

1 **Appendix 4**

2 **Appendix 4(1)**

3 List of generated crowd features. (*) the features that had an average score of less than 0
4 were assessed by three CRCs, which were marked in the *Evaluation A* after Step 2-d.
5 These were originally written in Japanese but are provided in English for explanation
6 purposes. Some crowd features included misspellings, and the misspellings of the
7 original Japanese crowd features were reflected.

Treatment that will be terminated in the future is described based on improvement of symptoms.

Records of what drugs are being administered to the patient and their current condition are present.

Records of detailed symptoms and test results for the patient are present.

Information about lesions is recorded.

The patient's condition is recorded as favorable.

English words are mixed into the Japanese text.

The sequence of events is recorded in detail. (*)

The stages of operations are recorded.

Information is recorded in English technical terms.

Lack of specific records makes understanding difficult later on.

The record states there are no problems.

Requests from the patient are recorded.

The patient's will be written down.

The patient's feelings regarding their physical condition are written down.

The patient's conditions as described by the patient themselves is recorded.

The patient's current symptoms are recorded in the patient's own words.

Records of test values are present.

Heart-related medical treatment is being conducted.

Test values are recorded.

Records of the specific findings of diagnostic imaging are present.

Test results are detailed and specific.

Test results are recorded in detail.

Medical condition is recorded in English.

Medical condition is represented by values.

Test item names and values are recorded.

Regarding how to proceed with future treatment, a few days' worth of information is written out in detail.

Information about outpatient treatment is recorded.

The content of consultations with doctors in other departments is recorded.

Specific times are recorded. (*)

Records of discharge from the hospital and outpatient treatment are present.

Future handling measure considerations are recorded.

Considerations for the timing of discharge from the hospital are recorded.

Regarding treatment, conditions when it was implemented, and decision-making are written down.

The specific details of meal content and intake volume are written down.

Information is recorded in full-width English alphanumeric characters.

Specific values for bodyweight and blood pressure are recorded.

English numbers are recorded using full-width characters. (*)

There is a lot of information and the content is easy for anyone to understand.

Records related to blood pressure are present.

The patient's suffering is recorded.

Specific symptoms are stated.

The content of the history-taking interview is recorded.

Procedures to be carried out today are written down.

Information about the symptoms the patient is complaining about is written down.

The patient's will and aspirations are written down.

Information about not only pain but explanations of the areas of the body where it occurs is recorded.

Patient complaint information is written down.

Patient has difficulty walking.

Messages between doctors are written down.

What measures to take if certain conditions occur is written down.

Specific instructions from the doctor for the medical staff are recorded.

Information about the patient about to undergo surgery is recorded.

Details of the name of the patient's illness, tests, and treatment are recorded.

Details of treatment are recorded.

Points for confirmation are itemized to ensure easy readability for anyone seeing it. (*)

Records related to bloody phlegm are present.

Instruction content is recorded.

Nouns which are thought to be the names of drugs are recorded.

Full-width English numbers are used.

Scheduled items and unconfirmed plans are recorded.

Records related to urine are present.

The treatment schedule is recorded.

Conditions are written in a straightforward manner and sentence components are kept to the bare minimum.

Information about rehab is recorded.

Information about rehabilitation is recorded.

It is not a diagnostic result. (*)

The facts of discharge from the hospital are written down.

A large number of test values are recorded.

Information about eyelid conjunctival anemia is recorded. (*)

Conversations between the doctor and the patient are recorded. (*)

Interactions with the patient are recorded unedited and in detail.

The patient's opinions are present.

Records related to lower back pain are present.

Numerical values are recorded.

Test results are written down.

It's unclear what the numbers and other information are referring to.

Specific details of the patient's condition are recorded.

Tests and their results are written down.

Information about awareness of hypoglycemia is recorded.

Problems with the patient are recorded.

Information which is conjecture by the doctor is recorded.

Symptoms and guessed reasons for them are written down.

The doctor's doubts and uncertainties regarding the patient's symptoms are recorded.

Causes and effects are discussed.

Blood test results are recorded.

Regarding the patient's condition, in addition to problems, current factual measurements and frequency are written down.

Test values are recorded along with dates using only English and numbers.

Records of the drugs being taken by the patient are present.

Test results and medical record items are written down.

Follow-up has been carried out.

Records of specific prognosis actions are present.

Records of patient data are present.

Test results are recorded.

For observations and measurements, only factual information is written down.

Number of bowel movements, stomach pain information, and meals consumed are recorded.

Information related to ingestion and defecation is recorded.

Patient status information is written down along with specific details such as test values and meals.

Records related to meals and defecation are present.

Patient status information is recorded along with the details of the sequence of events.

Patient symptoms are recorded in detail.

Specific details of the progression of the patient's status are recorded.

Information related to constipation is recorded.

The sequence of events is recorded.

Scheduled future measures such as drugs to administer and tests to perform are recorded along with specific details such as drug and test names and numerical values.

Messages and requests to doctors in other departments are recorded.

Disease diagnosis and treatment content are recorded.

Symbols and paragraphs are used for improved readability.

Surgeries performed are written down.

The patient's pessimistic feelings are recorded.

The patient's mental state can be estimated.

Records of drugs and treatments used for the patient are present.

The doctor's decision is written down in addition to records of tests and patient condition.

The content of interviews related to medication status is recorded.

Symptoms the patient was aware of are written down along with the time they occurred.

Symptom evaluations are recorded.

Specific test results and status of the patient are recorded.

Tomorrow's schedule is recorded.

Medical questionnaire contents are recorded.

Numbers are recorded along with what was measured.

Detailed interview results for each symptom are written down.

Disease names and other information are written along with progress reports.

Records regarding the progression of treatment are present.

English and Japanese words are mixed together in the descriptions of vital sign items.

It is not a medical instruction. (*)

The condition of the patient's lifestyle is easy to understand.

Symptoms and medical history information are written down.

Records of the passage of time are present.

Interrogative sentences are recorded.

The patient's progress is recorded.

There is confirmation of whether hypoglycemia occurred.

The patient has lower back pain.

Information about appetite is written down.

Lifestyle guidance is recorded.

Test results are recorded in detail.

Information about not just the latest visit but the progression up until now is recorded.

Blood sugar control is favorable.

Only the patient's condition is recorded. (*)

Along with testing numerical values, judgment of future prognosis is written down.

It is clear the patient will be hospitalized.

Test results are recorded.

Changes in the patient's illness are recorded.

Specific symptom content is recorded.

Records such as reports to doctors in other departments are present.

Detailed information about the health status of the patient is recorded.

The specific symptoms of the patient can be understood.

Specific treatment content is recorded.

Records of what illness is causing the symptoms are present.

Diagnosis results are recorded.

Along with the specific content of explanations to the patient's family, acquisition of a signature from a family member is recorded.

Information is recorded in half-width alphanumeric characters.

Not only test results but also visual observations are recorded.

Detailed explanations are present.

Background with the patient and ideas of the writer are written down.

Records related to dental treatment history are present. (*)

Progress of one person is written down.

Information related to the content of explanations to the patient is recorded.

Records of the disease name and the details of scheduled surgery are present.

Specific test results are recorded.

Information related to messages to other doctors is recorded.

Records related to time periods are present.

Records related to future treatment and the content of explanations to the patient are present.

For tests carried out, the implementation data is recorded.

Records related to symptoms are present.

Information related to articles of taste such as tobacco, coffee, and alcohol is recorded, as

well as guidance regarding them.

Detailed records related to the patient's disease are present.

In addition to records of reports on physical condition and mood, guesses as to the cause are also present.

Suffering, condition, and impressions related to the patient's disease are recorded.

Body temperature is recorded.

Information related to testing plans is recorded.

Specific physical information is written down.

Information is written down in a simple fashion.

Records are limited to completion of treatment, recovery, and discharge from the hospital.

Half-width numbers and English letters are used for order and readability.

Records related to specific symptoms are present.

Statements from the patient related to medication are recorded.

The patient's statements related to their suffering are written down unedited.

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10 **Appendix 4(2)**

11 List of CRC-nominated features. These were originally written in Japanese but are
12 provided in English. Some features included misspellings, and this was reflected in the
13 original Japanese features.

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| 14 | Since the date and action items/patient status are written, it is easy to understand when |
| 15 | reading and it is easy to collect information. |
| 16 | The current status is described. |
| 17 | Confirmation contents are described. |
| 18 | There is a description of the drug name and procedure. |
| 19 | Patient's statement is described. |
| 20 | Patient complaints are listed. |
| 21 | The person's complaint is described. |
| 22 | State is described briefly. |
| 23 | The views of the doctor should be included. |
| 24 | This text shows the interview with the patient. |
| 25 | The patient's statement is described. |
| 26 | Patient's subjective symptoms are described. |
| 27 | I felt it was a way of describing from the patient's perspective. |
| 28 | The content of the person's statement is described. |
| 29 | When the test was done is not described. |
| 30 | The description about future plans is ambiguous. |
| 31 | Describes current symptoms. |
| 32 | There is no time information for the matters described. |
| 33 | The doctor's judgment or instructions are not mentioned. |
| 34 | The complaint of the patient's condition is described. |
| 35 | There is no statement of opinion on the inspection result. |
| 36 | The interpretation result of the inspection result is described. |

- 37 Only the test results and findings are listed.
- 38 There is a description for future plans.
- 39 The details of the treatment, the situation and the condition are described.
- 40 The patient's remarks are described.
- 41 Describes the current state of the patient (worries?).
- 42 Only test results and symptoms are listed.
- 43 Looking at the current situation, the future policy is described.
- 44 There is a description of future plans.
- 45 The judgment of the doctor and future plans are written.
- 46 The contents of implementation and the wishes of the patient are described.
- 47 Patient information and future plans are described.
- 48 Japanese sentences represent the patient's condition.
- 49 The patient's future plans are described.
- 50 The test result is written simply.
- 51 It shows the patient's future plans and progress.
- 52 The content that the patient told is described as it is.
- 53 Since there is no date, it is unknown when it happened.
- 54 Present state and future plans are described.
- 55 Prescriptions and patient status are written in detail.
- 56 The current situation and treatment details for each symptom are described.
- 57 It describes what has been done and what has been judged.
- 58 What the numbers mean cannot be understood.
- 59 The current status, test results, and scores are listed.

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| 60 | The doctor's opinion on the interview should also be stated. |
| 61 | The doctor's judgment is not written regarding the content. |
| 62 | When the laboratory test performed is not stated. |
| 63 | Only test results are given; doctor's opinion is not written. |
| 64 | The history, consideration and future plans are described. |
| 65 | The content heard from the patient is described as it is. |
| 66 | Only the test results are described, so the doctor's view is unknown. |
| 67 | The next time you plan to respond and the comment of the person himself are described. |
| 68 | There are no specific findings on the content. |
| 69 | Details of what was done and what was explained are detailed. |
| 70 | Instructions for the current situation and emergency response are written. |
| 71 | It describes how to deal with possible risks. |
| 72 | It shows the patient's condition, test results, and current condition. |
| 73 | The meanings of the numbers of the patient's test result are not described. |
| 74 | The dates and future plans are well documented. |
| 75 | Statements contain only minimal information and do not express the clinician's views. |
| 76 | It is an inspection finding. I don't understand English abbreviations. |
| 77 | The test results and information visually recognized by the doctor are described. |
| 78 | The current situation, future policies and plans are described. |
| 79 | The current situation and opinion about test result are described. |
| 80 | Describes the current status and progress, details of the measures against it, and the |
| 81 | reason. |
| 82 | Describes possible causes for the procedure or lesion. |

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| 83 | The process is briefly described. |
| 84 | Future treatment policy is described. |
| 85 | There are many English abbreviations, and it is difficult for non-specialists to understand. |
| 86 | There is no statement of opinion, so we do not know what the symptoms indicate. |
| 87 | The volume varies, but there are descriptions about future plans. |
| 88 | There are various volumes, but there are descriptions about future plans and policies. |
| 89 | The inspection result (numerical value) is described. |
| 90 | The progress of the inspection is described. |
| 91 | It describes the current situation, views on the rise, and details of implementation. |
| 92 | The progress of the disease lesion and points that are not clear are stated. |
| 93 | Since the date and time lock are listed, the daily information is easy to understand. |
| 94 | The current situation is described, and future plans and policies are described. |
| 95 | It is difficult to understand what it means because it contains only the minimum |
| 96 | information. |
| 97 | The current situation, future plans, and comments from other doctors are described. |
| 98 | The content of what the writer heard is described as it is. |
| 99 | Only the contents of the interview are described, and the details or the results of the |
| 100 | interview are not described. |
| 101 | Only the contents of the interview are listed. |
| 102 | The doctor's views or guidance is not mentioned. |
| 103 | A lot of texts describe the doctors' opinions about the patient's condition. |
| 104 | There are various description methods and volumes, but there are descriptions about |
| 105 | future plans. |

106 The author may be different, but it is difficult to confirm because English and Japanese
107 are mixed.

108 There is no date, so I don't know when the incident or the examination happened.

109 Since only the test results are listed, the doctor's views and subsequent follow-up are
110 unknown.

111 Only the test results and the findings at the time of the test are described, and there is no
112 description of the doctor's opinion for them.

113 Since it is often written in English abbreviations, it seems difficult for non-specialists to
114 understand.

115 The contents of the interviews with the patients are described as they are, but there is no
116 opinion of the doctor.

117 Only the contents of the interview are listed, and I do not understand the doctor's views or
118 guidance regarding it.

119 It describes what you are considering, what you are doing, and what you must do.

120 The current condition and the consideration about it, future policies, and instructions are
121 described.

122 I don't understand the meaning of English abbreviations; Therefore, the meaning of the
123 numbers may not be clear.

124 The content of what the writer hear is given as it is.

125 The doctor's judgment regarding the content are unknown.

126 Although the background of the patient is unknown, it is difficult to read important parts
127 if the patient's description is described as it is.

128 It describes the current state and views on it.

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| 129 | Describes what to do in the future and what you should be careful of. |
| 130 | The main test results are listed. |
| 131 | The patient's environmental change (cause of worsening medical condition?) is described. |
| 132 | This text contains no writer's consideration on the test results. |
| 133 | |
| 134 | |
| 135 | |