

Towards Computer Assisted Verbal Autopsy:  
Comparing Large Language Models to Physicians  
for Assigning Causes to 6939 Deaths in Sierra Leone from 2019-2022

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### Abstract

**Background:** Verbal Autopsies (VAs) collect data on deaths and their causes outside of traditional hospital settings to provide representative Causes of Death (CODs). Current computer models for COD assignment in VAs perform similar to physicians at the population level, but poorly at the individual level, due to focuses on questionnaire data and neglecting free text from narratives. Recently, a

047 large language model called ChatGPT-4 demonstrated human-level performance  
048 on professional and academic exams. ChatGPT-4 shows promise in assigning  
049 CODs similar to physicians, but has yet been examined for assigning CODs using  
050 VA narratives.

051 **Methods:** 6939 VA records in Sierra Leone from 2019 to 2022 were used to  
052 compare four computer models, GPT-3.5, GPT-4, InterVA-5, and InSilicoVA, to  
053 physician COD assignment at population and individual levels. Narratives were  
054 used for GPT-3.5/4, while questionnaires were used for InterVA-5/InSilicoVA.  
055 COD assignments were grouped into general COD categories consisting of 19, 10,  
056 and 7 categories for adult, child, and neonatal age groups. Cause Specific Mor-  
057 tality Fraction (CSMF) accuracy and Partial Corrected Concordance (PCCC)  
058 were used to compare models to physicians at population and individual levels  
059 respectively. CSMF and PCCC were evaluated overall and by COD, age group,  
060 and age ranges.

061 **Results:** GPT-4 had the best performance overall (0.61 PCCC), followed by  
062 GPT-3.5 (0.56 PCCC), and InSilicoVA/InterVA-5 (0.44 PCCC). GPT-4 had  
063 the best performance for adult and neonatal records (0.64 and 0.58 PCCC),  
064 with GPT-3.5 for child records (0.54 PCCC). All models' performances trended  
065 upwards from 1 month to 14 years ( $\sim$ 0.1-0.75 PCCC) and downwards from 15-69  
066 years ( $\sim$ 0.7-0.35) of age. GPT-4, GPT-3.5, and InSilicoVA had the highest per-  
067 formances for 17, 9, and 4 of all 30 CODs respectively. At the population level,  
068 all models had CSMF accuracies between 0.74-0.79.

069 **Conclusion:** All models performed well at the population level, while GPT-  
070 3.5/4 and InSilicoVA performed well at the individual level for some CODs.  
071 GPT models have yet to replace physician coding, but made improvements over  
072 InSilicoVA and InterVA-5. Our research lays the foundation for future work in  
073 computer assisted VA, where physicians utilize alternative COD assignments from  
074 computer models to help reduce ill-defined codes and physician disagreement.

075 **Keywords:** Cause of Death, Physician Coding, Verbal Autopsy, GPT, AI, LLM

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## 078 1 Background

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080 In 2019, 41 million people die prematurely from noncommunicable diseases every year,  
081 accounting for 74% of all deaths globally [1]. Most of these deaths are preventable,  
082 but require adequate resource allocation, guided by evidence, to implement effective  
083 interventions and policies that target populations at risk [2]. Thus, reliable counts and  
084 diagnoses of deaths enable decision makers to identify populations at risk to save lives  
085 and reduce premature deaths worldwide [3–6]. However, most low-income countries  
086 do not have data on deaths or have registered less than half of the deaths in their  
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country, with an even fewer 8% of these registered deaths having a Cause of Death (COD) recorded [7]. To fill this gap in death registrations, an alternative method known as Verbal Autopsy (VA) is used to collect data on deaths and determine their likely causes at scale [8–10], outside of traditional healthcare facilities where over half of deaths occur at home [11].	093
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139 GPT-3, which had notable differences in training data sizes of 5 gigabytes to 45 ter-  
140 abytes from web sources that resulted in 117 million to 175 billion parameter models  
141 [33]. In March 2023, ChatGPT-4 was released with human-level performance on vari-  
142 ous professional and academic exams and benchmarks that outperformed ChatGPT-3  
143 [34]. Given the limited usage of free-text open narratives in computer models for  
144 determining CODs, and recent advances in LLMs that leverage natural language text  
145 prompts, we conducted a case study with Sierra Leone deaths from VA in 2019 to 2022  
146 to compare four models, GPT-3.5, GPT-4, InterVA-5, and InSilicoVA, to physicians  
147 for determining CODs.  
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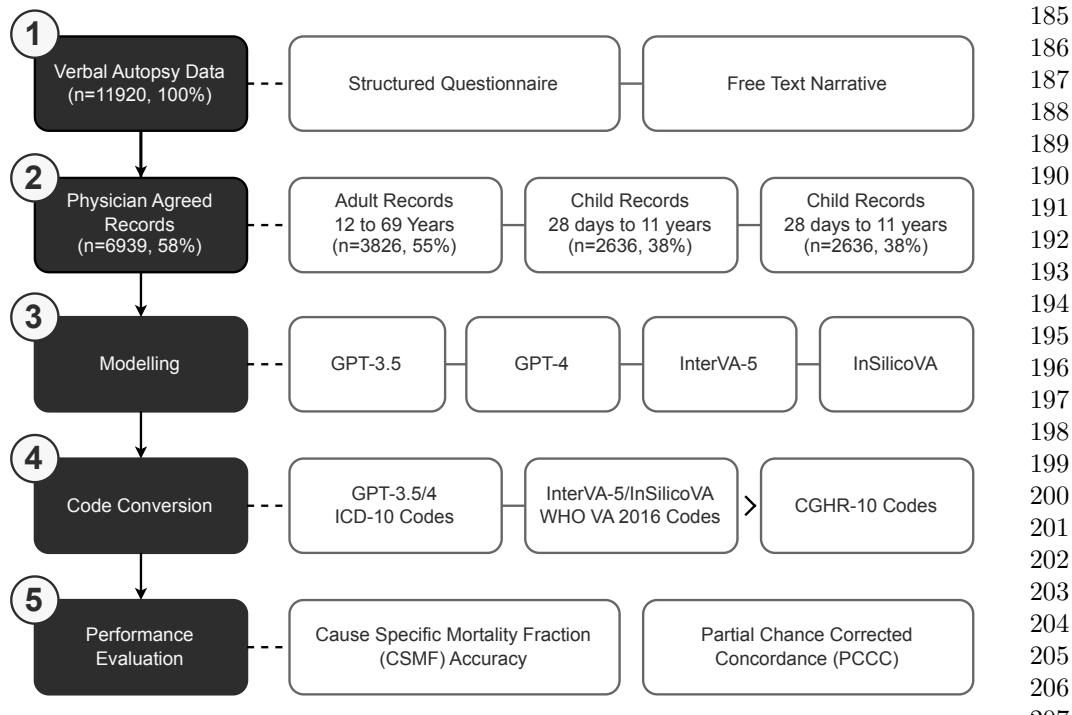
## 150 2 Methods

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152 This study details the methods used to compare the COD assignment from four mod-  
153 els, GPT-3.5, GPT-4, InterVA-5, and InSilicoVA, to physicians as seen in Figure 1.  
154 The initial VA data was filtered for physician agreed records as described in Section  
155 2.1. Section 2.2 describes the input and output of the four models for COD assignment,  
156 while section 2.3 details the performance evaluation of the models relative to physi-  
157 cians using population and individual level metrics. See Appendix A for additional  
158 details on the methods used in this study.

### 159 2.1 Verbal Autopsy (VA) Data

160 Initially, 11,920 records from the HEAL-SL study [35, 36] were collected from dual-  
161 coded EVA, where each record was randomly coded by two different physicians that  
162 assigned CODs as International Classification of Diseases Revision 10 (ICD-10) codes  
163 [37]. For each record, two codes were assigned by two different randomly selected  
164 physicians, where codes were evaluated for agreement using Central Medical Evalu-  
165 ation Agreement 10 (CMEA-10) codes. CMEA-10 groups a range of similar ICD-10  
166 codes together, where if they are in agreement if they are within the same group [38]  
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**Fig. 1** Case study methods.

(see Additional File 2). When codes were not in agreement, a record enters the reconciliation phase, where the two physicians were provided reasoning and initial codes from each other to: (1) keep their initial code (2) assign the other physician's code or (3) assign a new code. If codes were not in agreement after the reconciliation phase, a record enters the adjudication phase, where a third senior physician evaluates both physicians' reasoning and codes before and after reconciliation, and assigns a final code based on their evaluation.

Since computer models were compared to physicians in this study, there was more certainty that COD assignments agreed by both physicians were representative of physician assignment than when they disagreed [18, 39, 40]. Thus, we used 6942 physician agreed records of the 11,920 total records. For better comparison, we standardized all codes to CGHR-10 codes (see Additional File 1) that generalized ICD-10 codes into

231 19, 10, and 7 categories for the adult (12 to 69 years), child (28 days to 11 years), and  
232 neonatal (under 28 days) age groups. After conversion, a final total of 6939 physician  
233 agreed records (3826 adult, 2636 child, and 477 neonatal) were used for modelling and  
234 performance evaluation. See Appendix A.1 for further details on data preprocessing  
235 and characteristics of the physician agreed records.  
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## 238 2.2 Modelling

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240 Four computer models were used to assign COD for each of the 6939 physician agreed  
241 records: GPT-3.5, GPT-4, InterVA-5, and InSilicoVA. InterVA-5 and InSilicoVA are  
242 widely used and studied standard statistical models [13, 21, 22, 24, 25, 41, 42] for COD  
243 assignment in VAs under the openVA framework [43]. InterVA-5 applies Bayesian prob-  
244 abilistic modelling [44] using a set of standardized symptoms from reports and related  
245 conditional probabilities from medical experts to assign CODs based on the highest  
246 probability [20, 45]. InSilicoVA improves upon InterVA (e.g. comparable probabilities  
247 across individuals, measures of uncertainty, and inclusion of additional data sources)  
248 with a hierarchical Bayesian framework and Markov Chain Monte Carlo (MCMC)  
249 simulations [46–48] to incorporate multiple sources of uncertainty for assigning CODs  
250 based on the highest probability [17]. GPT-3.5 [49] and GPT-4 [34] are LLMs that  
251 utilize deep neural networks with transformer architectures [50] and reinforcement  
252 learning from human feedback [51–54] to follow instructions from prompts and pro-  
253 vide human-level responses, with known differences in GPT-4 possessing multimodal  
254 capabilites (e.g. image/voice input/output), more recent training data, and improved  
255 responses compared to ChatGPT-3 [33].  
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258 For GPT-3.5 and GPT-4, the following user prompt was used to instruct each  
259 model to produce COD assignments as ICD-10 codes, where <age> and <sex> from  
260 the questionnaire, and <narrative> from the narratives, were replaced with values  
261 from the data:  
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Determine the underlying cause of death and provide the most probable ICD–10 code for a verbal autopsy narrative of a <age> years old <sex> death in Sierra Leone: <narrative>	277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322
For InterVA-5 and InSilicoVA, the standardized questionnaire data from EVA were converted into OpenVA format [43], before being used as input for each model to produce COD assignments as WHO VA 2016 codes [55]. All model outputs were converted to CGHR-10 codes to evaluate performances of models for COD assignment relative to physicians. See Appendix A.2 for additional details regarding input parameters, output data, and code conversions for each model.	
<b>2.3 Performance Evaluation</b>	293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322
The performance of the four models were evaluated with metrics at the population and individual level by comparing their CGHR-10 COD outputs for 6939 records. Cause Specific Mortality Fraction (CSMF) accuracy was used to evaluate models on the population level (see Appendix A.3.1), while Partial Chance Corrected Concordance (PCCC) was used to evaluate models on the individual level (see Appendix A.3.2) [56]. Both CSMF accuracy and PCCC metrics are between 0 and 1 with 0 indicating low performance and 1 indicating perfect performance at the population and individual level respectively. As model performance can vary across ages and specific causes [41, 42, 57], the CSMF accuracy and PCCC metrics were compared for each model overall, by age group (adult, child, neonatal), by CGHR-10 COD codes, and across age ranges. For each of the adult and child age groups, metrics were calculated for five-year age ranges for records with ages at death of one-year or older and five-month age ranges for 28 days or older. For the neonatal age group, the age ranges of 0-6 days and 7-27 days were used. See Appendix A.3 for more details on performance metrics and evaluation strategy for comparing each model.	

323 **3 Results**

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325 This section details the performance results of GPT-3.5, GPT-4, InterVA-5, and InSil-  
326 icoVA models for assigning CGHR-10 CODs after applying the methods in Section 2.  
327 GPT-4 performed the best overall at 0.61 PCCC followed by GPT-3.5 at 0.56 PCCC.  
328 GPT-4 also had the highest PCCC for most age ranges and CODs across the adult (12  
329 to 69 years), child (28 days to 11 years), and neonatal (under 28 days) age groups with  
330 GPT-3.5, InterVA-5, and InSilicoVA having higher PCCC values for a few age ranges  
331 and CODs. Overall performance results are seen in Section 3.1, and performance by  
332 adult, child, and neonatal records are seen in Sections 3.2, 3.3, and 3.4 respectively.  
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334 **3.1 Overall Performance**

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336 Of all 6939 records, GPT-4 (0.61 PCCC) had the highest individual performance  
337 followed by GPT-3.5 (0.56 PCCC), InSilicoVA (0.44 PCCC), and InterVA-5 (0.44  
338 PCCC) (Figure 2). GPT-3.5 and GPT-4 had improvements ranging from 0.14-0.18  
339 PCCC over InSilicoVA and InterVA-5, while GPT-4 slightly improved over GPT-3.5  
340 by 0.05 PCCC. Population level performances were similar for all models (0.74-0.79  
341 CSMF). Figure 3 shows the PCCC performance across three age groups (adult, child,  
342 and neonate). GPT-4 had the best individual performance for adult and neonatal  
343 records (0.64 and 0.58 PCCC), while GPT-3.5 had the best performance for child  
344 records (0.54 PCCC) with GPT-4 performing slightly worse (0.51 PCCC). InSilicoVA  
345 and InterVA-5 performed the worse for adult and child records ( $\leq 0.5$  PCCC), while  
346 GPT-3.5 performed the worse for neonatal records (0.42 PCCC). Across age ranges,  
347 all models followed a similar pattern in individual performance (Figure 4). PCCC  
348 trended upwards for 1 month to 14 years ( $\sim 0.1-0.75$ ), and downwards for ages 15 to  
349 69 years ( $\sim 0.7-0.35$ ). The highest and lowest performances were observed for ages 10-  
350 29 years ( $\sim$ ) and 1-11 months respectively. Performances varied more across models  
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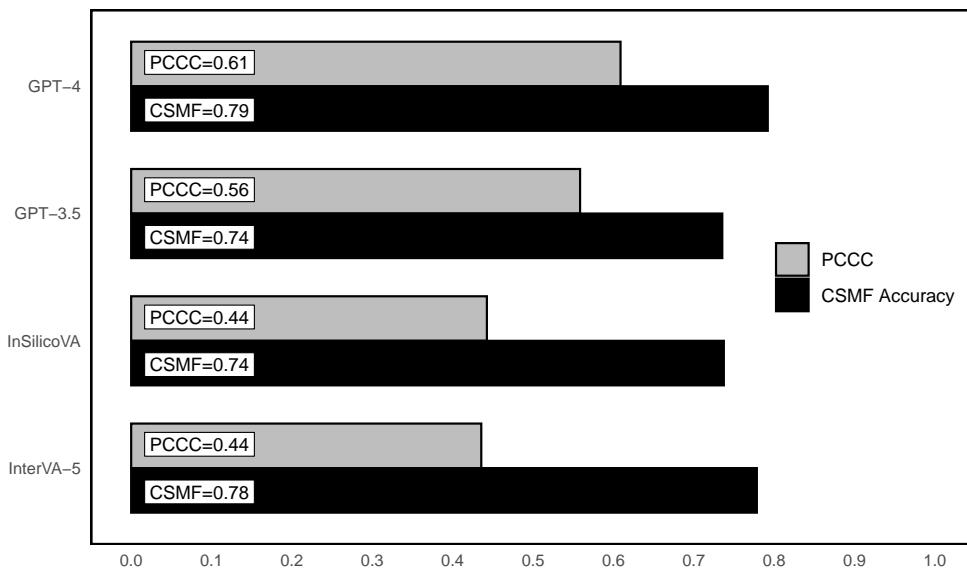
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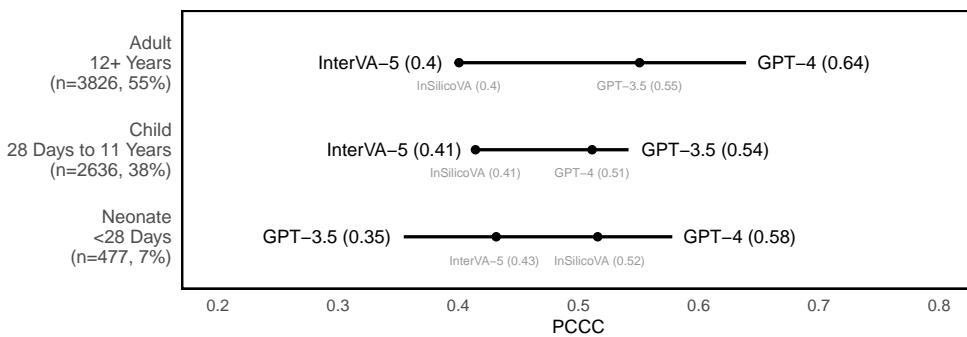
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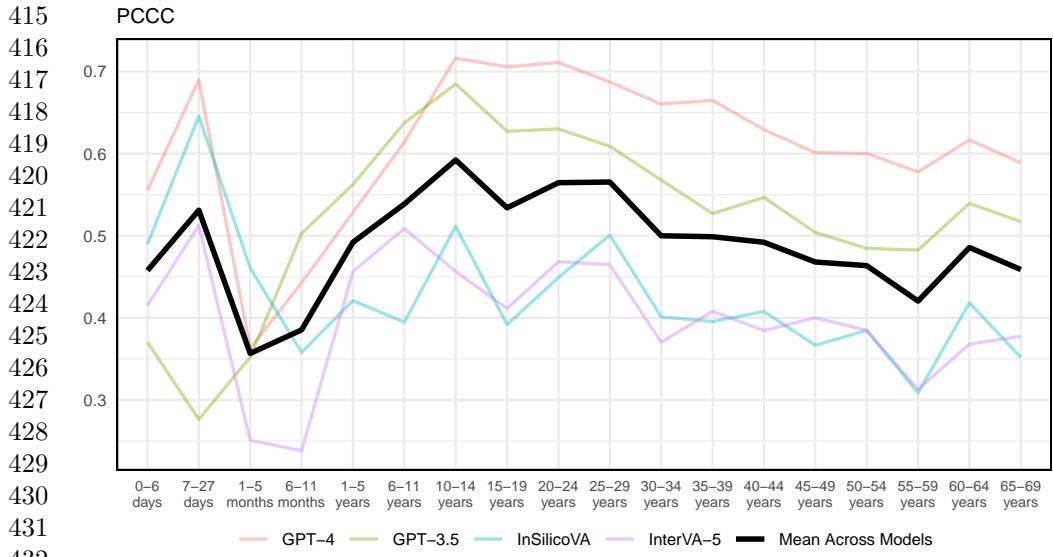
for ages 0 days to 5 years, while less variation was seen between GPT-3.5 and GPT-4, as well as InSilicoVA and InterVA-5, from 5 to 69 years.



**Fig. 2** Overall model performance.

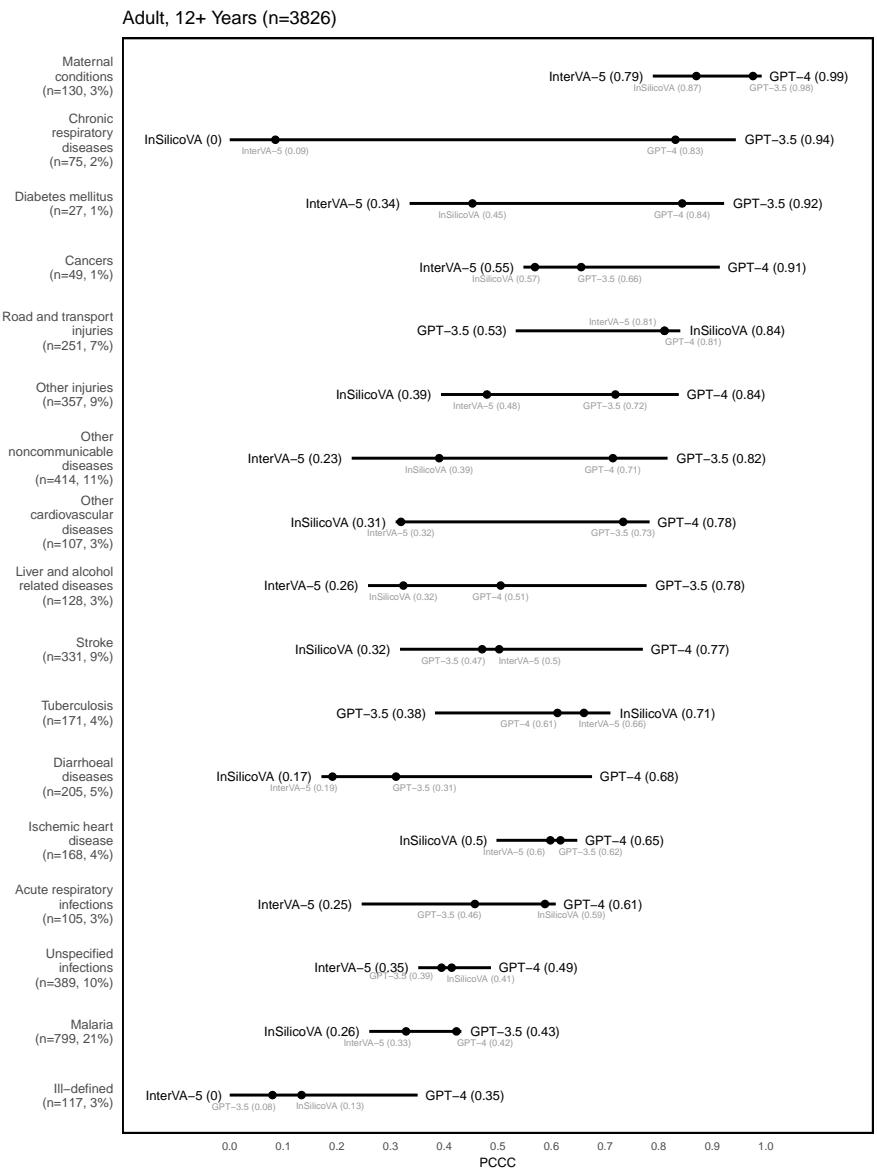


**Fig. 3** Model performance by age group.



438            Figure 5 shows model performance by PCCC across 17 adult CODs excluding suicide  
 439 due to low sample size ( $n=3$ , <1%). GPT-4 had the highest individual performance  
 440 for 10 of 17 CODs (0.35 to 0.99 PCCC), GPT-3.5 for 5 CODs (0.43-0.94 PCCC),  
 441 and InSilicoVA for 2 CODs (0.71 and 0.84 PCCC). InterVA-5 had the lowest perfor-  
 442 mance for 8 of 17 CODs (0-0.79 PCCC), InSilicoVA for 6 CODs (0.01-0.41 PCCC),  
 443 and GPT-3.5 for 2 CODs (0.38 and 0.53 PCCC). GPT-3.5/4 models improved over  
 444 InSilicoVA/InterVA-5 the most for chronic respiratory diseases (0.74-0.94 PCCC dif-  
 445 ference), and the least for Malaria (0.09-0.17 PCCC difference). All models had  
 446 >0.7 PCCC for maternal conditions (0.79-0.99 PCCC), while unspecified infections,  
 447 malaria, and ill-defined CODs models with <0.5 PCCC. GPT-4 had performance  
 448 improvements >0.2 PCCC compared to all other models for cancers (+0.25-0.36  
 449 PCCC), stroke (+0.27-0.45 PCCC), and diarrhoeal diseases (+0.37-0.51 PCCC), while  
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GPT-3.5 had similar improvements for liver and alcohol related diseases (+0.27-0.52 PCCC). 461  
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**Fig. 5** Model performance for adult records by COD.

507 **3.3 Performance for 2636 Child Records (28 Days to 11 Years)**

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509 Figure 6 presents individual performances for each of the models by 8 child CODs,  
510 excluding congenital anomalies due to low sample size (n=1, <1%). GPT-4 had the  
512 highest individual performance for 4 of 8 CODs (0.65-0.94 PCCC), GPT-3.5 for 3  
513 CODs (0.44-0.88 PCCC), and InSilicoVA for 1 COD (0.78 PCCC). InterVA-5 had  
515 the lowest performance for 4 of 8 CODs (0.09-0.79 PCCC), InSilicoVA for 3 CODs  
517 (0-0.35 PCCC), and GPT-3.5 for 1 COD (0.58 PCCC). All models had >0.7 PCCC  
518 for injuries (0.79-0.94 PCCC), and <0.6 PCCC for malaria (0.35-0.54 PCCC) and  
519 other infections (0.29-0.44 PCCC). GPT-4 had improvements >0.3 PCCC compared  
522 to other models for ill-defined CODs (+0.38-0.65 PCCC), and larger improvements  
523 over other models for injuries (+0.11-0.15 compared to +0.01-0.04 PCCC).

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527 **3.4 Performance for 477 Neonatal Records (Under 28 Days)**

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529 Model performance across 5 neonatal CODs, excluding congenital anomalies (n=2,  
530 <1%) and other (n=5, 1%) due to small sample sizes is shown in Figure 7. GPT-4  
532 had the highest individual performance for 3 of 5 CODs (0.39-0.71 PCCC), GPT-3.5  
533 for 1 COD (0.57 PCCC), and InSilicoVA for 1 COD (0.86 PCCC). GPT-3.5 had the  
535 lowest performance for 3 of 5 CODs (0-0.13 PCCC) and InterVA-5 for 2 CODs (0.01  
537 and 0.48 PCCC). All models had similar performance for stillbirth deaths (0.48-0.57  
538 PCCC), while only GPT-4 had a PCCC >0 PCCC. InSilicoVA had improvements  
539 over all other models for neonatal infection deaths (+0.18-0.73 PCCC).

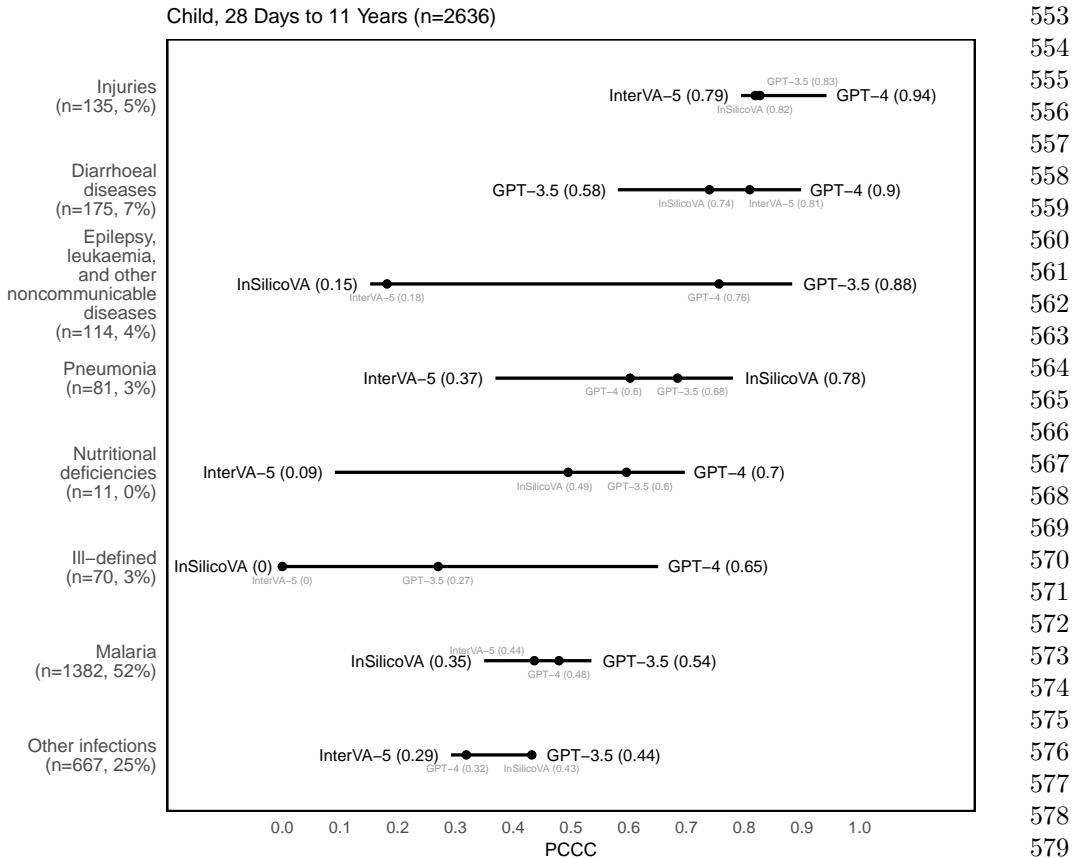
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542 **4 Discussion**

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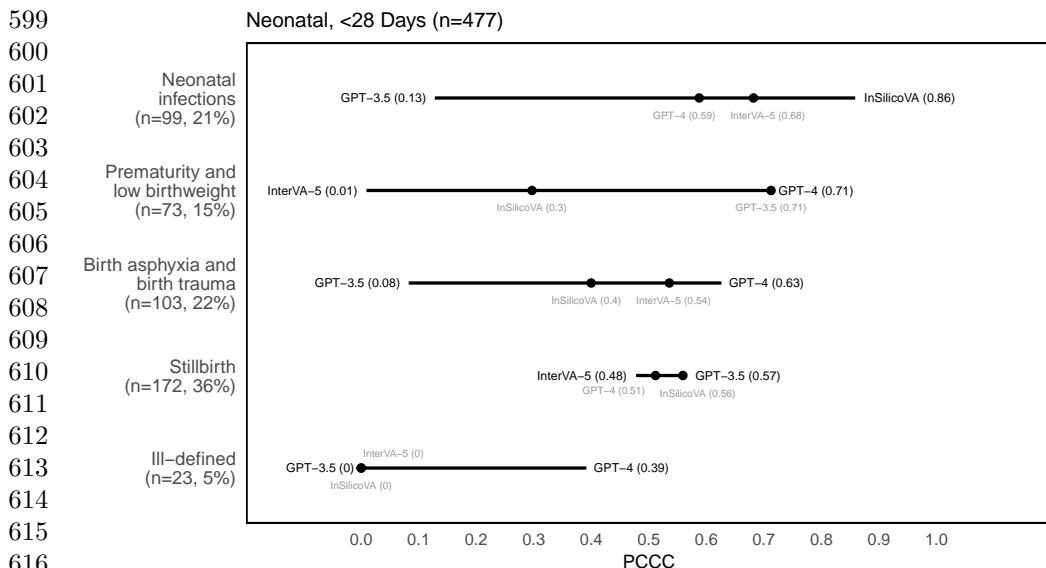
544 This section discusses and summarizes the results from Section 3. Advantages and dis-  
545 advantages of using GPT-3.5, GPT-4, InterVA-5, and InSilicoVA models for assigning  
546 CODs are discussed in Sections 4.1 and 4.2. Limitations of the study are mentioned  
547 in Section 4.3, while opportunities and future work are detailed in Section 4.4.



**Fig. 6** Model performance for child records by COD.

#### 4.1 Advantages

This section identifies the advantages of models for assigning CODs. Section 4.1.1 details the application of models for particular CODs and age ranges. Section 4.1.3 details the resource efficiency of computer models for assisting in physician COD assignment. Section ?? notes the strength of using natural language text in GPT models compared to structured questionnaire data for physician COD assignment.



**Fig. 7** Model performance for neonatal records by COD.

### 4.1.1 Cause-specific Models

At the population level, overall performances for all models were similar to physicians (0.74-0.79 CSMF), indicating potential for adequately estimating COD distributions for large populations. Although all models did not perform well for all records at the individual level (0.44-0.61 PCCC), several models performed well for certain CODs (0-0.99 PCCC). For most CODs, GPT-3.5/GPT-4 performed better than InSilicoVA/InterVA-5 (top PCCC for 15 of 17, 7 of 8, and 4 of 5 adult, child, and neonatal CODs respectively), while InSilicoVA performed better for particular CODs (road and transport injuries, tuberculosis, pneumonia, and neonatal infections with 0.84, 0.71, 0.78, and 0.86 PCCC respectively). For CODs with high performance (e.g. GPT-3.5/4 with 0.91-0.99 PCCC for maternal conditions, chronic respiratory disease, diabetes melitus, and cancers, InSilicoVA with 0.84 and 0.86 PCCC for road and transport injuries, and neonatal infections), the results suggest that GPT-3.5/4 and

InSilicoVA may assign CODs that are very similar to physicians. Thus, it may be beneficial to evaluate performance at the COD level, and apply a combination of models that perform well in comparison to physicians for each COD. For example, different models perform well for various leading CODs as seen in Table 1 [58, 59].

**Table 1** Leading causes globally in 2021 and most relevant models.

Leading Causes of Death (~53% of 68M deaths) <sup>1</sup>	Deaths (% of 68M) <sup>2</sup>	Best Model(s)	PCCC
Ischaemic heart disease	9M (13%)	GPT-4	0.65 (n=168)
Stroke	7M (10%)	GPT-4	0.77 (n=331)
Cancers	4.3M (4%)	GPT-4	0.91 (n=49)
Lower respiratory infections	2.4M (3%)	GPT-3.5/4	0.78 (n=180) <sup>3</sup>
Diabetes mellitus	1.6M (2%)	GPT-3.5	0.92 (n=27)
Tuberculosis	1.4M (2%)	InSilicoVA	0.71 (n=171)
Hypertensive heart disease	1.4M (2%)	GPT-4	0.78 (n=107) <sup>4</sup>
Cirrhosis of the liver	1.3M (2%)	GPT-3.5	0.78 (n=128) <sup>5</sup>
Diarrhoeal diseases	1.2M (2%)	GPT-4	0.68 (n=205)
Road injury	1,183 (2%)	InSilicoVA	0.84 (n=357)
Preterm birth complications	0.9M (1%)	GPT-4	0.71 (n=73)
Falls	0.7M (1%)	GPT-4	0.89 (n=492) <sup>6</sup>

<sup>1</sup>COVID-19, kidney disease, alzheimer disease, other dementias, and self-harm were excluded as a relevant CGHR-10 code was not present. Trachea, bronchus, lung, colon, rectum, stomach, and breast cancers were generalized into cancers.

<sup>2</sup>Percentage of ~68 Million (M) deaths globally. Numbers are rounded.

<sup>3</sup>Mean of chronic and acute respiratory infections.

<sup>4</sup>Derived from other cardiovascular diseases.

<sup>5</sup>Derived from liver and alcohol related diseases.

<sup>6</sup>Mean of adult and child injuries.

#### 4.1.2 Age-specific Performance Patterns

Across age ranges, all models followed a similar upward trend from 6 months to 14 years of age, and a downward trend from 15-69 years with GPT models having higher performance than InSilicoVA/InterVA-5 models, while more mixed trends were observed from 0 days to 5 months (recall Figure 4). For adult age ranges, performance generally decreased as age increased, which suggested that models had difficult assigning CODs for older than younger adults with some improvements after the age of 59. For child and

691 neonatal age ranges, the performance improved drastically as the age increased after 5  
692 months, suggesting less difficulty in COD assignment when children and neonates are  
693 more developed. As the models did not perform particularly well ( $\geq 0.8$  PCCC) for  
694 any specific five-year age range, it is not recommended to apply specific models that  
695 target cases by age. However, the patterns of increases and decreases of performance in  
696 relation to age provide valuable insight for comparison to expected physician diagno-  
697 sis patterns in well-studied medical literature and knowledge. For example, it may be  
698 expected that physicians are more uncertain in diagnosing diseases that are prevalent  
699 in neonatal patients [60, 61], which are present in our findings from Figure 4.  
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#### 702 4.1.3 Scalability and Availability

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704 The models in this study can assist physicians in assigning CODs in a variety of ways  
705 due to low costs and speed of COD assignment. Similar to differential diagnoses, GPT  
706 and InSilicoVA models offer alternative COD assignments for physicians to consider  
707 [39], which can potentially help lower the number of records with ill-defined causes or  
708 reduce disagreement between physicians. At the time of this study, running GPT-3.5  
709 cost  $\sim \$1.6$  USD ( $\$0.5$  per one million tokens), GPT-4 cost  $\sim \$115$  USD ( $\$30$  per one  
710 million tokens), and InSilicoVA was cost free on 6939 records [62]. These costs were  
711 lower than physicians (e.g. less than  $\$3$  USD per house in India [15, 16]), while it is  
712 possible to code over 10,000 records in under a day. When physicians are unavailable,  
713 GPT and InSilicoVA models can be a cost-efficient alternative to code large amounts  
714 of records for population estimates of CODs. However, it is recommended to apply  
715 these models only for certain CODs where models perform well, such as in Table 1. In  
716 addition, these models can also help divert physician resources to cases that are more  
717 difficult to code or require more attention. For example, physicians can validate cases  
718 where models performed well (e.g. maternal conditions at 0.79-0.99 PCCC), while  
719 spending more time on cases where models performed poorly (e.g. acute respiratory  
720 infections at 0.25-0.61 PCCC).  
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<b>4.1.4 Natural Language Input and Output</b>	737
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Training data was not required to assign CODs for all models, which allowed application without domain expertise or supplying training datasets. The main advantage to GPT-3.5/4 was the use of natural language text as input and output. Compared to InterVA-5 and InSilicoVA, GPT models were able to assign COD codes in ICD-10 standard, as physicians do, and potentially assign CODs in more broad categories depending on the prompts. In comparison, InterVA-5 and InSilicoVA relied on structured input and output data from WHO VA 2016 questionnaires, and assigned CODs in WHO VA 2016 codes only. This required that these codes and forms be maintained with conversions between different form (e.g. WHO VA 2012 to WHO VA 2016) and code standards (e.g. WHO VA 2016 to ICD-10), which reduces interoperability and comparability with other incompatible models. GPT models did not require strict formats for training and testing data, which can capture latent and more ambiguous patterns (e.g. health-seeking behaviours and social issues) outside the scope of WHO VA codes and forms [26, 28]. For example, GPT-3.5/4 had higher performance (+0.35-0.65 PCCC) than InterVA-5 and InSilicoVA for ambiguous ill-defined records across age groups. GPT models also performed better (+0.11-0.61 PCCC) on CODs with a rarer occurrence, such as nutritional deficiencies (n=11) and diabetes mellitus (n=27). Rarer CODs may be more difficult to capture by questionnaire due to lack of sample data, but it may possibly have richer contextual information from articles, web sources, or books that offer knowledge for GPT models to leverage.	739
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<b>4.2 Disadvantages</b>	773
This section discusses the disadvantages of GPT models for COD assignment. Section 4.2.1 identifies issues in reproducing GPT outputs for repeated runs on the same records and lack of up-to-date information, while Section 4.2.2 discusses the resource intensive infrastructure required by GPT and its relation to data privacy.	774
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783 **4.2.1 Reproducibility and Timeliness**

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785 Recall that the GPT models in this study had the temperature parameter set to 0 for  
786 more reproducible and reliable results. A short experiment in Appendix B revealed  
787 that GPT-3.5 assigns the same COD for the same record only more than 60% of the  
788 time, based on repeated runs on a sample of 100 records. This suggests that GPT  
789 models do not always reliably assign identical CODs for the same case on multiple runs,  
790 which may pose issues in reproducibility and reliability. For example, GPT models  
791 may achieve correct COD assignments solely due to random chance, but are difficult to  
792 test with large numbers (e.g. 10,000) of reruns due to costs (e.g. costs increased 10 fold  
793 per record when rerun 10 times). In comparison, InterVA-5 and InSilicoVA are open  
794 source and free, allowing a large number of reruns without incurring additional fees.  
795 In addition, InterVA-5 and InSilicoVA assign CODs and provide probabilities for each  
796 alternative COD, which offers more reproducible and reliable COD assignments despite  
797 lower performance overall. Lastly, a major disadvantage in all models was that they  
798 were trained on historical data up to particular points in time, which may not utilize  
799 the most up-to-date data available (e.g. latest online articles, social media, or books  
800 for GPT models). Emergent diseases (e.g. COVID-19) and changes in distributions  
801 (e.g. outbreaks) may not be caught by these models depending on how often they are  
802 updated.

803

804 **4.2.2 Infrastructure and Data Privacy**

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806 GPT-3.5 and GPT-4 models required large computing infrastructure to train and run,  
807 which was not possible to run on local computers, or setup due to costs and ownership  
808 of the models. This poses issues with data privacy as sensitive data (e.g. identifying  
809 information) need to be sent to company servers, which can be collected by companies  
810 (e.g. OpenAI) and misused [63]. For example, in our study, GPT models use prompts,  
811 which contain the narrative data, to assign CODs, and the data in these prompts  
812 813

may be unknowingly collected and misused by companies (e.g. companies) or their users (e.g. malicious prompts) to identify participants or leak sensitive sensitive data [64, 65]. In contrast, InterVA-5 and InSilicoVA can be run on local computers, which allows data to stay with the owner to protect data privacy, without reliance on external services.	829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874
<b>4.3 Limitations</b>	838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874
This section identifies limitations in this research in the context of GPT models. Section 4.3.1 identifies the omission of ICD-10 performance evaluations. Section 4.3.2 mentions the need for parameter tuning and evaluation of consistency and multiple COD assignments.	838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874
<b>4.3.1 ICD-10 Evaluation and Low Sample Sizes</b>	848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874
For the scope of this study, all models were evaluated for their performance in broad CGHR-10 COD categories as opposed to more specific ICD-10 codes. However, in practical cases, physicians assign more specific ICD-10 codes rather than broader COD categories. InterVA-5 and InSilicoVA assigned broader WHO VA codes, and were unable to assign ICD-10 codes, as the number of cases for specific ICD-10 codes are often low and inadequate for training statistical models. In relation, some broader CGHR-10 CODs were even removed for performance evaluation as <10 cases were captured (e.g. congenital anomalies, suicide). Although GPT models were able to assign ICD-10 codes, lower performance may be expected as even physicians do not agree completely on ICD-10 codes, noted that broader categories (CMEA-10 codes in Additional file 2) were used to assign equivalency or agreement.	850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874
<b>4.3.2 Model Tuning, Consistency, and Multiple Outputs</b>	870 871 872 873 874
GPT-3.5 and GPT-4 models used default parameters with the exception of setting the temperature to 0 for more consistent results. However, the temperature and other	870 871 872 873 874

875 model settings may be adjusted to possibly improve performance for GPT models  
876 [66]. This was not examined as sensitivity analyses on model parameters are costly  
877 across multiple reruns, noted in Section 4.2.1, which is required when testing various  
878 parameter settings. In addition, GPT models may possibly produce inconsistent results  
881 even with the temperature set to 0. Thus, it is important to also test the reliability  
882 and consistency of GPT outputs to avoid coincidental results due to randomness [67–  
884 69]. InterVA-5 and InSilicoVA were able to provide multiple COD assignments with  
886 probabilities for each COD. GPT models can be prompted to produce more than one  
887 COD assignment, but was not explored in this study as we only evaluated the most  
889 probable COD. This may be useful to evaluate the performance of multiple alternative  
891 COD assignments, which may provide additional diagnoses that have a higher chance  
893 of being similar to physician assignment, and better reflect causes leading to death  
894 [19].

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## 898 **4.4 Opportunities**

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900 This section discusses research opportunities to improve GPT models for assigning  
901 CODs. Section 4.4.1 discusses the potential to improve GPT models with prompt  
903 engineering and exploration of misclassified records, while Section 4.4.2 describes the  
905 application of GPT models for improving household surveys for better data quality.  
906 Section 4.4.3 identifies an opportunity to integrate GPT, InterVA-5, and InSilicoVA  
908 models into VA systems for improving physician COD assignment.

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910

### 911 **4.4.1 Prompt Engineering and Custom Models**

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913 Prompt engineering, the design of prompts to guide GPT models for better results [70],  
914 presents an important research opportunity that may improve performance of GPT  
915 models for COD assignment. An example exploration was conducted in Appendix C on  
917 misclassified GPT-4 records for neonatal infections, which found potential issues with  
919 920

the categorization of CGHR-10 codes, order of information in narratives, and guidelines of COD assignments. An analysis of misclassified records with domain experts (e.g. physicians, specialists) may yield insights on adjusting prompts to assign more correct CODs, or apply more relevant broad COD categories for evaluation. In addition, subsequent prompts, data, and examples can be used to include correctional instructions and refine results, while additional information from the questionnaire and physician VA manuals can provide contextual information (e.g. retrieval augmented generation [71]) for further performance improvements [72]. Sensitivity analyses may be conducted to assess the effects on performance and consistency of results from modified prompts on a COD basis. GPT models may also be customized to specific domains or contexts, where objectives, behaviours, extra data, privacy, and evaluation tests can be adjusted to produce custom models that perform better in targeted domains or circumstances (e.g. custom models for particular CODs) [73].	921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966
<b>4.4.2 Guided and Monitored Household Surveys</b>	944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966
Recall that VAs involve surveyors that visit households to gather information about the deceased from their family, next-of-kin, friend, or community. Although standard questionnaires are used during this visit, there is significant information, containing latent patterns, from the narrative that is not always captured by the questionnaire [26, 28]. These narratives often require a human connection between the surveyor and household members, where surveyor characteristics vary in social ability, cultural understanding, emotional capacity, and medical knowledge that affect the quality and bias of narratives [19, 74]. GPT models may help guide surveyors during VA interviews to probe households for better narrative information by generating and suggesting better questions, or providing questions that may have been missed by the surveyors. In addition, as models can assign CODs on-demand, there is potential for models to provide immediate COD estimates during the data collection process to monitor	944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966

967 data quality on-demand (e.g. comparing estimated to expected COD distributions for  
968 known areas as quality checks).  
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970

#### 971 **4.4.3 Computer Assisted Verbal Autopsy** 972

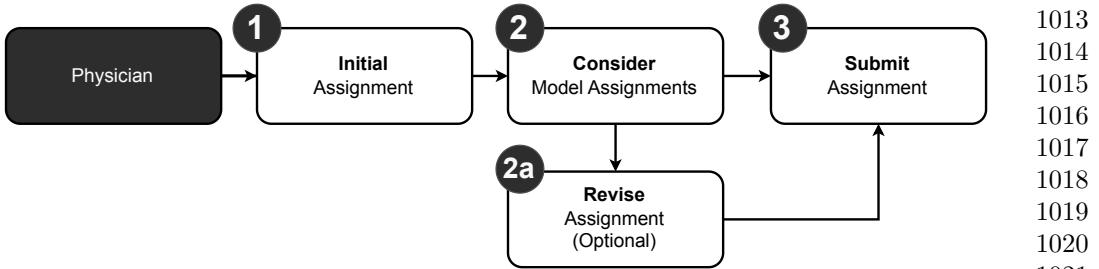
973 Our study lays the foundation for the integration of GPT, InterVA-5, and InSilicoVA  
974 models into VA systems to assist physicians in COD assignment. In dual-coded VA sys-  
975 tems (described in Section 2.1), two physicians are randomly assigned to each record  
976 and require second inspections of each other’s assignment (reconciliation) and evalua-  
977 tion by a third more senior physician if their assignments do not agree. As mentioned  
978 in Section 4.1.3, suggestion of alternative assignments from GPT and InSilicoVA mod-  
979 els potentially reduces the disagreement between physicians, and ill-defined records,  
980 while allowing physicians to focus on more difficult records. Thus, model suggestions  
981 can be integrated into VA systems by presenting COD suggestions to physicians after  
982 their initial COD assignment, which allows them to consider alternative assignments  
983 and possibly revise their assignments based on the suggestions. At step 2 in Figure 8,  
984 GPT, InterVA-5, and InSilicoVA models can suggest COD assignments to consider,  
985 providing the option in step 2b to revise or proceed with their initial assignment.  
986 Our future work will be a first step in computer assisted verbal autopsy, assessing the  
987 effects of these model suggestions on improve VA data quality (e.g. increase in agreed  
988 records, reduction of ill-defined deaths). In preparation, we have integrated GPT-  
989 4, InterVA-5, and InSilicoVA model suggestions into our on-going HEAL-SL study  
1000 1001 after survey round 2 [35] with goals of increasing physician agreement and reducing  
1002 1003 ill-defined COD assignments.  
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## 1007 **5 Conclusion** 1008

1009 This study evaluates the performance of GPT-3.5, GPT-4, InterVA-5, and InSilicoVA  
1010 1011 models compared to physicians for assigning CODs for 6939 VA records in Sierra  
1012



**Fig. 8** Model suggestions integrated in the physician assignment process.

Leone (2019-2022). At the population level, all models were similar (0.74-0.79 CSMF accuracy). At the individual level, GPT-4 had the best performance (0.61 PCCC), followed by GPT-3.5 (0.58 PCCC), and InSilicoVA/InterVA-5 (0.44 PCCC). Across CODs, GPT-4 had performed best for 10 of 17 adult, 4 of 8 child, and 3 of 5 neonatal CODs, with GPT-3.5 for 5 adult, 3 child, and one neonatal CODs, and InSilicoVA for 2 adult, one child, and one neonatal CODs. Model performance increased ( $\sim$ 0.1-0.75 PCCC) as children and neonates developed (0 days to 14 years), and decreased ( $\sim$ 0.7-0.35) as adults aged (15 to 69 years). Thus, GPT and InSilicoVA models were comparable to physicians for several CODs, but not across age ranges. As performance varied across CODs and age ranges, it is advantageous to combine several models to target CODs that each model performs well for, and to compare age-related performance patterns in relation to physicians. In addition, all models were able to scale to a large number of records and were available on-demand in comparison to physicians, enabling COD estimation and alternative diagnoses in low resource or physician scarce scenarios. As GPT models operate on natural language, they are able to adapt to more loosely defined data structures (e.g. assign in different COD coding standards, provide reasoning, and use contextual information when samples are low), making them behave more similarly to physician assignment. However, GPT models do not provide reliable CODs on repeated assignment, and were limited to past training data, with large computing infrastructure requirements, leading to reproducibility issues in COD

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1059 assignments, difficulty adapting to new or changing CODs, and data privacy issues.  
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1061 Limitations of this study included difficulty comparing ICD-10 codes directly due to  
1062 incompatible COD outputs from each model and low sample sizes, difficulty in con-  
1063 ducting sensitivity analyses for GPT models due to costs, and omitting evaluation of  
1064 multiple COD assignments due to study scope. We identified research opportunities  
1065 in refining GPT models using prompt engineering and custom models for improving  
1066 performance, guided household surveys to improve narrative quality, and future work  
1067 in computer assisted VA, where GPT and other models will be used to assist physician  
1068 COD assignment by offering multiple alternative assignments, with goals of increasing  
1069 agreement on COD assignment and reducing ill-defined deaths. GPT-4, InterVA-5,  
1070 and InSilicoVA has been integrated into future survey rounds of the HEAl-SL study  
1071 from 2022 onwards, offering alternative COD assignments to assist physicians with  
1072 second opinions. Future work in evaluating the effectiveness of computer assisted VA  
1073 to reduce disagreements among physicians and ill-defined deaths will help support the  
1074 advancement of more accurate and efficient VA systems across the world.  
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1077 **Supplementary information.** Additional files were used to supplement this paper:  
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- 1079 • Additional file 1: Centre for Global Health Research 10 (CGHR-10) codes. Codes  
1080 grouping ICD-10 code ranges into generalized categories. (.csv)
- 1081 • Additional file 2: Central Medical Evaluation Agreement 10 (CMEA-10) codes. ICD-  
1082 10 code ranges considered in physician agreement. (.csv)

1083  
1084 **Acknowledgments.** TBD.

1085  
1086

## 1087 **Declarations**

1088  
1089

## 1090 **Funding**

1091  
1092 TBD.

1093  
1094

<b>Competing interests</b>	1105
Not applicable.	1106
<b>Ethics approval</b>	1107
Not applicable.	1108
<b>Consent for publication</b>	1109
Not applicable.	1110
<b>Availability of data and materials</b>	1111
The datasets supporting the conclusions of this article are included within the article (and its additional files), at <a href="https://openmortality.org">https://openmortality.org</a> (available upon request) and at <a href="https://github.com/cghr-toronto/healsl-gpt-paper">https://github.com/cghr-toronto/healsl-gpt-paper</a> . Verbal Autopsy (VA) and narra- tive data by age group and survey rounds 1 and 2 available at <a href="https://openmortality.org/dataset/heal-sl">https://openmortality.org/dataset/heal-sl</a> . Cause of death code mappings to convert between ICD-10, WVA-2016, and CGHR-10 codes available at <a href="https://openmortality.org/dataset/icd">https://openmortality.org/dataset/icd</a> . Model evaluation result files at <a href="https://github.com/cghr-toronto/healsl-gpt-paper/tree/main/data">https://github.com/cghr-toronto/healsl-gpt-paper/tree/main/data</a> .	1112
<b>Code availability</b>	1113
All code for this paper is available at <a href="https://github.com/cghr-toronto/healsl-gpt-paper">https://github.com/cghr-toronto/healsl-gpt-paper</a> .	1114
<b>Authors' contributions</b>	1115
PJ and PB are the study Principal Investigators. ATA and RK implemented the data collection procedures. RW, and TKSN processed, documented, and prepared the data. RW, ASL, and RK ran the models. RW wrote the paper and conducted the analysis.	1116

1151 AB and RCM provided medical domain guidance and feedback. All authors reviewed  
1152 the results and contributed to the report. All authors read and approved the final  
1153 manuscript.  
1154

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## 1157 **Appendix A Details on Methods**

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1159 This section provides additional details on the methods described in Section 2. An  
1160 overview of the methods used in this study is seen in Figure A1 as a five-step process.  
1161 Section A.1 provides details on the preprocessed data used for modelling. Section A.2  
1162 describes the data and parameter inputs and outputs for each model, while Section  
1163 A.3 details the evaluation of model outputs at the individual and population level  
1164 across different CODs, age groups, and age ranges.  
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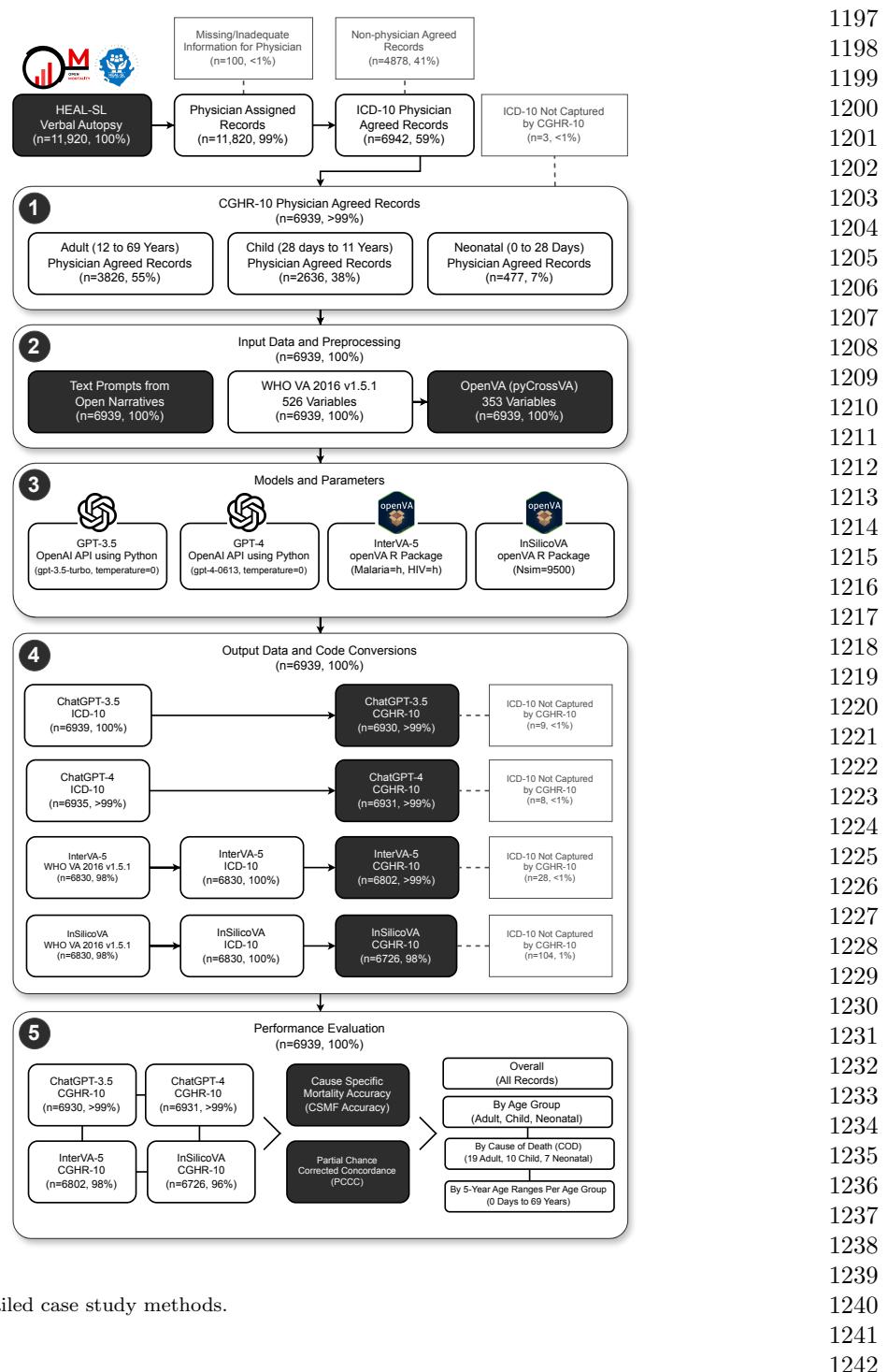
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**Fig. A1** Detailed case study methods.

1243 **A.1 CGHR-10 Physician Agreed Records**

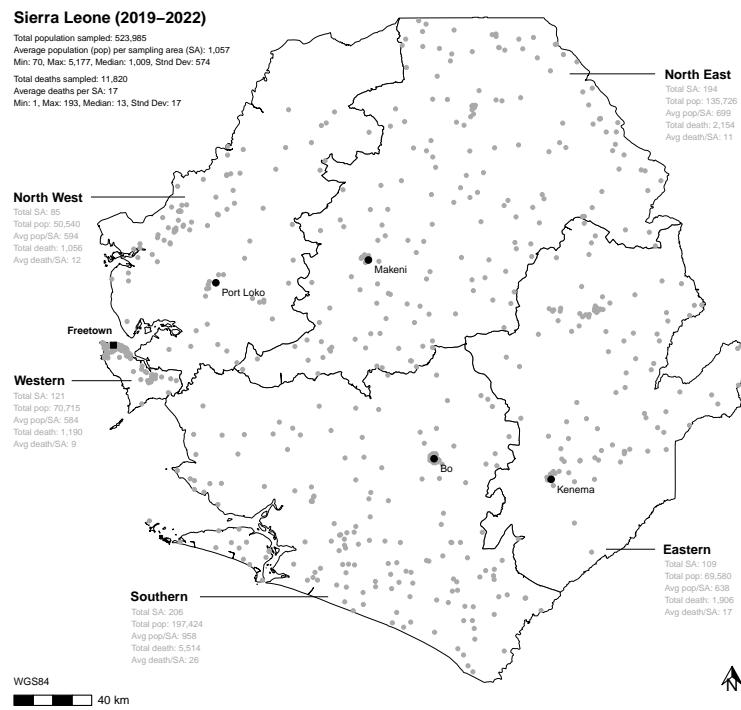
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1245 Initially, 11,920 records were collected from dual-coded EVA in the HEAL-SL study.  
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1247 Physicians were able to assign CODs for 11,820 of the 11,920 records, where 100 of  
1248 these records could not be assigned a COD due to missing or inadequate information  
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1250 (e.g. low quality narrative, data loss). The 11,820 physician coded records were further  
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1252 filtered for records where both physicians agreed on the assigned codes (records that  
1253 were not reconciled or adjudicated) resulting in 6942 physician agreed records (based  
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1255 on comparisons using CMEA-10 codes, see Additional File 2). The 6942 records were  
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1257 converted into CGHR-10 codes (see Additional File 1) that generalized ICD-10 codes  
1258 into 19, 10, and 7 categories for the adult (12 to 69 years), child (28 days to 11  
1259 years), and neonatal (under 28 days) age groups. After conversion, a final total of  
1260  
1261 6939 physician agreed records (3826 adult, 2636 child, and 477 neonatal) were used  
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1263 for modelling and performance evaluation, where three records were removed as their  
1264  
1265 ICD-10 codes did not have a matching CGHR-10 code.

1266

1267 The 6939 physician agreed records were collected using VA from the HEAL-SL  
1268 study between 2019-2022, where records were collected using nation wide samples  
1269 across Sierra Leone provinces seen in Figure A2. More populous areas (e.g. southern  
1270  
1271 and north east provinces with ~197,000 and ~135,000 population respectively) had  
1272 more sampling areas versus less populous areas (e.g. north west and eastern provinces  
1273 with ~50,000 and ~69,000 people respectively). The distribution of the case study  
1274  
1275 data are shown by CGHR-10 causes of death in Table A1. All age groups had relatively  
1276  
1277 evenly distributed female and male records (44-55% of 6939 records each). Across  
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1279 CODs, there were noticeably more female records for cancers (65%), and maternal con-  
1280 ditions (100%), while more male records for chronic respiratory diseases (61%), other  
1281  
1282 noncommunicable diseases (61%), other injuries (77%), road and transport injuries  
1283 (71%), and tuberculosis (68%). Most records were coded by physicians as malaria for  
1284 adults (20%) and children (52%), and stillbirth (36%) and neonatal infections (21%)  
1285  
1286

for neonates. Suicide, congenital anomalies, nutritional deficiencies, and other had low sample sizes for each age group (<1% of total records for each age group). Table A2 shows the distribution of the study data by age ranges. Across age ranges, there were more male records for 50-59 years (60-62%), while all other records had between 49-59% female and male records. Most records were in the 65-69 years age range for adults (15%), 1-5 years for children (62%), and 0-6 days for neonates (83%).



**Fig. A2** Case study data sampling areas.

## A.2 Modelling Details

Each model (GPT-3.5, GPT-4, InSilicoVA, and InterVA-5) required pre-processing of the 6939 records into input data, and standardization of output COD codes from models for performance evaluation as not all models produced comparable codes across outputs. Although each model can assign multiple CODs per record, only the first

1335

1336 **Table A1** Case study data by cause of death.

1337

1338	Age Group	CGHR-10 Cause of Death (COD)	Female	Male	Total	
1339		Acute Respiratory Infections	48 (45.7%)	57 (54.3%)	105 (2.7%)	
1340		Cancers	32 (65.3%)	17 (34.7%)	49 (1.3%)	
1341		Chronic Respiratory Diseases	29 (38.7%)	46 (61.3%)	75 (2%)	
1342		Diabetes Mellitus	14 (51.9%)	13 (48.1%)	27 (0.7%)	
1343		Diarrhoeal Diseases	102 (49.8%)	103 (50.2%)	205 (5.4%)	
1344	Adult (n=3826, 55.1%, 18 CODs)	Ill-Defined	56 (47.9%)	61 (52.1%)	117 (3.1%)	
1345	Adult Female (n=1681, 43.9%)	Ischemic Heart Disease	89 (53%)	79 (47%)	168 (4.4%)	
1346	Adult Male (n=2145, 56.1%)	Liver And Alcohol Related Diseases	58 (45.3%)	70 (54.7%)	128 (3.3%)	
1347		Malaria	372 (46.6%)	427 (53.4%)	799 (20.9%)	
1348		Maternal Conditions	130 (100%)	N/A	130 (3.4%)	
1349		Other Cardiovascular Diseases	59 (55.1%)	48 (44.9%)	107 (2.8%)	
1350		Other Noncommunicable Diseases	160 (38.6%)	254 (61.4%)	414 (10.8%)	
1351		Other Injuries	83 (23.2%)	274 (76.8%)	357 (9.3%)	
1352		Road And Transport Injuries	73 (29.1%)	178 (70.9%)	251 (6.6%)	
1353		Stroke	147 (44.4%)	184 (55.6%)	331 (8.7%)	
1354		Suicide	N/A	3 (100%)	3 (0.1%)	
1355	Child (n=2636, 38%, 9 CODs)	Tuberculosis	54 (31.6%)	117 (68.4%)	171 (4.5%)	
1356	Child Female (n=1290, 48.9%)	Unspecified Infections	175 (45%)	214 (55%)	389 (10.2%)	
1357		Congenital Anomalies	1 (100%)	N/A	1 (0%)	
1358		Diarrhoeal Diseases	79 (45.1%)	96 (54.9%)	175 (6.6%)	
1359		Epilepsy, Leukaemia, And	61 (53.5%)	53 (46.5%)	114 (4.3%)	
1360		Other Noncommunicable Diseases	34 (48.6%)	36 (51.4%)	70 (2.7%)	
1361		Ill-Defined	51 (37.8%)	84 (62.2%)	135 (5.1%)	
1362	Neonate (n=477, 6.9%, 7 CODs)	Injuries	680 (49.2%)	702 (50.8%)	1382 (52.4%)	
1363		Malaria	7 (63.6%)	4 (36.4%)	11 (0.4%)	
1364	Neonate Female (n=227, 47.6%)	Nutritional Deficiencies	338 (50.7%)	329 (49.3%)	667 (25.3%)	
1365	Neonate Male (n=250, 52.4%)	Other Infections	39 (48.1%)	42 (51.9%)	81 (3.1%)	
1366		Pneumonia	Birth Asphyxia And Birth Trauma	38 (36.9%)	65 (63.1%)	103 (21.6%)
1367		Congenital Anomalies	2 (100%)	N/A	2 (0.4%)	
1368		Ill-Defined	11 (47.8%)	12 (52.2%)	23 (4.8%)	
1369		Neonatal Infections	49 (49.5%)	50 (50.5%)	99 (20.8%)	
1370		Other	2 (40%)	3 (60%)	5 (1%)	
1371		Prematurity And Low Birthweight	39 (53.4%)	34 (46.6%)	73 (15.3%)	
1372		Stillbirth	86 (50%)	86 (50%)	172 (36.1%)	

1368

1369 generated COD response from GPT-3.5 and GPT-4, and the most probable COD  
13701371 from InterVA-5 and InSilicoVA were used for evaluation. Section A.2.1 describes the  
13721373 input data and parameters for each model, while Section A.2.3 details the outputs  
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1375 from running each model.

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**Table A2** Case study data by age range.

Age Group	Age Range	Female	Male	Total
Adult (n=3826, 55.1%)	10-14 Years	51 (37.8%)	84 (62.2%)	135 (3.5%)
	15-19 Years	115 (42.8%)	154 (57.2%)	269 (7%)
	20-24 Years	146 (53.1%)	129 (46.9%)	275 (7.2%)
	25-29 Years	159 (45.2%)	193 (54.8%)	352 (9.2%)
	30-34 Years	174 (50.9%)	168 (49.1%)	342 (8.9%)
	35-39 Years	153 (45.4%)	184 (54.6%)	337 (8.8%)
	40-44 Years	134 (42%)	185 (58%)	319 (8.3%)
	45-49 Years	148 (47%)	167 (53%)	315 (8.2%)
	50-54 Years	134 (39.6%)	204 (60.4%)	338 (8.8%)
	55-59 Years	96 (37.6%)	159 (62.4%)	255 (6.7%)
Adult Female (n=1681, 43.9%)	60-64 Years	128 (40.8%)	186 (59.2%)	314 (8.2%)
	65-69 Years	243 (42.3%)	332 (57.7%)	575 (15%)
Child (n=2636, 38%)	1-5 Months	146 (47.4%)	162 (52.6%)	308 (11.7%)
	6-11 Months	160 (50.8%)	155 (49.2%)	315 (11.9%)
	1-5 Years	822 (50.3%)	811 (49.7%)	1633 (61.9%)
	6-11 Years	162 (42.6%)	218 (57.4%)	380 (14.4%)
Neonate (n=477, 6.9%)	0-6 Days	184 (46.6%)	211 (53.4%)	395 (82.8%)
	7-27 Days	43 (52.4%)	39 (47.6%)	82 (17.2%)
	Neonate Male (n=250, 52.4%)			

### A.2.1 Input Data and Preprocessing

For GPT-3.5 and GPT-4, 6939 text prompts were generated for each physician agreed record as input to instruct the models to assign CODs based on the open narratives. Two types of text prompts were used: user prompts and system prompts. System prompts contained textual instructions to assign the role of a physician ICD-10 coder with expertise in Sierra Leone. The following system prompt was used for each record:

```
You are a physician with expertise in determining underlying causes
of death in Sierra Leone by assigning the most probable ICD-10
code for each death using verbal autopsy narratives. Return only
the ICD-10 code without description. E.g. A00. If there are
multiple ICD-10 codes, show one code per line.
```

User prompts contained textual instructions to perform coding of VA records based on the age, sex, and narrative of the deceased. The following template was used to

1427 generate user prompts for each record, where <age> and <sex> from the questionnaire,  
1428  
1429 and <narrative> from the narratives, were replaced with values from the data:  
1430  
1431 Determine the underlying cause of death and provide the most  
1432 probable ICD–10 code for a verbal autopsy narrative of a <age>  
1433  
1434 years old <sex> death in Sierra Leone: <narrative>  
1435  
1436 For InterVA-5 and InSilicoVA, the standardized questionnaire data from the HEAL-SL  
1437 EVA were first converted into 2016 World Health Organization (WHO) VA question-  
1438 naire revision 1.5.1 Open Data Kit (ODK) format [75, 76] consisting of 526 variables  
1439  
1440  
1441 [77], followed by further conversion into OpenVA format [43] consisting of 353 vari-  
1442 ables [78] using the pyCrossVA version 0.97 Python package [79]. The 6939 records  
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1444 were all converted into OpenVA formatted records for InterVA-5 and InSilicoVA.  
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#### 1447 **A.2.2 Models and Parameters**

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1449 The GPT-3.5 and GPT-4 Application Programming Interface (API) was accessed  
1450  
1451 using Python version 3.11.4 and used to assign CODs for each record. GPT-3.5 used  
1452 the gpt-3.5-turbo model, while GPT-4 used the gpt-4-0613 model. The parameter  
1453 temperature for GPT-3.5 and GPT-4, representing the sampling temperature ranging  
1454  
1455 from 0 to 2 (default of 1), was set to 0 to produce more deterministic outputs [66].  
1456  
1457 Higher values closer to 2 may produce less deterministic outputs, while lower values  
1458  
1459 closer to 0 produce more deterministic outputs.

1460

1461 The openVA R package was used to run InterVA-5 and InSilicoVA models to assign  
1462 CODs for each record in R version 4.3.1. The openVA package version 1.1.1 used  
1463 dependent packages InterVA5 version 1.1.3 and InSilicoVA version 1.4.0. The Nsim  
1464  
1465 (number of iterations to run) parameter [80] for InSilicoVA was set to 9500, while  
1466  
1467 the HIV (level of prevalence of human immunodeficiency virus) and Malaria (level  
1468  
1469 of prevalence of Malaria) parameters [81] for InterVA-5 were both set to 'h' (high)  
1470  
1471 reflecting HIV and Malaria disease assumptions in Sierra Leone [82, 83]. Note that the  
1472

default value of `Nsim=10000` for InSilicoVA ran until 9500 iterations before it stopped due to errors, thus `Nsim=9500` was used and ran successfully for all iterations.

### A.2.3 Output Data and Code Conversion

Of the 6939 input records, GPT-3.5, GPT-4, InterVA-5, and InSilicoVA were able to assign CODs for 6939 (100%), 6935 (>99%), 6830 (98%), 6830 (98%) records respectively. All 6830 (100%) InterVA-5 and InSilicoVA records with WHO VA 2016 v1.5 output codes [55] were converted into ICD-10 codes respectively. After all model outputs were converted to ICD-10 codes, they were further converted to CGHR-10 codes. The 6939 GPT-3.5 and 6935 GPT-4 output records with ICD-10 codes were converted into 6930 (>99%) and 6931 (>99) records with CGHR-10 codes, where <1% (9 and 8) records did not have matching CGHR-10 codes respectively. The 6830 InterVA-5 and InSilicoVA records with ICD-10 codes were converted into 6802 (>99%) and 6726 (98%) records with CGHR-10 codes respectively, where 28 (<1%) and 104 (1%) of records could not be converted into CGHR-10 codes.

## A.3 Performance Evaluation Details

The performance of GPT-3.5, GPT-4, InSilicoVA, and InterVA-5 models were evaluated with metrics at the population and individual level by comparing their CGHR-10 COD outputs for 6939 records to physician COD assignments. Section A.3.1 describes CSMF accuracy in detail for evaluating models on the population level, Section A.3.2 describes PCCC for evaluating models on the individual level. Records that were assigned a COD by physicians, but not by a model were considered to be an incorrect COD assignment by the model. CSMF accuracy and PCCC were calculated for each model overall and by three age groups (adult, child, and neonatal), then further into age ranges and COD for each age group.

1519 **A.3.1 Cause Specific Mortality Fraction (CSMF) Accuracy**

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1521 CSMF accuracy measures the performance of models at the population level, compar-  
 1522 ing distributions of CODs between the physicians and the models [56]. To calculate  
 1523 CSMF accuracy, we first calculate  $CSMF_j$  as is the fraction of physician or model  
 1524 records for cause  $j$ , given by dividing the number of records for cause  $j$  with the total  
 1525 number of records as seen in Equation A1. Then, the  $CSMFMaximumError$ , repre-  
 1526 senting the worst possible model, is calculated using Equation A2. Finally, the CSMF  
 1527 accuracy is given by Equation A3, where  $k$  is the number of causes,  $j$  is a cause,  
 1528  $CSMF_j^{true}$  is the true physician CSMF for cause  $j$ , and  $CSMF_j^{pred}$  is the prediction  
 1529 model CSMF for cause  $j$ . CSMF accuracy ranges from 0 to 1, where 1 means that the  
 1530 model completely matched the physician COD distribution and 0 means that it did  
 1531 not match the distribution at all.

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$$1536 \quad CSMF_j = Records_j / Records \quad (A1)$$

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$$1546 \quad CSMFMaximumError = 2(1 - \text{Min}(CSMF}_j^{true}) \quad (A2)$$

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### A.3.2 Partial Chance Corrected Concordance (PCCC)

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$$1565 \quad CSMFAccuracy = 1 - \frac{\sum_{j=1}^k |CSMF}_j^{true} - CSMF_j^{pred}|}{CSMFMaximumError} \quad (A3)$$

assignment is equal to the model COD assignment as shown in Equation A4. Higher PCCC values closer to 1 indicate that model COD assignments are similar to physician COD assignments, while values closer to 0 indicate that model COD assignments are not similar to physicians.

$$C = \frac{TP}{Records} \quad (\text{A4})$$

$$PCCC(k) = \frac{C - \frac{k}{N}}{1 - \frac{k}{N}} \quad (\text{A5})$$

## Appendix B Experiment on Repeated Runs of GPT-3.5

A short experiment was conducted to test the consistency of GPT-3.5 outputs repeated on the same record. 100 records, sampled randomly with approximately equal proportions across age groups, CODs, and survey rounds 1 and 2, were used to test repeated runs of GPT-3.5. Each record from the 100 records was rerun 10 times through GPT-3.5, resulting in ten COD outputs per record. The ICD-10 codes were then converted to CGHR-10 codes and tested for consistency, where completely inconsistent results had different ICD-10 or CGHR-10 codes for each of the 10 reruns (1 times+), and completely consistent results had the same ICD-10 or CGHR-10 code for all 10 reruns (10 times), on the same record.

The results are shown in Table B3. For all 100 records, GPT-3.5 assigns the same ICD-10 and CGHR-10 code for the same record 5 times or more out of 10. For 66 and 79 records, GPT-3.5 assigns the same ICD-10 and CGHR-10 code respectively for each record. This number increases to 94 (from 66) and 96 (from 79) when reducing the number of times out of 10 that GPT-3.5 assigns the same ICD-10 and CGHR-10 code respectively. Thus, GPT-3.5 does not always produce the same outputs when repeated on the same record (10 times out of 10), even when the temperature is set

1611 to 0, but does so for more than half the records. For most records (more than 90%),  
1612 GPT-3.5 will produce the same outputs for the same record 7 times or more out of 10.  
1613

1614

1615       **Table B3** Records with same GPT-3.5 outputs based on 10 repeated  
1616           reruns of 100 records

	Times with Same GPT-3.5 Outputs	ICD-10 Records	CGHR-10 Records
1619	1 times+ (inconsistent)	100	100
1620	2 times+	100	100
1621	3 times+	100	100
1622	4 times+	100	100
1623	5 times+	100	100
1624	6 times+	94	96
1625	7 times+	92	94
1626	8 times+	86	91
1626	9 times+	79	86
1626	10 times (consistent)	66	79

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## 1631       **Appendix C Exploration of Neonatal Infections**

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1633       An exploration of neonatal infections (n=99, 21% of 477 records) was done to under-  
1634 stand the low performance of GPT models (0.23 PCCC) for neonatal infections, and  
1635 high performance of InSilicoVA (0.87 PCCC). In Table C4, about half the records  
1636 were assigned correctly, and a majority (n=33, 33%) of the other records were mis-  
1637 classified as other, while prematurity and low birthweight, birth asphyxia & birth  
1638 trauma, and ill-defined make up the rest. On closer inspection of the 49 records with  
1639 misclassified assignments, the ICD-10 code R50 was assigned in 20 records. R50 falls  
1640 under unspecified infections in the adult CGHR-10 category, but in the other cate-  
1641 gory for neonates. B50 was assigned in 4 records, falling under malaria, but a similar  
1642 B54 falls under neonatal infections. P81 was assigned in 3 records, referring to fever  
1643 of unknown origin, which falls under other, and P07 was assigned in 7 records, falling  
1644 under prematurity and low birthweight.

1645

1646       In most misclassified records, there is mention of infections, but the misclassifica-  
1647 tions occur due to the finer details of the ICD-10 code classifications, the categorization  
1648

decisions of the CGHR-10 codes, and missing information from the questionnaire. For R50 misclassifications, GPT may have confused descriptions across adult and neonatal age groups. Using the same definition of R50, but in the context of neonates, may result in codes closer to neonatal infections (e.g. B54). For B50 misclassifications, the similar B54 was categorized in CGHR-10 as neonatal infections, but B50 was categorized as other. P81 refers to fever of unknown origin, which may be difficult to differentiate between infection and other causes without information from the questionnaire. P07 refers to prematurity and low birthweight, where GPT initially assigned P07 as the age of the neonate was mentioned first, but later mentions infections as an alternative following the order of information in the narratives. Thus, it may be possible to improve the performance GPT models using better prompts based on the context of VA manuals and CGHR-10 codes, and by also including questionnaire information in the prompts.

**Table C4** GPT-4 CGHR-10 COD assignment for physician coded neonatal infections records.

GPT-4 Assigned Cause of Death (CGHR-10)	Records
Neonatal infections	50 (51%)
Other	33 (33%)
Prematurity and low birthweight	9 (9%)
Birth asphyxia & birth trauma	5 (6%)
Ill-defined	2 (2%)
Total	99 (100%)

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