**Materials and Methods**

This study was approved by the Queensland University of Technology (QUT) Human Research Ethics Committee (approval No.: 1400000807). The trial was prospectively registered with the Australian and New Zealand Clinical Trials Registry (registration No.: ACTRN12616000989448). All participants provided written informed consent.

Data were obtained as part of the randomized controlled trial that compared the sensitivity and specificity of mobile teledermoscopy-enhanced SSE (*n* = 99) with naked-eye SSE (*n* = 101). The detailed methodology of the trial has been reported previously [9]. Naked-eye SSE was defined as an individual examining themselves for signs of early skin cancer without use of examination aids except a mirror or partner to look at hard-to-see areas while mobile teledermoscopy-enhanced SSE was defined as a store-and-forward system for sending images of skin lesions suspicious for skin cancer to a doctor. Recruitment for this trial was conducted from March 2017 to June 2018. Participants were eligible if they had at least 2 skin cancer risk factors as self-reported in the eligibility survey. These included light skin complexion and fair hair, skin that never or rarely tans, and always or mostly burns, a family history of melanoma or a personal history of skin cancer, or many naevi, and residing in Queensland. Participants were enrolled in 4 phases to accommodate the reuse of study dermatoscopes by subsequent participants. Participants in both groups were asked to complete whole-body home SSEs at baseline, 1 and 2 months later. Participants were provided with instructions on (i) how to conduct a whole-body clinical skin examination and (ii) how to detect a lesion suspicious for skin cancer. At the end of their involvement with the study, all participants underwent a clinical skin examination by a dermatologist in person and at that time completed an exit interview, which provided data for the present analysis. As qualitative data collection is commonly done until saturation is achieved, the interview guide was devoted to particular topics of interest and then changed to a new topic once no new themes or topics arose. The data used here were collected from interviews of study participants that specifically focused on their opinions of the different settings of mobile teledermoscopy, the patient-doctor relationship and their skin screening behaviours.

The audio-recorded interview was conducted by a research assistant according to a semi-structured format developed by the investigators. We first asked questions about previous clinical skin examinations conducted by a medical professional including frequency of examinations, type of medical professional and place of examinations and whether they visited the same medical professional each time. Participants were then provided with direct-to-consumer and doctor-to-doctor scenarios whereby mobile teledermoscopy could be used. Due to demand for clinical skin examinations in Australia, people can visit either a general practitioner (GP), a skin cancer clinic which has GPs who have additional training in skin cancer medicine or a board-certified dermatologist of the Australasian College of Dermatologists. GPs conduct many clinical skin examinations particularly in regional and rural areas. Skin cancer clinics with GPs who have additional training in skin cancer medicine are also common in Australia.

### Doctor-to-Doctor Setting

We explored participants’ views on the referral/triage doctor-to-doctor setting. We explained that in this setting, a GP would send images of patients' suspicious lesions to a dermatologist. If the lesion appears suspicious, the dermatology referral and appointment could be expedited. If the lesion is considered benign by the dermatologist, then the patient could avoid visiting a dermatologist. If the lesion is suspicious, then prioritised appointments could be provided to reduce waiting times.

### Direct-to-Consumer Setting

The direct-to-consumer setting involved two scenarios: (i) the patient sending photos of doctor-identified suspicious lesions to monitor changes over time; or (ii) the patient self-selecting lesions suspicious for skin cancer at home for remote diagnosis by a teledermatologist.

### Analysis

We used descriptive statistics to summarise participant demographic details and calculated counts and percentages for yes/no/unsure interview responses. All interviews were tape-recorded and transcribed verbatim. Each interview transcript was independently read and reread to facilitate thematic analysis by two researchers (C.H. and F.K.). During the scoping process, potential codes were developed inductively to create overarching concepts. Themes were extracted by each reader individually and then compared to assess and report key and recurrent ideas. Other patient opinions or comments that were notable and did not fit within a theme were also collected.