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Miscommunication In The Robotic OR: Speech Communication Interference

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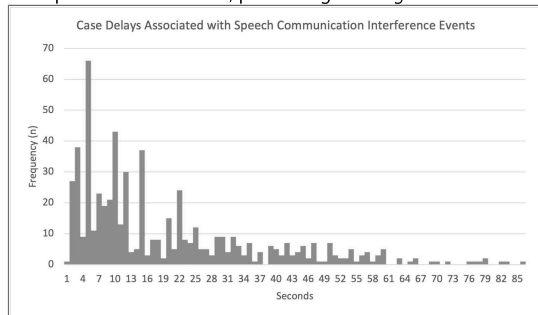
Abstract:

Introduction: Miscommunication in the OR is a threat to patient safety. Our objective was to measure the frequency and causes of miscommunication between robotic team members.

Methods: We observed 78 robotic surgeries over 214 hours. 65.8% were General Surgery, most commonly cholecystectomy. A validated Speech Communication Interference (SCI) method identified SCI events, defined as "surgery-related *group discourse that is disrupted according to the goals of the communication or the physical and situational context of the exchange*". We noted the causes and strategies to correct the miscommunication, near misses, and case delays associated with each SCI event. Post-surgery interviews with SCI participants supported observations and were thematically analyzed.

Results: We observed 687 SCI events (mean 8.8 ± 6.5 per case, 3.2 per hour). Every case had at least one SCI event, and one had 28. 48 (7.0%) occurred during docking and 136 (19.8%) occurred during a critical moment. 54.1% of SCI events involved the console surgeon and bedside assistant. The most common causes were concurrent tasks (81.8%); loud noises (22.1%) from patient cart, lightbox fan, and suction machine; and overlapping conversations (14.6%). 94.8% resulted in a case delay (Figure). Mitigating strategies included leaning out of the surgeon console to repeat the message or employing the resident as a messenger.

Conclusion: Miscommunication in the robotic OR is especially common between the console surgeon and bedside assistant. Possible interventions include microphones and headsets, positioning the surgeon console closer to the bedside and loud equipment further away, and upgrading the patient cart speaker.



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Has this abstract been, or slated to be, presented prior to the October meeting?: No

Please indicate the Primary Investigator (PI) on this abstract. : Gary Sutkin

Status: Finalized

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