

Decision Tree Classifiers to Determine the Patient's Post-Operative Recovery Decision

D.Shanthi

*Department of Computer Science and IT
Mazoon University College
Seeb, P.O.Box 101, Muscat, Sultanate of Oman*

dshan71@gmail.com

Dr.G.Sahoo

*Department of Information Technology
Birla Institute of Technology
Mesra, Ranchi, India*

gsahoo@bitmesra.ac.in

Dr.N.Saravanan

*Department of Computer Science and IT
Mazoon University College
Seeb, P.O.Box 101, Muscat, Sultanate of Oman*

saranshanu@gmail.com

Abstract

Machine Learning aims to generate classifying expressions simple enough to be understood easily by the human. There are many machine learning approaches available for classification. Among which decision tree learning is one of the most popular classification algorithms. In this paper we propose a systematic approach based on decision tree which is used to automatically determine the patient's post-operative recovery status. Decision Tree structures are constructed, using data mining methods and then are used to classify discharge decisions.

Keywords: Data Mining, Decision Tree, Machine Learning, Post-operative Recovery.

1. INTRODUCTION

Decision support systems help physicians and also play an important role in medical decision making. They are based on different models and the best of them are providing an explanation together with an accurate, reliable and quick response. Clinical decision-making is a unique process that involves the interplay between knowledge of pre-existing pathological conditions, explicit patient information, nursing care and experiential learning [1]. One of the most popular among machine learning approaches is decision trees. A data object, referred to as an example, is described by a set of attributes or variables and one of the attributes describes the class that an example belongs to and is thus called the class attribute or class variable. Other attributes are often called independent or predictor attributes (or variables). The set of examples used to learn the classification model is called the training data set. Tasks related to classification include regression, which builds a model from training data to predict numerical values, and clustering, which groups examples to form categories. Classification belongs to the category of supervised learning, distinguished from unsupervised learning. In supervised learning, the training data consists of pairs of input data (typically vectors), and desired outputs, while in unsupervised learning there is no a priori output. For years they have been successfully used in many medical decision making applications. Transparent representation of acquired knowledge and fast algorithms made decision trees what they are today: one of the most often used symbolic machine learning approaches [2]. Decision trees have been already successfully used in

medicine, but as in traditional statistics, some hard real world problems cannot be solved successfully using the traditional way of induction [3]. A hybrid neuro-genetic approach has been used for the selection of input features for the neural network and the experimental results proved that the performance of ANN can be improved by selecting good combination of input variables and this hybrid approach gives better average prediction accuracy than the traditional ANN [4].

Classification has various applications, such as learning from a patient database to diagnose a disease based on the symptoms of a patient, analyzing credit card transactions to identify fraudulent transactions, automatic recognition of letters or digits based on handwriting samples, and distinguishing highly active compounds from inactive ones based on the structures of compounds for drug discovery [5]. Seven algorithms are compared in the training of the multi-layered Neural Network Architecture for the prediction of patient's post-operative recovery area and the best classification rates are compared [6].

In this study, the Gini Splitting algorithm is used with promising results in a crucial way and at the same time complicated classification problem concerning the prediction of post-operative recovery area.

2. MOTIVATIONS AND RELATED WORK

In data mining, there are three primary components: model representation, model evaluation and search. The two basic types of search methods used in data mining consist of two components: Parameter Search and Model Search [15]. In parameter search, the algorithm searches for the set of parameters for a fixed model representation, which optimizes the model evaluation criteria given the observed data. For relatively simple problems, the search is simple and the optimal parameter estimates can be obtained in a closed form. Typically, for more general models, a closed form solution is not available. In such cases, iterative methods, such as the gradient descent method of back-propagation for neural networks, are commonly used. The gradient descent method is one of the popular search techniques in conventional optimization [16]. Decision trees are considered to be one of the most popular approaches for representing classifiers. It induces a decision tree from data. A decision tree is a tree structured prediction model where each internal node denotes a test on an attribute, each outgoing branch represents an outcome of the test, and each leaf node is labeled with a class or class distribution. Decision trees are often used in classification and prediction. It is simple yet a powerful way of knowledge representation. The models produced by decision trees are represented in the form of tree structure. Learning a decision tree involves deciding which split to make at each node, and how deep the tree should be. A leaf node indicates the class of the examples. The instances are classified by sorting them down the tree from the root node to some leaf node [2].

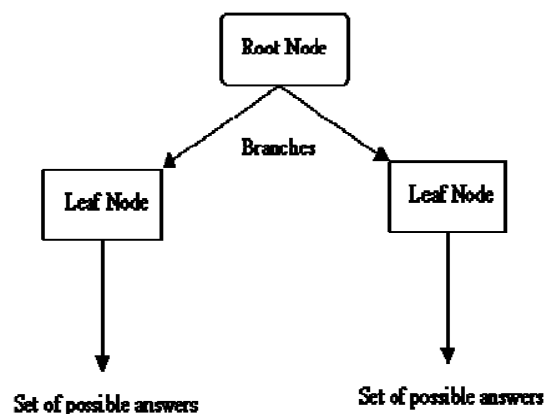


FIGURE 1: Decision Tree Structure

Decision trees (DTs) are either univariate or multivariate [17]. Univariate decision trees (UDTs) approximate the underlying distribution by partitioning the feature space recursively with axis-parallel hyperplanes. The underlying function, or relationship between inputs and outputs, is approximated by a synthesis of the hyper-rectangles generated from the partitions. Multivariate decision trees (MDTs) have more complicated partitioning methodologies and are computationally more expensive than UDTs. A typical decision tree learning algorithm adopts a top-down recursive divide-and-conquer strategy to construct a decision tree. Starting from a root node representing the whole training data, the data is split into two or more subsets based on the values of an attribute chosen according to a splitting criterion. For each subset a child node is created and the subset is associated with the child. The process is then separately repeated on the data in each of the child nodes, and so on, until a termination criterion is satisfied. Many decision tree learning algorithms exist. They differ mainly in attribute-selection criteria, such as information gain, gain ratio [7], gini index [8], termination criteria and post-pruning strategies. Post-pruning is a technique that removes some branches of the tree after the tree is constructed to prevent the tree from over-fitting the training data. Representative decision tree algorithms include CART [8] and C4.5 [7]. There are also studies on fast and scalable construction of decision trees. Representative algorithms of such kind include RainForest [9] and SPRINT [10].

3. METHODS AND METHODOLOGY

The tool used in this study is known as DTREG [14]. It basically follows the same principles as many other decision tree building tools, but it also implements different extensions. One of those extensions is called dynamic discretization of continuous attributes, which was used in our experiments with success. For this study, we have taken classification problem. The problem consists of determining the class (General Hospital, Go-home, Intensive care) for a certain input vector. For this study, the data was taken from UCI Machine Learning Repository. (<http://www.ics.uci.edu/~mlearn/MLSummary.html>) [11]. The data were originally created by Sharon Summers (School of Nursing, University of Kansas) and Linda Woolery (School of Nursing, University of Missouri) and donated by Jerzy W. Grzymala-Busse. The goal is to determine where patients in a postoperative recovery area should be sent to next. Because hypothermia is a significant concern after surgery. The attributes correspond roughly to body temperature measurements. The dataset contains 90 records with 8 characteristics of a patient's state in a postoperative period.

- 1) InternalTemp - patient's internal temperature in C: high (> 37), mid (≥ 36 and ≤ 37), low (< 36)
 - 2) SurfaceTemp - patient's surface temperature in C: high (> 36.5), mid (≥ 36.5 and ≤ 35), low (< 35)
 - 3) OxygenSat - oxygen saturation in %: excellent (≥ 98), good (≥ 90 and < 98), fair (≥ 80 and < 90), poor (< 80)
 - 4) BloodPress - last measurement of blood pressure: high ($> 130/90$), mid ($\leq 130/90$ and $\geq 90/70$), low ($< 90/70$)
 - 5) SurfTempStab - stability of patient's surface temperature: stable, mod-stable, unstable
 - 6) IntTempStab - stability of patient's internal temperature: stable, mod-stable, unstable
 - 7) BloodPressStab - stability of patient's blood pressure: stable, mod-stable, unstable
 - 8) Comfort - patient's perceived comfort at discharge, measured as an integer between 0 and 20
- A. *Target Column*
- 9) Discharge Decision - discharge decision (Intensive-Care, Go-Home, General-Hospital):
Intensive-Care (patient sent to Intensive Care Unit),
Go-Home (patient prepared to go home),
General-Hospital (patient sent to general hospital floor).

4. EXPERIMENTAL RESULTS AND EVALUATION

The input to a classification problem is a dataset of training records and each record has several attributes. Attributes whose domains are numerical are called numerical attributes (continuous attributes), whereas attributes whose domains are not are called categorical attributes (discrete

attributes). There is one distinguished attribute, called *class label*, which is a categorical attribute with a very small domain. The remaining attributes are called *predictor attributes*; they are either continuous or discrete in nature. The goal of classification is to build a concise model of the distribution of the class label in terms of the predictor attributes [12].

SI.No	Attributes
1.	InternalTemp
2.	SurfaceTemp
3.	OxygenSat
4.	BloodPress
5.	SurfTempStab
6.	IntTempStab
7.	BloodPressStab
8.	Comfort

TABLE 1: Input Attributes

In this data analysis the last column will be considered as the target one and other columns will be considered as input columns. The target classes are depicted below in Table 2.

SI.No	Output
1.	General-Hospital
2.	Go Home
3.	Intensive Care

TABLE 2: Target Classes

In this data set total numbers of variables are 9 and for data sub setting has been done using all data rows. The total numbers of data rows are 88 and total weights for all rows are 88. From analysis it has been noticed that number of rows with missing target or weight values are 0 and rows with missing predictor values are 3 and were discarded because these variables had missing values. Decision tree inducers are algorithms that automatically construct a decision tree from a given dataset. Typically the goal is to find the optimal decision tree by minimizing the generalization error. However, other target functions can be also defined, for instance, minimizing the number of nodes or minimizing the average depth.

Target variable	Discharge Decision
Number of predictor variables	8
Type of model	Single tree
Maximum splitting levels	10
Type of analysis	Classification
Splitting algorithm	Gini
Category weights (priors)	Data file distribution
Misclassification costs	Equal (unitary)
Variable weights	Equal
Minimum size node to split	10
Max. categories for continuous	200
Use surrogate splitters for missing	Yes
Always compute surrogate splitters	No
Tree pruning and validation method	Cross validation
Tree pruning criterion	Minimum cost complexity (0.00 S.E.)
Number of cross-validation folds	10

TABLE 3: Decision Tree Parameters

The Gini splitting algorithm is used for classification trees. Each split is chosen to maximize the heterogeneity of the categories of the target variable in the child nodes. Cross Validation method is used to evaluate the quality of the model. In this study, single decision tree model was built with maximum splitting level is 10 and misclassification cost (Equal) are same for all categories. Surrogate splitters are used for the classification of rows with missing values.

There are various top-down decision trees inducers such as ID3 [13], C4.5 [7], CART [8]. Some consist of two conceptual phases: growing and pruning (C4.5 and CART). Other inducers perform only the growing phase. In most of the cases, the discrete splitting functions are univariate. Univariate means that an internal node is split according to the value of a single attribute. Consequently, the inducer searches for the best attribute upon which to split. There are various univariate criteria. These criteria can be characterized in different ways:

- According to the origin of the measure: information theory, dependence, and distance.
- According to the measure structure: impurity based criteria, normalized impurity based criteria and Binary criteria.

Gini index is an impurity-based criterion that measures the divergences between the probability distributions of the target attribute's values. In this work Gini index has been used and it is defined as

$$Gini(y, S) = 1 - \sum_{c_j \in dom(y)} \left(\frac{|\sigma_{y=c_j} S|}{|S|} \right)^2 \tag{1}$$

Consequently the evaluation criterion for selecting the attribute a_i is defined as:

$$GiniGain(a_i, S) = Gini(y, S) - \sum_{v_{i,j} \in dom(a_i)} \frac{|\sigma_{a_i=v_{i,j}} S|}{|S|} \cdot Gini(y, \sigma_{a_i=v_{i,j}} S) \tag{2}$$

The summary of variables section displays information about each variable that was present in the input dataset. The first column shows the name of the variable, the second column shows how the variable was used; the possibilities are Target, Predictor, Weight and Unused. The third column shows whether the variable is categorical or continuous, the fourth column shows how

many data rows had missing values on the variable, and the fifth column shows how many categories (discrete values) the variable has, as shown in table 4.

No	Variable	Class	Type	Missing rows	Categories
1	InternalTemp	Predictor	Categorical	0	3
2	SurfaceTemp	Predictor	Categorical	0	3
3	OxygenSat	Predictor	Categorical	0	2
4	BloodPress	Predictor	Categorical	0	3
5	SurfaceTempStab	Predictor	Categorical	0	2
6	IntTempStab	Predictor	Categorical	0	3
7	BloodPressStab	Predictor	Categorical	0	3
8	Comfort	Predictor	Continuous	3	4
9	Discharge Decision	Target	Categorical	0	3

TABLE 4: Summary of variables

In Table 4, Discharge Decision is a target variable and the values are to modeled and predicted by other variables. There must be one and only one target variable in a model. The variables such as InternalTemp, SurfaceTemp, OxygenSat, etc are predictor variables and the values of this variable are used to predict the value of the target variable. In this study there are 8 predictor variables and 1 target variable are used to predict the model. All the variables except comfort are categorical variables.

Maximum depth of the tree	9
Total number of group splits	16
No of terminal (leaf) nodes of a tree	9
The minimum validation relative error occurs	with 9 nodes.
The relative error value	1.1125
Standard error	0.1649
The tree will be pruned	from 28 to 7 nodes.

TABLE 5: Model Size - Summary Report

Table 5 displays information about the maximum size tree that was built, and it shows summary information about the parameters that were used to prune the tree.

Nodes	Val Cost	Val std err	RS cost	Complexity
9	1.1125	0.1649	0.7200	0.000000
1	1.0000	0.0000	1.0000	0.009943

TABLE 6: Validation Statistics

Table 6 displays information about the size of the generated tree and statistics used to prune the tree. There are five columns in the table:

Nodes – This is the number of terminal nodes in a particular pruned version of the tree. It will range from 1 up to the maximum nodes in the largest tree that was generated. The maximum number of nodes will be limited by the maximum depth of the tree and the minimum node size allowed to be split on the Design property page for the model.

Val cost – This is the validation cost of the tree pruned to the reported number of nodes. It is the error cost computed using either cross-validation or the random-row-holdback data. The displayed cost value is the cost relative to the cost for a tree with one node.

The validation cost is the best measure of how well the tree will fit an independent dataset different from the learning dataset.

Val std. err. – This is the standard error of the validation cost value.

RS cost – This is the re-substitution cost computed by running the learning dataset through the tree. The displayed re-substitution cost is scaled relative to the cost for a tree with one node. Since the tree is being evaluated by the same data that was used to build it, the re-substitution cost does not give an honest estimate of the predictive accuracy of the tree for other data.

Complexity – This is a *Cost Complexity* measure that shows the relative tradeoff between the number of terminal nodes and the misclassification cost.

Category	Actual		Misclassified		Percent	Cost
	Count	Weight	Count	Weight		
General-Hospital	63	63	1	1	1.587	0.0616
Go-Home	23	23	15	15	65.217	0.652
Intensive-Care	2	2	2	2	100.00	1.000
Total	88	88	18	18	20.455	0.205

TABLE 7: Misclassification Table: Training Data

Table 7 shows the misclassifications for the training dataset and it describes the number of rows for “General – Hospital” misclassified by the tree 1, for Go-Home is 15 and for Intensive-Care is 2. This misclassification cost for Intensive-Care is high.

Category	Actual		Misclassified		Percent	Cost
	Count	Weight	Count	Weight		
General-Hospital	63	63	8	8	12.698	0.127
Go-Home	23	23	18	18	78.261	0.783
Intensive-Care	2	2	2	2	100.00	1.000
Total	88	88	28	28	31.818	0.318

TABLE 8: Misclassification Table: Validation Data

Table 8 shows the misclassifications for the validation dataset and total misclassification percent is 31.818%. A Confusion Matrix provides detailed information about how data rows are classified by the model. The matrix has a row and column for each category of the target variable. The categories shown in the first column are the actual categories of the target variable. The categories shown across the top of the table are the predicted categories. The numbers in the cells are the weights of the data rows with the actual category of the row and the predicted category of the column. Table 9 & 10 shows confusion matrix for training data and for validation data.

Actual Category	Predicated Category		
	General-Hospital	Go-Home	Intensive-care
General-Hospital	62	1	0
Go-Home	15	8	0
Intensive-Care	2	0	0

TABLE 9: Confusion Matrix- Training Data

The numbers in the diagonal cells are the weights for the correctly classified cases where the actual category matches the predicted category. The off-diagonal cells have misclassified row weights.

Actual Category	Predicated Category		
	General-Hospital	Go-Home	Intensive-care
General-Hospital	58	8	0
Go-Home	18	5	0
Intensive-Care	1	1	0

TABLE 10: Confusion Matrix - Validation Data

A. Lift/Gain for Training Data

The lift and gain table is a useful tool for measuring the value of a predictive model. Lift and gain values are especially useful when a model is being used to target (prioritize) marketing efforts. The following 3 table's shows Lift/Gain for the three different outputs such as General-Hospital, Go-Home, and Intensive Care.

Lift/Gain for Discharge Decision = General-Hospital

Bin Index	Class % of Bin	Cum % Population	Cum % of Class	Gain	% of Population	% of class	Lift
1	88.89	10.23	12.70	1.24	10.23	12.70	1.24
2	66.67	20.45	22.22	1.09	10.23	9.52	0.93
3	77.78	30.68	33.33	1.09	10.23	11.11	1.09
4	88.89	40.91	46.03	1.13	10.23	12.70	1.24
5	77.78	51.14	57.14	1.12	10.23	11.11	1.09
6	77.78	61.36	68.25	1.11	10.23	11.11	1.09
7	100.00	71.59	82.54	1.15	10.23	14.29	1.40
8	66.67	81.82	92.06	1.13	10.23	9.52	0.93
9	44.44	92.05	98.41	1.07	10.23	6.35	0.62
10	14.29	100.00	100.00	1.00	7.95	1.59	0.20

TABLE 11: Lift and Gain for training data (General-Hospital)

Average gain = 1.112

Percent of cases with Discharge Decision = General-Hospital: 71.59%

Lift/Gain for Discharge Decision = Go-Home

Bin Index	Class % of Bin	Cum % Population	Cum % of Class	Gain	% of Population	% of class	Lift
1	88.89	10.23	34.78	3.40	10.23	34.78	3.40
2	0.00	20.45	34.78	1.70	10.23	0.00	0.00
3	33.33	30.68	47.83	1.56	10.23	12.04	1.28
4	11.11	40.91	52.17	1.28	10.23	4.35	0.43
5	22.22	51.14	60.87	1.19	10.23	8.70	0.85
6	22.22	61.36	69.57	1.13	10.23	8.70	0.85
7	22.22	71.59	78.26	1.09	10.23	8.70	0.85
8	22.22	81.82	86.96	1.06	10.23	8.70	0.85
9	11.11	92.05	91.30	0.99	10.23	4.35	0.43
10	28.57	100.00	100.00	1.00	7.95	8.70	1.09

TABLE 12: Lift and Gain for training data (Go-Home)

Average gain = 1.441

Percent of cases with Discharge Decision = Go-Home: 26.14%

Lift/Gain for Discharge Decision = Intensive-Care

Bin Index	Class % of Bin	Cum % Population	Cum % of Class	Gain	% of Population	% of class	Lift
1	2.27	10.00	10.00	1.00	10.00	10.00	1.00
2	2.27	20.00	20.00	1.00	10.00	10.00	1.00
3	2.27	30.00	30.00	1.00	10.00	10.00	1.00
4	2.27	40.00	40.00	1.00	10.00	10.00	1.00
5	2.27	50.00	50.00	1.00	10.00	10.00	1.00
6	2.27	60.00	60.00	1.00	10.00	10.00	1.00
7	2.27	70.00	70.00	1.00	10.00	10.00	1.00
8	2.27	80.00	80.00	1.00	10.00	10.00	1.00
9	2.27	90.00	90.00	1.00	10.00	10.00	1.00
10	2.27	100.00	100.00	1.00	10.00	10.00	1.00

TABLE 13: Lift and Gain for training data (Intensive -Care)

Average gain = 1.000

Percent of cases with Discharge Decision = Intensive-Care: 2.27%

Lift and Gain for validation data

Lift/Gain for Discharge Decision = General-Hospital

Bin Index	Class % of Bin	Cum % Population	Cum % of Class	Gain	% of Population	% of class	Lift
1	77.78	10.23	11.11	1.09	10.23	11.11	1.09
2	55.56	20.45	19.05	0.93	10.23	7.94	0.78
3	77.78	30.68	30.16	0.98	10.23	11.11	1.09
4	77.78	40.91	41.27	1.01	10.23	11.11	1.09
5	88.89	51.14	53.97	1.06	10.23	12.70	1.24
6	88.89	61.36	66.67	1.09	10.23	12.70	1.24
7	100.00	71.59	80.95	1.13	10.23	14.29	1.40
8	44.44	81.82	87.30	1.07	10.23	6.35	0.62
9	44.44	92.05	93.65	1.02	10.23	6.35	0.62
10	57.14	100.00	100.00	1.00	7.95	6.35	0.80

TABLE 14: Lift and Gain for Validation data (General Hospital)

Average gain = 1.037

Percent of cases with Discharge Decision = General-Hospital: 71.59%

Lift/Gain for Discharge Decision = Go-Home

Bin Index	Class % of Bin	Cum % Population	Cum % of Class	Gain	% of Population	% of class	Lift
1	22.22	10.23	8.70	0.85	10.23	8.70	0.85
2	44.44	20.45	26.09	1.28	10.23	17.39	1.70
3	44.44	30.68	43.48	1.42	10.23	17.39	1.70
4	33.33	40.91	56.52	1.38	10.23	13.04	1.28
5	22.22	51.14	65.22	1.28	10.23	8.70	0.85
6	22.22	61.36	73.91	1.20	10.23	8.70	0.85
7	11.11	71.59	78.26	1.09	10.23	4.35	0.43
8	22.22	81.82	86.96	1.06	10.23	8.70	0.85
9	22.22	92.05	95.65	1.04	10.23	8.70	0.85
10	14.29	100.00	100.00	1.00	7.95	4.35	0.55

TABLE 15: Lift and Gain for Validation data (Go-Home)

Average gain = 1.160

Percent of cases with Discharge Decision = Go-Home: 26.14%

Lift/Gain for Discharge Decision = Intensive-Care

Bin Index	Class % of Bin	Cum % Population	Cum % of Class	Gain	% of Population	% of class	Lift
1	2.27	10.00	10.00	1.00	10.00	10.00	1.00
2	2.27	20.00	20.00	1.00	10.00	10.00	1.00
3	2.27	30.00	30.00	1.00	10.00	10.00	1.00
4	2.27	40.00	40.00	1.00	10.00	10.00	1.00
5	2.27	50.00	50.00	1.00	10.00	10.00	1.00
6	2.27	60.00	60.00	1.00	10.00	10.00	1.00
7	2.27	70.00	70.00	1.00	10.00	10.00	1.00
8	2.27	80.00	80.00	1.00	10.00	10.00	1.00
9	2.27	90.00	90.00	1.00	10.00	10.00	1.00
10	2.27	100.00	100.00	1.00	10.00	10.00	1.00

TABLE 16: Lift and Gain for Validation data (Intensive Care)

Average gain = 1.000

Percent of cases with Discharge Decision = Intensive-Care: 2.27%

Table 17 shows the relative importance of each predictor variables. The calculation is performed using sensitive analysis where the values of each variables are randomized and the effect on the quality of the model is measured.

SI.No	Variable	Importance
1	Comfort	100.00
2	BloodPressStab	51.553
3	InternalTemp	34.403
4	SurfaceTemp	25.296
5	IntTempStab	20.605
6	BloodPress	20.045

TABLE 17: Over all Importance of Variables

The results of this experimental research through the above critical analysis using this decision tree based method shows more accurate data prediction and helping the clinical experts in taking decisions such as General Hospital, Go-Home and Intensive-care. More accuracy will be guaranteed for large data sets.

5. CONCLUSION

This paper has presented a decision tree classifier to determine the patient's post-operative recovery decisions such as General Hospital, Go-Home and Intensive-care. Figure 2 depicts the decision tree model for the prediction of patient's post-operative recovery area.

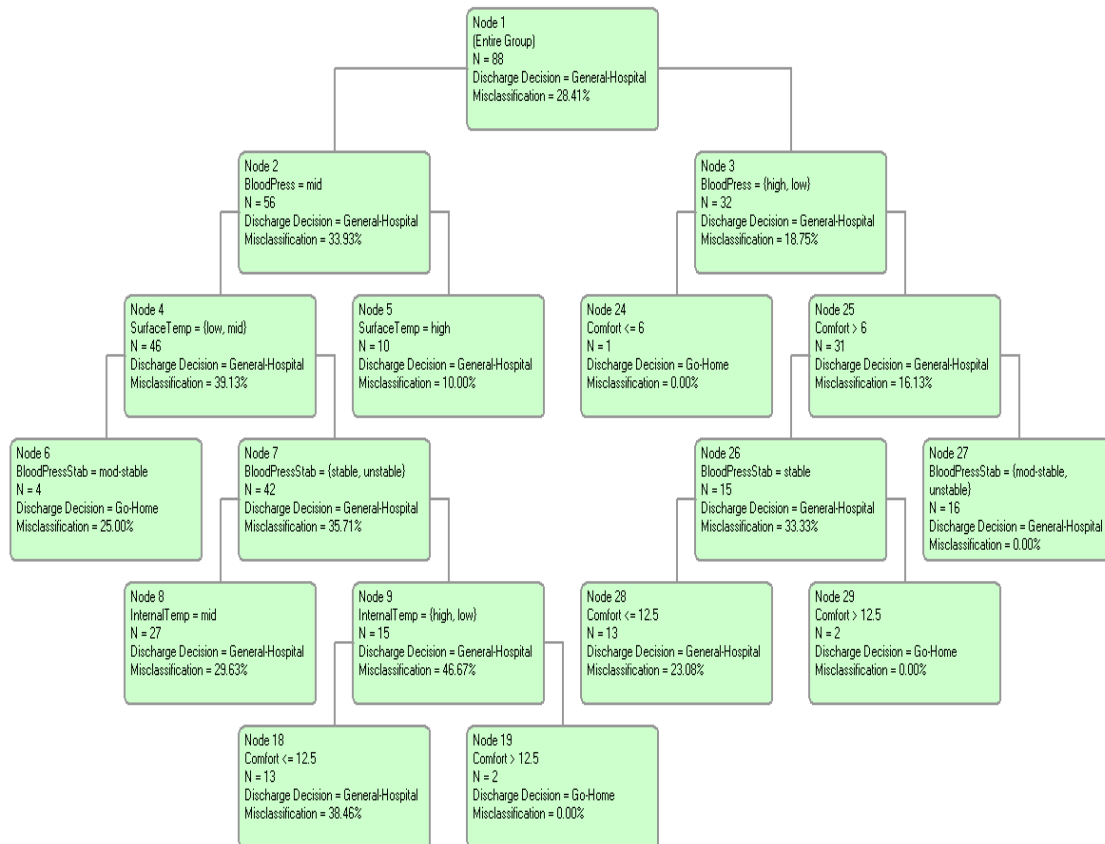


FIGURE 2: Decision tree for the prediction of post-operative recovery area

In figure 2, each node represents set of records from the original data set. Nodes that have child nodes such as 1, 2, 3, 4, 25, 7, 26, 9 are called interior nodes. Nodes 5, 24, 6, 27, 8, 28, 29, 18, 19 are called leaf nodes. Node 1 is root node. The value N in each node shows number of rows that fall on that category. The target variable is Discharge Decision. Misclassification percentage in each node shows the percentage of the rows in this node that had target variable categories different from the category that was assigned to the node. In other words, it is the percentage of rows that were misclassified. For instance, from the tree it is clearly understood the value of predictor variable comfort is ≤ 6 the decision is Go-Home. If Comfort is >6 additional split is required to classify. The total time consumed for analysis is 33ms.

The Decision tree analysis discussed in this paper highlights the patient sub-groups and critical values in variables assessed. Importantly the results are visually informative and often have clear clinical interpretation about risk factors faced by these subgroups. The results shows 71.59% of cases with General-Hospital 26.14% of cases with Go-Home and 2.27% cases with Intensive-Care.

6. REFERENCES

1. Banning, M. (2007). "A review of clinical decision making models and current research," Journal of clinical nursing, [online] available at:<http://www.blackwellsynergy.com/doi/pdf/10.1111/j.1365-2702.2006.01791.x>
2. T. af Klercker (1996): "Effect of Pruning of a Decision-Tree for the Ear, Nose and Throat Realm in Primary Health Care Based on Case-Notes". Journal of Medical Systems, 20(4): 215-226.

3. M. Zorman, V.Podgorelec, P.Kokol, M.Peterson, J. Lane (2000). "Decision tree's induction strategies evaluated on a hard real world problem." In: 13th IEEE symposium on computer-based medical systems 22-24 June 2000, Houston, Texas, USA: proceedings, Los Alamitos, IEEE Computer Society 19-24.
4. Shanthi D, Sahoo G, Saravanan N. (2008). "Input Feature Selection using Hybrid Neuro-Genetic Approach in the diagnosis of Stroke." International Journal of Computer Science and Network Security, ISSN: 1738-7906, 8(12):99-107.
5. F.S,Khan, R,M,Anwer, of Torgersson, and G. Falkman (2009), "Data Mining in Oral Medicine Using Decision Trees", International Journal of Biological and Medical Sciences 4:3.
6. Shanthi D, Sahoo G, Saravanan N. (2009), "Comparison of Neural Network Training Algorithms for the prediction of the patient's post-operative recovery area", Journal of Convergence Information Technology, ISSN: 1975-9320,4(1):24-32.
7. Quinlan JR (1993) *C4.5: "programs for machine learning"*. California: Morgan Kaufmann Publishers.
8. Breiman L, Friedman JH, Olshen RA, et al., (1984). "Classification and regression trees." Belmont Calif: Wadsworth International Group.
9. Gehrke, J., Ramakrishnan, R., & Ganti, V. (1998). "Rain-Forest A framework for fast decision tree construction of large datasets". Proceedings of the 24th International Conference on Very Large Data Bases, pp. 416–427.
10. Shafer, J., Agrawal, R., & Mehta, M. (1996). "SPRINT: A scalable parallel classifier for data mining." Proceedings of the 22th International Conference on Very Large Data Bases, pp. 544–555.
11. "UCI Machine Learning Repository" [online] available at: (<http://www.ics.uci.edu/~mllearn/MLSummary.html>). The data was originally created by Sharon Summers (School of Nursing, University of Kansas) and Linda Woolery (School of Nursing, University of Missouri) and donated by Jerzy W. Grzymala-Busse.
12. Abdel-badeeh M.Salem, Abeer M.Mahmoud (2002). "A hybrid genetic algorithm –Decision tree classifier," IJICIS, 2(2)
13. Quinlan, J. R. (1986). "Induction of decision trees". Machine Learning, 1, 81–106.
14. DTREG version 9.1 "Decision Tree Software for Predictive Modeling and Forecasting".
15. Fayyad, U., Piatetsky-Shaprio, G., Smyth, P. & Uthurusamy, R. (1996). (eds.), "Advances in Knowledge Discovery and Data Mining", MIT Press, Cambridge, MA
16. Hillier, F. & Lieberman, G. (2001). "Introduction to Operations Research," McGrawHill, Boston.
17. Abbass, H.A., Towsey M., &Finn G. (2001). C-Net: "A Method for Generating Non-deterministic and Dynamic Multivariate Decision Trees." Knowledge and Information Systems: An International Journal, Springer-Verlag, 5(2).