

Appendix 1. Additional quotations

Key theme	Quotation
<i>Consent</i>	<p data-bbox="1090 373 1910 675"><i>It's really important that only eye patients know that when you go under the knife, although the risk is very small, there is a risk you will end up totally blind. We actually have to articulate it in those words. We're advised against using words like loss of vision, because loss of vision to one person might be one line on the chart, loss of vision for another person might be total. The issue is you have to communicate what the material risk is. If the material risk is blindness, you have to communicate it. We have to articulate total extinction of vision, and I think that's absolutely right and very important. (P1)</i></p> <p data-bbox="1090 679 1120 699">**</p> <p data-bbox="1090 715 1910 911"><i>We need to give them the information they need to make a decision for themselves. Therefore one of the things I do in clinic, the eye you are going to operate on, the only eye, you cover it, so you show the patient what it means. If a catastrophic complication happened, what would that mean for the patients' vision? It means that they won't be able to see anything. (P4)</i></p>
<i>Strategies for risk reduction</i>	<p data-bbox="1090 952 1910 1050"><i>I just think one step at a time. People have talked about this, sporting professionals in particular, positive imagery, so they think about how it would feel to score a goal, that kind of thing. (P7)</i></p> <p data-bbox="1090 1054 1120 1074">**</p> <p data-bbox="1090 1090 1910 1286"><i>I think if you throw any two surgeons together, it might not work. There has to be a high level of trust and respect. You have to be happy to admit your own failings in front of the other person. It's quite an intimate relationship, really, and not something that happens easily. There is a danger, two surgeons can become more brave and foolhardy than one surgeon, and almost be more reluctant to say, no,</i></p>

I don't think we should do that. It's too risky. There can be this bravado kick in. That can be dangerous for patients. (P10)

I'll see them sooner, often at the next clinic I can. If the [intraocular] pressure is fine, they can go. I'd probably want to see them myself in clinic. (P6)

Training

One of the things that generally is consultant only is only eye [surgery]. I think we try to protect our trainees as much as possible. But there has to be a tipping point where they're going to have to deal with it at some stage. (P2)

What you do not want is get to the end of your training, become a consultant, and then all of a sudden be tasked to operate on one of those cases. (P7)

Only eyes get delegated to the most senior surgeon on the list, and I think rightly so, because although the risks for only eye are identical to any other eye, the risks to the patient are much greater, so it does influence who gets the case, and it's certainly not a trainee if it's an only eye. (P7)

Mentorship

Something that's very important for only eye procedures is that we debrief at the end of the session. I commend people on how supportive they were if they've been supportive and if they haven't I try to find out why. That strengthens the mutual support (P5)
