Appendix 1. Interview guide

- Can you tell us a little about yourself, such as your position, how long you've been working as a surgeon, and what your work entails?
- Have you experienced making mistakes or errors in judgment in your job as a surgeon?
- Do you remember what the first mistake or error in judgment was?
- How do you feel about being open about mistakes and adverse events with colleagues?
- Who, for example, immediate supervisors, experienced colleagues, less experienced colleagues, or others, do you find it easiest to be open with?
- Have you heard other colleagues talk about difficult situations and their own mistakes?
- Why do you think it can be difficult for some, especially within the field of surgery, to openly discuss their own and others' mistakes?
- Can you tell us a little about what usually happens following a serious adverse event?
- After a serious adverse event, is it routine to contact and inform the patient/family about what happened?
- Can you talk about your experiences regarding being open about mistakes and adverse events with patients and/or family members?
- Do you have examples of specific changes in routines and procedures that have resulted from and in the aftermath of an adverse event?
- How can mistakes you've made affect your work after the adverse event?
- How has it affected your confidence in performing your job in similar situations afterward?
- Have experiences you've gained as a surgeon affected other aspects of your life outside of work?
- In what ways have experiences you've gained as a surgeon affected collegial relationships and communication?
- To what extent have you experienced support from colleagues when you've been involved in an adverse event?
- What type of mental competence do you consider crucial for you to be able to have/do the job you have/do?
- Have you been offered any form of training or education in coping strategies or tips for handling serious adverse events during your career?
- Can you say something about what you believe should be given more emphasis in the follow-up of healthcare personnel after a serious adverse event?
- What disadvantages can there be in reporting an adverse event?
- Have you ever thought that you should have reported something and refrained from doing so?
- During your career, have you encountered/worked with colleagues whom you've thought should not work as surgeons?

- How do you understand the term "foreseeable risk"?
- Can you say something about which factors you consider central to contributing to reducing the incidence of patient harm in surgery?
- What disadvantages and advantages do you experience with checklists?
- Do you use the Safe Surgery checklist? If yes, is this by your own initiative or mandatory in the department? If not, why?
- If yes, are there any parts of the Safe Surgery checklist that you think are more important than others? If so, what, and why?
- If you or your close relatives were to undergo surgery, would you want this checklist to be used?
- What are your experiences with external assessment after serious adverse events?
- Have you experienced any of the cases you've been involved in being picked up by the media?
- How do you feel the regulatory; external inspection authorities involve you and your colleagues in their processes?
- What, if any, learning benefits have there been from external inspection, in your opinion?
- Looking ahead, what changes do you think should occur, at the system level, management level, and individual level, to promote greater openness about mistakes among your colleagues?
- Closing comment: Is there anything you think is important to mention or say that we haven't discussed?