

Bridging the Bias Gap: A Human-Centered Approach to Fair Post-Transplant Survival Prediction Across Racial Groups

Introduction:

ML models are used in healthcare to predict outcomes like cancer detection, survival rate and drug efficacy. Current predictive models often fall short in addressing disparities related to socioeconomic status, race, and geography. Addressing these gaps is crucial for enhancing patient care, optimizing resource utilization, and rebuilding trust in the healthcare system. These biased predictions are propagated due to imbalanced datasets and incorrect algorithms. This project tries to tackle this critical challenge in human-centered AI.

Problem statement:

Develop ML models to improve the prediction of transplant survival rates for patients undergoing allogeneic Hematopoietic Cell Transplantation (HCT) regardless of their ethnic and racial background.

Motivation:

I felt this is an important topic because I can potentially learn how to work on biases in medical dataset across different demographic groups and to develop models that provide fair predictions for the same. The goal is to address disparities by bridging diverse data sources, refining algorithms, and reducing biases to ensure equitable outcomes for patients across diverse race groups. Creating interpretable predictions that healthcare providers can trust across demographic groups is the main challenge of this project. Data analysis for bias, understanding fairness metrics, model development and fairness optimization will be the phases of the proposed project.

Dataset:

Tushar Deshpande, Deniz Akdemir, Walter Reade, Ashley Chow, Maggie Demkin, and Yung-Tsi Bolon. CIBMTR - Equity in post-HCT Survival Predictions.

<https://kaggle.com/competitions/equity-post-HCT-survival-predictions>, 2024. Kaggle.

Dataset description:

I felt this dataset is perfect because:

- a. It encompasses a range of demographic and medical characteristics of both recipients and donors, such as age, sex, ethnicity, disease status, and treatment details.
- b. It features equal representation across recipient racial categories including White, Asian, African American, Native American, Pacific Islander, and More than One Race.
- c. There are no privacy concerns since this dataset is synthetically generated.

Background and Related Work:

First, let's discuss what the allogeneic hematopoietic cell transplantation (HCT) procedure is. The human immune system comprises cells that develop from hematopoietic stem cells, a special type of cells that reside in the bone marrow. These stem cells are responsible for generating all blood cells, including red blood cells, platelet-producing cells, and immune system cells such as T cells, B cells, neutrophils, and natural killer (NK) cells. HCT can be used to replace an individual's faulty hematopoietic stem cells with stem cells that can produce normal immune system cells. In other words, a successful HCT can help fix a person's immune system by introducing healthy stem cells into their body. When hematopoietic stem cells are transferred from one person to another, the recipient is referred to as the HCT recipient. The term "allogeneic" indicates that the stem cells being used come from someone else, the hematopoietic stem cell donor. If the HCT is successful, the donor's hematopoietic stem cells will replace the recipient's cells, producing blood and immune system cells that work correctly. The source of hematopoietic stem cells can be bone marrow, peripheral blood, or umbilical cord blood. Depending on the source of the stem cells, HCT procedures may be called bone marrow transplants (BMT), peripheral blood stem cell transplants, or cord blood transplants. [1]

The evaluation metric for survival prediction is discussed next. The Concordance index (C-index) represents the global assessment of the model discrimination power: this is the model's ability to correctly provide a reliable ranking of the survival times based on the individual risk scores. The standard C-index (SCI) is adjusted to account for racial stratification, thus ensuring that each racial group's outcomes are weighed equally in the model evaluation. The stratified c-index is calculated as the mean minus the standard deviation of the c-index scores calculated within the recipient race categories, i.e., the

score will be better if the mean c-index over the different race categories is large and the standard deviation of the c-indices over the race categories is small. This value will range from 0 to 1, 1 is the theoretical perfect score, but this value will practically be lower due to censored outcomes. [1]

Earlier various statistical methods were used to predict survival rates and to perform survival analysis. The Cox proportional hazards (CPH) model is the most widely used multivariate statistical model for survival analysis. In outcomes research, especially clinical trials, a hazard ratio is often estimated from a CPH model and is reported as the main measure of therapeutic efficacy. While powerful, the **main limitation** of the Cox model is that it assumes proportional hazards over time, which isn't always the case in complex clinical scenarios like HCT. It may also struggle with high-dimensional data where the number of predictors exceeds the number of events. [2]

Various machine learning and deep learning-based models are created on top of existing statistical solutions to predict these survival rates. One of the most cited papers in this field is the systematic review of ML techniques in HCT carried out by Gupta, et.al. It provides a thorough overview of terms, metrics, methods and results needed for this project. [3]

A stacked ensemble of Cox Proportional Hazard (CPH) regression and 7 machine-learning algorithms was applied to develop a prediction model. The stacked ensemble model achieved better predictive accuracy evaluated by C-index than other state-of-the-art competing risk models (ensemble model: 0.670; Cox-PH: 0.668; Random Survival Forest: 0.660; Dynamic DeepHit: 0.646). [4]

This study from 2024 is one of the latest studies in this field. It focused on all age groups combined data and used Naïve-Bayes machine learning models that incorporated longitudinal data. They were significantly better than models constructed from baseline variables alone at predicting whether patients would be alive or deceased at the given time points. This proof-of-concept study demonstrated that unlike traditional prognostic tools that use fixed variables for risk assessment, incorporating dynamic variability using clinical and laboratory data improves the prediction of mortality in patients undergoing HCT. [5]

While focusing on optimizing survival prediction in children, one of the studies combined Chaotic mapping Harris Hawk Optimization (CHHO) and enhanced the conventional k-means clustering procedure to form CHHO with Deep clustering Model (CHHO-DCM). It performs the effective clustering of instances with the advantage of both local and global optimization. [6] A study also used gradient boosting machine (GBM) for

predicting long-term survival after allogeneic HCT in patients with hematologic malignancies.[7]

A study was undertaken to monitor potential disparities in survival after allogeneic hematopoietic stem cell transplantation (HSCT) with the aim of optimizing access and outcomes for minority and low-income patients. The overall survival probability was 61.8% at 36 months. Non-Hispanic white (63.6%) and especially Hispanic patients (49.2%) had lower survival probabilities at 36 months than non-Hispanic Black patients (75.6%, $p = 0.04$) [8]. Compared to matched related donor and matched unrelated donor HCT, more ethnically diverse patients received mismatched unrelated donor, haploidentical donor, and cord blood HCT. [9]

Sources:

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