

Lingard et al studied communication in the operating theatre and found that 36% of errors affected the teamwork negatively (Communication failures in the operating room: an observational classification of recurrent types and effects). From this study, five key points of communication in the operating theatre were found: time, resources, roles, safety and sterility, and situation control.

To counter human errors, and to reduce critical events, simulation based training has become increasingly popular over the years (The simulated operating theatre: comprehensive training for surgical teams). This applies to multiple professional and high risk contexts such as aviation and surgery. As the goal of simulated training is to involve all members of the surgical staff and to enhance their performance, R. Aggarwal suggests that the method can also be applied to other procedures such as robot surgery. As robot surgery is also a high risk context, virtual simulations of high risk procedures is also beneficial. This paper will explore the possibilities of simulating a medical emergency during surgery training in Virtual Reality (VR) and document the effects on teamwork and performance.

## Problem Statement

Based on the information above and focusing on the impact of recent Virtual Reality technology, this paper aims to answer the following problem statement:

*"How can virtual reality be utilized to simulate an emergency situation during RAMIS training?"*

## Success Criteria

Up for discussion. What do you think Martin?

Suggestions:

- have a working prototype - have a way of measuring teamwork - have a way of measuring performance - have a procedure for testing the above and plan statistical test

# Rules

## Designing Rules for a VR Environment

To ensure realism and to estimate functionality of the virtual reality simulation a set of rules for the system should be drawn. The core rules can be separated into three primary groups; the system, the users, and the virtual equipment. However, these rules are set prior to implementation but are based on observations made in the training room as well as interviews with Jane Petersson. The mindmap of these rules is shown in Figure Figure 1.

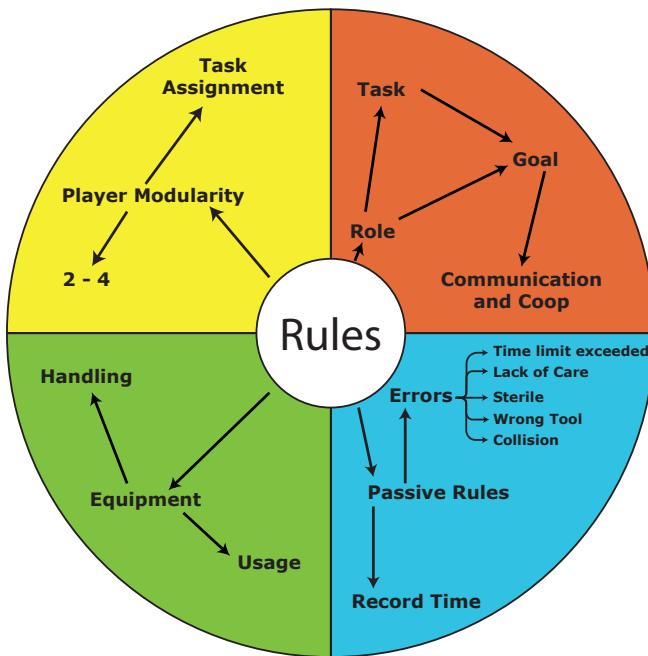


Figure 1: Mindmap

## The System

The rules set for the system can be considered passive. These rules primarily exist to accurately recreate the environment and ensure the proper functionality of the surgical equipment. These rules also track any errors that might be done by the users, such as poor positioning of the robot arms or incorrect tool placement.

## The User

The users in the scene should be designated a specific role which entails different tasks, but they should not be limited by that role. Completing a task as a group, rather than multiple individuals should be the primary focus for the users, since communication is vital to the success of the simulation.

## The Equipment

The equipment's rules should primarily focus on their specific use and how they should be handled by the users. Furthermore it should also include how the equipment should respond to certain user actions or other objects within the scene.

# Field Studies

## Purpose

The purpose of the studies was to understand how nurses and surgeons train to operate a da Vinci robot and perform robot assisted minimal invasive surgery (RAMIS), as well as to assess what must be included in a surgery scenario. Finally an evaluation of the finished product created is conducted on the basis of these interviews.

## Method

We observed a training session at MIUC followed by a semi-structured interview with Jane Petersson and Johan Poulsen to get an understanding of RAMIS and how surgeons practise. Furthermore, we performed a semi-structured interview with first assistant nurse Jane Petersson who is in charge of training nurses to handle the robot and how to act in a team environment.

A contextual inquiry is conducted to collect information resulting in different analysis models. To analyse and retrieve information in the matter the main method used is a contextual inquiry. This includes the different analysing models and interviews. We observed a robot assisted surgery at Aalborg University Hospital performed on a living human being.

The observation team took both pictures, notes, and some video from the operation. These illustrate the tasks and teamwork necessary to perform such an operation and were used to create different models used in contextual inquiries. The models used are; a physical model showing the layout of the room, a sequence model to clarify the work flow, and an artefact model showing objects used during the procedure.

To evaluate the simulation created, an expert review was conducted with both Jane Petersson and Johan Poulsen. They were both introduced to the simulation and

virtual reality and were able to try the simulation. Afterwards a scripted interview was conducted. The script for this is shown in Appendix A.

## Results

The results are split into three sections; one for the surgeon training at MIUC, one for the other interview with Jane Petersson regarding team training and the last for the expert review of the simulation.

### Surgeon Training at MIUC

The training sessions at MIUC varies depending on the skill level of the participants. In cases with skilled participants, the students takes on the role as instructors to help guide during the training session. This is beneficial as the surgeon often will be in charge of during surgery.

During the interview, Jane Petersson explained that during team training a surgeon will operate the robot while making calls for the nurses in training to do. The individual tasks for the nurses depends on their current role and what they are studying to become. For instance, a first assistant nurse is the one who assists the surgeon inside of the patient. In general, the training focus highly on getting familiar with the robot and how it operates during surgery. One particular task is important for the nurses to learn - how to dock the robot. As stated by both Jane Petersson and Johan Poulsen, ensuring that the robot is rightfully docked is key to enable the surgeon full movability of the robot. Johan Poulsen also expressed the importance of sterility of staff and tools, however in a VR simulated environment errors can be made without it causing complications which is beneficial for the learning process.

### Interview with Jane Petersson

One of the most important things during surgery and training is the emergency handling, however this requires extensive knowledge of the robot and tools. Another very important task is the placement of the robot arms because collisions during surgery can be very dangerous. Sometimes the surgeons adjust the arms manually.

In general, the training is for hands on experience with the robot and individual instruments, in preparation for a real surgery.

The team training consists of:

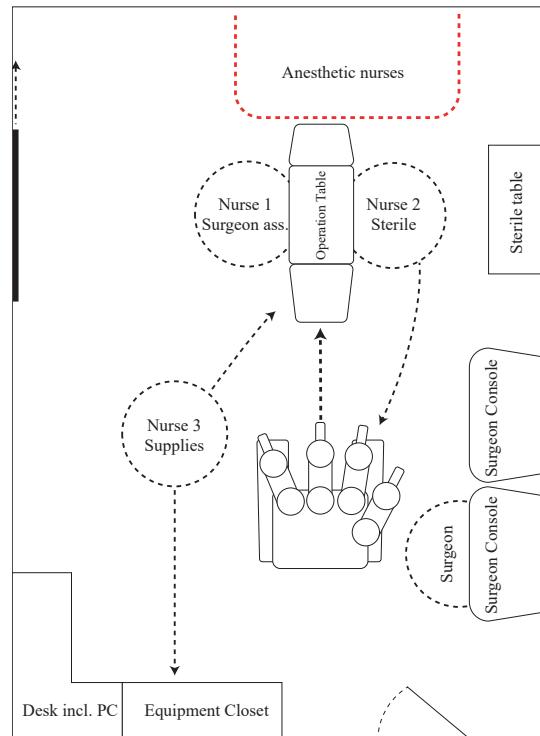
- First assistant nurse - Sterile, assists the surgeon inside the patient's body.
- Scrub nurse - Sterile, prepare unpacked tools for the first assistant nurse.

- Circulating nurse - Not sterile, unpacks tools, and can go outside the sterile area.

During training, on the first day Jane Petersson starts by talking and showing how tasks are done, students observe. On the second day, students are expected to do most of the tasks themselves. At the end of the second day, Jane Petersson sabotages some of the equipment and the students have to find and fix it. Any mistakes done by the students are used for learning purpose. At the beginning of the training, Jane Petersson makes most of the decisions, however later the surgeon is expected to take the lead.

## Contextual Inquiry

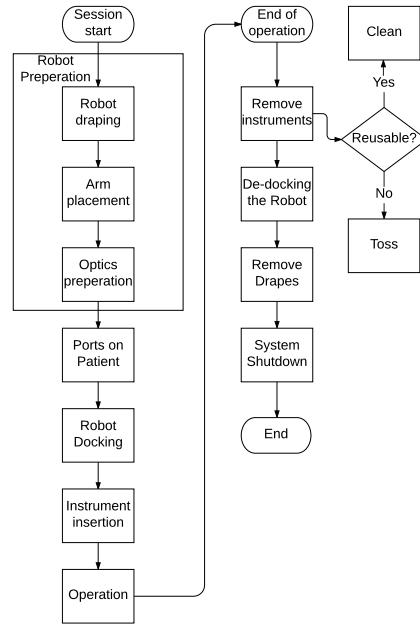
The physical model shows the layout of the operation room and the personnel's workspaces. The figure includes doors and their movement as well as other objects. The layout is shown in Figure 2.



**Figure 2:** The physical model showing the layout of the operation room

The physical enables the development and design of the room when creating the simulation.

The sequence model is based on Jane Petersson's worksheet used in team training at MUIC. The sequence model is shown in Figure 3.



**Figure 3:** Flowchart of the sequence model showing how the operation preparation and debrief is carried out

The sequence model describes the actions necessary to both start the operation and to end it. This enables the design of the tasks which should be included in the simulation and their order of appearance to the user. The model shown is for an operation without any complications, which could lead to de-docking of the robot in an emergency.

The Artefact models are shown in figures 4, 5, 6, 7, and 8. These are created from pictures taken during the observation. Figure 4 shows the plastic drapes used to cover the arms of the robot sterilising it. Figure 5 shows the endoscopic camera during calibration. Figure 6 shows the endoscopic camera up close. Figure 7 shows one of the ports used to insert the tools into the patient. Figure 8 shows the tools used with the robot.

## Expert Review

Jane Petersson and Johan Poulsen were both able to test the system. The following interview revealed that the system at present was satisfactory at simulating the scenario, but was not comprehensive enough to warrant implementation with them.



**Figure 4:** The drapes used to cover the arms of the robot, sterilising them



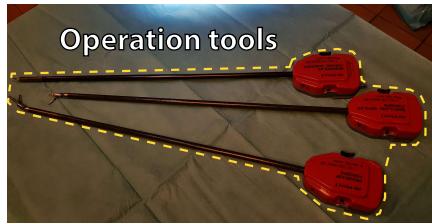
**Figure 5:** The camera used with the robot and a calibration tool



**Figure 6:** The endoscopic camera up close



**Figure 7:** One of the ports used to insert the tools in the patient



**Figure 8:** The tools used with the robot

They believed the interaction was sufficient, and that trainees didn't require additional features, however they both stated that several features should be available to the instructors, such as scene change and reset, interacting with procedures and progress, as well as changing the rules during play (for example by introducing emergencies).

One key point throughout the interview was realism. This was brought up many times during the interview, and the consensus was that the closer the simulation was to total realism, both with controls, models, and textures, the more it could replace or improve upon current training standards. This meant that, for example, the robot should have multiple end effectors to allow more realistic movement. The current da Vinci model has three control points and can rotate around itself which the simulated model does not. In addition, the robot itself should be moveable. Introducing tool ports would, together with the improved handling, allow for teaching docking and undocking in VR. Despite all this, draping the robot arms would need to be practiced at real facilities due to the need for accurate tactile feedback.

Johan Poulsen stated that there were limitations, but that systems such as this could be a must-have for the future of RAMIS. He talked about fully integrating the system with current simulators such as RAMIS console and anaesthetic nurse simulators. This could allow full surgery team training. As noted from the context study, Jane Petersson sabotages the robot setup during team training in order to train the nurses' and doctors' communication and emergency handling skills. Being able to control even more factors in virtual reality, such as patient fever, would allow for more detailed training of both nurses and surgeons. This concept could also be extended to include scenarios and scenario control. By being able to reset the scene and load a scenario where the setup is an appendectomy would also improve the utility of the system thereby having multiple scenarios to choose from.

Despite its limitations, the current version could be used to introduce medical students to RAMIS if realism was improved. Johan Poulsen also mentioned that, as there was no tactile feedback, the visuals in the scene had to become more realistic as the vision would overcompensate for the lack of tactile feedback.

Despite the current limitations both experts agreed that the controls of the system were intuitive and that the learning curve was appropriate for their level of expertise

with VR. Observations also showed that they both learned to teleport, grab, and interact with the robot fast.

## Conclusion

The observations and interviews have given an insight as to how both the surgeons and the nurses train and work with the da Vinci Surgical System. Furthermore, critical procedures have been explained by Jane Petersson. These procedures are a must know as failures within these could prove critical or even fatal.

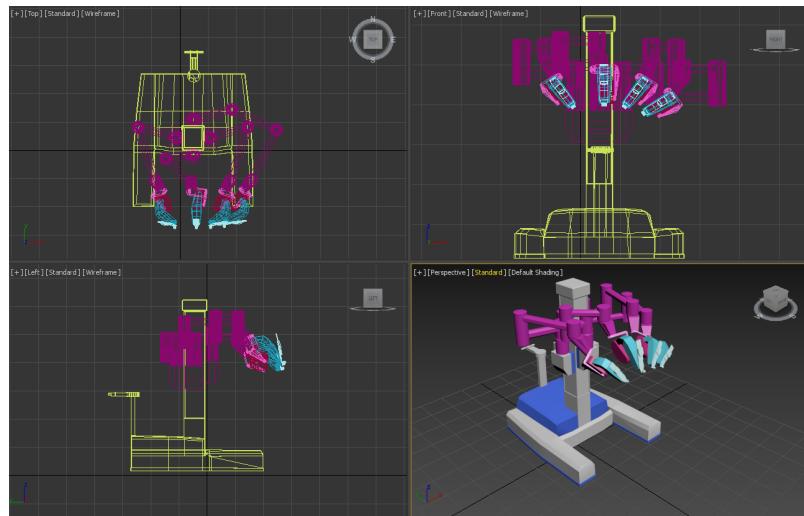
The concept of introducing VR training in established RAMIS training sessions seems feasible, however with some caveats. Currently, the system is too basic to warrant implementation at MIUC according to Johan Poulsen, but could serve other purposes such as introducing medical students to RAMIS. Experts stated that the system would require a high level of realism to accurately show the procedure and be useful in RAMIS training.



# 3D Modelling and Animation

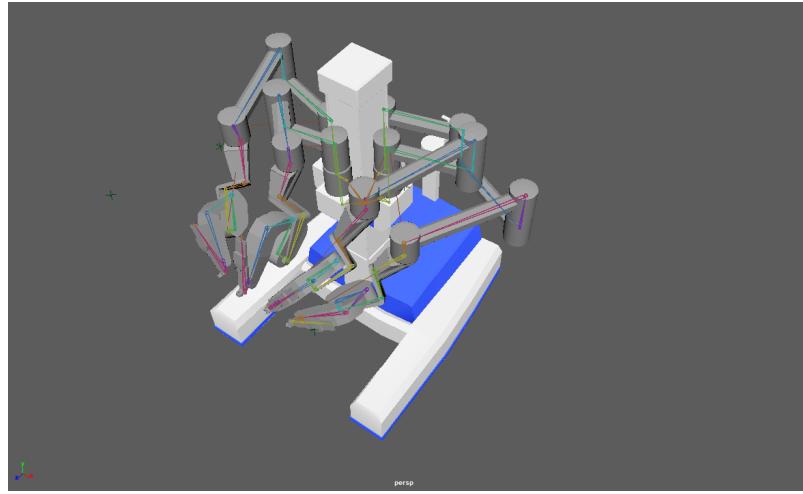
## 3D Modelling

The 3D model of the da Vinci robot was created in Autodesk 3DS Max. The robot needed to be modelled as realistic as possible and as such the program was chosen based on its level of detail and built-in functions. However, due to the location and visitation possibilities of the da Vinci Si System it was not possible to capture every detail of the robot. As such, the robot is modelled partially from images taken, images on the internet, and memory. The robot was modelled with box modelling and was compared to a human model to ensure somewhat realistic sizes of the individual parts.



**Figure 9:** The robot shown in Max' default workspace separated into four perspective views

After modelling finished the model was imported into Autodesk Maya which allows for easier rigging and animation. Maya is a tool that is tailored to animation whereas 3DS Max is primarily for modelling. Rigging the model was done according to where the robot is capable of rotating in real life.

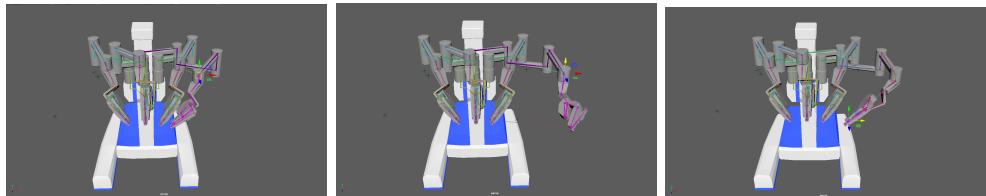


**Figure 10:** The robot shown in Maya's default workspace indicating bones

### 3D Animation

A 3D animation was created to ensure that realistic docking procedure could proceed as a backup for the real-time interaction. In the case of using animation instead of interaction, a button would have to be implemented in the scene to start the animation. As such, the robot would be in an initial "undocked" position and upon button press the robot would play the animation of docking. This animation could then be reversed to simulate undocking.

The animation was created in Autodesk Maya 2017, due to previous knowledge and its powerful animation tools. The robot had already been rigged in Maya for interaction in Unreal Engine 4, which allowed for quicker animation.



**Figure 11:** IK handles in Maya's workspace

# Shaders

## Purpose

The purpose was to create an outline that indicates to users whether the object they are nearing is interactable. The important objects in the scenario are the laparoscopic tools, the robot arms, and other items such as scissors and scalpels. Somehow indicating that items can be interacted with is important in VR and in many other graphical environments such as games.

## Method

Two different outlines were created using different techniques; inverted normal meshes and post processing. Inverted normal meshes, or front face culling, are applied over the regular mesh and upscaled slightly. They are easy on GPUs compared to many post processing effects, but lack in customizability and accessibility during runtime. They also get increasingly visually disruptive when applied to detailed meshes. Post processing is usually computationally expensive compared to the previous method since they require at least an extra depth render, but they perform better in edge cases (such as overlapping), and are very customizable even during runtime. This was implemented using Unreal Engine's post processing stack, a custom depth render on important objects, and a global custom material. In the case of overlapping, for example when users grab the objects, inverted normal meshes work as any other mesh in that it renders to the depth buffer, whereas post-processing requires an extra check for depth at each position.

The post-processing effect was implemented using edge detection. This means that colour differences at edges are detected, and a linear interpolation from normal colours to a chosen outline colour decides which to render based on a parameter called edge angle falloff.

## Results



**Figure 12:** Comparison between methods. Left: Post processing, line width 3. Right: Inverted normals mesh, upscaled 1.1

Figure 12 shows the two methods compared to each other. The inverted normal mesh is upscaled to 1.1 and uses black for both its main colour and its emission (meaning it is independent from light source blending). The post-processing effect uses texel width 3 and edge angle falloff -100 (which appears to only detect outer edges).

The post processing outline is a part of the mesh, whereas the inverted normals mesh extends over the regular mesh. The right side also shows some differences in line width, as well as some irregular lines around the eyes. On the left side, the lines being part of the monkey head mesh is also very obvious, as some of the detail is lost.

## Conclusion

Based on these results, we implemented the post-processing effect on the interactable objects in the scene. These were easily accessible and customizable, and provided a consistent look on all objects and at all angles without creating new meshes. The problem with detail loss from the outlines extending into the mesh was not an issue since the effect only appeared once users were close enough to grab the objects.

# FABRIK

Forwards and Backwards Reaching Inverse Kinematics (FABRIK) is an algorithm that efficiently solves inverse kinematics for a number of joints in a system. Being a heuristic model, FABRIK avoids solving rotational matrices as conventional IK solvers, and instead translate the joints to a point on a line. This results in low computational requirements and therefore faster computational speeds. A table comparing FABRIK to other IK solvers is shown in Figure Figure 13.

Average results (over 20 runs) for a single kinematic chain with 10 joints.						
	Reachable Target			Unreachable Target		
	Number of Iterations	Matlab exe. time (sec)	Time per iteration (in msec)	Iterations per second	Number of Iterations	Matlab exe. time (sec)
FABRIK	15.461	0.01328	0.86	1164	67.564	0.06207
CCD	26.308	0.12356	4.69	213	390.135	3.92869
Jacobian Transpose	1311.190	12.98947	9.90	101	6549.000	33.90473
Jacobian DLS	998.648	10.48051	10.49	95	2881.667	14.87918
Jacobian SVD-DLS	808.797	9.29652	11.50	87	2808.452	15.97591
FTL	21.125	0.02045	0.97	1033	22.325	0.02526
Triangulation	1.000	0.05747	57.47	21	1.000	0.06993

**Figure 13:** Comparisons of different IK solvers according to

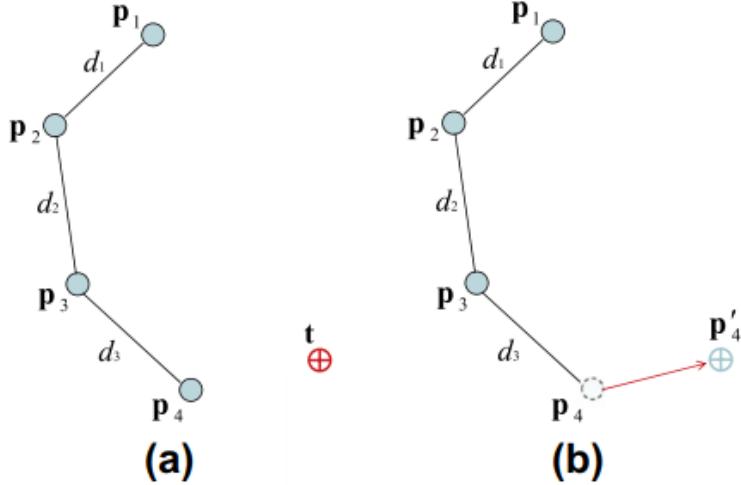
The following section describes how FABRIK have been implemented and applied to the virtual da Vinci robot. It also describes the current problems with the algorithm and its implementation in Unreal Engine. The algorithm have been implemented according to Andreas Aristidou and Joan Lasenby [].

FABRIK is implemented in Unreal Engine's Animation Blueprint, but as this only allows to define preset animation sequences, it cannot be used to interact with in real-time. Standard Blueprint does not allow for bone or joint transformations and therefore a Poseable Mesh has to be created from the skeletal mesh of the robot in order to program bone behaviour.

## FABRIK Algorithm Example

Figure ?? shows an example of a system consisting of four bones and an end effector. The goal of the algorithm is to get the outermost bone (P4) as close to the end effector (t) as possible and maintaining the original distance between each bone. The FABRIK algorithm starts by adding all bone lengths together to determine if

the target is reachable or not. As FABRIK is a heuristic bone translation algorithm it starts at the end effector P4 and sets its position to the target's position as seen in Figure XX. The new heuristic joint is called P'4



**Figure 14:** •

A line is then drawn from P'4 to P3, and since the original distance have to be maintained, P'3 is translated to somewhere on that line as seen in Figure ??(c). The position on the line is calculated by

$$P'3 = (\hat{P}3 - \hat{P}4) * d3$$

This procedure is then repeated for each bone in the system, creating a heuristic position for all joints, as seen in Figure XX. This results in the root bone(P1) being translated as well.

The root joint is then moved back to its initial position and the same process now repeats in the other direction (root to outer joint) as seen in Figure ??.

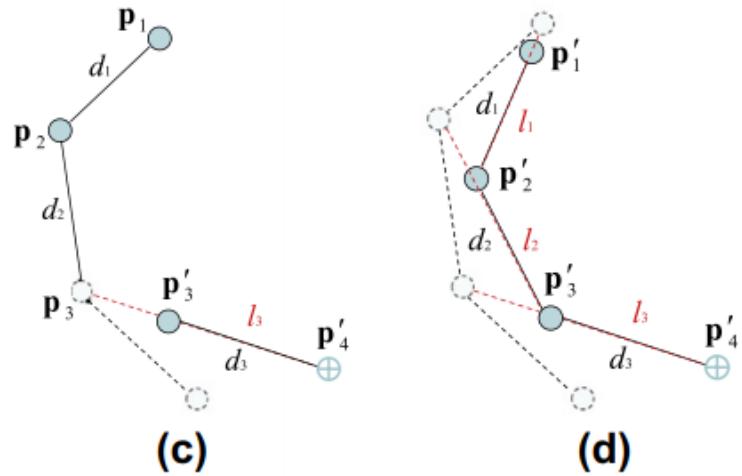
This process is then repeated until the end effector hits the target or gets sufficiently close.

### Implementation in Unreal Engine

For implementation purposes, Unreal's Poseable Mesh blueprint was used to translate the bones toward the target. Below is a table of the variables used by the blueprint with a description of its use.

The code is split up in four main parts;

- BeginPlay



**Figure 15:** •

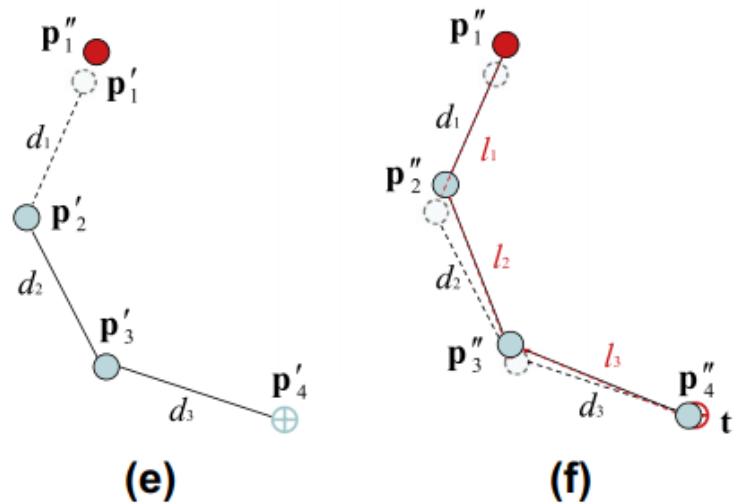


Figure 16: •

**Table 1:** My caption

Name of Variable	Type	Use
<b>Arm1</b>	Array of Bones	Contains all the bones of the robot arm. Used to re
		Contains all the bones positions in world space.
<b>BoneLocations</b>	Array of Positions	Used in the start to calculate the original distances
		between joints and updated later when new positions
		are calculated.
<b>Lengths</b>	Array of Bone Lengths	The array of bone lengths are constant and is needed
		to calculate heuristics.
<b>Target</b>	Object	The actual object that the end effector will try to reach.
		This is a red semi transparent cube. Used to set the effector's position to the target and to calculate proximity.
<b>Origin1</b>	Position	The root's original position. Used in the start of the loop where the root's position is set to its original position.

- OutOfReach
- Backwards (Heuristics)
- Forwards (Positioning joints)

BeginPlay initializes and calculates all of the variables in Table 1. OutOfReach determines if the target is out of reach and, if so, stretches all bones in the target's direction. Backwards handles the heuristics of the algorithm and the flow of this program can be seen in Figure 17. The Forwards then calculates the real position of the joint and sets the position of the joint in world space. The forwards look like the flow in Figure 17 the only difference being a positive for loop and the order in the "pos" calculation.

## Results

## FABRIK Backwards

This flowchart shows the backwards part of the FABRIK algorithm.

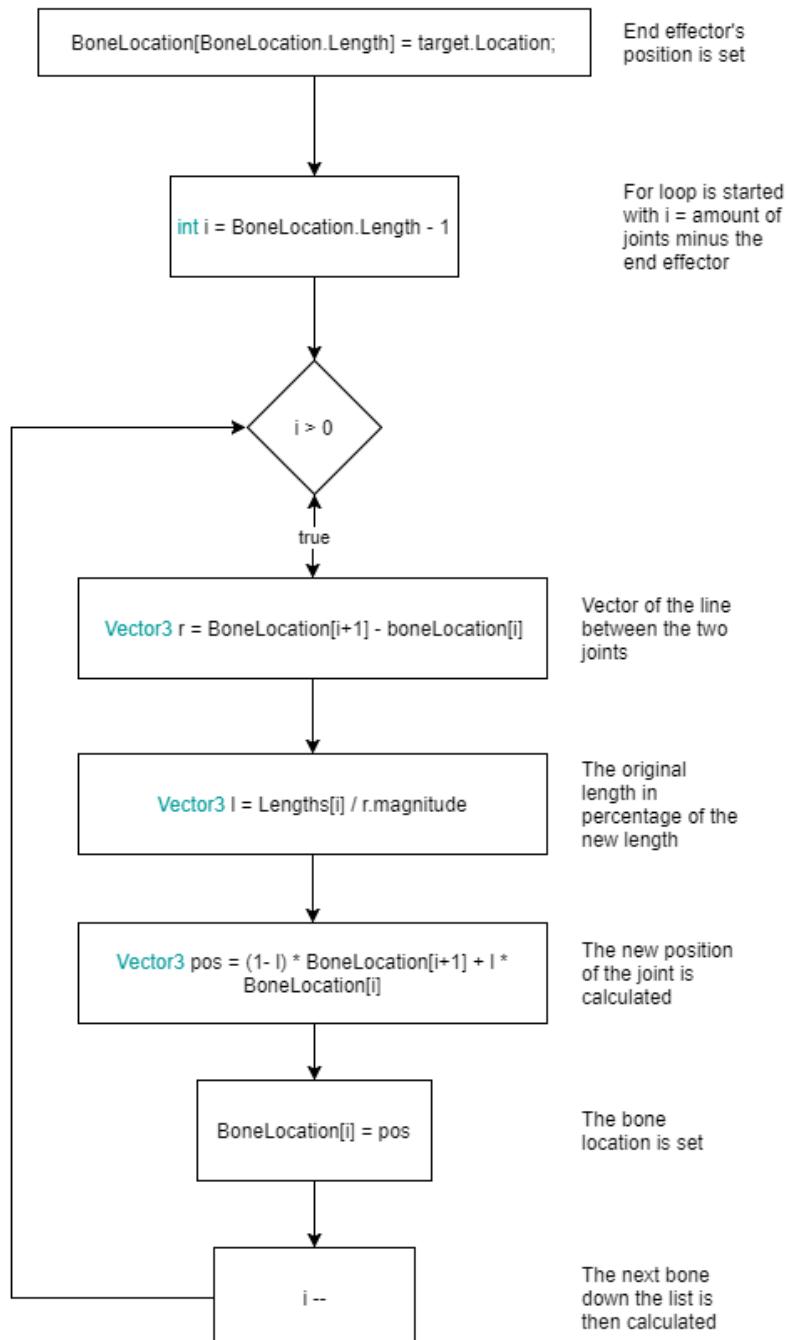


Figure 17: Caption here



# Internal Test

## Purpose

The purpose was to test the system used in the expert review, including hardware load and frame times. This was done to ensure a "smooth" (pls fix) test and to determine whether potential issues could be attributed to physical limitations. Since the review and system test were both performed over LAN, no latency testing was performed.

## Methods

The test was performed at AAU's Audio-Visual Arena using the computers described in Table 2.

Two players and two observers were present. The players moved around in an introduction scene and in the final scene used in the system review. The observers recorded data using MSI Afterburner and Fraps to measure CPU and GPU load as well as framerate.

	<i>Computer</i> <i>A</i>	<i>Computer</i> <i>B</i>
<b>CPU</b>	Intel Core i7-4770	Intel Core i7-6700
<b>GPU</b>	Nvidia GTX 980	Nvidia GTX 980
<b>RAM</b>	16GB	16GB

**Table 2:** Specifications of the computers used

## Results

The results from the hardware monitoring is shown below. The range indicates roughly 10 minutes of play.

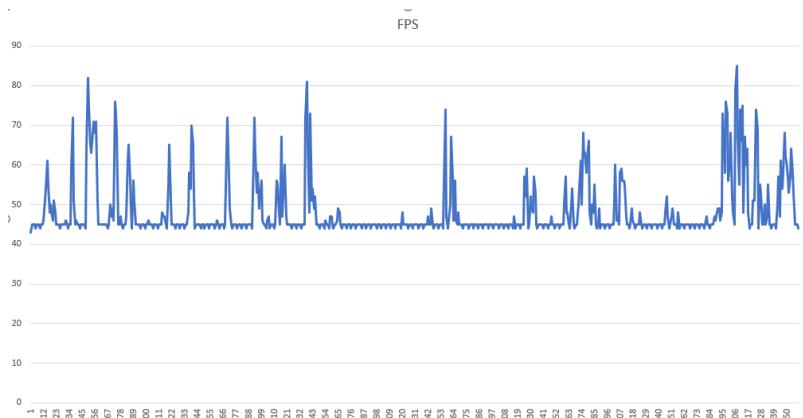


**Figure 18:** Hardware usage of Computer A



**Figure 19:** Hardware usage of Computer B

The results from recording framerate is shown below.



**Figure 20:** Results from recording framerate in Computer A



**Figure 21:** Results from recording framerate in Computer B

## Conclusion

The framerate results show line at 45 frames per second, however monitoring in the same scene before beginning the recording showed a steady 90 frames per second. We hypothesize that the recording software is at fault, and cannot accurately record framerate in virtual reality applications. This was, however, the only possible solution since no native software can log it.

The results show a steady decline in framerate for the client computer. This was confirmed in several tests to be the case for any computer used as client, but does not seem to be caused by overheating. The client's GPU usage steadily drops while CPU usage seems to jump.

This may be the fault of the Proteus multiplayer template for Unreal, and the issue could be writing to a file or otherwise adding data to an array that must be processed at each frame. The issue can be fixed by starting the scene using "25 minutes play time" instead of 10 minutes.



# Final System

## Description

The purpose of the project is to develop a simulation environment for training nurses in participating in RAMIS. The simulation needs to allow trainees to practice different tasks and scenarios that might occur during real surgery or be part of physical training. The simulation should allow for three to four trainees and an instructor to be simultaneously in the same virtual operating room. In the room, trainees have access to all the tools and equipment that would be available to them in a physical training. At this point we are simulating only emergency undocking since it is one of the most important asks during procedure according to Jane Petersson. The simulation allows trainees to walk to move on short distance or teleport for long distance movement. Interactable objects in the simulation, such as tools and the robot, can be grabbed to carry and use. Tools are two types, hand tools and robot equipment. The hand tools are used mainly by the first assisting nurse. The robot equipment includes the camera and tools that can be attached to the arms. Trainees can interact with the robot by moving its arms to achieve optimal placement, which is required for proper functioning of the robot. Additionally, voice over IP (VOIP) service is implemented to support communication between the trainees.

## Conclusion



## Appendix A

# Interview Script Including Notes

We firstly introduce Jane and Johan to the simulation. They will get to watch one from the group “play around”, while being explained how the controls work etc. The robot will be in un docked position, but the patient is still on the table. The 4 ports, camera and 3 tools are presented on the tool table, they can insert these and “play around”. Afterwards they will be able to try the simulation themselves and evaluate the scene.

### A.1 Simulation Feasibility

*Which aspects of the simulation works well?*

- The basic functionality is working well.
- The squares which was used to control the robot may need an indication of the orientation
- Nice that the instruments could be socketed
- The room itself worked well

*Which aspects of the simulation does not work well?*

- The cart needs to be moved closer to the patient.
- The arms didn’t work properly, as they weren’t moving in the same as the real robot did.
- The instruments should be able to move instead of just pointing down.

*Is anything crucial missing from the simulation?*

- More realism in general.

- You should be able to see the other “players” with each their dedicated roles.
- Working together.
- Being able to go from the nurse position and docking the robot to sitting at the console and operate the robot. – A full simulation of the surgery.
- Even expanding with anaesthetics and information hereof.
- Implementing disaster/accidents as well, which you would need to adept to.

*Is anything in the simulation redundant/superfluous?*

- No

*How would you describe the realism of the simulation? How did it affect the experience?*

- Nice and spacious.
- Needs more realism to be considered a useful simulation

*What details did you find missing/lacking in the scene?*

- The console is missing from the simulation
- Ports in the patient, to give an end goal for the. Maybe attach the arms to the ports and make insertion of the tools in the ports.
- When the arms are docked they should still be movable, but around the port socket of course.

## A.2 Further Work

*What is the next step for us to implement?*

- 5 ports and making the arms’ endpoints socket to the ports.
- Results of too much force
- It is too basic, but the idea has great potential.
- Refinement and realism are key points.

*What would you use this kind of simulation for? Opportunities, purposes, direction of development.*

- As of right now, it may be able to give a basic idea to a completely new user. But it’s not detailed enough. People will not be able to train with this simulation. It has a lot of simulation.

- It's too basic right, but with further development, it can yield enormous possibilities.

*Could it be used for showcasing?*

- As before, it should be refined and more realistic, but it is a possibility to use it to showcase what is going on, how the team work together and what is going on.

*Do the controls suit your needs? How?*

- The two control options are good.
- A reset button for a “mentor”/admin/supervisor.
  - A laser pointer which should be visible for everyone.
  - Regular controls as well.
- Admin controls to switch pre-set scenarios and the different kinds of operations/setups.

*Which scenarios are important as well?*

- Role designation

*What would be nice to have later on?*

- A complete simulation of a surgery where you're able to do everything which is done in real life.
- Tactile feedback would be nice – but you use your eyes and compensate as you know the visual signals.
  - We could use the vibration in the controllers



## **Appendix B**

### **Consentforms**

# Samtykkeerklæring

Jeg giver hermed samtykke til at deltage i projektet af gruppe VGIS743 fra Aalborg Universitet.

Jeg er indforstået med at deltagelse i dette projekt er frivilligt og at jeg til hver en tid har mulighed for at stoppe interviewet hvis jeg føler det nødvendigt.

Jeg giver hermed samtykke til at alt indsamlet information må blive anvendt i studierelateret sammenhæng. Lydoptagelser bliver slettet ved projekts afslutning, med mindre andet er aftalt.

Underskrift:

Dato:

  
Per  
4/12/12



# Samtykkeerklæring

Jeg giver hermed samtykke til at deltage i projektet af gruppe VGIS743 fra Aalborg Universitet.

Jeg er indforstået med at deltagelse i dette projekt er frivilligt og at jeg til hver en tid har mulighed for at stoppe interviewet hvis jeg føler det nødvendigt.

Jeg giver hermed samtykke til at alt indsamlet information må blive anvendt i studierelateret sammenhæng. Lydoptagelser bliver slettet ved projekts afslutning, med mindre andet er aftalt.

Underskrift: Jann Tørgaard

Dato: 4/12/17





## **Appendix C**

### **Peer Reviews**

# Review of: Introducing Virtual Reality in Robot Assisted Minimally Invasive Surgery Team Training

## Overall assessment

In general a decent paper with a nice and clear progression throughout the paper. The overall language used is clear and is well written and formally formulated, though with some inconsistencies. The overall goal is clear, but in a few places the line of thought or the argumentation could benefit from some revision or further elaboration.

A good investigation of an area of application of VR, make sure to emphasize the scientific contribution of the work.

## General Comments

*GC1:* The comparisons between surgery styles presented seem to compare only between open surgery and RAMIS. Would it not be more interesting to compare between RAMIS and normal Minimal Invasive Surgery in the cases where it is applicable?

*GC2:* The switch from the introduction to methods seem somewhat abrupt, maybe it would help with a small clear outline in the end of the introduction of what the work strives to achieve and what the main contributions are.

*GC3:* The paper in general includes a reasonable amount of figures, which also supports the written text well.

*CG4:* Make sure to include units on axes, legends etc. in the figures.

*CG5:* In general the language is clear but occasionally sentences seem incomplete or it could be formulated in a more elegant way. Considering your general style you probably will spot this when you review your article again before hand-in.

## Specific Comments

*SC1:* In regard to the statistics provided about deaths related to RAMIS it is a bit unclear whether the information in the table represents deaths or not and whether the 410 injury reports correspond to the 17.4% of deaths( that occur during operations). Also, what about people who die *after* the operation due to complications caused by the RAMIS?

*SC2:* In Figure 1 you have a nice caption to each of the subfigures, therefore the text in the subfigures seems redundant. Only put text in the figure if it is very important that it is there as opposed to in the caption.

*SC3:* In the beginning of the section context study you have a wall of text. Maybe try to break it for better readability.

*SC4:* Figure 3 is a great way to present the actions that are occurring simultaneously, however, the flow with the blue background is a bit difficult to read.

*SC5:* In the Section context study a point is made of the importance of and experienced user of RAMIS being present to answer questions. Where any considerations done in regard to how to incorporate that in a VR application (especially in respect to the training at non certified locations)

*SC6:* The SUS is a more less generally know scale. You can write that you calculate an average score for the participants and that u further more calculate the SUS score in the way that is specified by the developers of the SUS, but explaining it in detail and showing the formula seems a bit redundant. Also, usually the sus score is just provided as a number between 0 and 100, Is there a specific reason why you provide it as a percentage?

*SC7:* It should be clearer what information you gain from plotting the mean scores of the sus against the age (especially as your age span is so small).

# Introducing Virtual Reality in Robot Assisted Minimally Invasive Surgery Team Training

## Group 743

### **Overall:**

Overall the user experience test and references to the study about your project are really nice and useful for the reader to understand where your product is useful and why it can be useful. However it is not clear what your product is about, since it didn't get described very well. For your Introduction segment it seems to follow the "Why and what for (four)" somewhat, but is severely lacking the last what, as it is about explaining what will be presented in this paper.

The Discussion stated that the product was made for multiplayer use in a procedure - second paragraph - but this was not made clear enough through your paper as it was not stated anywhere else. You should at least describe what you are implementing and go more into details what RAMIS and Da Vinci is.

Overall your Discussion segment should be split into 3 sections, Discussion, Conclusion and Future work where the Discussion needs to include a discussion of your results, if they went well or not and why. You made some good points in your introduction and it would be nice if you write a conclusion and conclude if a nurse was/wasn't better trained using your product.

### **General comments:**

- Your abstract is very well written and easy to understand.
- The introduction is very long and shouldn't have any subsection.
- The context study seems to belong under methods and not in the introduction.
- When you reference to an image, use numbers and letters like Figure 3.a not "top image".
- When giving a random number like a price you need to reference where it is from.
- Good idea to use the SUS to evaluate the usability of the system.
- The discussion seems to be a mix of a conclusion, discussion and future work.
- The discussion should discuss your results. What went right, what went wrong and what should be improved and what was good enough.
- Make a conclusion to conclude on the introduction you set up. (we're guess you didn't do that because you don't have enough results to conclude on your product yet, but it would still have been nice to see an indication that you planned to implement it).

### **Specific comments:**

See attached PDF-file for detailed comments.

# Review of Introducing Virtual Reality in Robot Assisted Minimally Invasive Surgery Team Training

## Title

The title is okay. Maybe find another way of saying minimally invasive or use “collaborative training” instead of “team training”, but the title is already good as it is.

## Layout

The introduction is too long. Maybe a “Context” section could replace part of it. Besides, there may not need to put an “A” subsection if there is no “B”. There again, this could maybe fit in a “Context” Section.

However, the Method section has no subsections. This could be improved by separating the description of your approach, the actual protocol used in different subsections.

## Content

In the abstract you mention usability score. What kind of metric is that? What is it based on?

The median score was 67.5, with the first quartile scoring 45 and the third scoring 86.25.

You should consider reporting your test results in a more structured way, like having important values in one table, instead of mid-text. All your graphs need to have their axis labeled. I couldn't figure out what 0-4 on the y axis represents since you're talking about SUS scores which are in the range of 0-100.

Why did you choose to use SUS as the method to measure your results. Was there other approaches to it ?

This paper lacks some maths.

## Figures

The figures at the end of the paper are not aligned and without captions. It's not even mentioned what they are showing.

Graphic doesn't make sense. You need to label your axis:

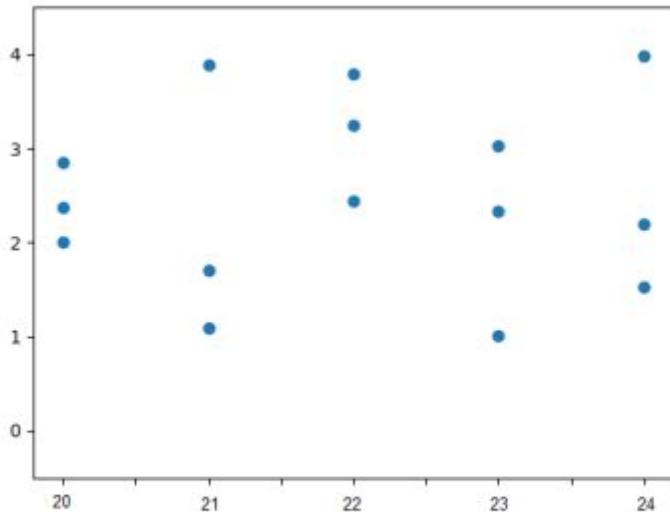


Fig. 5: Mean scores plotted as a function of participant age

Figure 5 shows the participants' scores plotted as a function of their age. Linear regression returns  $y = 0.03x + 2.06$ .  $R^2$

It looks like you're performing regression on figure 5, but the y-axis looks categorical and not continuous. Seems a little weird.

General notes:

You should consider reporting your test results in a more structured way, like having important values in one table, instead of mid-text. All your graphs need to have their axis labeled. I couldn't figure out what 0-4 on the y axis represents since you're talking about sus scores which are in the range of 0-100.