Machine Learning in Health Care

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# Part 1: Clustering

**1. Run K-means clustering on the above heart disease dataset and answer the following questions**

1. Why should the attribute “*class”* in ***heart-c.csv*** (“***num***”) **not** be included for clustering?

The class num is the ended cluster predictions, so in essence these outputs are the labels. As K-Means is an unsupervised algorithm these are not needed and are a way for us to check that the algorithm has plotted/predicted well.

1. Run K-means algorithm by choosing different numbers of clusters, *numCluster* = 2, 3, 4,5, then observe the differences of clusters generated:
   1. How are the *Within Cluster Sum of Squared Errors1* changed for different numbers of clusters?
   2. What can you conclude?
   3. How can you explain this conclusion from clustering analysis point of view?

**2. Run the hierarchical clustering on above heart disease dataset, and answer the following questions**

1. Show the clustering results in tree structure
2. Describe the link method you used
3. What are the strengths and limitations of this link method in hierarchical clustering?

# Part 2: Classification

Naïve Bayes:

1. Did you undertake any prepossessing? If so, why?

The data frame first had the variables X and Patient\_ID removed due to these values not having any significant values. X Is just the column number originally and Patient\_ID is the auto id number given to the patient when they are first entered into a database system.

The data frame then has any NA values removed and the class variable is converted to a factor value. This was done in order to make sure that all the variables had values and that any observations that had missing values would be removed completely from the dataset. The class changed to a factor was done to allow the algorithms to know that the class is are a category data type that is needed to classify the data predictions.

The data frame is then spilt into a train and test set while a 75-25% split to the data. This was done to allow us to see how well the models would predict on an unseen dataset. The 75% of the data was used to train the model while the 25% withheld was used to test the model’s predictions.

1. Run the classifier with default parameters.
   1. How accurately can the classifier predict those that develop heart disease? What is in the output that signifies this?
   2. How many people are misclassified as developing heart disease? Where is this answer found in the output?
2. Plot and submit the ROC curve for the class that develops heart disease. What is another measure of accuracy commonly used? Please provide this.

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Random Forrest:

1. Did you undertake any prepossessing? If so, why?
2. Run the classifier with default parameters.
   1. How accurately can the classifier predict those that develop heart disease? What is in the output that signifies this?
   2. How many people are misclassified as developing heart disease? Where is this answer found in the output?
3. Plot and submit the ROC curve for the class that develops heart disease. What is another measure of accuracy commonly used? Please provide this.

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Random Forrest (Model) Optimised:

1. Why did you choose this classifier over the other?

The random forest performed better than the naïve bayes model when compared on the ROC graph, AUC value and the accuracy percentage with training. The random forest was getting a higher true positive rate to a lowers false positive value compared to the naïve bayes model. Due to the random forest doing better, it was decided to try and improve this model by changing some of the parameters.

1. Briefly explain how this classifier works from a theoretical point of view.
2. Try to optimize the classifier to achieve a higher accuracy (no matter how small) than first found. Remember that we have a particular focus on predicting those that develop heart disease.
   1. Were there any features that could be removed? Please print the output that helped you make this decision.

The value pacemaker overall had no importance on the predicting factor of the output. Therefore, this feature could be dropped with not having any impact on the model’s performance.

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* 1. Did changing the way data is sampled during training/testing affect the accuracy?
  2. What about some of the internal parameters specific to the classifier? Please explain how one of these parameters can affect accuracy.

Changing the parameters would have either a negative or positive effect on the model’s predictions, as these parameters change the way in which the algorithms will work. For example, changing the number of ntree will change how many trees to grow in the forest, with the default being 5 trees.

In this case, when the random forest’s parameters ntree, mtry and max nodes were changed to 800, 4 and 24 this created a slightly higher accuracy. The original random forest had an accuracy of 84.35%, error rate of 16.96% and an AUC value of 0.8786355. While the optimised model had an accuracy of 84.78%, an error rate of 15.94% and a AUC value of 0.8781676.

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1. In general, a classifier is only as good as the data it is trained on. Please comment on what is needed from training data to train a good classifier. How can utilizing classifiers help feed back into healthcare settings with regards to data collection?