Supplementary Table S1. Overview of responses receiving an accuracy score of ≤3 from at least one evaluator

Model	Question No.	Question topic	Accuracy scores (R1/R2/R3)	Main accuracy concern identified on response review
ChatGPT	3	DVT vs varicose veins	3/5/4	The statement that varicose veins are "more benign" and "do not pose an acute danger" may understate the thrombotic and complication potential of superficial venous disease.
ChatGPT	13	DVT and pulmonary embolism	3/4/5	The statement that distal (calf) thrombi "generally do not travel to the lungs" oversimplifies PE risk; although the risk is lower in distal DVT, it is not absent.
ChatGPT	14	DVT and mortality	3/5/5	Although the statement that DVT is "generally not directly fatal" is broadly reasonable, this framing may cause patients to underestimate the clinical significance of the DVT-PE relationship.
ChatGPT	24	Pharmacologic treatment of DVT	4/3/5	The response generalizes that acute DVT should begin with LMWH/fondaparinux followed by a DOAC; some DOACs do not require initial parenteral therapy. The mention of NSAIDs also warrants caution because of additional bleeding risk during anticoagulation.
ChatGPT	25	Duration of anticoagulation	3/4/5	Inherited thrombophilias are linked too directly to lifelong anticoagulation. Treatment duration should be individualized according to provoking factors, recurrence risk, and bleeding risk.
ChatGPT	26	Need for hospitalization	2/4/4	The response implies that proximal or large DVT generally requires hospitalization. In current practice, many clinically stable and otherwise suitable patients can be managed as outpatients.
ChatGPT	27	Surgical/interventional treatment	3/3/4	The indications for intervention are stated too broadly. Inability to receive anticoagulation is relevant to IVC-filter use rather than an indication for thrombectomy or thrombolysis, and IVC-filter placement is presented as a "surgical option."
Claude	2	Which doctor treats DVT?	2/5/5	The response lists "Cardiovascular Surgery" and "Heart and Vascular Surgery" as if they were separate specialties and gives an overly definitive recommendation for first-line referral; care pathways may vary by country and clinical context.
Claude	3	DVT vs varicose veins	3/4/4	The basic distinction is correct, but the relationship between superficial venous disease and thrombosis/complications is only briefly addressed, making the comparison somewhat overly categorical.
Claude	7	Common causes of DVT	3/3/3	The question asks about causes of DVT, but the response presents DVT itself as the "most common cause" and mixes venous insufficiency, post-thrombotic syndrome, and heart failure into the same list, conflating DVT risk factors with other causes of leg swelling or venous disease.
Claude	11	Smoking and DVT	2/1/3	There is a clear domain mismatch: instead of focusing on DVT, the response shifts to peripheral arterial disease, atherosclerosis, vasoconstriction, claudication, and ischemic ulcers.
Claude	12	COVID-19 vaccination and DVT	3/5/4	The response combines several risk claims without clearly distinguishing ordinary VTE from rare vaccine-associated thrombosis with thrombocytopenia syndromes, and presents some numerical/evidentiary statements with excessive certainty.
Claude	13	DVT and pulmonary embolism	3/3/4	The question asks whether every DVT causes PE, but the response explains how PE can occur without clearly stating that not every DVT leads to PE, leaving the magnitude and scope of risk insufficiently clarified.
Claude	14	DVT and mortality	3/4/4	The main message is correct, but the response explains mortality almost entirely through PE and gives limited contextual distinction between DVT itself and fatal PE.

Model	Question No.	Question topic	Accuracy scores (R1/R2/R3)	Main accuracy concern identified on response review
Claude	15	Initial symptoms of DVT	4/5/3	Some listed findings, such as a tender cord-like vein, are more suggestive of superficial thrombophlebitis; presenting them as early DVT findings may blur the clinical distinction.
Claude	16	Pain in DVT	5/3/3	Within a question specifically about DVT, the response also lists superficial venous thrombosis and chronic venous insufficiency as examples of painless venous obstruction, mixing distinct venous conditions.
Claude	17	Unilateral vs bilateral DVT	5/3/4	Bilateral DVT is linked directly to conditions such as heart failure and severe infection, which are more commonly associated with bilateral edema; the distinction between bilateral DVT and the differential diagnosis of bilateral leg swelling is not sufficiently clear.
Claude	21	Role of Doppler ultrasonography	5/5/3	The response makes broad claims that ultrasonography measures the "degree of obstruction," determines a wide range of thrombus characteristics, and has >95% diagnostic accuracy, without sufficiently accounting for anatomic location and variation in test performance.
Claude	26	Need for hospitalization	3/5/5	Although outpatient care is acknowledged, the response still generalizes hospitalization for "large/extensive thrombosis" or "high PE risk." Admission decisions depend on hemodynamic status, bleeding risk, comorbidities, and the safety and feasibility of outpatient treatment.
Claude	27	Surgical/interventional treatment	3/3/4	The indications for invasive treatment are too broad: severe swelling/pain or risk of post-thrombotic syndrome is presented as if it were, by itself, a routine indication. Stenting and bypass are also listed as general options without specifying patient or anatomic selection.

* Low-accuracy responses were defined as responses receiving an accuracy score of ≤3 from at least one of the three independent evaluators. R1, R2, and R3 denote the accuracy ratings assigned by the three evaluators. The statements in the final column are not written comments provided by the evaluators; they are brief, post hoc descriptive summaries generated by the authors after re-reviewing the lower-rated responses during revision. These summaries should not be interpreted as an additional formal qualitative error analysis or as a new statistical outcome.