

**Designing A Radiology Workstation: A  
Focus on Navigation During the  
Interpretation Task**

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## ABSTRACT

The potential cost and logistic improvements of PACS (Picture Archive and Communication System) over film-based medical image management awaits the development of viable radiology workstations (RWS) targeted for the primary interpretation task. While the quality of electronically displayed images has been highly investigated, only recently has design and experimental work been devoted to the other critical aspect of RWS design, mainly its computer human interaction, and in particular, its *navigation*. By RWS navigation we include its underlying mental model or metaphor, and the commands and hand motions used to access patient folders and to display images.

For the last five years, the University of North Carolina Medical Image Display Research Group has analyzed the primary interpretation task and designed, developed, and evaluated the FilmPlane series of radiology workstation prototypes. This work has helped us understand both radiology workstation requirements and viable design approaches. In this paper, we describe the issues and problems with RWS navigation and present the objectives and design of FilmPlane2 as well as our human computer interaction strategy. We also detail three rapid evaluation techniques for quickly gaining feedback on a design. These techniques may aid other radiology workstation designers.

**Keywords:** computer human interaction, radiology workstations, human factors, medical image display.

## 1 INTRODUCTION

Designing an acceptable computer-human interaction (CHI) is art rather than science. Nevertheless, a general methodology has been widely adapted that allows for the rapid evolution toward a viable product [1]. First, a well designed CHI starts with a complete task analysis including an understanding of the users and their tasks. Second, a clear mental model or metaphor must be developed which allows the user to understand quickly the workstation operation. Third, the complete interaction must be carefully designed and implemented. Fourth, various subject experiments, observation sessions, and time-motion analysis techniques must be used to refine the workstation into a viable tool. Designers must remember that as toolmiths, their objective is to develop a productive tool for the users. In the final analysis, "the quality of a swordsmith is measured by the longevity of his customers" [2].

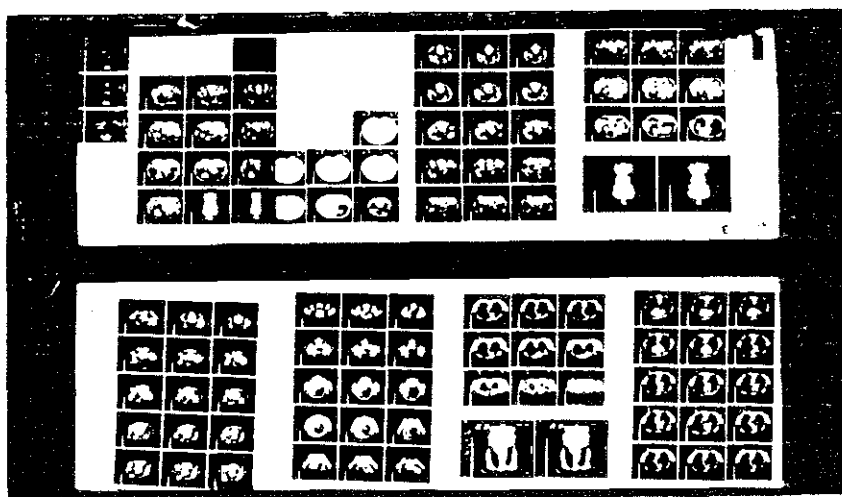
First, the radiology interpretation task is described. Second, workstation design issues are discussed. Third, the design of FilmPlane is presented including objectives, mental models, direct-manipulation interaction, image navigation, display-area requirements, and response-time requirements. Fourth, a series of experiments are described which were used to evolve FilmPlane. These experiment designs may prove useful to other workstation designers.

## 2. RADIOLOGY WORKSTATION TASK ANALYSIS

Workstation design must be based on a clear understanding of tasks performed with film and viewbox, including both projection radiographs and multiple cross-section digital studies such as CT [3,4]. During the interpretation task, the radiologist views the images resulting from the radiology procedure, and together with other information (patient history, images from previous procedures, input from the referring physician, etc.), interprets the images for the referring physician. The primary interpretation task is typically performed on either a "four over four" viewbox array, or an "alternator", a device which stores the films on a large horizontal strip of clear plastic which is mechanically moved over a row of four viewboxes, alternating which four films are displayed (see Figure 1). Smaller viewbox configurations are used for viewing single studies.

There is large variation in the amount of film to be viewed for an interpretation, ranging from a single 14"x17" plain radiograph to a complex case involving several multi-image, cross-sectional-slice CT or MR studies with hundreds of images arrayed on thirty or more films. The possible permutations of images for an interpretation are too large to enumerate, but our research has led us to focus

on two classes of interpretations: those involving two or more time-separated CT studies of the same body area and interpretations involving several 14"x17" radiographs. We believe that a workstation design that is viable for these two classes of interpretations should be adaptable to most others.



**Figure 1**  
**Alternator with**  
**Multiple CT studies**

A successful interpretation requires text as well as image information. The *requisition form* details the medical questions the referring physician wants the radiology procedure to answer; these medical questions greatly affect the search patterns the radiologist uses when viewing the images [8]. The radiology procedure date, slice thickness, type of radiologic device, the name of the technician that performed the procedure, whether contrast was administered, etc. is provided. The radiology information system (RIS) provides patient information. Finally, the *interpretation reports* generated from previous radiology studies are (ideally) available.

## 2.1 Image Scan Patterns

The following details how radiologists view medical images. At UNC, we have used an Eyemark EMR-V eyetracker to study interpretation of one class of critical patient folders: those containing single and multiple CT chest studies [5]. An eyetracker determines the position of a subject's eyes, and superimposes markers corresponding to these positions on a video signal, generated from a camera mounted in front of the forehead on the eyetracker helmet, and directed to monitor and recorder. This provides the experimenter with a recording of both the subject's field of view and eye posi-

tions. The Eyemark EMR-V allows subject head and body movement, making it particularly useful for analyzing medical image interpretation.

The following search pattern has been found to occur generally during interpretation of a single CT study: first, images are removed from the patient folder, sorted, and some of the films are placed onto the viewbox. Images are viewed during this viewbox loading process. In some institutions, this step is performed by the technologist, but a large number of radiologists seem to prefer to load the films themselves. Second, a systematic search pattern is performed over all the images. Sometimes this is by organ, but in general, a systematic sequential scan pattern is initially used to view the slices in a multiple slice study.

This sequential pattern often occurs first through the images intensity-windowed for the mediastinum, followed by sequential review of the images intensity windowed for the lungs. (Intensity windowing is a contrast adjustment technique used to allow viewing of different density anatomy. It is described in more detail shortly.) Little or no cross comparison between images of different intensity windowing occurs. Third, critical slices showing important anatomy are reviewed in detail. Fourth, an interpretation report is dictated, often while continuing to view the images. Fifth, the films are removed from the viewbox and replaced, often in a random order, back into the patient folder.

A great deal of time is spent locating and accessing small clusters of images that show important anatomy. An image cluster is identified when a radiologist repeatedly fixates on the same proximate images. When asked how much of the patient's folder radiologists need to view simultaneously, they typically answered "all of it" [6,7]. However, based on our eye movement studies, radiologists only seem to view small localities of reference, that is, small clusters of typically one to four CT images. But radiologists are not incorrect in feeling they need to have all of the patient folder simultaneously displayed. The remaining images appeared to be used as a pictorial image index, allowing the radiologist to locate quickly any particular image.

With patient folders containing multiple studies the search patterns are more complex. Generally radiologists first read the requisition form and possibly one or more interpretation reports. Second, they arbitrarily access critical slices in the previous study, and sequentially view the current study; the order of these tasks often is reversed. Third, radiologists often compare clusters of images from the current study to clusters from previous ones to determine whether an anatomical object is abnormal, or whether it had increased or decreased in size. Since radiologists need to compare anatomical objects which occupy many CT slices, this can be a complex task. Typically clusters of

one to four images are cross-compared, even if the anatomical objects occupy a larger number of slices. Radiologists sometimes rapidly move their eyes back and forth between the clusters, and at other times slowly examine the first cluster followed by the second. Comparisons are also done between studies of different modalities (imaging techniques such as CT or radiography) to improve anatomical understanding. When there are symmetries around a vertical center axis, radiologists often compare the left and right sides to aid in locating abnormalities.

If the patient folder contains no more than eight films, the typical "four over four" viewbox is an effective tool for viewing medical images. But for more complex cases, a patient folder may contain more films than available viewbox space. While the alternator is an improvement, it does not solve the problem. Films must either be left in piles on nearby tables, or double stacked on several viewboxes. Time is wasted locating and moving films. A great deal of frustration is generated.

Others have recorded eye movements of radiologists reading medical images [8,9,6], though most of this research was for determining source of interpretation errors, rather than developing task analyses. Experienced radiologists employ a variable, though basically circumferential, scan pattern when reading radiographs [10]. Search patterns develop with experience [11], are affected by prior knowledge [8], and deviate from textbook recommendations [9]. While some studies have suggested that misreadings (false negatives which range around 30% [12,13,14]) may occur because large areas of film are not foveally viewed (viewed with the fovea area of the retina which affords acute vision) [15], or because there is non-uniform coverage of the film [16], eyetracking experiments indicate that only about 30% of missed lung nodules can be attributed to the lesion not having been foveally viewed [17]. More recently, studies have been initiated to determine workstation requirements for interpreting single small radiographs [18,19].

## 2.2 Advanced Tools

Visually comparing images from different studies is difficult, though necessary to determine changes in the size of anatomy. Tools that help radiologists determine the size of anatomical objects reduce the amount of visual comparison. One dimensional measuring tools are useful. Tools that accurately measure the volume of anatomical objects in multiple-slice studies would be even more beneficial. Radiologists currently measure the size of anatomical objects manually or with the CT or MR machine's console.

Several new techniques allow reconstruction of multiple slice CT or MR studies into three dimensional pictures of anatomical features [20]. These three dimensional pictures appear to be particu-

larly useful for understanding complex spatial structures such as intricate bone fractures. Advanced volume rendering techniques [21] are particularly good for viewing bone, but also may be used on soft tissue. While current three dimensional volume rendering techniques do not produce sufficient image quality to serve as the only view of a study's images during the interpretation, such renderings can serve an important auxiliary role, and eventually should be incorporated into a viable two-dimensional image-viewing workstation.

## 2.7 Image Quality and Contrast Adjustment

Any viable radiology workstation must have adequate *image quality*. To display an image, the system must have adequate values for screen size, number of pixels, gray-scale dynamic range, number of digital intensity levels, and should be standardized so that a gray-scale value produces the same luminance regardless of the screen on which it is displayed. Theoretical calculations [22] indicate that radiographs require a sampling of  $4000^2$  16-bit pixels to capture their full resolution. Anecdotal reports by radiologists revealed that pneumothorax pleural lines on chest x-rays that have been digitized at 2000 lines were seen well only when the image was displayed at that resolution, and that these same pleural lines were discernible at lesser resolution only if edge enhancement processing were performed. Controlled studies, e.g. [23,24,25], have confirmed the need for at least  $2000^2$  pixel display of radiographs, and in some cases,  $4000^2$ .

Contrast enhancement or intensity windowing creates an image focused on presenting a particular anatomy; it is almost essential for the electronic display of medical images [26,27,28]. Such contrast adjustment allows details of the very dense bone, and details of soft tissue to be available from the same slice. When intensity windowing an image, the radiologist chooses a *window* of a certain *width* from the entire total range of contrast in the CT or other digitally produced image, and then places this window at a certain *level* in the total contrast range. If a given pixel value falls within this window, it is translated into a corresponding pixel value in the (typically) eight-bit framebuffer. Pixel values outside the window are set at 0 or 1 respectively. Image processing such as contrast-limited adaptive histogram equalization (CLAHE) and unsharp masking are also very useful. Overviews may be found in [4] and [29]. Discussion of detailed topics also can be found in [30,31,32,33].

Multiple film images frequently must be made from the same digital slice in order to allow for viewing the image at multiple contrast levels. One critical advantage of a workstation over film is dynamic contrast adjustment, that is, the ability to change dynamically the window width and level (WWL) used to display an image. While radiologists need the ability to select all possible intensity



windows, most often a selection from a small standard set of WWLs refined for bone, lung, soft tissue, brain, etc. is preferred. With a press of a button, the radiologist can rapidly change the contrast range of a displayed image. Since multiple images, displaying intensity windows for bone, lung, etc. required for film, are not necessary, fewer separate images are needed to convey the same information [4].

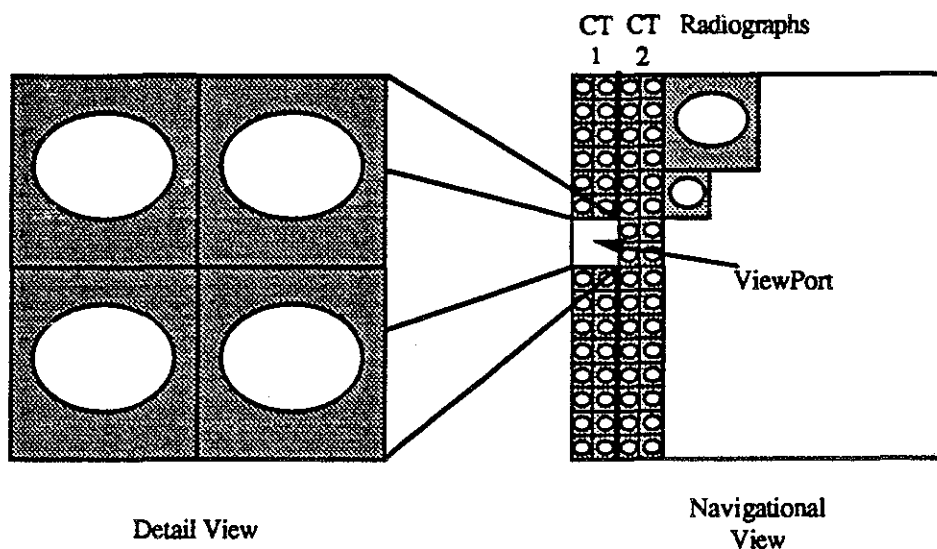
### 3. FILMPLANE

#### 3.1 Design Objectives

Producing a workstation with acceptable navigation is difficult. The typical viewbox array can easily display over 64 megabytes of images which the physician can quickly access using techniques -- the movement of eyes and head -- which have been practiced for an entire professional career. Even the best workstations barely have this much real memory, let alone display area. Further, the cognitive motor skill requirements of the viewing task create additional technical complexities for workstation design.

We concentrated on several critical navigational tasks when developing and evaluating FilmPlane: *Image location* for locating any image in the patient folder, *arbitrary-access*: for displaying and viewing the images, and *sequential access*: for moving through slices and for roaming within a radiograph. *Side-by-side comparison*: is also needed to compare various images from one study with images from another or for comparing one side of a chest radiograph with the other. Our goal is to develop a workstation prototype upon which a radiologist can conduct an interpretation with quality equal to that of film and viewbox, and in equal or less time. We feel that the radiologist should be able to conduct a simple interpretation after only five to ten minutes of training. Developing a radiology workstation viable for the primary interpretation is very difficult, and while the FilmPlane design looks promising, it may prove insufficient for the task, particularly for viewing and comparing images from many different multiple cross-section studies. Controlled subject experiments are being designed to determine FilmPlane's viability.

The original version of FilmPlane used a single 1024x900 pixel display, but we are currently implementing the FilmPlane2 prototype on a Stellar high performance graphics workstation which uses three 1280x1024 displays. FilmPlane2 will also operate on a Sun 3/60 with a single greyscale monitor. The current design can be adapted quickly to operate with a varying number of 1024<sup>2</sup>, 2048<sup>2</sup>, or even larger displays.



**Figure 2**  
**Navigation View, Detail View, and Viewport**

### 3.2 Mental model

A key objective of computer human interaction (CHI) is for the user to obtain an understanding of the computer tool by developing a *mental model* of its operation [34,35,36,37,38,39,40]. Such a mental model is critical, for it not only allows users to quickly perform tasks, but it also helps them feel more "in control" of the computer. Developing and teaching an arbitrary mental model of a complex tool is difficult and frustrating. As an alternative, a mental model of a real-world tool, such as a desk top or the radiologist's viewbox, can be used as a metaphor for the operation of the computer tool. Thus, as long as the computer tool stays within the bounds of the metaphor, the user will, a priori, understand its operation. Basing computer-tool operation on a metaphor is particularly useful when designing for non-computer specialists, especially when that tool must be use after only minimal training.

FilmPlane's operation is based on the metaphor of a two-dimensional *navigation view* upon which all the images in the patient folder are systematically arrayed in two, four, or more column strips (see figure 2) [41]. In the navigation view, these columns are arranged horizontally and ordered by time. A 1024<sup>2</sup> pixel image of this navigation view is provided to the user to reinforce the metaphor, with the medical images displayed at a fraction of their full resolution. Times and dates for each study are provided. This index can either be permanently displayed or only appear on command. The permanent display of the navigation view reinforces its metaphor to the user and eliminates the cognitive

load and hand-motions required to make it appear and disappear. On the other hand, permanent display takes up valuable screen space.

### 3.3 Direct-Manipulation Interfaces

Interfaces with a direct manipulation style [42,2], are based on the mental model of a desk top and use a very simple *one-place verb grammar* to simplify the interaction and improve user performance. With such a grammar, most common statements are of the form <subject><one-place-verb>, where the subject is indicated by being "grabbed" or selected by the mouse, and the one-place-verb to be applied to the subject is often selected from the pull-down menu. So to delete an object, one selects the object with the mouse and applies the one-place verb "cut."

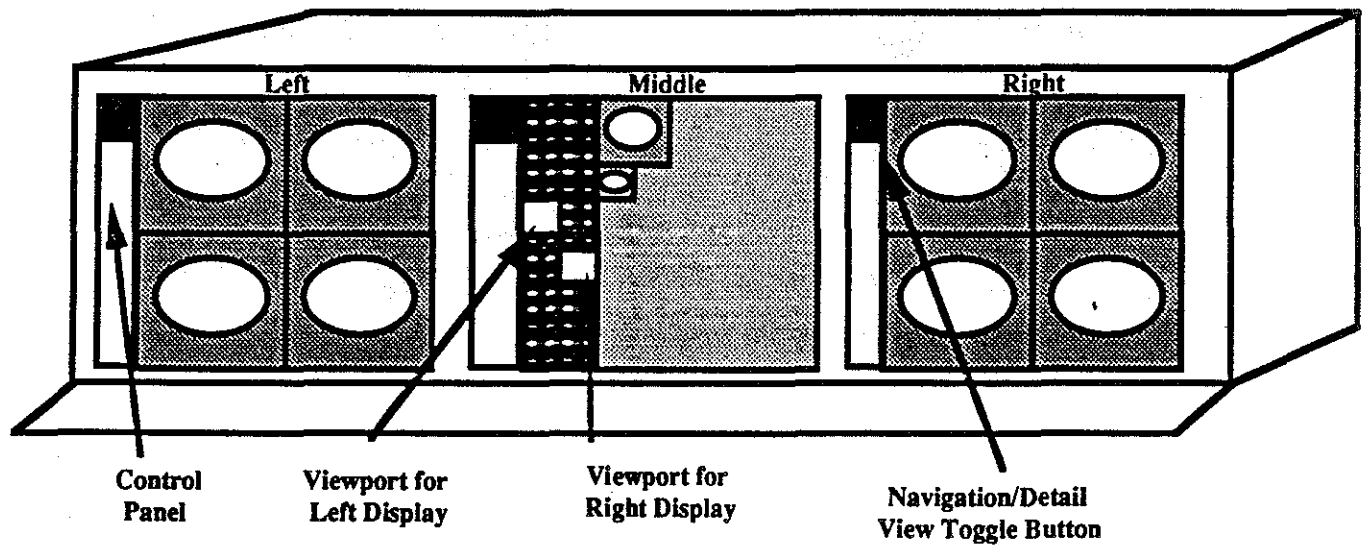
Direct manipulation interfaces such as the Macintosh [43] are often said to be mode-less or state-less. This is incorrect in that the Macintosh has a large number of state variables that control the font, size of the text, etc. But state control on such interfaces is simple and clear for several reasons: First, critical states, such as which object on the screen is selected, are represented visually. Second, state variables are *orthogonal*, that is, one state variable can be changed without affecting another. Thus, with the Macintosh, one can modify font without affecting text size. A little arithmetic should make obvious the advantage of managing five orthogonal binary state variables over managing the corresponding  $2^5$  alternatives. Since state variables are typically represented visually, direct manipulation interfaces can be said to have *orthogonal-visual state control*. We have adapted this strategy in FilmPlane2.

### 3.4 Navigation

Superimposed on the FilmPlane navigational view are one or more wire-framed boxes called viewports, each corresponding to one of the workstation's display screens (figure 2). Each viewport is sized to contain enough miniature images to fill the corresponding display screen when displayed at full resolution. (One small radiograph, four CT, or 16 MR images are needed to fill the current  $1024^2$  display screen). The position of the viewports can be controlled by the mouse (or some other pointing device) and any display screen can be toggled to either display the navigation view or the full resolution images, which when displayed are called the *detail view*.

Taken together, the navigation view, the movable viewports, and the ability to display the images in the viewports at full resolution provide *two-dimensional pictorial image-location* and *arbitrary access* to all the images in the patient folder. Radiologists can quickly locate any image in the patient

folder by scanning the navigation view. They can quickly display any arbitrarily-selected image by moving the cursor to a viewport, selecting the viewport by depressing the mouse button, dragging the viewport to a new location, and releasing the mouse button. These actions cause the images in the viewport to be displayed at full resolution on the corresponding display (figure 3).



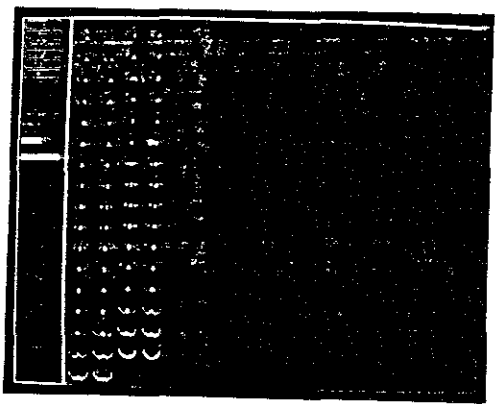
**Figure 3**

**Any of the Three Displays can be Toggled to Display Either the Detail or the Navigation View.**

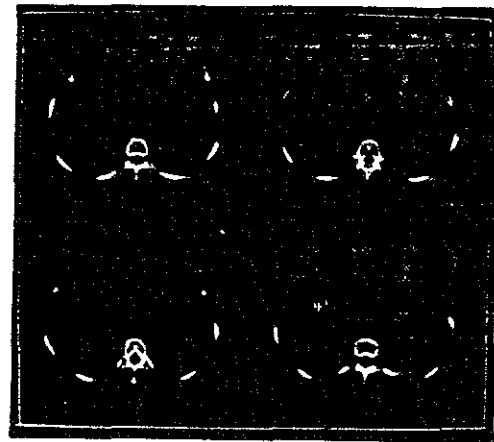
Two alternatives to a pictorial image index have been constructed. The Arizona workstation [44] provides image location using a text listing of all the studies in the patient folder and images in each study. Text image-indexing is acceptable for locating studies consisting of a few large images, each having clear text-labels such as "chest, 20Jul89". However, we suspect that for experienced radiologists accessing several multi-slice CT studies containing 40 or more slices, no text label will work as well as the images themselves in indicating contents.

A second alternative to a pictorial index is an icon index [18] in which a simple icon of the body is used to represent and access the contents of the patient folder. An experiment described in the above citation indicates that icon indexing may be superior to text indexing. While no comparison between pictorial and icon indexing has been undertaken, we speculate that an icon index would be superior to a pictorial index, such as FilmPlane's navigation view, for inexperienced users who can not in-

stantly determine the modality and represented anatomy of a medical image. But for typical experienced radiologists, we expect the navigational view to be advantageous. Not only do the miniature medical images themselves serve as icons denoting general represented anatomy, but their relative time ordering and the exact size and coverage of each study are available at a glance.



Navigational View



Detail View

Figure 4  
FilmPlane Alternate Display Screens

Radiologists hold their fingers on viewbox-displayed images to provide a visual and tactile reference [5] thus speeding access. FilmPlane allows radiologists to quickly *mark* critical images, causing a bright border to be displayed. Such markers not only allow the radiologist to locate critical images more quickly, but also tell the computer system which images are important to the radiologist allowing improved memory management. Some radiologists have also suggested a tool for moving viewports quickly to one of several standard locations within a typical multi-slice study.

Radiologists often wish to view images *near* the ones currently being viewed, either by *roaming* around on a radiograph that is too large to completely display at full resolution, or by sequentially moving *up* or *down* through a multiple-slice CT or MR study. In particular, it is important that the interaction be optimized for long strings of sequential movement in the same direction; this often occurs when the radiologist is sequentially viewing a multiple-slice study. To facilitate sequential

movement, FilmPlane2 provides the user with a simple mechanism for moving sequentially up, down, left or right through a multi-slice study or radiograph.

To move sequentially, the radiologist presses the mouse button with the cursor in a display screen showing a detail view. A "diamond" appears with an arrow pointing up, down, left, or right, depending of the last direction of sequential movement in that display screen. If the radiologist wishes to continue in the same direction, he simply releases the mouse button and the next image(s) appears on the screen. If the radiologist wishes to sequentially move in a new direction, he moves the mouse in the new direction and the diamond arrow follows. Then by releasing the mouse button, the display moves in the new direction.

Sequential movement in a radiology workstation can be either *continuous* or *discrete*, and either *aligned* or *unaligned*. With *continuous sequential movement*, either the viewport, or the underlying FilmPlane appear to scroll in the direction of sequential movement. Continuous sequential movement or scrolling enforces the mental model or metaphor with the user. However, fast response time for high resolution images requires expensive hardware. With *discrete sequential movement*, the next set of images are simply displayed with no apparent motion. Some other movement direction indicator, such as the arrow used in FilmPlane, is required to reinforce the underlying mental model.

FilmPlane uses *aligned discrete sequential* movement. With *aligned* discrete movement, the viewport always "snaps to a grid" on the navigation view. Aligned movement eliminates the need for the radiologist to carefully align the viewport with the borders of an image after a move operation. This should not be a disadvantage to the radiologist roaming over a radiograph larger than the display screen. Our observation indicates that an aligned discrete sequential movement should only replace half the display screen's contents per movement. Sequentially moving only half the display size at a time doubles the number of sequential movements required to move a given distance, but it is essential if a radiologist will be able to maintain context and compare images

Zooming, the ability to minify or magnify the images in the patient folder, provides two functions: First, minification allows more images to be displayed simultaneously, though at lower resolution. Second, magnification allows an image to be viewed larger, and possibly at higher resolution, if it originally was displayed at less than full resolution. While zooming may be occasionally useful, it adds complexity to the interaction. FilmPlane is designed to minimize the need for zooming. Images in the detail view are displayed at full resolution, and display screens are large enough to

eliminate the need for zooming merely to increase the size of an image. FilmPlane does provide a tool that allows the images in a study to be displayed at half resolution.

### 3.5 Comparing Two Studies

Radiologists often need to compare two or more studies in a patient folder to complete an interpretation. With multiple slice studies such as CT, the radiologist typically views two studies side-by-side comparing corresponding slices of the studies, sequentially moving through both studies at the same time. This is one of the most difficult tasks to be performed on a radiology workstation. Not only are many handmotions involved, but a great deal of judgement and effort is required to insure that the same anatomy from the two studies is compared. Multiple cross-section studies may have slices taken at different intervals requiring, for example, ten slices from one study to be compared with six from another. Further, technologists often backup the CT machine and re-scan the same body area, so that the same study may contain multiple slices of the same anatomy. If the workstation knows the slice intervals of each study and offsets of each slice, it can automatically increment the displays so that the same anatomy from each study is always viewed. Eventually, CT machines should digitally encode into each cross-section study file the slice thickness, interval size, and the mm. offset of each slice from the starting position. Until then the technologists should (ideally) enter this information into the PACS system manually.

To side-by-side compare two studies with FilmPlane, the radiologist places a viewport for one display screen at the beginning of one study, and the viewport of a second display screen over the second study. Then by sequentially moving each viewport downward, the corresponding anatomical regions of the studies are compared. Viewport may be split-in-two and each half independently navigated. While this method does allow side-by-side comparison of two multiple slice studies, it requires a considerable number of hand-motions; the radiologist must first move the cursor to one viewport and sequentially move it down, then move it to the second and move it, and then back to the first. To compare two studies each containing 40 slices would require almost three minutes just to complete the required hand-motions [45]. To reduce the required number of hand-motions, FilmPlane2 allows the radiologist to connect viewports; the radiologist need only move one viewport to move the other. Synchronization is indicated by a white line connecting the two viewports in the navigation view. The synchronized viewports will automatically track the same anatomy because FilmPlane takes into account the slice intervals of the studies.

### 3.6 Display area

*Display area* refers to the number of pixels that can be displayed simultaneously. It is difficult to determine how much display area is sufficient for a primary interpretation workstation. The four-over-four viewbox, with 8000x4000 pixels (eight 2000<sup>2</sup> radiographs) might be taken as a starting point, but even its large display area is often insufficient for very large patient folders with many films. [5] indicates that most of the images placed on the viewbox serve as a pictorial index into the patient folder, and that far fewer images are actually needed for simultaneous viewing. But how much display area for a workstation is sufficient?

While roaming and zooming is possible, full resolution display of images is superior. Therefore 2048<sup>2</sup> monitors (the generally accepted minimum resolution for large radiographs [4]) are necessary, and at least two are needed if multiple films are to be compared. More than two 2048<sup>2</sup> monitors may be useful, but since only two studies are generally compared at a time, additional monitors may not be needed with well-designed navigation and very-fast response time. 1024<sup>2</sup> monitors are acceptable if only smaller images are to be viewed. Based on [5] we believe that a display area capable of showing at least eight CT images is required for multiple CT study interpretations. This amount of display area is available with several 1024<sup>2</sup> monitors. Note that these side-by-side comparisons often can be conducted with images displayed at less than full resolution, possibly reducing the required display area. A large display area is available either using a smaller number of the largest available screens, or a larger number of small ones. All else being equal, larger screens are superior because a large array of small screens is really an inflexible single screen crisscrossed with big ugly lines.

[19] considers the possibility of comparing images displayed in sequence rather than side-by-side. A preliminary experiment is described involving non-radiologists and non-medical images, that indicates little or no difference between these two methods, besides the time to change the display. Sequential comparison does reduce by 50% the amount of required display area, but it is not clear whether the additional cognitive load sequential viewing imposes on the radiologist is prohibitive. Until more definite studies are completed, we will continue to assume the side-by-side comparisons are required.

*Display size* refers to the total square feet of all the display screens. We believe the four-over-four viewbox at about 3'x5' represents a reasonable outer-bound on the total square footage that can be used for display without strain.



### 3.7 Response time

Sufficiently fast response time is critical to a primary interpretation workstation. This is particularly true for interpretations that require viewing multiple-slice studies with many sequential movements. Slower response time not only increases the total interpretation time, but also causes frustration and increases cognitive load. Our observations [41,45] indicate that for common operations such as roaming or moving to the next slice in a CT study, a response time of 1 second is acceptable, with improvements down to 0.5 seconds or more having a significant effect on total interpretation time. Several radiology workstation research groups have reported success with slower response times, but these research efforts appear to be confined to interpretations of radiographs, which involve a small number of large images, with a correspondingly small number of movement operations.

Work by [46] and others indicates that consistency in response time may be as critical as absolute speed, for if the system first takes one second to respond and then 12, users may become frustrated or think they have damaged the workstation. Given the cost of main memory, a sizable portion of the patient folder may need to be stored in the swap space portion of virtual memory in a radiology workstation. This may cause wildly varying response times as images are moved in from disk. The generally accepted solution is to display a "wait" icon such as a *hourglass* [47] or *watch* [43] whenever the system response is delayed. For long delays such as waiting for a patient folder to be moved from the archive to the workstation, a rough estimate of the response time should be provided.

## 4. IMPLEMENTATION

FilmPlane2's interaction design, allowing any screen to access any portion of the image space, presents two difficult-to-achieve requirements: a very large image memory, and the ability to move rapidly any image from that memory to any screen's framebuffer. Radiology workstation memory often needs to contain over 60MB of images; cost prohibits using this much main memory. We have found that virtual memory can be an effective alternative when three requirements are met: first, there must be sufficient main memory to store a minimum of 16MB for a single screen workstation. Second, the disks must be fast. Third, there must be function to anticipate which images will be displayed next, and to insure these images are pre-fetched into main memory from disk.

Moving images from virtual memory into the framebuffers with sufficient speed can be very difficult, particularly for the single-bus workstations typically used to implement radiology workstations.

We suspect that eventually (five or more years) PACS image management will be implemented with very high speed networks such as HSC (High Speed Channel) or BISDN (Broadband Integrated Services Digital Network) providing a sustained 150 megabits per second to each framebuffer in the workstation from a very high-speed central archive. A multi-screen FilmPlane2 can be implemented with current technology, at a high cost, by either increasing the main memory to framebuffer transfer rate, or greatly increasing the size of the each framebuffer.

For the above reasons, most current commercial radiology workstations use *separate* image memories for each display screen; thus a multi-screen workstation is a simple concatenation of several single screen consoles. Such an approach is likely to add complexity to the computer human interaction, but may be required for cost-effective implementation with today's technology.

## 5. RAPID EVALUATION OF RWS NAVIGATION DURING DEVELOPMENT

We have utilized two response-time experiments – described below – as well as time-motion analysis to quickly compare and evaluate workstation navigation [41,45]. They are designed for very rapid evaluation of a navigation technique or tool and only require a minimal amount of radiologist time. Both experiments use patient folders containing several multiple-slice studies as their interpretation is a very challenging navigation task. These evaluation methods may prove useful during radiology workstation development.

### 5.1 Experiment One

The first experiment determined the effectiveness of FilmPlane's arbitrary movement and pictorial image index vs. film and viewbox, by comparing response times for radiologists locating anatomical targets or landmarks in four patient folders, each containing two abdomen CT studies.

**Methods and Materials:** FilmPlane1, an early single-screen prototype workstation was used in the experiment. The single viewport could be split in two and each half independently navigated allowing side-by-side comparison of images. It was implemented on a Sun 3/180 with a 1024<sup>2</sup> greyscale monitor and 16MB of main memory. This hardware was able to complete a sequential movement operation in about 0.75 seconds. Dynamic contrast window adjustment was available. Films were reviewed with a four-over-four viewbox in an environment controlled for light and sound. The single contrast window setting, typically used with abdomen CT, was picked by the technologist for each study and used for both film and workstation display. Three radiologists participated, each having several years experience with CT. They all had limited experience with word-

processors and two had previously used a mouse. The radiologists were given about 10 minutes training with FilmPlane1 as well as sufficient time to become familiar with the layout of the viewbox controls. The radiologist without mouse experience was given an additional 5 minutes training with the mouse. After training, the radiologists appeared to both understand and feel comfortable with the workstation.

For each trial, radiologists were asked to locate a CT slice containing a particular small body feature or "landmark", such as the pancreatic duct, in one of the two abdomen CT studies in each patient folder. The experimenter stated the landmark to be located, which study was to be searched, and then gave the start signal. Trials always began when all needed films were mounted on the viewbox or loaded into FilmPlane. The radiologists were instructed to work as quickly as possible without making errors. Time for each trial ended when the radiologist displayed an image and pointed to the "landmark." Each subject repeatedly located targets in each study of each patient folder using both film and FilmPlane. Sessions with film and FilmPlane were separated by time and alternated in order to control for bias and learning. The independent variable was the use of film and FilmPlane. The dependent variable was error-free response time. Very few errors were noted.

**Results and Conclusions:** Radiologists averaged 19.1 seconds to locate a target slice using FilmPlane1, and 9.4 seconds with film and viewbox. Film and viewbox was significantly faster (0.975 confidence). Several points were noted: First, the FilmPlane1 mental model worked, in that it allowed the radiologist to locate the required images. Analysis of the search patterns (automatically recorded by FilmPlane) indicated that for the most part, radiologists moved directly to the target slice. This indicates that the tiny images in the navigation view ( $50^2$  pixels) were sufficient for locating and accessing images. Analysis of the video tape showed very few incorrect actions and the radiologists' verbal protocol, that is the comments they made during the trials, indicated that they were comfortable with the interaction.

Failure to locate an object, particularly due to a confusing or slow radiology workstation, would be very frustrating, so the fact that radiologists were consistently able to locate and successfully display the landmarks shows a fundamental soundness in the design. While landmark location was not a problem for experienced radiologists, we would expect referring physicians, beginning residents, and medical students to have difficulty because they could not determine as quickly the anatomy represented in a slice. Either another type of image index should be optionally available, or some tool should be provided to move automatically the viewports to one of several standard anatomical locations. Further, the workstation interaction was too slow. Based on these results, subsequent FilmPlane prototypes were modified to reduce response time for landmark location.

Locating slices containing landmarks appears to be a good task for evaluating the radiologist's general comprehension of the workstation mental model and navigation. While the only formal dependent variable is response-time, the other observations mentioned above must be taken into consideration before one can assume that workstation design is viable.

## 5.2 Experiment Two

The second experiment determined the time to interpret four patient folders each containing a current and a previous abdomen CT study using film and FilmPlane. No prior interpretation report, patient history, or requisition form were provided.

**Material and Methods:** FilmPlane1, the viewbox, the subjects, and the experimental environment were the same as in experiment one. For each trial, The radiologists were asked to look through both abdomen CT studies and "indicate anything they could about the patient." This task utilizes image access-patterns similar to a standard diagnostic task without prior knowledge. Radiologists were instructed to "insure their interpretation quality was up to typical professional standards." Tasks were timed from the moment the films were loaded onto the viewbox, or displayed on the navigation view, until the end of the interpretation. The time to load and unload the films on the viewbox was also measured. In addition to verbal protocol, observation data were gathered manually, by computer, and with video tape. Radiologists were asked to describe how confident they were in their interpretations. During two separate sessions, each radiologist read two studies using FilmPlane, and two studies using film and viewbox. Presentation method and patient folder orders were systematically varied to control for learning and bias.

**Results and Conclusions:** FilmPlane1 averaged 482 seconds for interpretation of these abdomen studies. An interpretation with film and viewbox averaged 264 seconds. Film and viewbox were significantly faster (0.995 confidence). In general, the following pattern was used to review the two CT studies: first, the radiologist sequentially scanned all the images in the older study, and second, a differential comparison of the old and the new study was made by splitting the screen into two viewports, moving the halves to the top of each study, and then moving the half viewports down through both studies, side-by-side comparing the corresponding images. During this comparison, only two slices from each study could be simultaneously viewed. This is insufficient, and either more display area is required, or the images would have to be viewed at lower resolution. We suspect that had the requisition form and/or the interpretation report for the previous study been pre-

sent, the initial sequential scan through the older study would have been replaced with a highly-directed viewing of the anatomical area in question.

The radiologists felt they were able to conduct viable interpretations with the FilmPlane1 workstation for patient folders containing two abdomen CT studies. However, they also felt the system had "imposed itself" on them during the interaction, that is, they had found themselves thinking about manipulating the workstation rather than thinking about interpreting the images. The radiologists had only the training and experience from experiment one so a certain unfamiliarity is expected. Nevertheless, this initial version of FilmPlane had too much "friction" in the interaction. To correct this, the system has been refined using the time-motion calculations described in the next section. In addition, the single 1024<sup>2</sup> available for the experiment did not appear to have sufficient display area for comparing two CT studies at full resolution. On the average, each radiologist made 3.3 arbitrary-access moves and 69 sequential moves when viewing each patient folder indicating both that the radiologists understood the FilmPlane1 mental model, and the importance of reducing the time for a single sequential movement operation.

Ideally, one should not measure response time without carefully measuring accuracy. However, precisely measuring interpretation quality with receiver operating characteristics (ROC) [48] or agreement experiments [49] requires from 200 to 300 data points [33,48], many hundreds of hours of scarce radiologist time, and many months of experimenter time. While ROC or agreement experiments are required to analyze the effectiveness of a workstation compared to another display device, they are too time consuming to be part of the workstation development cycle. Thus experiment two is an appropriate experiment design for providing rapid feedback on navigation to interface designers, and as a formal framework for observing radiologists use a workstation.

### 5.3 Time-Motion Analysis

Once a general workstation design has been accepted, the design must be "lapped" and improved to reduce "friction". Besides observation and user comments, one of the best methods for rapidly polishing an interaction is with the use of time-motion analysis calculations. In brief, time motion analysis is used to estimate how long a user will require to perform a specific task using a specific tool [50]. Time motion analysis of a small aspect of a computer tool can be as simple as counting keystrokes or as complex as a detailed keystroke analysis [51] which takes into account the mental pauses a user makes, even when doing a complex but well-learned task.

After completing the above experiments, we used the keystroke model to compare several alternative interactions for sequential movement in FilmPlane2 [45]. While the keystroke model was designed for analysis of experts and our users are novices, it is still valid for comparing two design alternatives. To verify the accuracy of the time-motion analysis model, we used it to calculate the duration of a sequential movement operation with FilmPlane1, and then conducted several simple timing studies of this operation. Generally, the keystroke estimates were within 0.1 second of the actual sequential-movement duration. These keystroke estimates showed that the old sequential operation took 2.7 seconds while the improved sequential operation would take about 1.6 seconds. Additional analysis show that only 47 sequential operations would be needed with the new interface to complete the same task requiring 69 operations with the old. These changes would result in a total potential improvement of about 110 seconds out of the 482 average for the task in experiment two. Together with several other improvements, this new sequential access method should cut interpretation time almost in third for patient folders containing two CT abdomen studies and no previous information. Considering the weeks of time required to conduct even a simple experiment, time-motion analysis, even with its limited accuracy, is an important tool in CHI development. Further, the analysis comes before the prototype has been implemented, further reducing the time for obtaining feedback on a design idea.

## 6. CONCLUSIONS

In this paper, we have described the issues and problems with radiology-workstation navigation design and described the objectives and design of the FilmPlane2 radiology workstation as well as our human computer interaction strategy. We have also presented three rapid evaluation techniques for quickly gaining feedback on a radiology workstation navigation design. Radiology workstations are the essential component to the acceptance of electronic medical image management, and adequate workstation computer-human interaction is essential to workstation acceptance.

In general, radiologists are currently not willing to work without film using a computer workstation, even if all modalities are available on-line. This is understandable for the *information bandwidth* of even the best workstations, including FilmPlane, is still insufficient. This seems particularly true for interpretations involving multiple studies. Analogously, as scientists, engineers, and toolsmiths, we are still unwilling to work without paper using our computer workstations. Radiologists have become understandably skeptical of success claims after repeatedly hearing of new workstations and constantly finding them unacceptable.

Nevertheless, there is a light at the end of the PACS tunnel. Relatively low cost 2048<sup>2</sup> display monitors of acceptable quality are available, as are workstation busses that can move 60 million 32 bit pixels a second. All this, in our opinion, adds up to sufficient hardware to construct viable radiology workstations. Now can begin the process of developing, evaluating, evolving, and lapping the surfaces of a viable tool.

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