Supplementary table 1. Ethical Questions Provided to Stakeholders

List of questions we seek answers for by the end of the afternoon session:
What factors govern the ethics of immediately sequential bilateral cataract surgery (ISBCS) for bilateral visually significant cataract in adults?
Should the same ethics apply for bilateral laser refractive surgery, lid surgery, squint surgery, retinal detachment surgery, and intravitreal injections for wet age-related macular degeneration (AMD) which are done on the same day most of the time? AMD injections bear a higher risk of endophthalmitis, but two wrongs do not make it right.
What further evidence do we need to declare ISBCS no less safe than delayed sequential surgery or otherwise?
Should ISBCS prove to be overall better (convenience for patients carers and hospitals, more rapid visual recovery, benefit to health economy) and no less safe than delayed sequential surgery, does ethics govern that we should broaden the use of this method of delivery?
Should patients be given a choice: to decline ISBCS if offered? to have ISBCS if not practiced by their consultant / at their local unit?
How do we ensure patients receive correct information from doctors, the media and their friends and relatives so they are not scared off ISBCS or get lured into ISBCS with risks exaggerated or played down respectively?
Is it ethical for surgeons to decide themselves without giving this option to the patients?
Further is it ethical for surgeons to unconsciously exaggerate the risk of ISCBS because of being reluctant to think or do different than routine? Equally, is it ethical for surgeons to decide on behalf of their patients that a small risk of bilateral blindness for individuals is worth taking to save the health service money and make it run more efficiently / conveniently?
The only valid risk of ISCBS is bilateral endophthalmitis. The risk is very low. We know that there is nothing in the life without risk. Is it rational to avoid benefits of ISCBS because very unlikely risk of bilateral endophthalmitis, the risk of which is unlikely to be different from delayed sequential surgery? Remember first eye endophthalmitis can put a patient off second eye cataract surgery so beneficial surgery is delayed or never done.
How should doctors and commissioners balance the interests of the individual patients, public health, and societal interests given limited resources?
As it is the public who pay, should they be the ones who call the tune?
What ethics govern good for the many and harm to the tiniest minority?
How should we judge between option A with a little more safety with higher cost and discomfort and option B with saving money and being more comfortable with higher risk (real or perceived)? How can we determine the level of risk that we should not exceed for any operation?
Given the improved safety of cataract surgery, should ISBCS remain a taboo subject? If not how do we de-stigmatize it?

We are already using three strategies to improve safety: • Exclusion of high-risk eyes • Not to proceed with second eye surgery if first eye surgery lengthy or complicated • Re-scrubbing, re-draping and using new instrument sets and products from different manufacturers or bear different batch numbers What else can be done to make ISBCS even safer?
How should we decide which surgeons and units are good enough to offer ISBCS?
How do we maintain standards should ISBCS become common practice?
We have identified the following areas for research: • Patient experience in ISBCS and delayed sequential including psychology and fear, actual pathway on the day, postop discomfort and care • Surgeon and service experience including financial savings • Streamlining theatre staff preparations What other areas would you suggest?

Supplementary table 2. Stakeholder Quotations

Themes and Subthemes	Stakeholder Quotations
1. Beneficence and Non-Maleficence	
1.1 Patient Benefits	• *"Again, I see people that have had one done, the frustration where they haven't had their (second) eye done, they can't get the glasses, they have a lot of imbalance. And of course for me, the imbalance would have been very difficult for me to work."* Patient and nurse • *"In fact, more often I have patients, before I even raise the subject, they are begging me – 'please, will you do both on the same day', one said 'I can't face the journey', another said 'my husband has got dementia and I've got to arrange care, I'm not going to be able to cope to do it twice.'"* Ophthalmologist
1.2 Patient Risks	• *"Although intuitively, we feel it ought to make a difference, one would want to have strong evidence that there was a benefit from the ability to choose a second lens".* Ophthalmologist and Public Health Ophthalmologist

	• *"it's just a practicality, I think it can be quite unpleasant and difficult for the patient to deal with"* Ophthalmologist • *"You obviously have to take extreme precautions before you do it. So I'm not saying it's strict liability. But I do say that the issues of patient selection and technical performance will be very challenging if you have a problem."* Lawyer
1.3 The Uncertainty of Risk	• *"So that's the sort of level of evidence that you're likely to get, but that's only one hundred thousand patients, we almost need one hundred million patients to really tell us what the risk is of having bilateral infections."* Ophthalmologist and Public Health Ophthalmologist • *"If you've got an antibiotic resistant germ on your skin it will be in both eyes, if you open both eyes the risk is now become one in thousand. If you said the risk is one a thousand, and you say you're doing two eyes, you can either say that's one in two thousand or one in a million, and you can't really justify which those two figures you're using."* Ophthalmologist
1.4 Patient Interpretation of the Risk-benefit Analysis	• *"I don't think personally we can actually make that judgment for other people, we have to present as best the limited information we have and say what do you want."* Ophthalmologist • *"When we talk to individuals on a routine one eye patient basis, we say its roughly 1 in 1000 chance you will lose your sight, nobody ever believes that will happen to them."* Ophthalmologist • *"So the percentage of harm happening is perhaps the same, but the hazard or the severity of what will happen if a risk does occur, if the*

	probability goes the wrong way, and these things is very important." Bioethicist and Political Philosopher
2. Autonomy	
2.1 Informed Consent	• *"Consent is not just a consent, it has to be an informed consent. So if we involve the patient in all the scenario of the operation and give them the information, enough to make a firm decision then this from my point of view will be enough for the patient to make a decision whether to go ahead or to choose just one eye."* Ophthalmologist of Muslim faith • *"Now to me this (ISBCS) is a realistic and valid option, which some patients might not wish, but it is an option, and I think to withhold it is incorrect."* Ophthalmologist
2.2 The Barriers to Communication	• *"One of the challenges is, how you deliver enough information for people to give informed consent, it's a really complicated area for clinicians, with lots of different risks and hazards to consider, and I can't pitch at how you could communicate that in a satisfactory way, to make a truly informed objective decision from a patient perspective."* Optometrist • *"So you've got to find a way with people who are semi-literate, who don't share the same language as the doctor, about all of the range of options that you could be offering them, including the ones that you are not offering them. And you have to do that in a way that records their understanding."* Lawyer
3. Distributive Justice	

3.1 The Allocation of Resources: The Individual *vs* the Collective	• *"There is a probable cost-saving to the NHS and there is a resource reduction, what we didn't do is set against that the what if we blind the patient"* Ophthalmologist • *"And I think that's something we should change and try and expand it, so it's more performed more routinely, or offered more routinely to patients, because of this this reason we have to realise that we are sharing resources"* Ophthalmologist and Ethicist • *"We want doctors that fight from the individual patient and someone higher up telling them you're right but we can't do it because we care for the system."* Rabbi • *"This brings in really the ethics of I think what everyone has boiled up to the surface of this brew, which is the individual and individual choice."* Ophthalmologist and Ethicist