Anonymous Standardized Patient Visit Feedback Reports

"Development of an Assessment and Feedback (AnF) Strategy to Improve the Quality of Internet-based Medical Consultation Services" — Research Project

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Case 1 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On July 28, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform. Please allow us to take the liberty of sending you this feedback report.

- This report is individually tailored, not a platform-average feedback.
- The purpose of this assessment is not comparison; it is solely for scientific research into whether feedback can improve the quality of medical care.
- The feedback reflects only your performance on this single encounter and does not represent your overall quality of care.
- The study has passed ethics committee review, and privacy of the data is guaranteed — it will not be shared with any institution or individual (Nanfang Medical University Ethics Review [2025] No. 63).

Clinical Context Review

- Visit time: 2023-07-28, 12:43:00–12:43:00
- Access channel: WeDoctor (WeYi), text/image consultation
- Standardized-patient profile (script-based): Woman, 23–33 years old, bachelor's degree, married, 50 days postpartum, unfamiliar with psychiatry
- Body type slightly overweight; rarely exercises; normal diet; enjoys shopping and following celebrities in her spare time
- Chief complaint (proactively stated, entered into the pre-consultation intake form): Low mood, difficulty falling asleep, decreased appetite for one month
- Exams (passively stated, only elicited if the physician asks): Edinburgh Postnatal Depression Scale score 20; Patient Health Questionnaire score 19

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **21.74%**

You asked about: presentation of low mood, decreased interest, sense of fatigue and its triggers, duration of illness, and "anything else uncomfortable / do you need help?" (5/23)

Exams you suggested/asked about: None

Guideline-recommended exam checklist includes: EPDS, PDSS, HADS, PHQ-9, BDI, SDS, HAMD psychological screening scales

Your diagnosis: Suspected depressive episode — identical to the case design prototype. Thank you for your careful diagnosis!

Diagnosis designed for the standardized-patient case: (1) suspected moderate postpartum depressive episode; or (2) suspected postpartum depressive episode; or (3) suspected depressive episode

Your management recommendations for this case:

- Correct portion: "Recommend referral of the patient to psychiatry or psychological counseling."
- Partially correct: none
- Inappropriate portion: none

Original design intent — per the guideline, the following treatment measures should be taken: refer the patient to an offline hospital's psychiatry or psychological counseling department; respect the patient's wishes and conduct joint risk assessment with family members; provide appropriate psychological support; provide health education (guidance on breastfeeding, newborn massage, bathing, etc., or explain postpartum depression-related knowledge to the patient to reduce mood problems arising from a lack of postpartum knowledge).

Note: The completion rate of guideline-recommended history items is based on standardized-patient (USP) records, secondarily confirmed by quality-control staff via audio recording/screenshots. It only includes questions the patient heard being asked during the consultation, and does not include the chief-complaint summary organized by the platform's assistant chatbot. Even when guideline adherence is low, experienced physicians may still reach a correct diagnosis based on limited information; however, a comprehensive history helps uncover potential problems and comorbidities.

Guideline-Recommended History-Taking Items (minimum items recommended by clinical guidelines; "√" = items you asked about)

Item	Source
Presentation of low mood — key diagnostic information √	*Expert Consensus on the Prevention and Treatment of Postpartum Depressive Disorder — Based on Obstetric and Community Physicians* (hereafter "Prevention & Treatment Consensus"), Part 2, I.(1).1
Suicidal or infant-harm ideation — diagnostic information	Prevention & Treatment Consensus, Part 2, (2).6
Mother–infant relationship — impact	NICE 2014, p.32
Decreased interest — key diagnostic information √	Prevention & Treatment Consensus, Part 2, I.(1).2
Suicidal or infant-harm behavior — diagnostic information	Prevention & Treatment Consensus, Part 2, (2).6
Marital relationship — trigger	NICE 2014, p.31
Perinatal life events — personal history / differential diagnosis	Prevention & Treatment Consensus, Part 3, IV.4
Pessimism, hopelessness, helplessness — diagnostic information	Prevention & Treatment Consensus, Part 2, (2).5
Quality of social and interpersonal relationships — social support	NICE 2014, p.31
Appetite or weight change — diagnostic information	Prevention & Treatment Consensus, Part 2, I.(3)
Presence of anxiety symptoms — diagnostic information	Prevention & Treatment Consensus, Part 2, (2)
Housing, employment, and financial status — economic stress/hardship	NICE 2014, p.31
Sleep quality (and related timing) — diagnostic information	Prevention & Treatment Consensus, Part 2, I.(3)
Course and evolution of the illness — diagnostic information / differential diagnosis	Prevention & Treatment Consensus, Part 3, I
Burden of caregiver role at home — family stress	NICE 2014, p.31
Sense of fatigue and its triggers — key diagnostic information √	Prevention & Treatment Consensus, Part 2, II.2

Item	Source
Duration of illness — diagnostic information / differential diagnosis √	*Management of Perinatal Mood Disorders: A National Clinical Guideline*, SIGN (2012), p.18
Family history of illness — family history	Prevention & Treatment Consensus, Part 1, II
Perinatal medication history and special diet history — differential diagnosis	Prevention & Treatment Consensus, Part 3, IV.2
"Is there anything else uncomfortable? Do you need help?" — patient-centered √	NICE 2014, p.31
Personal past medical history — past history	Prevention & Treatment Consensus, Part 1, II
Prior similar symptoms and their duration — key history	Prevention & Treatment Consensus, Part 3, IV.2
Woman's attitudes toward pregnancy, childbirth, and the baby — trigger, possible harm	NICE 2014, p.31

Patient-Centeredness Score

72/100 — average across three dimensions (your score/full score)

This score is based on the Chinese version of the Patient-Centeredness Scale (PPPC-CN); it reflects the standardized patient's subjective experience of this consultation and does not represent an evaluation of the physician's professional competence.

- Dimension 1 (proactive exploration of the disease course, symptoms, and patient experience — e.g., asking about the main health concern, discussing etiology; a higher score indicates more effective understanding of the patient's health problem): **72/100**
- Dimension 2 (shared negotiation of the treatment plan — e.g., discussing treatment options, responding to patient concerns; a higher score indicates stronger collaboration and empathy): **68/100**
- Dimension 3 (patient's subjective experience and feelings after the consultation — e.g., feeling respected, given the chance to ask questions, trusting the physician; a higher score indicates greater patient satisfaction): **75/100**

(As internet consultation is primarily advisory in nature, this evaluation is for reference only.)

Contact us: WeCom (Enterprise WeChat) / WeChat Official Account
Fund note: Youth Fund 72304129, Lebup Foundation

Case 2 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On November 14, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform. Please allow us to take the liberty of sending you this feedback report.

(Same boilerplate disclaimers as above: individually tailored, not for comparison, ethics-approved, privacy protected — Nanfang Medical University Ethics Review [2025] No. 63.)

Clinical Context Review

- Visit time: 2023-11-14, 19:41:35–20:33:53
- Access channel: Haodaifu Online (Good Doctor), text/image consultation
- Standardized-patient profile: Woman, 50–60 years old, junior college education, married, somewhat stubborn, holds some mistaken beliefs about hypertension
- Overweight body type; no exercise habit; prefers salty food
- Chief complaint: Dizziness and headache for the past 3 days, not much relieved by rest
- Exams: Blood pressure 160/100 mmHg

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **19.35%**

You asked about: circumstances of dizziness/headache (frequency, location, etc.), prior management measures after past episodes, effectiveness of prior treatment for past episodes, past blood pressure status, presence of nausea/vomiting/blurred vision, presence of slurred speech, limb numbness, choking while drinking, or drooling (6/31)

Exams you suggested/asked about: None

Guideline-recommended exam checklist includes: complete blood count; urinalysis; ECG; lipid panel; fasting glucose; renal function; liver function

Your diagnosis: Hypertension — identical to the case design prototype. Thank you for your careful diagnosis!

Diagnosis designed for the standardized-patient case: (1) primary hypertension (Grade 2, moderate risk); or (2) hypertension

Your management recommendations for this case:

- Correct portion: "low-salt, low-fat, anti-hypertensive diet; regular exercise; weight reduction; explaining what hypertension is; monitoring blood pressure or adverse reactions during medication; timely dose adjustment based on the patient's condition"
- Partially correct: "one oral antihypertensive medication"
- Inappropriate portion: none

Original design intent — per the guideline, the following treatment measures should be taken: low-salt, low-fat diet; regular exercise for weight loss; explaining what hypertension is and its dangers; combination therapy with two oral antihypertensive drugs; monitoring blood pressure or adverse reactions.

(Same methodology note as Case 1, adapted to hypertension guidelines.)

Guideline-Recommended History-Taking Items ("√" = items you asked about)

Item	Source
Circumstances of dizziness/headache (frequency, location, etc.) — key diagnostic information √	*National Grassroots (Primary Care) Hypertension Prevention and Management Guideline (2017 edition)*, p.19, referral section
Cardiac symptoms (chest pain, etc.) — differential diagnostic information	Primary Care Hypertension Guideline (2017), p.15, comorbidities
Recent sleep status — diagnostic information	*Chinese Guidelines for the Prevention and Treatment of Hypertension (2018 Revision)*, p.6, history
What the patient was doing before the dizziness started — diagnostic information	Chinese Hypertension Guideline (2018), p.6, history
Presence of tinnitus — differential diagnostic information	Chinese Hypertension Guideline (2018), p.6, history
Recent tests performed — diagnostic information	Primary Care Hypertension Guideline (2017), p.9
Diagnostic/treatment course of the current episode	Primary Care Hypertension Guideline (2017), p.9

Item	Source
Presence of nausea, vomiting, blurred vision — differential diagnostic information √	Primary Care Hypertension Guideline (2017), p.19, referral section
Past medical history — past history	Primary Care Hypertension Guideline (2017), p.9, history
Whether this has happened before — diagnostic information	Primary Care Hypertension Guideline (2017), p.9
Slurred speech, limb numbness, choking while drinking, drooling — differential diagnostic information √	Primary Care Hypertension Guideline (2017), p.19, referral section
Prior trauma or surgery	Primary Care Hypertension Guideline (2017), p.9, history
Prior management measures after past episodes — diagnostic information √	Primary Care Hypertension Guideline (2017), pp.10–18
Presence of fever — differential diagnostic information √	Primary Care Hypertension Guideline (2017), p.9, hypertension diagnostic evaluation
Drug or food allergies — important allergy/medication history	Primary Care Hypertension Guideline (2017), pp.22–23
Effectiveness of prior management of past episodes √	Primary Care Hypertension Guideline (2017), pp.10–18
Generalized weakness/fatigue — differential diagnostic information	Primary Care Hypertension Guideline (2017), pp.9–10
Smoking status — key personal history	Primary Care Hypertension Guideline (2017), p.9, history
Past blood pressure status √	Primary Care Hypertension Guideline (2017), pp.6–8
Recent notable weight change — differential diagnostic information	Primary Care Hypertension Guideline (2017), p.10
Family history of illness — family history	Primary Care Hypertension Guideline (2017), p.9, history
Prior diagnostic/treatment course	Primary Care Hypertension Guideline (2017), p.9
Dietary taste and habits — diagnostic information	Primary Care Hypertension Guideline (2017), p.10
For general practitioners: occupation, family relationships, cohabitants, worry about hypertension, awareness of its	—

Item	Source
dangers, most concerning issue, expected physician management/advice — general-practice history, patient-centered shared decision-making (ICE)	

Patient-Centeredness Score

67/100 average

- Dimension 1: **64/100**
- Dimension 2: **61/100**
- Dimension 3: **75/100**

Peer Ranking

- Technical quality: **62/152** — your history-item completion rate exceeded 60% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 1/5** (grading: 1 = fully correct; 2 = essentially correct; 3 = partially correct; 4 = incorrect; 0 = unable to determine) — 48% of peers were at this level
- Service quality: **96/152** — your patient-centeredness score exceeded 38% of peers (peer average: 69.78)

(As internet consultation is primarily advisory in nature, this evaluation is for reference only.)

Case 3 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On September 4, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-9-4, 12:58:00–21:41:00
- Access channel: Haodaifu Online, text/image consultation
- Standardized-patient profile: Woman, 24 years old, bachelor's degree, unmarried, office worker, essentially no medical knowledge
- Slim body type; non-smoker, occasional red wine; enjoys coffee; high work stress

- Chief complaint: Recurrent episodic fronto-temporal headache for 1+ years, recurrence 1 day ago
- Exams: Vital signs stable; pale-red tongue with a thin white coating; no other specific signs

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **50%**

You asked about: headache location, character of pain, frequency of pain, disease course, prodromal symptoms of headache (visual blurring or sensorimotor abnormalities, etc.), associated symptoms during headache attacks (nausea and/or vomiting), whether parents had similar symptoms, past medical history, trauma/surgical history, medication treatment history (10/20)

Exams you suggested/asked about: None

Guideline-recommended exam checklist includes: skin rash, consciousness, nystagmus and eye movement, facial examination, tongue (protrusion only, deviation or not), limb muscle strength (rough assessment sufficient)

Your diagnosis: Migraine — identical to the case design prototype. Thank you for your careful diagnosis!

Diagnosis designed for the standardized-patient case: (1) migraine with aura; or (2) migraine; or (3) menstrual migraine

Your management recommendations for this case:

- Correct portion: "Non-pharmacologic prevention: avoid cold exposure, overexertion, alcohol, strong tea, chocolate, citrus fruits, etc.; ensure adequate sleep, provide psychological reassurance. Acute-phase medication: NSAIDs, disease-specific medications, etc. Preventive medication."
- Partially correct: none
- Inappropriate portion: none

Original design intent: non-pharmacologic prevention (avoid cold exposure, overexertion, alcohol, strong tea, chocolate, citrus, etc.; ensure adequate sleep and provide psychological reassurance); acute-phase medications (NSAIDs, disease-specific medications, etc.); preventive medications.

Guideline-Recommended History-Taking Items ("√" = items you asked about)

Item	Source
Onset time — key diagnostic information	*Chinese Guideline for Diagnosis and Treatment of Migraine (2011)*, p.69
Trigger — menstruation — key diagnostic information	Chinese Migraine Guideline (2011), p.69
Whether parents had similar symptoms — family history √	Chinese Migraine Guideline (2011), p.69
Headache location — diagnostic information √	Chinese Migraine Guideline (2011), p.69
Trigger — overexertion or tension — key diagnostic information	Chinese Migraine Guideline (2011), p.69
Past medical history — past history √	Chinese Migraine Guideline (2011), p.69
Character of pain — key diagnostic information √	Chinese Migraine Guideline (2011), p.69
Trigger — diet — key diagnostic information	Chinese Migraine Guideline (2011), p.69
Trauma/surgical history — past history √	Chinese Migraine Guideline (2011), p.69
Frequency of pain — key diagnostic information √	Chinese Migraine Guideline (2011), p.69
Prodromal symptoms — fatigue or other bodily discomfort before headache — key diagnostic information	Chinese Migraine Guideline (2011), p.69
Medication treatment history — past history √	Chinese Migraine Guideline (2011), p.69
Severity — key diagnostic information	Chinese Migraine Guideline (2011), p.69
Prodromal symptoms — visual blurring or sensorimotor abnormalities √	Chinese Migraine Guideline (2011), p.69
Occupational history — basic information	Chinese Migraine Guideline (2011), p.69
Duration of illness — key diagnostic information √	Chinese Migraine Guideline (2011), p.69
Associated symptoms — nausea and/or vomiting — differential diagnostic information √	Chinese Migraine Guideline (2011), p.69

Item	Source
Smoking, alcohol, dietary preferences — key personal history √	Chinese Migraine Guideline (2011), p.69
Headache relief pattern — key diagnostic information	Chinese Migraine Guideline (2011), p.69
Associated symptoms — photophobia and/or phonophobia — differential diagnostic information	Chinese Migraine Guideline (2011), p.69

Patient-Centeredness Score

86/100 average

- Dimension 1: **97/100**
- Dimension 2: **75/100**
- Dimension 3: **85/100**

Peer Ranking

- Technical quality: **7/152** — history-item completion rate exceeded 96% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 1/5** — 48% of peers at this level
- Service quality: **12/152** — patient-centeredness score exceeded 93% of peers (peer average: 69.78)

Case 4 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On April 18, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-4-18, 18:07:09–18:09:09
- Access channel: WeDoctor, telephone consultation
- Standardized-patient profile: Man, 23–40 years old, emotionally stable, courteous in speech, high-school education, essentially no medical knowledge

- Irregular diet, frequently eats cold, spicy, or fried food
- Chief complaint: Nasal congestion and runny nose for 2 days, sore throat for 1 day
- Exams: Slightly congested nasal mucosa with small amounts of white discharge; mildly red throat

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **13.33%**

You asked about: presence of headache or muscle aches, personal lifestyle (diet, exercise, smoking/drinking) (2/15)

Exams you suggested/asked about: None

Guideline-recommended exam checklist includes: pharyngeal examination; whole-body skin examination for rash, petechiae, etc.; complete blood count, etc.

Your diagnosis: Viral cold — we're confident you'll be more precise next time.

Diagnosis designed for the standardized-patient case: (1) common cold; or (2) upper respiratory infection; or (1)/(2) (either) + "wind-heat" pattern common cold (TCM)

Your management recommendations for this case:

- Correct portion: "Avoid triggering factors: prevent cold exposure and overexertion, keep warm; ventilate and sun-expose rooms; avoid crowded places during high-incidence seasons; quit smoking; prevent cross-infection. Symptomatic treatment: drink plenty of water, rest."
- Partially correct: none
- Inappropriate portion: none

Original design intent: avoid triggering factors; boost immunity; symptomatic treatment (plenty of water, rest); health education (explain why antibiotics are not used).

Guideline-Recommended History-Taking Items ("√" = items you asked about)

Item	Source
Triggering factors for nasal congestion/runny nose — diagnostic information	*Acute Upper Respiratory Tract Infection Primary Care Guideline (2018)*, p.423, diagnostic method (1) risk factors
Whether people nearby have similar symptoms / fever or cold — differential diagnosis	Same guideline, p.424, differential diagnosis: influenza/infectious disease

Item	Source
Onset time of nasal congestion/runny nose — diagnostic information	Same guideline, p.423, diagnostic method (2) history
Recent tests/treatment — diagnostic/treatment course	Same guideline, p.423, diagnostic method 2, ancillary tests
Nature of nasal discharge — diagnostic information	Same guideline, p.423, diagnostic method (2) history / past history
Onset time of sore throat — diagnostic information	Same guideline, p.423, diagnostic method (2) history
Personal lifestyle (diet, exercise, smoking/drinking) — lifestyle related to cold/reduced immunity √	Same guideline, p.423, diagnostic method (1) risk factors
Severity of sore throat — diagnostic information	Same guideline, p.423, diagnostic method (2) history
Work stress, etc. — psychosocial factor	—
Exposure to mites, dust, animal dander, etc. — differential diagnosis	Same guideline, p.424, differential diagnosis 1: allergic rhinitis
Drug or food allergies — important allergy history	—
Presence of chills or high fever — differential diagnosis	Same guideline, p.424, differential diagnosis
Note: recommended items also reference the Expert Consensus on the Use of Chinese Patent Medicine for Acute Upper Respiratory Tract Infection and the 9th edition of Diagnostics (People's Medical Publishing House).	
Presence of headache or muscle aches — differential diagnosis √	Same guideline, p.424, differential diagnosis

Patient-Centeredness Score

62/100 average

- Dimension 1: **66/100**
- Dimension 2: **56/100**
- Dimension 3: **65/100**

Peer Ranking

- Technical quality: **84/152** — history-item completion rate exceeded 45% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 3/5** — 32% of peers at this level

- Service quality: **119/152** — patient-centeredness score exceeded 22% of peers (peer average: 66.5)

Case 5 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On April 26, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-4-26, 14:32:00–14:35:00
- Access channel: WeDoctor, telephone consultation
- Standardized-patient profile: Woman, around 55 years old, Han ethnicity, university-level education, married, essentially no medical knowledge
- Overweight body type; dislikes exercise; enjoys meat, few vegetables/fruits; enjoys German-style/pilsner beer and playing cards (mahjong)
- Chief complaint: Increased thirst, increased urination, and increased appetite for one month with no relief, worsening over the last week
- Exams: Recent test results — fasting venous blood glucose 8.5 mmol/L; glycated hemoglobin 7.3%

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **4.35%**

You asked about: frequency and amount of water intake (1/23)

Exams you suggested/asked about: None

Guideline-recommended exam checklist includes: fasting/random capillary glucose or oral glucose tolerance test; glycated hemoglobin (HbA1c); urine/blood ketone testing; fundus monitoring

Your diagnosis: Diabetes — we're confident you'll be more precise next time.

Diagnosis designed for the standardized-patient case: (1) type 2 diabetes; or (2) type 2 diabetes + Grade 3 hypertension, very-high-risk group (and/or) hyperlipidemia

Your management recommendations for this case:

- Correct portion: "Further evaluation at a specialty department."
- Partially correct: none
- Inappropriate portion: none

Original design intent: health education (dietary guidance, appropriate exercise, appropriate medication, blood-glucose monitoring, disease education); oral medication; further evaluation at a specialty department.

Patient-Centeredness Score

67/100 average

- Dimension 1: **69/100**
- Dimension 2: **57/100**
- Dimension 3: **75/100**

Peer Ranking

- Technical quality: **134/152** — history-item completion rate exceeded 13% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 3/5** — 32% of peers at this level
- Service quality: **97/152** — patient-centeredness score exceeded 37% of peers (peer average: 69.78)

Case 6 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On July 21, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-7-21, 11:11:10–8:55:00 [as recorded]
- Access channel: Haodaifu Online, text/image consultation
- Standardized-patient profile: Man, 25–35 years old, sales representative; high work stress, frequent headaches, self-medicates with "ibuprofen"

- Irregular diet, frequently eats cold, spicy, or fried food
- Chief complaint: Recurrent upper abdominal pain and bloating for 1 year, recurrence over the past week
- Exams: Blood pressure, pulse, respiration, temperature normal; mild upper-abdominal tenderness; brought own gastroscopy report

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **27.27%**

You asked about: when the abdominal pain began and how long it lasted, location of abdominal pain, character of pain sensation (e.g., dull, stabbing, or cramping) (3/11)

Exams you suggested/asked about: reviewed gastroscopy results; asked about/requested a 13C urea breath test

Guideline-recommended exam checklist includes: review gastroscopy results; recommend repeat gastroscopy + histopathology if necessary; ask about 13C urea breath test; recommend ECG (for differential diagnosis)

Your diagnosis: Considering gastric disease — we're confident you'll be more precise next time.

Diagnosis designed for the standardized-patient case: (1) chronic superficial gastritis / chronic non-atrophic gastritis; or (2) chronic gastritis

Your management recommendations for this case:

- Correct portion: "Dietary/lifestyle guidance: regular, light diet, avoid cold, spicy food, reduce coffee and alcohol. Recommend 13C urea breath test (if prescribing PPI or bismuth, inform the patient to discontinue before testing). If H. pylori infection present, provide eradication therapy. Prokinetic medication to relieve bloating and post-meal fullness."
- Partially correct: "prescribed antacid (Gaviscon, sucralfate) or acid suppressant (PPI, H2RA) without instructing on timing of administration"
- Inappropriate portion: none

Original design intent: dietary/lifestyle guidance; recommend reducing "ibuprofen" use, or combine with acid suppressants/gastric mucosal protectants; recommend 13C urea breath test (when prescribing PPI or bismuth, inform patient to stop the drug for 2 weeks [PPI] or 4+ weeks [bismuth] before testing to avoid false negatives); if H. pylori infected, provide eradication therapy; select gastric mucosal protectant/antacid/H2RA/PPI etc. for upper abdominal pain and inform of dosing timing; prokinetic medication for bloating/post-meal fullness; digestive enzyme treatment; recommend regular follow-up gastroscopy and 13C breath test (repeat 13C testing should be informed to occur 4+ weeks after completion of H. pylori eradication therapy).

Guideline-Recommended History-Taking Items ("√" = items you asked about)

Item	Source
When the abdominal pain began and its duration — diagnostic information √	*Chronic Abdominal Pain Primary Care Guideline (Practice Edition, 2019)*, p.629
Relationship to eating/fasting — diagnostic information	Same guideline, p.629
Work stress, etc. — psychosocial factor	Same guideline, p.629
Location of abdominal pain — diagnostic information √	Same guideline, p.629
Black stool or hematemesis — red-flag identification	Same guideline, p.629
Recent notable weight loss — red-flag identification	Same guideline, p.629
Character of pain sensation (dull, stabbing, cramping) — diagnostic information √	Same guideline, p.629
Chest tightness, chest pain, palpitations — red-flag identification	Same guideline, p.629
(Also references: Chinese Consensus on Chronic Gastritis (2017, Shanghai))	
Radiation to other sites — diagnostic information	Same guideline, p.629
Recent notable weight loss — red-flag identification (repeated)	Same guideline, p.629
(Also references: Diagnostics, 8th edition, People's Medical Publishing House)	
Conditions under which pain worsens/improves — diagnostic information	Same guideline, p.629
Personal lifestyle (diet, exercise, smoking/drinking) — lifestyle related to chronic gastritis	Same guideline, p.629
(Also references: TCM Diagnosis and Treatment Guideline for Chronic Non-Atrophic Gastritis, Primary Care Physician Edition)	

Patient-Centeredness Score

47/100 average

- Dimension 1 (proactive exploration of the illness): **61/100**
- Dimension 2 (interaction and communication): **39/100**
- Dimension 3 (subjective experience): **40/100**

Peer Ranking

- Technical quality: **30/152** — history-item completion rate exceeded 81% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 3/5** — 32% of peers at this level
- Service quality: **145/152** — patient-centeredness score exceeded only 5% of peers (peer average: 69.78)

Case 7 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On June 5, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-6-5, 14:55:48–15:04:49
- Access channel: WeDoctor, telephone consultation
- Standardized-patient profile: Consulting on behalf of an infant — parent, woman, 25–35 years old, tends to get anxious easily; child is 1.5 years old
- Mother of normal body type; non-smoker, occasional alcohol; spends most of her rest time with the child
- Chief complaint: Infant started having diarrhea and vomiting the evening before last, with low-grade fever (37.6°C), poor spirits, and decreased urination
- Exams: Tears present when crying, lips/oral mucosa slightly dry; soft, non-distended abdomen, no tenderness; yellow watery stools

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **35%**

You asked about: dietary status before onset, frequency and volume of stools (not distinguishing time period), stool character (not distinguishing time period), dehydration status, mental status, feeding status, presence of fever (7/20)

Exams you suggested/asked about: body temperature, mental status

Guideline-recommended exam checklist includes: electrolytes; stool routine; rotavirus antibody; CBC + CRP

Your diagnosis: Acute gastroenteritis, gastrointestinal dysfunction — we're confident you'll be more precise next time.

Diagnosis designed for the standardized-patient case: (1) acute rotavirus enteritis; or (2) acute diarrheal disease; or (1)/(2) (either) + mild dehydration

Your management recommendations for this case:

- Correct portion: "Continue feeding, ensure adequate nutrition. Oral rehydration salts to correct dehydration and electrolyte imbalance. Mucosal protectants such as montmorillonite powder to protect the digestive mucosa. Probiotics/prebiotics such as Bifid triple viable to regulate gut flora."
- Partially correct: none
- Inappropriate portion: none

Original design intent: recommend the parent take the child for further in-person evaluation; continue feeding, ensure adequate nutrition; oral rehydration salts to correct dehydration/electrolyte imbalance; mucosal protectants (e.g., montmorillonite powder); probiotics/prebiotics to regulate gut flora; zinc supplementation to promote mucosal repair; racecadotril to reduce intestinal secretion.

Guideline-Recommended History-Taking Items ("√" = items you asked about)

Item	Source
Onset time — key diagnostic information	*Chinese Clinical Practice Guideline for Acute Infectious Diarrhea in Children*, p.484
Stool character (most recent) — key diagnostic information	Same guideline, p.484
Feeding status — dehydration assessment √	Same guideline, p.484
Dietary status before onset — trigger √	Same guideline, p.484
Vomiting (presentation and frequency) — key diagnostic information	Same guideline, p.484
Presence of fever — cause of diarrhea √	Same guideline, p.484
Frequency and volume of stools (not distinguishing time period) — key diagnostic information √	Same guideline, p.484
Dehydration status — dehydration assessment √	Same guideline, p.484

Item	Source
Respiratory symptoms — cause of diarrhea	Same guideline, p.484
Frequency and volume of stools (at onset) — key diagnostic information	Same guideline, p.484
Mental status — dehydration assessment √	Same guideline, p.484
Progression of respiratory symptoms — cause of diarrhea	Same guideline, p.484
Frequency and volume of stools (most recent) — key diagnostic information	Same guideline, p.484
Lip condition — dehydration assessment	Same guideline, p.484
Details of any treatment given — prior treatment history	Same guideline, p.484
Stool character (not distinguishing time period) — key diagnostic information √	Same guideline, p.484
Urine output — key diagnostic information	Same guideline, p.484
Recommend prompt hospital visit if condition does not improve or worsens (internet consultation context — consultation-on-behalf-of situation)	
Stool character (at onset) — key diagnostic information	Same guideline, p.484
Extremity temperature — dehydration assessment	Same guideline, p.484

Patient-Centeredness Score

95/100 average

- Dimension 1: **100/100**
- Dimension 2: **96/100**
- Dimension 3: **90/100**

Peer Ranking

- Technical quality: **20/152** — history-item completion rate exceeded 88% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 3/5** — 32% of peers at this level
- Service quality: **6/152** — patient-centeredness score exceeded 97% of peers (peer average: 69.78)

Case 8 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On June 8, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-6-8, 10:52:00–15:49:00
- Access channel: Haodaifu Online, text/image consultation
- Standardized-patient profile: Man, 30–50 years old, bachelor's degree, married, outdoor-activity enthusiast, essentially no medical knowledge
- Regular lifestyle; no smoking/drinking; enjoys outdoor activities; ordinary office worker
- Chief complaint: Felt short of breath and somewhat wheezy for the past week, with noticeable coughing
- Exams: BP, pulse, temperature, and auscultation all normal; ECG roughly normal; reduced lung capacity (spirometry)

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **9.09%**

You asked about: allergy history (1/11)

Exams you suggested/asked about: None

Guideline-recommended exam checklist includes: blood pressure, chest X-ray, pulmonary function test, ECG or echocardiogram, oxygen saturation, heart rate, respiratory rate

Your diagnosis: Asthma — we're confident you'll be more precise next time.

Diagnosis designed for the standardized-patient case: (1) bronchial asthma (chronic persistent phase); (2) cough-variant asthma

Your management recommendations for this case:

- Correct portion: "appropriate asthma education"
- Partially correct: none
- Inappropriate portion: none

Original design intent: recommend further evaluation; appropriate asthma education; appropriate oral medication (e.g., salbutamol aerosol, salbutamol tablets, aminophylline,

beclomethasone dipropionate, budesonide, fluticasone propionate, montelukast, ketotifen, loratadine, astemizole, azelastine, terfenadine, tranilast, tiotropium bromide).

Guideline-Recommended History-Taking Items ("√" = items you asked about)

Item	Source
Cough — key diagnostic information	*Bronchial Asthma Primary Care Guideline (2018 edition)*, p.751, I.1
Persistent/intermittent nature, relief pattern — key diagnostic information	Same guideline, p.753, III.(1).1
Whether similar symptoms occurred in childhood — diagnostic information	Same guideline, p.761, VII
Nocturnal wheezing — key diagnostic information	Same guideline, p.753, III.(1).1
Duration of episodes — diagnostic information	Same guideline, p.753, III.(1).1
Allergy history — key diagnostic information √	Same guideline, p.761, VII.(3)
Severity of episodes / triggering factors — key diagnostic information	Same guideline, p.753, III.(1).1
Family history — key diagnostic information	Same guideline, p.753, "3. genetic mechanism"
Frequency of episodes — key diagnostic information	Same guideline, p.751, I.1
Presence of palpitations/chest tightness — differential diagnostic information	*Internal Medicine* (8th ed.), pp.31–32

Patient-Centeredness Score

66/100 average

- Dimension 1: **61/100**
- Dimension 2: **61/100**
- Dimension 3: **75/100**

Peer Ranking

- Technical quality: **104/152** — history-item completion rate exceeded 32% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 3/5** — 32% of peers at this level
- Service quality: **102/152** — patient-centeredness score exceeded 34% of peers (peer average: 69.78)

Case 9 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On June 24, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-6-24, 9:40:00–9:57:00
- Access channel: Haodaifu Online, text/image consultation
- Standardized-patient profile: Woman, 40–55 years old, Han ethnicity, high-school education, married, essentially no medical knowledge
- Prefers heavier/saltier flavors; enjoys smoking (1 pack/day, over 10 years) and drinking (5 years)
- Chief complaint: Intermittent chest pain for 1 year, worsening over the past week
- Exams: Blood pressure, pulse, temperature, and auscultation all normal; no other abnormal signs

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **16.13%**

You asked about: pain location, pain type, pain severity, hypertension, hyperlipidemia (5/31)

Exams you suggested/asked about: None

Guideline-recommended exam checklist includes: ECG; cardiac enzyme markers, etc.

Your diagnosis: Coronary atherosclerotic heart disease (CAD): angina/unstable angina — identical to the case design prototype. Thank you for your careful diagnosis!

Diagnosis designed for the standardized-patient case: (1) coronary atherosclerotic heart disease (CAD): angina/unstable angina; or (2) acute coronary syndrome

Your management recommendations for this case: Correct portion: none; Partially correct: none; Inappropriate portion: none

Original design intent: recommend the patient go to an offline hospital capable of cardiac catheterization; medications: aspirin, clopidogrel, statins, beta-blockers, ACE inhibitors, nitrates

(isosorbide dinitrate or its sustained-release form), together with nitroglycerin tablets for sublingual use as needed during chest pain episodes.

Guideline-Recommended History-Taking Items ("√" = items you asked about)

Item	Source
Age — differential diagnostic information	*Guideline for the Diagnosis and Treatment of Unstable Angina and Non-ST-Elevation Myocardial Infarction*, p.4, Table 3
Time when this pain symptom first began — key diagnostic information	Same guideline, p.2
Drug or food allergies — important allergy history	Same guideline, p.9
Trigger — diagnostic information	*Chest Pain Primary Care Guideline (2019)*, p.914, precipitating factors
Shortness of breath / difficulty breathing — key diagnostic information	*Internal Medicine*, p.237
Occupation — basic information	Reference: paper on clinical features/treatment of unstable angina, p.60
Pain location — key diagnostic information √	Unstable Angina/NSTEMI Guideline, p.4, Table 3
Radiating/referred pain — key diagnostic information	*Internal Medicine*, p.237
Smoking status — key personal history	Unstable Angina/NSTEMI Guideline, p.13
Time of most recent pain onset — key diagnostic information	Same guideline, p.2, Table 1
Nausea — key diagnostic information	*Internal Medicine*, p.237
Alcohol use — key personal history	—
Family history of illness — differential diagnostic information	—
Pain type — differential diagnostic information √	Same guideline, p.2, clinical presentation point 1
Diarrhea — key diagnostic information	*Internal Medicine*, p.364 — unstable angina common but easily misdiagnosed in the elderly
History of gastric disease — differential diagnostic information	—
Whether similar pain occurred before — differential diagnostic information	Same guideline, p.2, clinical presentation point 1

Item	Source
Bowel habits — key diagnostic information	—
Acid reflux — key diagnostic information	—
History of respiratory diseases (asthma, bronchitis, etc.) — differential diagnostic information	Same guideline, p.7
Duration of each pain episode — differential diagnostic information	Same guideline, p.2, clinical presentation point 1
Sweating — key diagnostic information	*Internal Medicine*, p.237
Diabetes — differential diagnostic information	Same guideline, p.13
Pain severity — key diagnostic information √	Same guideline, p.2, clinical presentation point 1
Abdominal pain — key diagnostic information	Reference: elderly unstable angina clinical features paper, p.364
Hypertension — differential diagnostic information √	Same guideline, p.13
Ability to perform daily activities (walking, stairs, chores, etc.) — key diagnostic information	Same guideline, p.2, Table 1
Past medical history — past history	Same guideline, p.4, Table 3
Hyperlipidemia — differential diagnostic information √	Same guideline, p.13
Change in pain with breathing (worse with deep breathing?) — key diagnostic information	—
Prior trauma or surgery — differential diagnostic information	Same guideline, p.4, Table 3

Patient-Centeredness Score

74/100 average

- Dimension 1: **81/100**
- Dimension 2: **68/100**
- Dimension 3: **75/100**

Peer Ranking

- Technical quality: **79/152** — history-item completion rate exceeded 49% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 1/5** — 48% of peers at this level
- Service quality: **52/152** — patient-centeredness score exceeded 66% of peers (peer average: 69.78)

Case 10 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On July 23, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-7-23, 9:21:20–9:39:18
- Access channel: Ping An Good Doctor, text/image consultation
- Standardized-patient profile: Woman, 50–60 years old, high-school education, married, believes urine leakage is normal with age (visiting at her daughter's urging)
- Overweight body type; dislikes exercise; prefers meat over vegetables/fruit; frequently plays mahjong in her spare time
- Chief complaint: Urine leakage on coughing or laughing for 2 years, markedly worse in the past 10 days
- Exams: Stress test, cough stress test, Q-tip test, and pad test all positive

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **0%**

You asked about: nothing (0/22)

Exams you suggested/asked about: pelvic floor assessment

Guideline-recommended exam checklist includes: genital examination; stress test; Q-tip (cotton-swab) test; urinalysis, etc.

Your diagnosis: Stress urinary incontinence — identical to the case design prototype. Thank you for your careful diagnosis!

Diagnosis designed for the standardized-patient case: Stress urinary incontinence

Your management recommendations for this case:

- Correct portion: "avoid activities that increase abdominal pressure; treat chronic cough, chronic constipation, etc.; pelvic floor muscle training; guidance on pelvic floor muscle training."
- Partially correct: none stated
- Inappropriate portion: none

Original design intent: lifestyle intervention (avoid or reduce activities that increase abdominal pressure; treat chronic conditions such as chronic cough or long-term constipation); pelvic floor muscle training guidance; pelvic floor muscle training combined with biofeedback; recommend further evaluation at an offline specialty/tertiary hospital (referral indications: incontinence with abdominal/pelvic pain or hematuria without bacterial UTI; suspected vesicovaginal fistula; physical exam showing pelvic organ prolapse; suspected overflow incontinence, etc.).

Guideline-Recommended History-Taking Items (reference numbers ①②③ correspond to the three source guidelines listed below)

Item
Recent urine leakage pattern (frequency and amount, etc.) — key diagnostic information
Whether there is a delay before voluntarily initiating urination — assessing hesitancy
Lifestyle habits — diagnostic information
Whether leakage also occurs under other circumstances (frequency and amount) — key diagnostic information
Whether significant straining is needed to urinate — assessing voiding difficulty
Complications associated with stress urinary incontinence — differential diagnosis: organ prolapse, vaginal wall bulge, etc.
Onset time and severity of leakage symptoms — key diagnostic information
Nighttime leakage during sleep — assessing nocturnal enuresis
Medication history — diagnostic information
Disease course and evolution — key diagnostic information
Sensation of incomplete emptying after urination
Pelvic surgical history — diagnostic information
Frequency and amount of voluntary urination (e.g., urinary frequency) — assessing severity
Pelvic radiotherapy/chemotherapy history — diagnostic information

Item
Discomfort before, during, or after voiding (e.g., dysuria) — assessing other urinary symptoms
Impact of leakage on daily life
Drug allergy history — important allergy history
Number of nighttime bathroom trips — differentiating from nocturia
Past medical history — diagnostic information
Sudden urgent need to urinate requiring immediate bathroom access (urgency), and its frequency — differentiating from urge incontinence
Menstrual and reproductive history — diagnostic information

Recommended history items reference: (1) Urinary Incontinence in Women (ACOG/AUGS Practice Bulletin, 2015); (2) Chinese Society of Obstetrics and Gynecology, Pelvic Floor Group, Guideline for Diagnosis and Treatment of Female Stress Urinary Incontinence (2017); (3) NICE Guidance — Urinary Incontinence and Pelvic Organ Prolapse in Women: Management (2019).

Patient-Centeredness Score

55/100 average

- Dimension 1: **61/100**
- Dimension 2: **54/100**
- Dimension 3: **50/100**

Peer Ranking

- Technical quality: **143/152** — history-item completion rate exceeded only 7% of peers (peer average: 18.28%)
- Diagnostic accuracy grade: **Grade 1/5** — 48% of peers at this level
- Service quality: **135/152** — patient-centeredness score exceeded 12% of peers (peer average: 69.78)

Case 11 — Dr.

Dear Dr.

Hello, we are the Health Care Quality Cohort Research Group at Southern Medical University. On July 19, 2023, we sent a rigorously trained standardized patient to consult with you on an internet consultation platform.

(Standard disclaimers as above.)

Clinical Context Review

- Visit time: 2023-7-19, 10:21:45–11:01:00
- Access channel: Haodaifu Online, text/image consultation
- Standardized-patient profile: Woman, 45–60 years old, Han ethnicity, technical-secondary education, married, good mental state, currently unemployed
- No hobbies; daily life mostly consists of housework and caring for grandchildren; sits for long periods
- Chief complaint: Intermittent lower-back pain for about 6 months, worsening in intensity over the past 2 days
- Exams: Localized tenderness of muscles in the region above the gluteal crease and between the mid-axillary lines on both sides

Primary Medical Quality Outcomes

Your completion rate of guideline-recommended history-taking items: **18.52%**

You asked about: pain onset time, initial cause of the pain, pain location, leg pain status (lower limbs/legs/feet), past treatment history (whether previously seen a doctor / medication use) (5/27)

Exams you suggested/asked about: None

Guideline-recommended exam checklist includes: visual inspection; gait pattern assessment; straight-leg-raise test; FABER (patrick / "4") test; components of Waddell signs (e.g., seated straight-leg raise)

Your diagnosis: Lumbar muscle strain, degenerative disc disease — identical to the case design prototype. Thank you for your careful diagnosis!

Diagnosis designed for the standardized-patient case: (1) chronic non-specific low back pain; or (2) lumbar muscle strain; or (3) lumbar sprain; or (4) myofascial pain syndrome; or (5) degenerative disc disease; or (6) degenerative disc disease (repeated); or (7) myofasciitis; or (8) low back pain; or (9) lower back pain; or (10) unspecified back pain

Your management recommendations for this case:

- Correct portion: "pharmacologic treatment, exercise therapy, physical/rehabilitation therapy"
- Partially correct: none
- Inappropriate portion: none

Original design intent: pharmacologic treatment; exercise therapy; manual therapy (tuina); psychological rehabilitation; cognitive behavioral therapy; physical/rehabilitation therapy; acupuncture; invasive/minimally invasive treatment.

Guideline-Recommended History-Taking Items ("√" = items you asked about)

Item	Source
Onset time of pain — disease course √	*Chinese Expert Consensus on the Diagnosis and Treatment of Acute/Chronic Non-Specific Low Back Pain*, p.1134, 1.3.1
Aggravating circumstances — aggravating factors	Same consensus, p.1134, 1.1
Prior treatment experience — treatment course	—
Initial cause of the pain — trigger √	*CASP: Consensus on the Assessment and Management of Chronic Nonspecific Low Back Pain*, p.5, Table 2
Relieving circumstances — relieving factors	Chinese Consensus, p.1134, 1.1
Psychological state — psychological	CASP, p.4, Table 1
Pain location — location √	Chinese Consensus, p.1134, 1.3.1
Age — differential diagnosis	Chinese Consensus, p.1135, Table 1
Prolonged sitting — general information	*Evidence-Based Practice Guidelines for the Diagnosis and Treatment of Lumbar Spinal Conditions* ("EBP of LP"), p.1, presentation
Character of pain — nature	Chinese Consensus, p.1135, Table 1
Fever — differential diagnosis	CASP, p.4, Table 1
Past medical history — diagnostic information: history-taking √	CASP, p.4, Table 1
Pain frequency — frequency	Chinese Consensus, p.1135, Table 1
Saddle-area sensory disturbance — differential diagnosis	CASP, p.4, Table 1
History of trauma — diagnostic information: history-taking	CASP, p.5, Table 2
Leg pain status (lower limbs/legs/feet) — radicular pain √	CASP, p.4, Table 1
Intermittent claudication — differential diagnosis	*EBP of LP*, p.3

Item	Source
Steroid use — diagnostic information: history-taking	CASP, p.4, Table 1
Relationship of pain to day/night — relationship to circadian pattern	CASP, p.5, Table 2, third-review recommendation
Urinary difficulty — differential diagnosis	CASP, p.4, Table 1
Recent spinal infection history — diagnostic information: history-taking	CASP, p.4, Table 1
Pain severity — severity	Chinese Consensus, p.1134, 1.3.1
Bowel incontinence — differential diagnosis	CASP, p.4, Table 1
Surgical history — diagnostic information: history-taking	CASP, p.5, Table 2
Abnormalities in daily activity — relationship to activity/posture	Chinese Consensus, p.1134, 1.1
Sudden significant weight loss — differential diagnosis	CASP, p.4, Table 1
Substance/medication misuse history (long-term use/dependence) — diagnostic information: history-taking	—

Patient-Centeredness Score

63/100 average

- Dimension 1: **72/100**
- Dimension 2: **57/100**
- Dimension 3: **60/100**

Peer Ranking: not shown on this page for the technical-quality/service-quality boxes in the source document.

(As internet consultation is primarily advisory in nature, this evaluation is for reference only.)

End of translated document. All 11 physician feedback reports from the "AnF" (Assessment and Feedback) strategy development study, Southern Medical University Health Care Quality Cohort Research Group, are included above.