SCIENTIFIC PAPER

*SLS* 

# **Criterion-Based Training With Surgical Simulators: Proficiency of Experienced Surgeons**

Wm. LeRoy Heinrichs, MD, PhD, Brian Lukoff, MS, Patricia Youngblood, PhD, Parvati Dev, PhD, Richard Shavelson, PhD, SLS Committee on Surgical Simulation: Harrith M. Hasson, MD, Richard M. Satava, MD, Elspeth M. McDougall, MD, Paul Alan Wetter, MD

# **ABSTRACT**

**Objective:** In our effort to establish criterion-based skills training for surgeons, we assessed the performance of 17 experienced laparoscopic surgeons on basic technical surgical skills recorded electronically in 26 modules selected in 5 commercially available, computer-based simulators.

**Methods:** Performance data were derived from selected surgeons randomly assigned to simulator stations, and practicing repetitively during one and one-half day sessions on 5 different simulators. We measured surgeon proficiency defined as efficient, error-free performance and developed proficiency score formulas for each module. Demographic and opinion data were also collected.

**Results:** Surgeons' performance demonstrated a sharp

Department of Obstetrics–Gynecology, Stanford University, Stanford, California, USA (Dr Heinrichs)

Stanford University Medical Media and Information Technologies (SUMMIT), Stanford, California, USA (Drs Heinrichs, Youngblood, Dev)

School of Education, Stanford University, Stanford, California, USA (Mr Lukoff, Dr Shavelson)

RealSim Systems, Albuquerque, New Mexico, USA (Dr Hasson)

Department of Surgery, University of Washington, Seattle, Washington, USA (Dr Satava)

Department of Urology, University of California–Irvine, Irvine, California, USA (Dr McDougall)

Society of Laparoendoscopic Surgeons (SLS), Miami, Florida, USA (Dr Wetter).

The cooperation of the participants was commendable. The assistance of Margaret Krebs has been invaluable for organizing these study events, and the simulator setups by Robert Cheng are greatly appreciated. SLS personnel (Susan Mazzola, Linda Collier, Connie Cantillo) and AAGL personnel (Frank Loffer, MD, Linda Michaels) provided valuable space and project support. The voluntary collaboration of the simulator companies and their representatives is the backbone that enabled the success of this endeavor: we thank Surgical-Science (LapSim), Simbionix (Lap Mentor), RealSim Systems (LTS 2000 ISM60), METI (Surgical Sim), and Haptica (ProMIS) for providing systems and supportive personnel. Encouragement from Parvati Dev, Director of SUMMIT, is greatly appreciated. The financial aid of TATRC (Telemedicine and Advanced Technology Research Center – Gerry Moses, PhD) and of DARPA (Defense Advanced Research Projects Agency – Richard Satava, MD) made this study possible.

Address reprint requests to: Wm. LeRoy Heinrichs, MD, PhD, SUMMIT, 251 Campus Dr West, Stanford, CA 94305, USA. Telephone: 650 723 4040, Fax: 650 725 7412, E-mail: Brian.Lukoff@stanford.edu

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learning curve with the most performance improvement seen in early practice attempts. Median scores and performance levels at the 10th, 25th, 75th, and 90th percentiles are provided for each module. Construct validity was examined for 2 modules by comparing experienced surgeons' performance with that of a convenience sample of less-experienced surgeons.

**Conclusion:** A simple mathematical method for scoring performance is applicable to these simulators. Proficiency levels for training courses can now be specified objectively by residency directors and by professional organizations for different levels of training or posttraining assessment of technical performance. But data users should be cautious due to the small sample size in this study and the need for further study into the reliability and validity of the use of surgical simulators as assessment tools.

**Key Words:** Surgical simulation, Proficiency scores, Laparoscopic surgery, Experienced surgeons.

# **INTRODUCTION**

The 1999 Institute of Medicine report *To Err is Human*<sup>1</sup> riveted the medical establishment's attention onto errors made during patient care. A significant portion of the errors occurred during the care of surgical patients, and the report made recommendations for mitigation. Also in 1999, the American Council on Graduate Medical Education (ACGME) endorsed 6 competencies required for resident medical education.2-4 Those in *Patient Care* and in *Practice-Based Learning* concern several components of surgical management, one of which is technical competence in conducting surgical procedures. By 2002, training programs were required to implement the ACGME recommendations to achieve program certification. Simultaneously and independently, surgical simulation has become established as a valid technique for training basic surgical skills performance of novice surgeons and demonstrating that their performances suffer compared with those of experienced surgeons.<sup>5–7</sup>

Performance can be measured electronically on many surgical simulators, thereby affording objective assessments of technical competency not possible with prior methods of training and assessment.<sup>6,8-11</sup> Commercially available surgical simulators have unique outputs of performance and errors that are different between systems because standards have not been developed. The metrics found in simulators are of several types including units that describe distances that instrument tips travel (mm) in pursuit of a prescribed target, an economy measure (%) that relates the distance traveled compared with the direct distance, smoothness of the movement (a rate), the percentage of targets touched and transferred, the number (#) of minor or major errors, and other things (**Appendices 1-4**). This diverse set of outputs provides immediate feedback to users, but only a few (such as time taken) can also be utilized for determining normative performances across the various commercially available simulators. This research project has its roots in the need to document these metrics, to establish performance data for guiding the use of simulators in surgical training, and to develop a criterion-based training capability that is useful for residency program directors, vendors, and professional surgical organizations that seek to adopt surgical simulation as a learning and assessment technology.

# **METHODS**

The Surgical Simulation Committee of the Society of Laparoendoscopic Surgeons (SLS) (Drs Satava, McDougall, Hasson, Heinrichs, Youngblood, Wetter) authorized SUMMIT to conduct this study before the 15th Annual Meeting in San Diego, California, during September 2005. Committee members and vendors met at SUMMIT on July 25th to review the modules of each simulator and select the 26 modules to be performed **(Table 1)**. Based on professional reputation of surgical excellence and volume of surgical cases, laparoscopic surgeons in General Surgery, 7; Obstetrics and Gynecology, 6; and Urology, 3, (one surgeon's specialty was unknown) were recruited by committee members not conducting the trials. The 17 surgeon-participants included members of the following professional organizations: the American Association of Laparoendoscopic Laparoscopists, American College of Surgeons, American Urological Association, Society of American Gastrointestinal Endoscopic Surgeons, and Society of Laparoendoscopic Surgeons. The participants were paid to join this one and one-half day study group to provide their performance of surgical skills in an IRB-approved study. The number and type of systems available from vendors were *Lap Mentor* (2, Symbionix, Cleveland,

OH), *LapSim* (4, Surgical-Science AB, Göteborg Sweden), *LTS2000 ISM60* (4, RealSim, Albuquerque, NM), *ProMIS* (2, Haptica, Boston, MA), and *SurgicalSIM,* (3, METI, Sarasota, FL).

Data were collected anonymously, and participants completed 2 questionnaires, one providing demographic information and the other a rating scale filled out immediately after participants completed their last performance on each simulator. Participants were assigned randomly to each system that was initially demonstrated by trained personnel who then answered the subjects' questions before logging them into the system. After the demonstration, surgeons completed the first module at least once and repeated the module if time were available before participants were signaled to move to another system; performance data were collected on all trials. After completion of a trial, assistants logged participants out and saved their results. On Day 1, 35 minutes was allocated for each system; later sessions allocated 30 minutes per system. In the interest of accumulating the maximal number of performances, a flexible schedule allowed participants to complete a module before moving to their next assigned system. The mean number of trials per surgeon was 3.5, and the maximum was 10. A preliminary report of this study has been presented.12

These procedures are very similar to those developed and used on 2 previous occasions for collecting data from a "convenience sample" of attendees at the 2004 annual meetings of the SLS and the AAGL in New York City and San Francisco, respectively.13 These trials, used in this report as a reference sample of less-experienced surgeons, were limited to the Peg Manipulation module of the LTS 2000 and the Lifting and Grasping module of the LapSim. These trials were not timed and were not repetitive, although some surgeons performed them more than twice.

We developed a proficiency score formula for each module of the form  $b_0 + b_1 X_1 + b_2 X_2 + \ldots + b_k X_k$ , where  $b_0$ ,  $b_1, b_2, \ldots, b_k$  are constants (called coefficients) and  $X_1$ ,  $X_2, \ldots, X_k$  are the measures (variables) recorded in the module. As an example, one possible proficiency score formula is proficiency  $score=120 - (2 \times Time) - (4 \times$ Errors). The number 120 is arbitrary and can be adjusted upward or downward to achieve a desired shift of the values. Achieving a theoretical proficiency score of 120 would require using zero time and making zero errors during a performance, obviously impossible conditions. The coefficient of each variable indicates the amount by



which the proficiency score changes for each unit increase in the measure. In the example proficiency score formula above, each extra error results in a proficiency score decrease of 4 points.

Assumptions in the analysis are that the proficiency levels of our participants (the experts) are at least 50 on a  $0-100$ scale, proficiency increases with practice, and that best performances are near 100. We compared other formulas that made assumptions of longer-time-to-plateau in proficiency scores, but the data reported below represent the "best fit" to the formulas.

### **RESULTS**

The dataset for this benchmark study comprises 204 measurements for the 26 modules selected and was performed 0 to 10 times each by 17 surgeons. As expected and illustrated in **Figure 1**, the earlier practice attempts demonstrate a sharp learning curve followed by less proficiency score improvement. **Table 2** provides data that guided our decision for using attempt #4 for presenting benchmark data: out of 204 measures across all of the modules, 183 (90%) exhibited their largest changes between attempts by attempt #4.

Median scores and performance levels at the 10th, 25th, 50th, 75th, and 90th percentiles are provided in **Table 3** to characterize the behavioral (performance) domain for experienced surgeons performing each module. See **Appendices 1–5** for the remaining data. To provide the most uniform dataset and proficiency scores, data points further than 2 SD away from the mean were purged, to reduce the influence of outliers.

Each proficiency score has behind it a formula that combines the measures taken by the simulator into a single score. For LapSim Lifting & Grasping, that formula is:



For example, a surgeon with a median-level performance on each of the variables (the 50th percentile column in **Table 3**) would have a proficiency score of



Mean values and SDs were also computed for completeness. However, for technical reasons, we prefer the use of percentiles rather than means and standard



**Figure 1.** Graph of proficiency scores: (A) ideal practice curve; (B) lifting and grasping module of LapSim.



\*We present Attempt #2 data from the LapMentor tasks because less data were available for these tasks.

†Because the number of surgeons present for Attempt #3 was on average about 2.1 higher than the number present for Attempt #4, the accompanying website presents data for both Attempts #3 and #4.

deviations, so such information can be found in **Appendix 1.**

Some participants were unable to complete the 3 halfdays due to competing activities and unexpected responsibilities. Also, one vendor's systems were delayed in US Customs, and 2 provided fewer than the ideal number of 4 systems needed for this number of participants. The consequence was fewer data for those systems, particularly the Lap Mentor.

# **Opinions for Surgeon Users**

On the third half-day of the study, the surgeons evaluated the overall effectiveness of the 5 simulators as training tools (in comparison with training not given on a computer) on a 4-point scale. Their average ratings ranged from 3.1 to 3.8, signifying the range of *very good* to *excellent* **(Figure 2)**. Nevertheless, the mean effectiveness ratings for each

# **Reliability**

One simple way to get a measure of reliability is to compute the correlation between proficiency scores on successive attempts after the learning curve has flattened out. We computed the correlations between proficiency scores on attempts 3 and 4 on all the systems except LapMentor tasks for which we had only 2 attempts. The average correlation was 0.65, with quite a large range (0.14 to 0.96).

# **Validity**

One simple measure of the validity of our proficiency score formula is to see whether it distinguishes between the experts in our sample and the "convenience sample" taken at the 2004 SLS and AAGL meetings. Unfortunately, we only had 2 tasks of overlap between the 2 samples, and the sample sizes were fairly small. However, the results do suggest some validity for the proficiency score formulas tested. For the Peg Manipulation task of the LTS 2000 simulator, our expert sample had a mean score of 85.49, while the convenience sample had a mean score of 81.43. However, this difference was not significant (P=0.25). For the Lifting and Grasping task of the LapSim simulator, our expert sample had a mean score of 79.36, while the convenience sample had a mean score of 68.04. This difference was statistically significant  $(P<0.01)$ . It should be noted that these results are merely suggestive





Figure 2. Mean ratings of the effectiveness of the 5 simulators (1) is poor and 4 is excellent).

for a number of reasons (eg, only 2 tasks were available for comparison, and the expert sample was used to create the proficiency score in the first place). Further work is needed to ensure that our proficiency score formulas are valid. For example, a validity study might compare our proficiency score formulas with independent ratings of surgeon performance by experts in the field.

# **DISCUSSION AND CONCLUSION**

This study provides the surgical community with the first set of performance data for criterion-based training on a group of 5 surgical simulators based on the performance of 17 experienced laparoscopic surgeons. Three objectives were met<sup>1</sup>: acquiring standardized data simultaneously from a practically large group of experienced surgeons,<sup>2</sup> providing vendors with data for guiding their development of courses for general use, and<sup>3</sup> providing surgical program directors and professional organizations with data for setting standards for criterion-based training and assessment. Using these criteria, training program administrators will tentatively be able to calibrate their training programs and requirements with any of these systems. We say tentatively because experience with the proficiency scores will provide feedback only as to reasonable levels of performance in practice, because *none of the simulators were developed as an assessment instrument per se, and because future studies should map the link between performance on the simulator tasks and performance in surgery*. Although we believe that these data are too few for attempting to certify the technical skills of surgeons with the present systems, they provide a strong resource for guiding self-learning goals by surgical residents and residency achievement benchmarks. They also may inform medical students making career decisions

about the level of technical skills required in laparoscopic surgery.

The data provide a criterion against which trainee performance can be evaluated. Two different representations of the criterion data were provided: percentiles and means  $\pm$ SD. We recommend use of percentiles for criterion setting as this representation is directly interpretable—for example, a trainee's performance is equivalent to the 25th percentile performance of experienced surgeons, is less influenced than means by extreme performance scores, and does not depend on the assumption of normality to interpret, as does the interpretation of means with SD.

A *Proficiency Score* at or near the median is consistent with performances by the middle individual among a group of experienced surgeons who performed this exercise/module; a score at or near the 25th percentile indicates a performance better than those given by 25% of the experienced group, and a score at or near the 75th percentile indicates a performance better than those given by 75% of the experienced group."

With further experience with criterion-referenced data, our objective will become competence-based training, fulfilling the ACGME objectives. Academic surgeons, professional societies, and certifying boards must soon adopt training objectives and curricula that move away from the calendar as a training-endpoint.14 The United Kingdom has already taken a step in that direction.15,16

The language of metrics used within the surgical community deserves comment. All of the several skills required for performing these tasks are based on and reflect the inherent *abilities* of each user, including eye-hand coordination, visual-spatial perception, focus, neuro-muscular stability, and other such things.17,18 The *skills* required for performing the *tasks* listed in **Table 1** require practice to improve performance and are shared by most of the simulators. Beyond *tasks,* procedures are the product of choreographing multiple *tasks* that, when combined, comprise a surgical manipulation or procedure.19,20 Some systems describe tasks by using the names of skills, providing confusion for users. For example, grasping and transfer or grasping and lifting are individual skills, not tasks, but the combination of 2 skills has been labeled as a task in the LapSim. As development of simulators evolves, additional graphics and functions are being introduced, moving toward "part-procedure" trainers. Thus, nomenclature too has not been standardized across systems.21 Delineation of the skills that comprise each task is presented in **Table 1** to clarify the nomenclature.

Similarly, error(s) recorded vary among modules. In the Peg Manipulation module of the LTS2000, dropping a peg is recorded as one error. Errors could also reflect touching the target with the shaft of a grasper, or striking the edge of a bounding box with the target-in-transfer, or the instrument tip, or the instrument shaft, etc. The LapSim module on Lifting and Grasping records errors of several types, such as touching the cover lying over a target object (surgical needle) with the shaft of a handle or touching the background (producing a *red-out*), and it records the depth of pressure-distortion of the background. It does not record the number of attempts the user makes in lifting the lid, nor the number of times that it is dropped inadvertently. These are additional features by which stability of performance can be assessed on that module. The Simulation Committee will respectfully address each vendor with suggestions for improvement of the measures recorded, with a request that such changes be introduced as an incentive for obtaining endorsement from professional surgical societies.

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# **Appendix 1. LapSim Modules (Medium Difficulty) Attempt #4**

### **Module 2: Instrument Navigation**

*Proficiency* - *136.4479 - 36.7202 Left instrument path length 21.4565 Right instrument path length -0.012 Right instrument angular path - 0.6106 Right instrument time - 0.2756 Tissue damage - 0.1563 Maximum damage*

# Variables Measured and Criterion Percentile Values Variable 10 10 25 50 75 90 Left instrument path length 0.06 0.65 0.72 0.77 0.81 Left instrument angle path 168.37 180.38 204.47 228.95 245.88 Left instrument time  $9.20$  10.13 11.11 12.76 14.86 Right instrument path length 0.58 0.62 0.70 0.74 0.81 Right instrument angle path 131.35 142.44 155.53 180.19 194.22 Right instrument time 9.74 11.39 14.11 15.53 17.32 Tissue damage  $0.00$   $0.00$   $1.00$   $1.00$   $4.00$ Maximum damage  $0.00$  0.00 0.00 0.75 1.37 5.33 Proficiency score 77.49 78.89 84.37 88.50 93.37 Means  $\pm$  Standard Deviations for Each Variable



#### **Module 3: Grasping**

*Proficiency* - *111.5076 2.9354 Left instrument path length 0.0013 Left instrument angular path -0.0632 Left instrument misses - 1.2948 Right instrument path length - 0.2603 Right instrument time -0.1122 Right instrument misses 0.1343 Maximum damage*





#### **Module 4: Cutting**

*Proficiency* - *120.2763 - 0.0461 Cutter angular path - 0.4382 Total time - 0.0685 Maximum stretch damage - 0.1884 Rip failure*



### **Module 5: Lifting and Grasping**

*Proficiency* - *132.0551 - 9.7609 Left instrument path length - 0.002 Left instrument angle path - 0.098 Right instrument misses - 1.6881 Right instrument path length - 0.4771 Total time - 0.0971 Max damage*







# **Appendix 2: LTS2000 ISM60\* Attempt #4**





### **Module 4: Knot Integrity** *R-Proficiency* - *106.8519 - 0.1852 Time*





Dr. Hasson).

**Appendix 3: Surgical Sim Attempt #4**





### **Module 3: Retract and Dissect**

*Proficiency* - *105.6126 - 0.244 Total time - 6.8972 Dissected outside target left - 5.3848 Dissected outside target right - 1.3444 Lost aligned pod left - 10.7167 Lost aligned pod right*







# **Appendix 4. ProMIS Attempt #4**



### **Module 2: Instrument Handling**

*Proficiency* - *127.6061 - 0.7341 Total time - 0.09 Left instrument path - 0.0171 Left instrument smoothness - 0.0149 Right instrument smoothness*

Variables Measured and Criterion Percentile Values					
Variable	10	25	50	75	90
Total time	39.457	36.848	32.855	29.105	25.323
Left instrument path	121.697	117.532	113.115	102.043	93.457
Right instrument path	120.204	114.25	109.845	99.373	95.195
Left instrument smoothness	110.7	105.75	94.5	82.5	71.8
Right instrument smoothness	120.2	117	112	97	81.4
Proficiency score	84.392	86.033	90.194	93.06	98.247
Means $\pm$ Standard Deviations for Each Variable					
Variable	$-1.5$	$-1$	$\theta$	$+1$	$+1.5$
Total time	24.296	27.04	32.526	38.012	40.756
Left instrument path	88.268	95.651	110.417	125.183	132.566
Right instrument path	92.082	97.361	107.921	118.481	123.76
Left instrument smoothness	66.525	75.383	93.1	110.817	119.675
Right instrument smoothness	79.733	88.155	105	121.845	130.267
Proficiency score	82.336	85.075	90.554	96.032	98.771

#### **Module 3: Suturing & Knot Tying**

*R-Proficiency* - *100.1275 - 0.005 Left instrument path - 0.013 Right instrument smoothness*



# **Appendix 5: LapMentor Modules Attempt #2**



# **Module 2: Camera Navigation (30°)**

*Proficiency* - *131.2485 0.1744 Total time 11.6569 Total no of camera shots 0.0118 Total path length of camera in cm 9.8071 No of correct hits*



### **Module 3: Eye-hand Coordination**

*R-Proficiency* - *183.0005 2.0767 Total number of touched balls 1.5668 Number of movements of left instrument 0.5533 Total path length of right instrument in cm*





# **Module 4: Clip Applying**

*Proficiency* - *143.5707 0.4326 Total time 0.0838 Number of movements of right instrument 0.2969 Number of movements of left instrument 0.1786 Relevant path length of right instrument in cm*





# **Module 5: Grasping and Clipping**

*Proficiency* - *148.6876 2e-04 Total time 7e-04 No of lost clips2e-04 No of movements of right instrument 0.1511 Total path length of clipper in cm 0.1518 Total path length of grasper in cm 6e-04 Relevant path length clipper in cm*

Variables Measured and Criterion Percentile Values



# **Module 5: Continued**



### **Module 7: Cutting - Dissecting**

*Proficiency* - *112.6316 0.13 Number of movements of right instrument 0.071 Total path length of left instrument in cm*







#### **Module 6: Two-handed Maneuvers**

*Proficiency* - *103.6793 0.2457 No of movements of right instrument 0.0311 Total path length of left instrument in cm 0.0357 Relevant path length right instrument cm 0.0377 Relevant path length left instrument cm 1.9945 No of exposed green balls that are collected*

Variables Measured and Criterion Percentile Values





# **Module 8: Scarification - Hook Electrodes**

*Proficiency* - *144.9011 0.116 Total time 0.2142 Total cautery time 1.2048 No of nonhighlighted bands that were cut 0.1173 No of movements of right instrument 0.09 Total path length of left instrument in cm*

Variables Measured and Criterion Percentile Values





### **Module 9: Translocation of Objects**

*Proficiency* - *100.8715 0.1731 No of dropped objects 0.0386 No of movements of right instrument 0.0067 No of movements of left instrument 0.0039 Total path length of left instrument cm 0.8116 No of properly placed objects 0.2401 No of translocations*



