

Robotic surgeon. According to whom?

A conversation about outcomes
and the claims we make.

The title needs evidence

Training

Supervised progression

Assessed competence

Audited outcomes

A photograph at the console establishes none of these.

What the evidence says

The platform alone cannot promise recovery

A randomised trial found similar urinary and sexual function at 24 months after robotic and open surgery.

Outcomes vary between surgeons

MUSIC found variation in sexual recovery after adjustment. Case volume was not significantly correlated in this analysis.

Coughlin et al. Lancet Oncol. 2018;19:1051–1060.
Agochukwu-Mmonu et al. JAMA Surg. 2022;157:136–144.

“95%”

continent.

Zero pads?

At what time?

How many followed up?

An illustrative claim. The definition changes the meaning.

What are we measuring?

Cancer control

Margins by stage. PSA recurrence. Further treatment.

Continence

Pad use and patient reports at defined time points.

Sexual recovery

Baseline function, nerve-sparing and treatment aids.

Safety

90-day complications, readmissions and reinterventions.

Audit already has a blueprint

Martini-Klinik

Hamburg

Longitudinal patient outcomes and surgeon feedback.

MUSIC

Michigan

Patient-reported recovery before and after surgery.

NPCA

England & Wales

National assessment of care and treatment outcomes.

PCOR-ANZ

Australia & New Zealand

Clinical outcomes, patient reports and benchmarking.

Different audit models. No universal public surgeon scorecard.

An honest audit includes everyone

Every consecutive patient.

Including the difficult cases.

Including missing follow-up.

Compare fairly. Account for age, baseline function and cancer complexity. Report uncertainty.

Should robotic privileges depend on outcome audit?

I believe they should.

With structured training, fair comparison
and support to improve.

That standard should apply to all of us.