Clinical Decision Support Systems: The Fascination with Closed-Loop Control

R. M. Gardner
Emeritus Professor and former Chair, Department of Medical Informatics, University of Utah, Salt Lake City, Utah, USA

To the engineer a closed-loop control system refers to using a controller with a feedback loop to control states or outputs of a dynamic system. That dynamic system might be the cruise (speed) control on your automobile, maintaining a patient’s \( \text{p}_2 \) with a ventilator, controlling depth of anesthesia with an anesthesia machine, or controlling arterial blood pressure with medications from an IV pump. To a cowboy from the Wild West a closed “loop” might be considered a lariat or lasso rope, used to rope cattle. Similarly, for some in medical informatics, closed-loop control means surrounding a medical problem area to better manage it.

I suggest that, in fact, there is a broad range of Clinical Decision Support (CDS) systems and that closed-loop controllers represent only one specific type. CDS systems include diagnostic systems, intelligent Computerized Physician Order Entry (CPOE), alarming and alerting systems, care advice systems, etc. These CDS systems can be used to help with tasks such as optimizing blood ordering, medication selection and dosing, and using protocols to improve and optimize patient care.

Since the 1950’s, when physicians began to understand control system theory, there has been a fascination with having these control systems be closed-loop without the need for any human intervention. Bickford at the Mayo Clinic was one of the first to suggest closed-loop anesthesia, using the electroencephalogram (EEG) as the measure [1]. In 1968 Sheppard and his colleagues, at the University of Alabama, showed that the blood pressure of postoperative open-heart patient’s blood pressures could be controlled with closed-loop strategies [2].

Since those early times, when the use of closed-loop systems was the ultimate decision support strategy, there have been a myriad of other decision support methods developed. However, there still seems to be some magic in being able to “close the loop.” Just to give an update on how we are doing some 50 to 60 years later with implementing closed-loop systems, articles in this Yearbook have addressed the topic [3, 4]. Recently, considerable literature on the clinical implementation of closed-loop control has begun to appear. Two examples: a) the accuracy and clinical feasibility of closed-loop control of the hypnotic component of anesthesia was recently reported [5]; b) in addition, news reports indicate that closed-loop control of insulin administration for diabetics, the so-called “artificial pancreas,” is coming closer to reality [6].

As I was preparing this Keynote manuscript, I began to ask myself why hadn’t our group at LDS Hospital in Salt Lake City developed and published ANY work on operational closed-loop control systems. After all, our entire group has hundreds of publications, and most of them are in the field of decision support and Medical Informatics. So, I took the opportunity to refresh my memory on the almost 50 years of Medical Informatics history that I have lived through. It quickly became apparent that as a consequence of working at LDS Hospital with our mentor Homer R. Warner [7] and colleagues T. Allan Pryor, R. Scott Evans, Paul D. Clayton, multiple graduate students and other professional colleagues, we...
have had unique and unusual opportuni-
ties in the field of, what I would term, “Op
erational Clinical Informatics.” We were
involved in the development and implemen-
tation of the HELP Decision Support
system and began by using it to computerize
Intensive Care Units (ICU) [8]. That experience thrust us into the
practice of clinical informatics in
medicine. In the process of computerizing
this ICU, we attended daily physi-
cian/nurse rounds. We watched as data
was automatically gathered and stored
into computer records and displayed for
physicians, nurses and other clinicians
to use. Almost immediately it became
apparent that the quality of physiological
data being collected at the ICU bed-
sides was highly variable and of inter-
mittent quality. So, to be able to use
and display that physiological data col-
clected, we had to fix some of the data
collection problems [9]. Soon it became
apparent that the physicians and nurses
did not understand issues about the need
for “timely charting data” and not
batch-charting data at hourly intervals
or at the end of the shift. Also the fre-
cuency of medical data collection and
quality improvement methods for data
collection had not been widely explored.
For example, how often should a blood
pressure signal be recorded – every beat,
every minute, every 15 minutes or does
it depend on other variables? Since we
wanted only high-quality data in our
computerized record systems, methods
for assuring that quality data was col-
clected had to be developed. On subse-
quent investigation, it was determined
that there were few quality standards
available for collecting high-quality
physiological data. This led us to what
is still an active part of my professional
life: developing high-quality automated
methods for acquiring medical data, de-
veloping data collection standards,
training and encouraging clinicians to
use those strategies to acquire high-
quality data for the patient’s record.

The establishment of quality data
collection methods was crucial in estab-
lishing the HELP system as a deci-
sion-support tool [10-13]. Soon we
were interpreting blood gas results and
pulmonary function tests [14, 15]. It
became clear from these interpretation
systems that we needed to gather and
present data better, as well as integrate
data from other data sources. For
example, with blood gases, we needed to
have data about what nurses and respi-
atory therapists had been charting on a
particular patient. As a consequence,
computerized Respiratory Therapy
charting was begun [16]. Then as more
extensive laboratory data became avail-
able, it was possible to consider proto-
cols for improving patient care. These
included ventilator weaning protocols
[17, 18], optimization of blood ordering
[19], detecting and preventing ad-
verse drug events [20, 21]. With coded
microbiology data and having medica-
tion orders in computerized form, it was
then possible to have the computer moni-
tor infectious disease events and make
recommendations about the type and dose
of antibiotic that should be given. From
those activities came the better comput-
erized monitoring of infectious diseases
and the antibiotic-assistant [22, 23].

Implementing these decision support
systems required very sensitive and care-
ful interaction with the clinicians car-
ing for the patients – physicians, nurses,
pharmacists, respiratory therapists, etc.
We soon found that social, political and
intellectual challenges were very impor-
tant ingredients to successful imple-
mentation of these systems [24, 25]. On
many occasions I explained to my col-
leagues that what we were doing was
only about 20% technology and 80%
sociology. Little did we know we were
dealing in the field of human factors
research, a field that had its beginnings
about the same time that medical
informatics began [26]. As the article
by Saleem and colleagues in this Year-
book show, human factors and how the
system integrates with the care giver
are crucial to the successful implementa-
tion and value of such systems [27].
A recent editorial by Chaudhry supports
the importance of implementation chal-
lenges: “The question is not whether
computerized decision support systems
should or will be integrated into care
delivery. Rather, the question of fun-
damental importance is how can these
systems be best used to improve care.
If health technology is going to trans-
form healthcare, a deeper understand-
ing of complex dynamics underlying
system adoption and use is needed.” [28]

Then we were challenged by our
medical informatics peers and those
who wanted to know a broad answer to
the “So what” questions: Were the sys-
tems effective? Did users like them?
What did they like? What didn’t they
like and why? Were these systems cost-
effective and if so, why? As a conse-
quence, we have spent and continue to
spend considerable effort to answer
these questions. It was rewarding to
read, in an Annals of Internal Medicine,
an article entitled “Systematic Review:
Impact of Health Information Technol-
ogy on Quality, Efficiency and Cost of
Medical Care,” published in May 2006
that LDS Hospital was classified as one
of the four benchmark hospitals [29].

Perhaps we were distracted by the
day-to-day provision of care using com-
puters. I think not. I think we were mo-
tivated by real needs and real opportu-
nities, gained by being immersed in the
clinical environment. With that informa-
tion as background, I will now con-
sider what I think are gaps and oppor-
tunities for application of decision sup-
port systems and the challenges of
implementing better CDS systems, in-
cluding closed-loop systems.

**What Are the Challenges and Opportunities for the Future of Clinical Decision Support, Including Use of Closed-Loop Systems?**

I would classify these challenges into
the following five groupings:

1. “It isn’t easy!”
2. Clinical Informaticists are needed
3. Major problems with data acquisi-
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1. "It Isn’t Easy!"

I still recall the many times my recently departed colleague Al Pryor said “It isn’t easy!” When times got tough during the process of developing and installing the HELP system, he would often exclaim, “It isn’t easy!” Indeed, as a review, this 2009 IMIA Yearbook provides plenty of evidence of Dr. Pryor’s thoughtful observations. However, one must be careful as they read the literature. Some of the literature would suggest that CDS and closed-loop control systems were items that could be purchased “off the shelf.” [30]. However, the people who have built such closed-loop systems are operational in the clinical care setting have typically taken decades to make those systems work [5].

So why isn’t it easy? The human body is made up of very complex physiological and neurological systems with an amazing array of sensors and feedback control systems, which maintain homeostasis. We should not be surprised or discouraged at the complexity of trying to mimic these systems. To implement an operational CDS system we must gather real-time data that was of high-quality. Since our work began in the ICU, we had to develop methods to gather real-time data that was of high-quality. The process of collecting sufficient, appropriate clinical data is still a very difficult task. Real-time data collection is a complex and challenging task that many investigators in the field of Medical Informatics still do not understand. Since our work began in the ICU, we had to develop methods to gather real-time data that was of high-quality.

2. Clinical Informaticists Are Needed

Safran and colleagues have provided an excellent overview and justification for the need of “Clinical Informaticists” in their section on Research and Education in this Yearbook [40]. The American Medical Informatics Association has recently published the core content and training requirements for what it is hoped will become a new medical specialty: Clinical Informatics [41, 42]. Clearly clinical informaticists will be essential in implementing CDS systems.

Recently, I was with a colleague who was describing his hospital’s implementation of a new decision-support module in the clinical setting. As I understood it, the module was a CDS system provided by a commercial vendor, but which needed to be customized to fit the clinical practice of their institution. After a considerable time, this colleague explained to me that he had “parachuted in” a clinical informaticist to help resolve the problem. Once the clinical informaticist was in place, the parties began to better communicate, changes were made in the module, and the system was successfully installed. Using the terminology “parachute in” reminded me of military techniques used in guerilla warfare. Perhaps implementing Computerized Decision Support systems is similar to guerilla warfare. Certainly implementing such systems is challenging and difficult.

3. Major Problems with Signal Acquisition, Data Integration and Coding

The process of collecting sufficient, reliable, representative, timely, and appropriate clinical data is still a very difficult task. Real-time data collection is a task that many investigators in the field of Medical Informatics still do not understand. Since our work began in the ICU, we had to develop methods to gather real-time data that was of high-quality.

Recently the Agency for Health Care Research and Quality (AHRQ) has published two important documents that provide a state of the art survey and a how-to guide for implementing CDS systems [32, 33]. These two documents, which are readily available on the Web, provide an excellent overview and set of references that cover the vastness of the issues that must be addressed when implementing CDS systems. In addition, there are grand challenges and urgings for responsible thought and action when implementing CDS systems [34, 35]. Other recent literature is also helpful. David Bates and his colleagues at Brigham and Women’s Hospital implemented a COPE system and felt that they had made observations that were so important that they called them the “Ten Commandments” [36].

There appear to be differences in how medical devices and computerized decision support strategies are conceived and implemented in the United States and in Europe [38]. European investigators seem to have more liberty to apply experimental devices and clinical software systems than investigators in the United States. In the United States, the Food and Drug Administration regulates clinical software [39]. As a consequence, very careful documentation and validation processes must be carried out to be in compliance with those regulations. It is my opinion that additional medical software regulation will only slow and discourage important and innovative developments.

Finally, since many of the CDS systems that will be installed in the future will likely be commercial systems supplied by vendors, there is still a big unknown about how these vendors will enable the customization that will be needed. It is still not known if those systems will be agile enough to adapt to the CDS needs of each specific hospital. Notably, the results from the four benchmark hospitals reviewed by Chaudhry and associates were based on clinical decision systems that had been “internally developed” [29].
quality [9]. Now some 40 years later, we
and others are in pursuit of that goal. In
the meantime, we have helped develop
the “Medical Information Bus” as a data
standard [43]. In addition, we have ex-
plored gathering data from ventilators
and other devices automatically. A re-
cent publication showed that manually
charted data had many flaws, despite
the fact that respiratory therapists were dedi-
cated and diligent about manually enter-
ing their computer charting data [44].

I was surprised and disappointed that the
Signal Acquisition, Processing & Integra-
tion section of the Yearbook only dealt with
image acquisition [45]. Recent work at
Massachusetts Institute of Technology has
made a large real-time database publicly
available to enable many investigators to try
strategies for improving the determina-
tion of such simple parameters as heart
rate [46, 47]. This database is a marvel-
ous example of how data-mining tech-
niques can be used [48].

Having systems that are interoperable
is a major goal of the field of medical
informatics. Yet in most health care sys-
tems, integrating patient data from
multiple sources is very difficult and
next to impossible. For example, hav-
ing access to data from outpatient record
systems may not be available to physi-
cians caring for a patient in an emer-
gency room or a hospital. Rassinoux
addresses many of these problems in
this Yearbook [49].

Today, much of a patient’s medical
record is in “free-text” format, either
written by hand or entered into the com-
puter. Even with excellent word pro-
cessor and natural language processors,
that data is not available in coded for-
mat for decision making.

If the CDS system that one wanted
to build were a closed-loop system, the
above noted problems of integrated,
accurate, and real-time signal availabil-
ity would be crucial. Very few systems
in existence today have the ability to
collect such data. Only devices like
pacemakers and, hopefully, insulin in-
fusion pumps have that capability. In
those cases, only one or two primary
physiological signals are used.

4. We Need to Build and Maintain
Reliable Systems

Lenz has provided a very thoughtful as-
essment of the state-of-the art and out-
lined steps that must be taken to pro-
solve sustainable healthcare information
systems [50]. Taking these steps should
prevent the necessity of costly systems
replacements every five or ten years. An
excellent reference is given in this paper
to Sauer who discusses “deciding the fu-
ture for IS failures; not the choice you
might think” [51]. I found these two pa-
pers very informative since CDS sys-
tems; especially closed-loop control sys-
tems require remarkable reliability.

Two recent papers have pointed to
what some would consider unusual fail-
ure modes: “unintended consequences”
and “e-latrogenesis” [52, 53]. The issues
surrounding the reasons for these fail-
ures are complex with details noted in
the publications. I suspect that many of
these complex issues would have been
avoided if well-trained “Clinical
Informaticists” been involved in the de-
velopment and implementation process.

A recent report by the National Acad-
emy of Science and a 2009 publication
in the Communications of the ACM
points to medical software as being par-
ticularly undesirable [54, 55]. The
ACM article claims that, although medi-
cal software can save lives, it can also
kill. Unreliability of medical devices and
medical software systems was used as a
bad example of dependability. Medical
deVICES such as pacemakers were dis-
cussed. However, CDS systems raise
many of the same issues. We, in Medical
Informatics, must take such challenges
of providing highly dependable systems
seriously and demonstrate those capabil-
ities in systems we develop.

5. There is Optimism for the Future

Bates and his colleagues have provided
us with excitingly optimistic results with
their two manuscripts, assessing the
effects of Health Information sys-
tems technology [56, 57]. We can still
be fascinated and challenged by closed-
loop control systems, but it is not the
be-all and end-all of Medical
Informatics. In my opinion, closed-loop
control is NOT the ultimate CDS sys-
tem because remarkable progress has
been made with remarkable quality of
care improvement by using “open-loop”
strategies, which involve having the cli-
nician in the loop [28, 29, 56, and 57].

I am inspired and motivated by the
comments made by Goethe almost 200
years ago:

“Knowing is not enough; we must
apply.

Willing is not enough; we must do.”

Johann Wolfgang von Goethe

I would add the statement:
Theorizing is not enough: we must
find out!

The opportunities and challenges are
there for us to develop and clinically
apply more and better Computerized
Decision Support systems.

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Correspondence to:
Dr. Reed M. Gardner
745 Cornell Circle
Salt Lake City, Utah 84108
USA
E-Mail: Reed.Gardner@hsc.utah.edu