

Figure S1



OSCE #1

This is a station with standardized healthcare personnel.

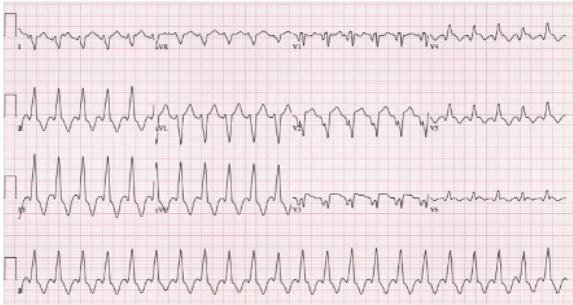
You are an on-call medical intern in your hospital. You arrive at the nursing station upon the call of the nurse who shows you the electrocardiogram he/she just performed on Mr. Picard, 58 years old, presenting chest discomfort.

You must:

- ✓ Inquire from the nurse about the relevant clinical elements
- ✓ Describe your ECG analysis to the nurse and provide your diagnosis
- ✓ Announce the immediate non-pharmacological management plan to the nurse

You must not:

- ✗ Examine the patient
- ✗ Propose a pharmacological treatment plan
- ✗ Conduct an etiological assessment



A



OSCE #1

Instructions for the Standardized Healthcare Professional (SHP)

Context: You are the nurse in the post-emergency department caring for Mr. P., who is hospitalized for syncope and palpitations.

The brief and informative sentence that you must state at the beginning of the OSCE: «Hello, I am Frederique, an emergency nurse, and I have just performed an ECG on Mr. Picard because he has been experiencing chest pain.»

Characteristics of the SHP:

Name: Dupont - First name: Frederique - Gender: Indifferent - Profession: Nurse

SHP's state of mind (anxiety/experience): Experienced nurse

Questions/answers that the SHP may be required to ask/provide to the student according to the instruction and scenario:

Question	Answer
Why did you perform the ECG? What symptoms did the patient present that prompted the ECG?	Patient felt chest discomfort that persists.
When? How long ago did the patient experience these symptoms?	A few minutes ago, I immediately performed an ECG.
Is there a previous ECG?	Yes, we performed one upon admission which was normal; it was reviewed by the cardiologist.
How is the pain?	The patient did not describe any radiation or constrictive nature; the pain score is 4/10
What are the vital signs? The student must specify which vital signs he wants (Heart rate, Blood pressure, Temperature, Saturation)	Only give the requested parameters: HR: 140/min, BP: 126/74 mmHg, SaO2: 96% Temperature: 37.3°C.
How is the patient? Is he conscious?	The patient is conscious and communicating.
Did you perform a trinitrin test?	No, I was waiting for you.
Do you know his medical history? Has the patient had any cardiac history?	The patient's file indicates a myocardial infarction with stent placement 3 years ago (does not know which artery).
Why is he hospitalized?	Mr. P came for syncope with palpitations yesterday in the ER. He remained under observation awaiting the cardiologist's visit.
Do you know his treatment? What medications is he taking?	Her regular treatment includes: Aspirin 75mg/day, Atorvastatin 10mg/day, Ramipril 10mg/day
Is he monitored, on telemetry?	The patient is not monitored, but I can put him on a scope.

If the student does not address the question of putting the patient on a scope, ask: "Can I continue my patient rounds?"

B

If the student asks a question that is not covered in the guide, respond with "no" or "I don't know" according to the question.

Figure S2



OSCE #2

This is a station with standardized patient

You are an intern in a private practice, and you are caring for Mr./Mrs. Pomme, a 55-year-old patient who has been experiencing diarrhea for the past 2 days. The patient has no significant medical history other than a tonsillectomy during childhood.

You must:

- ✓ Conduct targeted questioning regarding the diarrhea
- ✓ Provide immediate therapeutic management

You must not:

- ✗ Perform a physical examination
- ✗ Prescribe additional tests
- ✗ Make a definitive diagnosis

A



OSCE #2

Instructions for the Standardized Patient

Context: You are seeing a general practitioner for diarrhea that has been evolving for 2 days. The doctor will ask you questions to try to clarify the origin.

Brief and uninformative sentence that you must formulate at the beginning of the station: "Hello Doctor, I'm coming to see you because I've had diarrhea for 2 days, and it's not calming down."

Characteristics of the Standardized Patient: Last name: Apple - First name: Camille - Age: 55 years old - Gender: Mixed station - Waist: 170 cm - Weight: 70kg (form weight: 71kg)

Situation: Family situation: You are married and have two children, aged 20 and 22, who no longer live with you. No small children. Profession: Insurance executive, active

Background: Personal: You have had tonsil surgery. Vaccines: Up to date, including COVID-19 (4 doses, the last one 2 months ago). Known Allergies: None. Family: No known family history.

Treatments: Drug treatments: None daily. You haven't taken anything for the moment, and you have not taken antibiotics or other medications recently. Non-drug treatments: None

Lifestyle habits: You live in an apartment and have not made a recent trip abroad in the last 5 years (last trip to the Drôme in July). No sick people in your entourage, haven't eaten in a restaurant for 1 month. Dependencies and/or addictions: None; you don't drink alcohol and don't smoke; you don't use drugs. Sedentary lifestyle: Yes, you don't play sports

Current history:

Reason for consultation with the attending physician: You have had diarrhea for 2 days. These diarrheas appeared suddenly 2 days ago.

- You have had about five bowel movements daily for 2 days; it remains stable.
- You don't really have a stomachache, but your stomach is rumbling.
- You didn't vomit.
- You have felt a fever but have not taken your temperature because you do not have a thermometer at home.
- You have lost 1 kg in 2 days.
- You have less appetite, but you can drink well.

If the student asks you to, and only if he asks you:

- You don't have any sick people around you (including your wife, husband, or children).
- You didn't take antibiotics before you had diarrhea or other medications.
- You haven't changed your eating habits, and you haven't gone to a restaurant.
- There is no blood or mucus (they do not float) in the stool.
- You don't have pain in your buttocks, nor a false need.
- You have not had or made a recent trip abroad.

The PS's state of mind: General behavior: You are tired but not anxious.

If the student asks a question not covered in the worksheet, answer "no" or "I don't know" depending on the question.

B

Figure S3



OSCE #3

This is a station with standardized patient

You are seeing Mr./Mrs. Raisin, 33 years old, at the office for a cough that has been evolving for 3 months. The vital parameters are normal: BP 120/70 mmHg, HR 70 bpm, SpO₂ 98% in ambient air, RR 15/min, T° 37°C

You must:

- ✓ Conduct targeted interrogation
- ✓ Propose a diagnostic strategy

You must not:

- ✗ Perform a physical examination
- ✗ Prescribe treatment

A



OSCE #3

Instructions for the Standardized Patient

Context: You are seeing a general practitioner because you have been coughing for 3 months.

Brief and uninformative sentence that you must formulate at the beginning of the station: " Hello Dr, I am consulting because I have been coughing for 3 months, and it worries me. In addition, I can't take it anymore to cough during my classes, it's painful. "

Characteristics of the Standardized Patient: Last name: Grape – First name: Axel/Axelle - Age:33 years old - Gender: Mixed station - Height: 170 cm - Weight: 65 kg

Situation: Family Status: You are single and have no children. Profession: Piano teacher

Background: Personal: eg fracture, eczema. Asthma in your childhood treated with salbutamol until the age of 12 (to be said only if the student specifically requests it). Vaccines: COVID-19 vaccination (3 doses received), otherwise up-to-date childhood/adolescent vaccinations. Known allergies: Pollen (rhinitis, conjunctivitis in spring). Familial: Asthma in the mother

Treatments: Drug treatments: None. Non-drug treatments: None

Lifestyle habits: You cycle daily to get around, go to the swimming pool regularly, and give home lessons in the city's four corners. Dependencies and/or additions: Tobacco: 1 pack per day since you were 17 years old, alcohol very occasionally, never toxic/drugs. Pets: a cat at home for 3 years. Sedentary: Active

Current history:

Reason for consultation: Cough. Description of symptoms: Cough for 3 months, occurring during the day, especially after cycling. Rarely at night. Repercussions of symptoms: important ("fed up"). Presence of ENT signs: rhinorrhea, regular sneezing, stuffy nose. Descriptions of missing signs (possibly so that the student can rule out differential diagnoses): no whistling heard by the patient, no weight loss, no coughing up blood, no chest pain, no alteration in general condition or appetite disorders, no esophageal symptoms (gastric burning, regurgitation, acid reflux)

The PS's state of mind: General behavior: Coughs regularly. Anxiety level: Low

Answers to be provided to the student:

If the student asks:	Answer:
If the cough is dry/productive (=with sputum/secretions) or Quinteuse (by fits)	Coughing occurs in fits
If the cough occurs during exertion, at night or while lying down (decubitus)	It happens especially after cycling, the fits are terrible! Rarely at night Rarely in a lying position
If the patient has had any episodes similar in the past	When I was little, I had asthma
The presence of ENT signs	What do you mean by that? If the student specifies "symptoms in the throat, ears or nose": Yes, I have the "Runny nose", "stuffy nose", sneezing intermittently but regularly
If your vaccinations are up to date	Which ones? I don't really remember.
The presence of signs of GERD (gastroesophageal reflux disease)	What do you mean by that? If the student specifies "gastric burning", "regurgitation", "acid reflux": no

B If the student asks a question not covered in the worksheet, answer "no" or "I don't know" depending on the question.

Figure S4

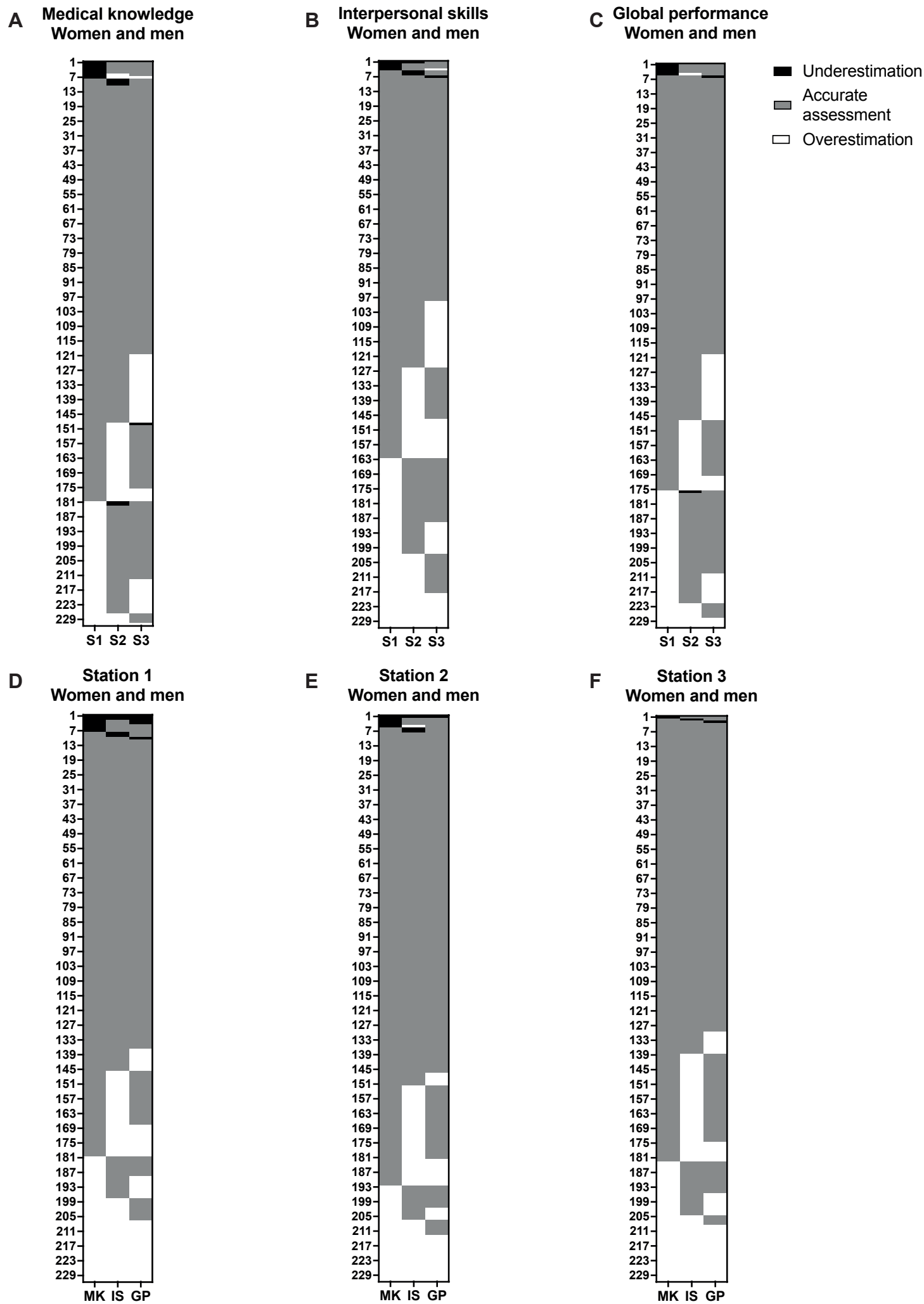


Figure S5

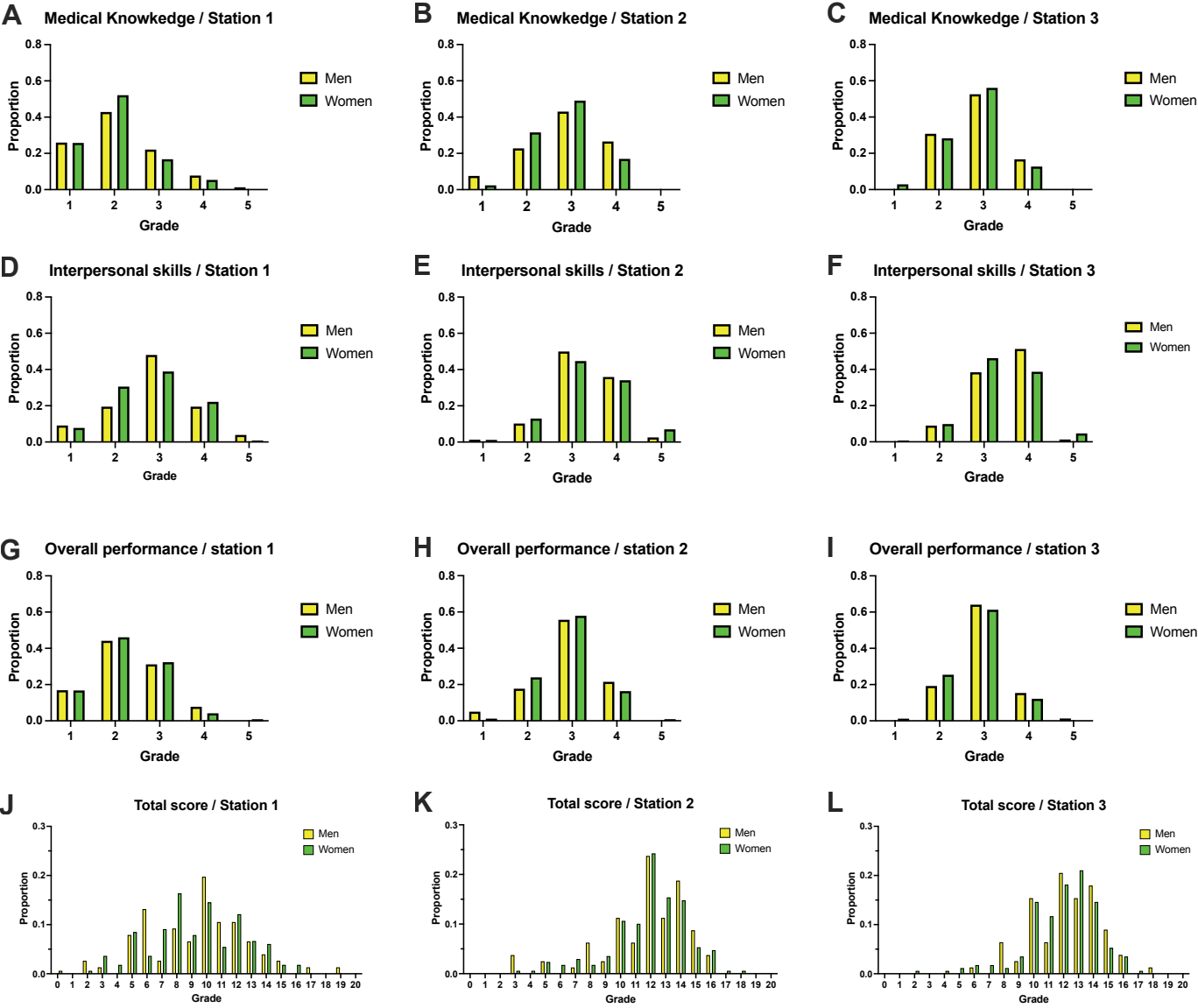


Figure S6

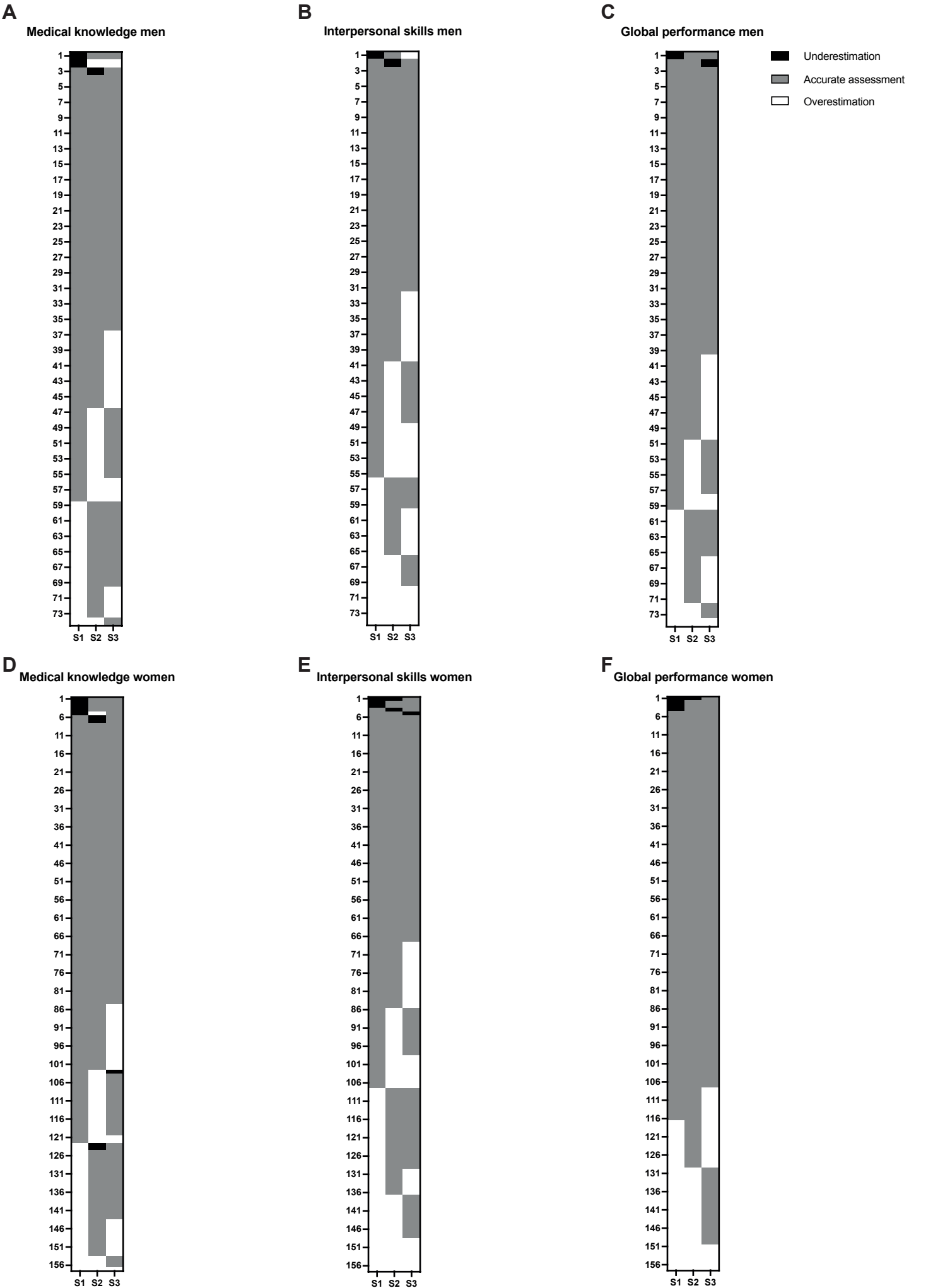


Figure S7

