History of Computing in Medicine
Beginnings

- 1950’s computers in bioengineering
- Early 1960’s
  - Medline
  - Laboratory instrumentation computers (LINC)
  - MUMPS developed at MGH
  - GEMISCH (generalized medical information system for community health at Duke) (Stead MD)
- 1975 8080 processor – Altair 8800
- 1976 Apple Computers

Hackers: Steven Levy
Beginnings

• Initial application: automated patient questionnaire (Slack: ‘55) 1965
  – Patient centered computing
  – Cybermedicine

• Center for Clinical Computing
  – Dr. Slack maintained of Eliza that soliloquy, (with or without a computer) can be a valuable tool of mental health. He wrote: "Contrary to the common notion that soliloquy is a manifestation of mental illness, we believe that it is normal behavior---behavior serves to help maintain emotional equilibrium."
Figure 1.10. Departmental system. Hospital departments, such as the clinical laboratory, were able to implement their own custom-tailored systems when affordable minicomputers became available. Today, these departments often use microcomputers to support administrative and clinical functions. (Photograph courtesy Hewlett-Packard Company.)
Eliza

• Eliza (MIT 1960’s) initially designed as a spoof vs. attempt to pass the Turing test
  – Eliza
  – Quack Eliza
MUMPS

• MGH utility multi-programming system
  (Octo Barnett 1966)
  – Thou shalt not declare variable types or file sizes.
  – Thou shalt not KILL, except for globals and variables.
  – Thou shalt not covet thy neighbor's UCI (User Class Identification = computing area).
  – Remember string handling, for it shall make MUMPS special.
MUMPS

• Now known as M
  – A programming language with extensive tools for the support of database management systems. MUMPS was originally used for medical records and is now widely used where multiple users access the same databases simultaneously, e.g. banks, stock exchanges, travel agencies, hospitals.
MUMPS

- Language plus data structure
- Designed by MD’s and engineers
  - Designed for medical environment
    - Low computing power – data entry >>> computing
    - Flexible string structure
    - Inverted tree structure (sparse)
    - Multi-user environment
    - Interpreted
      - More flexible, efficiency not necessary
MUMPS code

• f p=2,3:2 s q=1 x "f f=3:2 q:f*f>p!'q s q=p#f" w:q p,?$x\8+1*8

– prints a table of primes, including code to format it neatly into columns
Beginnings

• 1977 – Medical Informatics defined
  – Discipline dealing with the problems associated with information, its acquisition, analysis and dissemination in the health care delivery process

• 1978 – DEC transitions from PDP to VAX

• 1980 – IBM PC (MS-DOS)

• 1982 – medical informatics definition expanded to include care, education and research
Beginnings

- 1983 – Shortliffe “medical informatics covers more than just applications of computers to medicine”
- 1986
  - Macintosh developed
  - AAMC “medical informatics combines medical science with several disciplines in the information and computer sciences…and provides methodologies by which these can contribute to better patient care”
Artificial Intelligence in Medicine

• Clancey, Shortliffe (1984)
  – Medical artificial intelligence is primarily concerned with the construction of AI programs that perform diagnosis and make therapy recommendations. Unlike medical applications based on other programming methods, such as purely statistical and probabilistic methods, medical AI programs are based on symbolic models of disease entities and their relationship to patient factors and clinical manifestations
Early AIM

• Internist/QMR
  – Designed at University of Pittsburgh

• Mycin, Oncocin
  – Designed at Stanford by Shortliffe’s group
AIM

• Internist
  – Designed to reproduce the behavior of a diagnostician
The Hypothetico-Deductive Approach

1. Generate Hypotheses Based on Initial Patient Data
2. Select Leading Set of Competing Hypotheses (the "differential diagnosis")
3. Select a Strategy for Gathering Additional Data about the Patient
4. Ask Questions
5. Reassess Hypothesis Set
6. Manage the Patient Accordingly

Decision Point: Do you know the "answer?"
Internist-1 / QMR

Task: Diagnosis in internal medicine and neurology
- Scope: The entire field!
- Began in early 1970s as collaboration between Dr. Jack Myers (physician) and Prof. Harry Pople (computer scientist) at University of Pittsburgh
- Dr. Randy Miller (physician) worked on project throughout the 1970s and became project leader in 1980s
- Internist-1 was mainframe (Lisp) version of program, used to develop methods and extensive clinical knowledge base
- QMR is microcomputer version developed by Dr. Miller and collaborators during 1980s and now commercially available
QMR (Quick Medical Reference) is the powerful diagnostic decision support knowledge base designed for integration into your healthcare environment.

Developed to provide physicians with assistance in expanding and refining differential diagnoses, the QMR knowledge base includes a comprehensive list of over 700 disease profiles and the clinical manifestations reliably reported to be associated with them, including 5,000+ related symptoms, signs and labs.

With QMR you can:
- Formulate differentials
- View the most common findings for a particular disease
- Generate the best labs to order or questions to ask for ruling in or ruling out a diagnosis
- Generate case analyses
- And more...

QMF Toolkit™ This new application programming interface (API) captures the power of the QMR knowledge base and eases integration into your electronic medical record (EMR) system. Windows®, UNIX® (Sun® Solaris™), and ActiveX™ Server versions available.

QMF Net™ An intranet solution that gives you the power of the QMR knowledge base with the potential and flexibility of an intranet. Perfect for a group practice, hospital setting or educational institution.

QMF for Windows Stand-alone software to help you make diagnostic decisions. Single user or network versions.

FirstDatabank
Point-of-Care Knowledge Base

www.firstdatabank.com
800-633-3453
Jack D. Myers, MACP

Jack D. Myers, MACP, a pioneer in medical informatics, a member of the National Academy of Sciences and a former ACP President and Regent, died Jan. 31. He was 84.

After serving overseas in the Army medical reserves, Dr. Myers was chair of the department of medicine at the University of Pittsburgh. Dr. Myers was well known among the school’s medical students and residents for his thorough teaching style and received ACP’s Distinguished Teaching Award in 1981.

During the late 1970s, Dr. Myers began studying the field of artificial intelligence and computer-assisted medical education, and he became involved in building databases such as the Quick Medical Reference. He continued to contribute to the field of medical informatics almost until his death.

Dr. Myers served as an ACP Regent from 1971-75 and President from 1976-77. He also served on advisory councils for the National Institutes of Health, the National Academy of Sciences, Institute of Medicine, and was elected to membership in ACP’s Academy of Distinguished Teachers in 1987.

ACP Observer, June 1998
<table>
<thead>
<tr>
<th>Disease Description in Internist-1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DISEASE NAME</strong></td>
</tr>
<tr>
<td><strong>DISEASE MANIFESTATIONS</strong></td>
</tr>
<tr>
<td>– Manifestation name</td>
</tr>
<tr>
<td>– FW: Frequency weight (1, 2, 3, 4, 5)</td>
</tr>
<tr>
<td>– ES: Evoking strength (0, 1, 2, 3, 4, 5)</td>
</tr>
<tr>
<td><strong>LINKS TO OTHER DISEASES</strong></td>
</tr>
<tr>
<td>– (each link has an ES and FW)</td>
</tr>
<tr>
<td>– Types of disease-disease links:</td>
</tr>
<tr>
<td>» Disease1 causes Disease2</td>
</tr>
<tr>
<td>» Disease1 predisposes-to Disease2</td>
</tr>
<tr>
<td>» Disease1 precedes Disease2</td>
</tr>
<tr>
<td>» Disease1 coincident-with Disease2</td>
</tr>
<tr>
<td>» Disease1 systemic-manifestation-of Disease2</td>
</tr>
<tr>
<td>» Disease1 equivalent-to Disease2</td>
</tr>
</tbody>
</table>
Evoking Strengths

0 Nonspecific (i.e., manifestation occurs too commonly to be used to construct a differential diagnosis of individual diseases)

1 Diagnosis is rarely associated with listed manifestation

2 Diagnosis causes a substantial minority of instances of listed manifestation

3 Diagnosis is the most common but not the overwhelming condition associated with the listed manifestation

4 Diagnosis is the overwhelming consideration in the presence of listed manifestation

5 Listed manifestation is pathognomonic for the diagnosis
Evoking Strengths

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2  Diagnosis causes a substantial minority of instances of listed manifestation

3  Diagnosis is the most common but not the overwhelming condition associated with the listed manifestation

4  Diagnosis is the overwhelming consideration in the presence of listed manifestation

5  Listed manifestation is pathognomonic for the diagnosis
## Formulaic Use of Evoking Strengths

<table>
<thead>
<tr>
<th>Evoking Strength</th>
<th>Weight of ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>5</td>
<td>80</td>
</tr>
</tbody>
</table>
Internist-1 Disease Example

- **NAME**  Primary Hyperparathyroidism
- **MANIFESTATIONS**
  - Serum phosphate decreased (ES3, FW3)
  - Constipation (ES0, FW2)
  - History of peptic ulcers (ES1, FW2)
    ..... (plus many others)
- **LINKS TO OTHER DISEASES**
  - Causes Nephrolithiasis (ES2, FW3)
  - Predisposes-to Pyelonephritis (ES1, FW2)
  - Coincident-with Pheochromocytoma (ES2, FW2)
Internist-1 Disease Counts For Abdominal Pain

Data as of 1982 — 502 disease in knowledge base

RUQ

106

109

74

LUQ

RLQ

53

79

46

LLQ

SP

31

13


# Hypothesis Invocation

(Data-Directed)

Positive Components:

<table>
<thead>
<tr>
<th>A: Evoking Strength</th>
<th>Score A</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>5</td>
<td>80</td>
</tr>
</tbody>
</table>

B: Bonus Score (for links to previously diagnosed diseases)

Score B = 20 x (frequency weight of the hypothesis as noted in the description of a disease already diagnosed)

Note: Range 0 to 100
Hypothesis Invocation

(Data-Directed)

Negative Components:

C: If a manifestation **expected** for an hypothesis is **known** to be absent:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Weight</th>
<th>Score C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>-1</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>-4</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>-7</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>-15</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>-30</td>
</tr>
</tbody>
</table>

D: If a manifestation is present but **not** explained by the hypothesis:

<table>
<thead>
<tr>
<th>Importance</th>
<th>Score D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-2</td>
</tr>
<tr>
<td>2</td>
<td>-6</td>
</tr>
<tr>
<td>3</td>
<td>-10</td>
</tr>
<tr>
<td>4</td>
<td>-20</td>
</tr>
<tr>
<td>5</td>
<td>-40</td>
</tr>
</tbody>
</table>
Hypothesis Invocation

(Data-Directed)
For each disease evoked by at least one of the manifestations entered by the physician, a net score is calculated:

\[
\text{Net score} = A + B + C + D
\]

positive components  negative components

The disease with the highest net score becomes the pivotal disease for formulating a differential diagnosis.
Determining the Differential Diagnosis

The Partitioning Algorithm

- The task is to determine all evoked hypotheses that are competitors to the topmost diagnosis (i.e., the hypothesis with the highest net score).

- Disease A and Disease B are competitors if, taken together, they explain no more observed manifestations than does one of them taken alone (ignoring frequency weight so long as it is greater than or equal to 1).

- Internist-1 then "considers" all manifestations explained by the current differential diagnosis (the "current problem area", or CPA) and sets aside for later ("disregards") all manifestations not yet explained.
Internist Partitioning Algorithm

Highest Scored Hypothesis

D6  D5  D4  D3  D2  D1
F1  3  F1  2  F1  1  F1  0  F9  F8  F7  F6  F5  F4  F3  F2  F1
Internist Partitioning Algorithm

Highest Scored Hypothesis

D6    D5    D4    D3    D2    D1
F13   F12   F11   F10   F9    F8    F7    F6    F5    F4    F3    F2    F1
Internist Partitioning Algorithm

Disregard While Pursuing CPA

Current Problem (CPA)

Highest Scored Hypothesis
Pursual Mode

- Used when $45 < [\text{top net score} - \text{second net score}] < 90$

- Select questions designed to establish diagnosis with top score

- Use findings with a high evoking strength for the first hypothesis
Rule-out Mode

- Used when at least five hypotheses exist in the range within 45 points of the top scoring hypothesis
- Ask questions designed to eliminate the competitors with the lowest net scores
- Use findings that have a high frequency weight for the lowest scoring competitors
Discriminate Mode

- Used when two to four hypotheses exist within the range of 45 points from the score of the first diagnosis
- Ask questions attempting to maximize the variance of the scores for the hypotheses in the top group
<table>
<thead>
<tr>
<th>General Question-Generation Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ask questions in small groups, recalculating disease scores after each batch of questions</td>
</tr>
<tr>
<td>• Ask questions ordered by ease with which the information can be obtained clinically (history first, then physical exam, then tests ordered by their degree of risk, discomfort, and expense)</td>
</tr>
<tr>
<td>• Process all answers in one batch, thereby creating a new differential diagnosis, possibly with a different pivot disease</td>
</tr>
<tr>
<td>• Repeat the partitioning and differential diagnosis using the partitioning algorithm and the question-selection strategies</td>
</tr>
</tbody>
</table>
Evaluation of Internist-1

(Miller et al., NEJM, 8/19/82)

- Used CPC's from 1969 issues of the New England Journal of Medicine
- Published CPC's included difficult, complex cases, often with multiple diagnoses
- Diagnoses assigned by ward team and by expert discussant were known for each case
- "Gold standard" was generally the tissue diagnosis determined by pathologists from biopsy or autopsy
- Only cases in which the final diagnoses were in the Internist-1 knowledge base were used (19 of 42 cases [45%] in which there were an average of 3 major diagnoses per case)
# Results for the 19 Cases

<table>
<thead>
<tr>
<th></th>
<th>Internist-1</th>
<th>Clinicians</th>
<th>Discussant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total possible diagnoses</strong></td>
<td>43</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>Definitive, correct</td>
<td>17</td>
<td>23</td>
<td>29</td>
</tr>
<tr>
<td>Tentative, correct</td>
<td>8</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Failed to make correct diagnosis</td>
<td>18</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Definitive, incorrect</td>
<td>5</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Tentative, incorrect</td>
<td>6</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Total no. of incorrect diagnoses</td>
<td>11</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Total no. of errors in diagnosis</td>
<td>29</td>
<td>28</td>
<td>21</td>
</tr>
</tbody>
</table>
Internist-1 Evaluation

- Out of 18 diagnoses missed by the program, 11 were missed by one of the other groups.
- Program was right in 7 cases where at least one of the other groups was wrong.
- In 80% of the cases where Internist-1 was wrong, one of the other groups was wrong too.
- Overall mistakes: Internist-1 29, clinicians 28, experts 21.
- **Note:** CPC's are not representative of routine clinical cases seen in normal hospital or outpatient clinic environment.
Internist/QMR Problems

- No anatomical reasoning
- No temporal reasoning
- Concluding a diagnosis causes deletion of explained findings — cannot be used again to support another diagnosis
- No treatment of compensating symptoms or synergistic diseases
- No true use of causality or pathophysiological model
- Assumes conditional independence of findings
- No clear probabilistic model
MYCIN: An Overview

Start

Clinical Information Provided by the Clinician

Consultation System

Corpus of Decision Rules

Ongoing Record of the Current Consultation

Explanation System

Rule-Acquisition System for use by Experts

Exit
Nature of Clinical Consultation

- **Patient Data**
- **Advice**
- **Explanations**

**Physician Seeking Advice**

**Expert Consultant**
Sample MYCIN Rule

PREMISE:  ($AND (SAME CNTXT GRAM GRAMPOS)
            (SAME CNTXT MORPH COCCUS)
            (SAME CNTXT CONFORM CLUMPS))
ACTION: (CONCLUDE CNTXT TALLY STAPHYLOCOCCUS
        TALLY 700)
or (translated into English):

IF:  1) The gramstain of the organism is gramos
    2) The morphology of the organism is coccus
    3) The conformation of the organism is clumps
THEN: There is suggestive evidence (.7) that the identity
      of the organism is staphylococcus
Sample MYCIN Case -1

30) Is Case 168 a compromised host (e.g., alcoholic, sickle-cell-disease, immunosuppressed)?

** NO

31) For how many days has Case 168 had abnormal neurologic signs?

** 1

32) For how many days has Case 168 had neurological symptoms?

** 9

Has Case 168 had recent evidence of tender or enlarged salivary glands?

** WHY
Sample MYCIN Case -2

[i.e., WHY is it important to determine whether Case 168 has shown symptoms of mumps?]

[2.0] This will aid in determining the type of infection.
   It has already been determined that:
      [2.1] the infection which requires therapy is meningitis
   Therefore if:
      [2.2] Case 168 has shown symptoms of mumps
   Then:
      there is weakly suggestive evidence (.4) that the type of infection is viral

Author: Yu
Sample MYCIN Case -3

My therapy recommendation will be designed to treat for organisms that either are very likely or, although less likely, would have a significant effect on therapy selection if they were present. It is important to cover for the following probable infection(s) and associated organism(s):

INFECTION-1 is MENINGITIS
+ <Item-1> MYCOBACTERIUM-TB [from clinical evidence only]
    ....... COCCIDIOIDES [from clinical evidence only]
    ....... CRYPTOCOCCUS [from clinical evidence only]
    ....... VIRUS [from clinical evidence only] - Give Supportive Therapy

[My recommendation will cover for all of the most likely items (indicated by a + above). Less likely items will be covered unless this would require an excessive number of drugs.]
Sample MYCIN Case -4

My preferred therapy recommendation is as follows: Give the following in combination:

1) **ETHAMBUTAL**
Dose: 1.28g (13 100mg tablets) q24h PO for 60 days [calculated on basis of 25 mg/kg] then 770 mg (7.5 100mg tablets) q24h PO [calculated on basis of 15 mg/kg]

Comments: Periodic vision screening test are recommended for optic neuritis

2) **INH**
Dose: 513mg (5 100mg tablets) q24h PO [calculated on basis of 10 mg/kg]

3) **RIFAMPIN**
Dose: 600 mg q24h PO
Comments: Administer dose on an empty stomach
Sample MYCIN Case -5

** HOW DID YOU DECIDE TO TREAT FOR MYCOBACTERIUM-TB IN THIS CASE? 

ITEM-1 is Mycobacterium-tb associated with meningitis. I decided to treat ITEM-1 on the basis of clinical evidence alone.

The following rules concluded about:

the likelihood that Mycobacterium-tb is one of the organisms (other than those seen on cultures or smears) that might be causing the infection

523 579

Which of these rules do you wish to see?

** 579
Sample MYCIN Case -6

RULE 579

If: 1) The infection that requires therapy is meningitis,  
2) The patient’s chest x-ray is abnormal, and  
3) Active-tb is one of the diseases that the patient’s chest x-ray suggests

Then: There is strongly suggestive evidence (.8) that Mycobacterium-tb is one of the organisms (other than those seen on cultures or smears) that might be causing the infection

Author: Yu
Reasoning Methods in AI Systems

- Goal-Directed Reasoning (Backward Chaining)
  - e.g., MYCIN
- Data-Driven Reasoning (Forward Chaining)
  - e.g., Ventilator Manager (VM)
- Hypothesis-Directed Reasoning
  - e.g., Internist-1
- Opportunistic Reasoning
  - e.g., the “blackboard” architecture
MYCIN’s MONITOR Mechanism

1. Start
2. Consider the first condition in the Premise of the rule
3. All necessary information gathered to decide if the condition is true?
   - Yes
     - Is the condition true?
       - Yes
         - Add the Conclusions of the rule to the dynamic database for the current consultation
       - No or Unknown
         - Reject the rule
4. No
   - Gather the information using the Findout mechanism
   - Consider the next condition in the Premise
     - Yes
       - Are there more conditions to consider?
         - Yes
         - Add the Conclusions of the rule to the dynamic database for the current consultation
         - No
         - Exit
       - No or Unknown
         - Reject the rule
         - Exit
MYCIN’s *Findout* Mechanism

1. **Retrieve Y = List of rules that may be helpful in determining the value of the parameter**

2. **Apply Monitor to each rule in the list Y**

3. **Is the value of the parameter known?**
   - **Yes**: **Ask user for the value of the parameter**
   - **No**: **Return**

4. **Is the parameter a piece of laboratory data?**
   - **No**: **Return**
   - **Yes**: **Ask user for the value of the parameter**

5. **Is the value of the parameter known?**
   - **Yes**: **Retrieve Y = List of rules that may be helpful in determining the value of the parameter**
   - **No**: **Apply Monitor to each rule in the list Y**
Generic Algorithm for Goal-Directed Rule Invocation

- Invoke rule of interest
- Consider first condition in premise of rule
- Retrieve all rules that could determine the truth of the condition in question
- Is condition already known to be true or false?
  - Yes
  - Consider next premise condition
  - Any more premises?
    - Yes
    - Rule has succeeded; accept its conclusion
    - No
    - Rule has succeeded; reject the rule
  - No
  - Ask user for value of pertinent parameter
- Invoking each rule in order, stopping only if a rule succeeds or all rules have failed
- Did any rule succeed?
  - Yes
  - Ask user for value of pertinent parameter
  - No
  - Consider next premise condition
- N.B. This algorithm is depth-first and assumes that users may know the value of a parameter if the rules are unsuccessful in concluding it. Rule premises are assumed to be conjunctions of conditions.
MYCIN’s Goal Rule

IF:

1) Information has been gathered about organisms isolated from this patient, organisms noted on smears taken from this patient, negative cultures of this patient, suspected infections without microbiological evidence, current drugs of this patient, and prior drugs of this patient,

2) An attempt has been made to deduce the organisms which require therapy, and

3) You have given consideration to organisms (other than those noted in cultures and smears) that might be present

THEN:

Determine the best therapy recommendation from among the drugs likely to be effective against the significant organisms, or indicate that no therapy is required at this time
Sample MYCIN Reasoning Network
Maturation of medical computing

<table>
<thead>
<tr>
<th>Data</th>
<th>The individual items made available to the analyst. Examples would be a patient's sex, age, weight or blood pressure value.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>A set of data with some interpretation or value added. For example, we say we infer that a difference exists if an 80-kg person has a height of 150 cm or 195 cm.</td>
</tr>
<tr>
<td>Knowledge</td>
<td>A set of rules, formulas, or heuristics used to create information from data and information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPLICATION</th>
<th>1950s</th>
<th>1960s</th>
<th>1970s</th>
<th>1980s</th>
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</thead>
<tbody>
<tr>
<td>Data</td>
<td>Research</td>
<td>Prototype</td>
<td>Mature</td>
<td>Refined</td>
</tr>
<tr>
<td>Information</td>
<td>Concepts</td>
<td>Research</td>
<td>Prototype</td>
<td>Mature</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Concepts</td>
<td>Concepts</td>
<td>Research</td>
<td>Prototype</td>
</tr>
</tbody>
</table>
History 1985-1995

• Emergence of HIS
  – Financial information ahead of clinical information

• Introduction of PC’s into offices (initially for clerical use)

• PC’s on units for data output
  – Statlan (DOS based – non Y2Kcompliant)

• Clinical information systems (CIS)
History 1995-present

- Internet medicine
- Wiring of health systems
- PC’s in MD’s offices
- PC’s for order entry, web access etc.
- Acquisition of large data bases
Now

• AI in medicine (nascent)
• Computers in the business of medicine
  – Electronic billing (maturing)
• Information flow
  – Lab, radiology (maturing)
  – Medical Record (nascent)
• Patient care
  – Intelligent monitoring (nascent)
Now

• Consumer awareness
  – Information availability (growing rapidly)
  – Quackery!!! (growing rapidlier)

• Efficiency gains
  – Decreased personnel (nascent)
  – Best/least costly practices (nascent)
  – Information flow (nascent)
Current resources

- AMIA curriculum 2001
- Health information resources on the web
- IT Medical Literature
- Newsgroups/chat rooms/support
- Health news
Future

• Compare American (vs. Japanese) industry in the late 1980’s
• Barriers