How well does decision support software perform in the emergency department?

M A Graber, D VanScoy

Objective: To determine how well general decision support systems perform given the data collected in an emergency department (ED).

Methods: A convenience sample of 25 patients was selected from those patients having a diagnostic question on presentation to the ED. All interactions with the patients were audiotaped and abstracted into a structured data form. All other data such as written notes, laboratory, and EKG results were also abstracted. All data were entered into two general diagnostic decision support programs (Quick Medical Reference (QMR Version 3.82, Knowledge Base 10–07–1998 Copyright University of Pittsburgh and The Hearst Corporation) and Iliad (Version 4.5 Copyright 1996 Applied Medical Informatics)). The diagnoses generated by the computer programs were compared with the final diagnoses of the ED attending.

Results: The final ED diagnosis was found in the differential diagnosis generated by Iliad and QMR 72% and 52% of the time respectively. The final ED diagnosis was found in the top 10 diagnoses 51% and 44% of the time and in the top five diagnoses 36% and 32% of the time for each program respectively. This approximates to the performance of these programs in other clinical settings.

Conclusions: Diagnostic decision support software has the same success in finding the “correct” diagnosis in the ED as in other clinical settings where more extensive clinical data are available. The accuracy is not sufficiently high to permit the use of these programs as an arbiter in any individual case. However, they may be useful, prompting additional investigation in particularly difficult cases.

Decision support algorithms and software have been developed in an attempt to improve decision making in the emergency department (ED). However, the usefulness of these tools is limited by their narrow scope, as they are usually designed to improve diagnostic accuracy in the analysis of specific problems such as chest pain or abdominal pain. The scope of emergency medicine is wide. General decision support systems such as Quick Medical Reference (QMR) and Iliad can help the ED physician consider remote diagnostic possibilities in a time and resource efficient manner. Previous studies of these programs have focused on difficult, inpatient, or paper cases developed from a medical record after extensive clinical and laboratory data are available. No study has assessed how these programs perform using the limited amount of data that are collected during an ED visit. The purpose of this study is to evaluate how well Quick Medical Reference (QMR Version 3.82, Knowledge Base 10–07–1998 Copyright University of Pittsburgh and The Hearst Corporation) and Iliad (Version 4.5 Copyright 1996 Applied Medical Informatics) parallel physician decision making in common ED situations.

QMR and Iliad (named for the originator, Homer Warner at The University of Utah) are “expert systems”. Expert systems are designed to emulate the solutions to problems that one might expect from a human expert. In the cases of QMR and Iliad, medical symptoms, signs, and laboratory results are entered, compared to known entities, and a differential diagnosis is generated. Both QMR and Iliad allow for an adjustment to reflect the prevalence of a disease in the population. Iliad uses Bayesian analysis while QMR uses non-Bayesian algorithms. For example, headache and fever may indicate meningitis. But because the prevalence of influenza in the population is higher, influenza would be listed as the more probable diagnosis.

One limitation of these expert systems is that they only encompass a finite set of illnesses, symptoms, and signs. As more entities are added to their databases, it can be expected that the accuracy and relevance of the differential diagnosis generated to improve. Additionally, as they are designed by humans, they may reflect the biases of the authors and put more weight on one finding (for example, fever) than on another (for example, headache). To minimise the risk of bias, the symptom complex representative of a disease is generally arrived at by consensus (personal communication, Homer Warner).

One scenario in which these programs are useful is when the investigator is presented with an unusual constellation of symptoms or a presentation about which they have limited knowledge. For example, the differential diagnosis of a monoarticular arthritis includes not only common illnesses such as gout, pseudogout, and gonococcal arthritis but also more obscure entities that may not readily come to mind such as Brucellosis. An expert system can help by expanding one’s differential diagnosis and suggesting other avenues of pursuit including what questions to ask as well as the most cost effective method of evaluating the patient.

METHODS

A convenience sample of 25 patients was selected from all patients seen in our ED, a tertiary care academic medical centre. The study period was from 15 July to 15 August 2001. Exclusion criteria included age under 18, residence in a correctional facility, inability to give consent, psychiatric complaints, and inability to communicate in English. Patients were also excluded if there was no diagnostic question (for example, trauma such as lacerations, fractures, corneal abrasions, etc).

After consent was obtained, clinical information about the patient visit was prospectively collected. The basic information was recorded by ED examiners (generally a resident or supervised medical student) on a structured data form (T-System,
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DISCUSSION
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were successful in about one third of the cases. Overall, the ED
physicians’ diagnosis appeared somewhere in differential
Accepted manuscript
1 Massel D, Dawdy JA, Melendez LJ. Strict reliance on a computer
diagnosis with about the same frequency that has been found in
other studies (around 50%–70%).” Thus, while these
programs may be helpful in a general sense, applying them as
an arbitrator in any particular case may be problematic. The
considerable length of the differential produced by the
programs, often greater than 30 diagnoses, and the length of
time it takes to input a case may hinder their usefulness. The
strength of these programs is their ability to expand the
differential diagnosis and make suggestions about further
testing and evaluation.10 11 This can be done by entering a few
key findings. Further study of decision support software for
this purpose in the ED is warranted.

Several limitations in the design of these programs became
clear during this study. The type of information that can be
entered into the programs is limited. Iliad and QMR do not
take into account the drugs that a patient may be taking. The
ability to input the duration of signs and symptoms is also
limited, especially with QMR, and the programs are unable to
account for the sequence of symptom development. Other
findings are simply not in the programs’ vocabulary despite
trying multiple synonyms and therefore cannot be entered as
part of case. Further development of these programs may
mitigate these problems.

The main limitation of this study is the reliance on the ED
physicians’ diagnosis as the “criterion standard”. The final
diagnosis after hospitalisation or subsequent outpatient visits
may or may not differ from the ED diagnosis. However, this is
after additional information has been collected and additional
time has elapsed. We concentrated on how these programs
perform given the limited information collected in the ED. All
of the physicians involved in the study were academic
emergency physicians at a major teaching university. So, even
though the final, post-hospitalisation, diagnosis may vary
from that made in the ED, this study reflects the best available
diagnosis in the ED. In conclusion, diagnostic decision support software has the
same success in finding the “correct” diagnosis in the ED as
has been found in other clinical settings. The accuracy is not
sufficiently high to permit the use of these programs as an
arbiter in any individual case. However, they can be used to
broaden the differential diagnosis.

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REFERENCES
1 Massel D, Dawdy JA, Melendez LJ. Strict reliance on a computer
algorithm or measurable ST segment criteria may lead to errors in

Table 1 Final diagnoses made by the clinician*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Abdominal wall trigger point (2)</th>
<th>Venous insufficiency</th>
<th>Unstable angina, r/o MI (3)</th>
<th>Chronic paroxysmal hemicrania</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD exacerbation (2)</td>
<td>Post-concussion syndrome</td>
<td>Deep venous thrombosis</td>
<td>Bilateral pneumonia with hypoxia</td>
<td>Bacterial vaginosis</td>
</tr>
<tr>
<td>Digoxin toxicity</td>
<td>Vomiting with dehydration</td>
<td>Transient ischaemic attack</td>
<td>Herpes simplex II</td>
<td></td>
</tr>
<tr>
<td>Urticaria</td>
<td>Pelvic inflammatory disease (2)</td>
<td>Conjunctivitis</td>
<td>Heat exhaustion with dehydration</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Viral pharyngitis</td>
<td>Peripheral vertigo</td>
<td>Alcoholic liver disease with encephalopathy (2)</td>
<td>Pulmonary embolism</td>
<td></td>
</tr>
</tbody>
</table>

*Numbers in parentheses represent the number of times this final diagnosis appeared. Some patients had more than one diagnosis.

Table 2 Final ED diagnosis found in program’s differential

<table>
<thead>
<tr>
<th>Program</th>
<th>Anywhere</th>
<th>Top ten diagnoses</th>
<th>Top five diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMR</td>
<td>52</td>
<td>44</td>
<td>32</td>
</tr>
<tr>
<td>Iliad</td>
<td>72</td>
<td>51</td>
<td>36</td>
</tr>
</tbody>
</table>

Data shown as percentages.


