

Parental Experiences of Anesthesia Consent for Children with Retinoblastoma Undergoing Ophthalmologic Examinations under Anesthesia: A Qualitative Interview Study

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Abstract:

Objective: This study explored parents' experiences in providing anesthesia consent for their children undergoing ophthalmologic examinations under anesthesia (EUA).

Material and Methods: This qualitative interview study employed a descriptive phenomenological approach using Colaizzi's method of content analysis. Participants were parents of children with retinoblastoma who had undergone at least one EUA at Srinagarind Hospital, Faculty of Medicine, Khon Kaen University, selected through purposive sampling. Data collection took place from August 22 to November 14, 2024.

Results: In-depth interviews with fourteen parents of children with retinoblastoma revealed varied responses to the anesthesia informed consent process. Although all parents received the necessary information, only half fully understood it. Most parents experienced fear and anxiety, while some felt reassured. The majority understood the information but felt compelled to sign the consent form. Nearly all parents viewed consent as compulsory and trusted the medical team, yet continued to experience fear and anxiety after providing consent. However, most did not engage in discussions with the anesthesia team.

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Conclusion: Parents of children with retinoblastoma experience anxiety, fear, and sometimes relief throughout the anesthesia informed consent process for EUA. Healthcare professionals should provide comprehensive information and sufficient time for parents, fostering trust and confidence in their child's care.

Keywords: anesthesia, child, consent forms, qualitative research, parents, perception

Introduction

Retinoblastoma is a rare but potentially life-threatening eye cancer that primarily affects children under five years old¹. It has a relatively stable global incidence of approximately 1 in 18,000 to 1 in 20,000 live births². Childhood retinoblastoma mortality rates are 40–70% in Asia and Africa, compared to 3–5% in high-income countries, primarily due to delayed diagnosis and insufficient treatment³. This malignant intraocular tumor poses significant risks to young children, making early detection and prompt treatment critical for improving survival outcomes³. Advancements in treatment, including systemic chemotherapy, cryotherapy, laser photocoagulation, and selective use of radiotherapy, have improved survival rates and reduced the need for enucleation. Nonetheless, these therapies are associated with complications such as retinal damage, secondary cancers, and ocular side effects⁴.

Most pediatric patients with retinoblastoma require repeated ophthalmologic examinations under anesthesia (EUA) because young children are unable to cooperate during comprehensive eye exams⁵. These procedures carry risks at each step and cause significant emotional and physical stress for children and their caregivers⁶. Repeated anesthesia exposure can worsen behavioral difficulties, increasing trauma for both children and their families⁷. Parents of children requiring surgery under general anesthesia (GA) often experience significant worry and stress⁸. Additionally, parents of children with retinoblastoma are more likely to report severe fatigue, anxiety, and depression⁹. Thus, parental experiences with anesthesia

consent for children with retinoblastoma may differ from those of parents whose children have other diseases.

From 2019 to 2022, 178 pediatric retinoblastoma patients at Srinagarind Hospital underwent EUA. There are no previous data on parental experiences with anesthesia consent for retinoblastoma at our institution. Therefore, this study assessed parents' experiences, perceptions, and understanding of the informed consent process for GA in children with retinoblastoma. The findings from this study will help assess the accuracy and extent of parental comprehension of anesthesia consent, guide efforts to enhance communication practices, improve patient safety, and further integrate family-centered care principles into clinical practice.

Material and Methods

This qualitative interview study uses a descriptive phenomenological approach based on Husserl's philosophy¹⁰. Ethical approval was obtained from Khon Kaen University's Human Research Ethics Committee (HE671309), and the study was registered in the Thai Clinical Trial Registry (TCTR20240810006) prior to commencement. The study was conducted from August 22 to November 14, 2024 at Srinagarind Hospital, Faculty of Medicine, Khon Kaen University. Reporting was conducted in accordance with the Standards for Reporting Qualitative Research (SRQR), following the EQUATOR Network guidelines to ensure comprehensive and transparent disclosure (Supplementary Table 1).

Patient population

We included parents of pediatric patients aged 0–15 years with retinoblastoma who underwent at least one EUA at Srinagarind Hospital, Faculty of Medicine, Khon Kaen University, as either outpatients or inpatients. Eligible parents were able to communicate in Thai, share their experiences, and willing to participate. A certified registered nurse anesthetist (CRNA) specializing in pediatric and ophthalmology anesthesia, who was not assigned to the operating room during data collection, identified eligible parents in the area and employed purposive sampling for this study. Data were collected through in-depth individual interviews, which continued until data saturation was achieved.

Data collection

Research tools

In this qualitative study, the research team (consisting of CRNAs, staff anesthesiologists, and nursing faculty with expertise in qualitative research) served as the primary instrument for data collection. The tools, developed from literature and validated by experts, included a demographic form, an open-ended interview guide, field notes, and a voice recorder.

The demographic form collected parental characteristics (gender, age, marital status, level of education, occupation, family type, number of family members, and family income) and child characteristics (gender, age, length of hospital stay, prior general anesthesia experience, and healthcare entitlement).

The interview guide (refined through expert input) included open-ended questions exploring parental experiences. Individual interviews lasted 30–45 minutes and continued until data saturation, with the main questions as follows:

- Can you describe your experience with consent forms for GA when your child needed surgery for

retinoblastoma or another condition requiring an operation under GA?

- How do you manage the care of a child with retinoblastoma who needs GA? Did you notice any unusual symptoms, and how did you respond? Did your child have other symptoms?

- How did you feel when your child needed GA for surgery? How did you handle the situation, including the GA consent form, and what are your reflections on that experience?

- What are your opinions or beliefs about EUA for children with retinoblastoma?

- Is there anything else you would like to share or discuss, including the consent form for GA?

Field notes documented nonverbal cues and interview context. All sessions were audio-recorded to ensure accurate transcription and analysis, and interviews were conducted in private rooms to maintain confidentiality and encourage participant openness.

Data collection process

After receiving approval from Khon Kaen University's Human Research Ethics Committee, the researcher reviewed qualitative methods and interview questions before collecting data. Key informants were selected using specific criteria to ensure they could offer relevant experiences and were willing to participate. Parents were fully informed about the study, and consent was obtained after their child had undergone EUA with GA and had recovered safely. Interviews were conducted in private rooms to ensure confidentiality: outpatients were interviewed in a private consultation room, and inpatients in a private ward room. Data collection continued until saturation was reached, with each interview lasting 30–45 minutes. Information was gathered through interviews and field notes, and all sessions were audio recorded.

Statistical analysis

Experiences of parents of children with retinoblastoma regarding EUA were analyzed using Colaizzi's content analysis method¹¹. Data were continuously verified with key informants during the collection phase. Following data collection, interviews were transcribed verbatim and meticulously reviewed to capture participants' thoughts, feelings, and experiences. Transcripts were examined to identify significant statements and recurring themes. Key points were extracted, categorized, and summarized. Core themes and concepts were analyzed and integrated with relevant theoretical frameworks, with conclusions supported by examples. Finally, findings were validated with informants to ensure accuracy and reliability.

Results

Interviews and data collection continued until saturation was reached. We analyzed data from 14 parents of pediatric patients with retinoblastoma who had undergone at least one EUA.

Parental characteristics

All participants were mothers of children undergoing EUA. Most were in their thirties and represented a range of educational and occupational backgrounds. The majority lived in extended families, with a mean monthly family income of 24,786 baht (Table 1).

Child characteristics

The children were predominantly male with a mean age of 1.7 years. They had undergone GA an average of 3.4 times and typically stayed in the hospital for one day per visit. Most were covered by Thailand's universal coverage scheme (gold card) (Table 1).

Parental experience

The study found that all parents received the

essential information required for informed consent, including the anesthetic process, anesthesia methods and choices, risks and benefits of each, potential perioperative risks and management, and pre-anesthetic preparation such as fasting times; however, only half fully understood this information. Nearly two-thirds experienced fear and anxiety after receiving the information. More than half of the parents understood the information but felt compelled to sign the consent form. Nearly all parents perceived consent as compulsory, and a similar proportion had confidence in the anesthesiology team, the attending physician, and the hospital's reputation, which were key factors influencing their decision to provide consent. Despite this, after providing consent, almost all parents continued to experience fear and anxiety. Furthermore, most parents did not engage in discussion or ask questions when communicating with the anesthesia team (Table 2).

Exploring parents' experiences, perceptions, and understanding of the informed consent process for GA

This section presents the results of the study on the experiences of parents of retinoblastoma patients in providing anesthesia consent for their children to undergo EUA. The findings are organized into four main topics: (1) essential information for anesthesia consent and its impact on parents, (2) parents' understanding and willingness to provide consent, (3) consequences after providing consent, and (4) communication with the anesthesia team.

1) Essential information for anesthesia consent and its impact on parents

Medical information provided by the anesthesia team was often perceived as serious or frightening, especially when highlighting possible complications or worst-case scenarios related to EUA. Many parents experienced stress and uncertainty due to the emphasis on high-risk situations

and multiple choices, which intensified their worries about potential consequences and made selecting the best option more distressing.

“The anesthesiologist explained the risks of anesthesia, which increased my worry because my child is so young. I was especially afraid my child might not wake up after the procedure.”

Although parents experienced significant anxiety, none refused to sign the consent for their child’s EUA.

“At each visit, the anesthesiologist explained the procedure and available options. As my child was too young to cooperate for an EUA, GA was required. I was initially anxious about providing consent, but as I came to understand its necessity, my concerns decreased.”

Table 1 Parental and child characteristics (N=14)

Variables	n (%)
Parental characteristics	
Gender	
Female	14 (100)
Age (years, mean (S.D.), min-max)	34.4 (4.2), 27-40
Marital status	
Single	1 (7.1)
Married	11 (78.6)
Divorce/Separated	2 (14.3)
Level of education	
Primary school	1 (7.1)
Junior high school	3 (21.4)
Senior high school	1 (7.1)
Vocational certificate	3 (21.4)
Bachelor’s degree	4 (28.6)
Above bachelor’s degree	2 (14.3)
Occupation	
Freelancer	6 (42.9)
Office worker	3 (21.4)
Merchant	3 (21.4)
Housewife	2 (14.3)
Family type	
Nuclear family	4 (28.6)
Extended family	10 (71.4)
Number of family members (persons, mean (S.D.), min-max)	5 (1), 4-7
Family income (Baht/month, mean (S.D.), min-max)	24,786 (10,245), 8,000-40,000
Child characteristics	
Gender	
Male	9 (64.3)
Female	5 (35.7)
Age (years, mean (S.D.), min-max)	1.7 (1.1), 0.3-3.7
Length of hospital stay (days)	1
Number of previous general anesthesia procedures (mean (S.D.), min-max)	3.4 (1.8), 1-7
Healthcare entitlement	
Universal coverage scheme (gold card)	12 (85.7)
Direct payment	2 (14.3)

Table 2 Parental experiences of anesthesia consent for children with retinoblastoma undergoing ophthalmologic examinations under anesthesia (N=14)

Parental experience	n (%)
1. Acknowledgement of essential information for informed consent	
Information received and fully understood	7 (50.0)
Information received but not understood	7 (50.0)
2. Emotional impact on parents	
Experienced fear and anxiety	9 (64.3)
Felt at ease, without fear or anxiety	5 (35.7)
3. Parental understanding and willingness to provide consent	
Understood and willingly signed consent	3 (21.4)
Understood but felt compelled to sign consent	8 (57.1)
Did not understand and felt compelled to sign consent	3 (21.4)
4. Parental perceptions of the meaning of consent	
To protect medical personnel	3 (21.4)
A matter of feeling compelled	10 (71.4)
Recognition and respect for the patient's rights	1 (7.1)
5. Factors influencing consent decisions	
Confidence in the anesthesia team, attending physician, and hospital reputation	10 (71.4)
Previous experience	4 (28.6)
6. Consequences after providing consent	
Experienced fear and anxiety	10 (71.4)
Felt at ease	4 (28.6)
7. Communication with the anesthesia team	
Engaged in discussion and asked questions	4 (28.6)
Did not engage in discussion or ask questions	10 (71.4)

2) Parents' understanding and willingness to provide consent

All parents provided consent. Most felt compelled to do so despite understanding the process. The study categorized parental perceptions of consent for their child's EUA into two types: protecting medical personnel and feeling compelled to act.

To protect medical personnel

Parents viewed the consent form as an official document primarily offering legal protection to the doctor and anesthesia team. They believed that by signing it, they waived the right to hold the medical team accountable for any incidents or errors during anesthesia that might affect their child.

"I understood the consent form was mainly to protect the doctor and hospital staff, so if something unexpected happened, they would not be held responsible."

Feeling compelled

Parents reported that they felt compelled to sign consent for their child's EUA, as they had no real alternative, and refusing would mean their child could not receive the examination or necessary treatment.

"I had to sign because I wanted my child to get the examination and treatment. Without my consent, my child wouldn't receive care, so I felt I had no choice."

Informants stated that clear information from the anesthesia team and healthcare staff was essential to the consent process. Parents who received information from the

anesthesia team had varying perceptions. Most understood that signing a consent form was required for their child's EUA. However, the anesthesia team often did not fully explain the consent form, its benefits, or risks. Parents also felt they had insufficient opportunity to ask questions about their concerns.

"The doctor explained the anesthesia and risks, but I don't recall the details. I was worried my child might go blind and wanted the procedure done quickly, so I didn't ask further questions."

Moreover, the study found that parental consent was primarily influenced by trust in the anesthesia team, the attending physician, as well as confidence in the hospital's reputation and previous experience with similar procedures.

Confidence in the anesthesia team, attending physician, and hospital reputation

Parental trust in the anesthesia team, attending physician, and the hospital's reputation was a key factor in their decision to consent to an EUA for their child. This trust, based on perceived expertise and experience, reassured parents about safety and quality of care, increasing their willingness to proceed.

"At the time, I was focused on completing the examination and signing the consent form. After consenting to anesthesia for my child, I felt reassured because I trusted the doctor to take good care of my child."

Previous experience

Parents with previous experience signing anesthesia consent for themselves, a spouse, or their child made quicker and more confident decisions. Familiarity with the process reduced their anxiety and fear, as they understood it was a routine part of medical care. This experience increased their trust and comfort in consenting to GA for their child.

"I understood the procedure because the doctor and nurses clearly explained the anesthesia options. My own past experience with anesthesia helped me grasp the necessity of signing the consent form for my child's surgery."

3) Consequences after providing consent

Signing the consent form for GA gave parents relief and hope by enabling timely diagnosis and treatment, and reassured healthcare providers. However, parents also worried about possible side effects and rare complications from GA.

Positive consequence

Many parents felt relief and happiness after signing the anesthesia consent, as it meant their child would receive appropriate care, and they were hopeful it would lead to better health outcomes.

"Parents are hopeful their child will receive the best possible examination and treatment, leading to recovery. After signing the consent form this time, there are no major concerns, as I have previously given consent for anesthesia."

Negative consequence

After signing the anesthesia consent form, many parents reported fear and anxiety, particularly about any potential complications of GA and possible harm during or after the procedure. They were also concerned that any negative outcome could be irreversible and, having already given consent, feared they might be unable to seek accountability for adverse events.

"After signing the anesthesia consent, I still worried that the endotracheal tube might injure my child's airway or cause an adverse reaction to anesthesia."

4) Communication with the anesthesia team

Empathetic, two-way communication with the anesthesia team that allows sufficient time, including clear explanations and opportunities for questions, is essential for building trust and confidence during consent. Open dialogue helps parents feel informed, reassured, and engaged in decision-making.

“The doctor explained that anesthesia was necessary for my young child because they couldn’t stay still. Initially anxious about signing the consent, I realized its necessity and became less worried over time.”

Discussion

This study analyzed the experiences of fourteen parents of children with retinoblastoma regarding the process of signing anesthesia consent for their child’s EUA. In-depth interviews showed that parental understanding of the anesthesia informed consent process varied, with some parents understanding the information while others did not, but all parents received the essential information required for informed consent. Most parents experienced fear and anxiety, while some felt reassured. The majority understood the information but felt compelled to sign the consent form. Nearly all parents viewed consent as compulsory, trusted the medical team, yet continued to experience fear and anxiety after providing consent. However, most did not ask any questions or engage in discussions with the anesthesia team.

After their child safely recovered from EUA under GA, parents were fully informed about the study, and consent was obtained to let them experience the consent process. This assessed parents’ experiences, perceptions, and understanding of informed consent for GA in children with retinoblastoma. Interviews were conducted in private rooms to ensure confidentiality and promote participant openness⁸.

Parental knowledge of retinoblastoma and related procedures is typically moderate and strongly linked to educational background¹². Parents’ understanding and emotional responses, such as anxiety and confusion, significantly affect decision-making regarding their child’s care¹². In this study, over half of the parents had an education level below a bachelor’s degree, with most experiencing fear and anxiety. Additionally, more than half of the parents understood the consent process but signed consent forms under pressure, indicating that ongoing emotional distress and limited knowledge continue to negatively affect informed consent and care decisions.

Parents experienced a range of emotions, from relief to anxiety, but consistently valued clear information and involvement in decisions about their child’s care. Transparent communication from the anesthesia team helps parents feel safer and more confident^{8,13,14}. To reduce anxiety, providers should address family needs by sharing information and, when appropriate, permitting parental presence during anesthesia induction⁸. In our study, most parents did not engage in discussion or ask questions during consultation with the anesthesia team, likely reflecting a high level of trust in the medical staff and the hospital’s reputation; however, many still felt compelled to sign consent forms^{13,14}. This highlights the importance of active communication to ensure that consent is genuinely informed, not just based on trust^{13,14}. Our hospital allows all parents to accompany their child into the operating theatre to initiate the induction of anesthesia, promoting transparency and active parental involvement⁸.

Informed consent from the patient or legal representative is required before invasive procedures like anesthesia or surgery to protect rights and avoid legal issues¹⁵. However, in pediatric anesthesia, parents often feel coerced or without alternatives because they trust the medical team to provide the best treatment for their child^{13,14}.

Moreover, prior studies have reported that explanations of the risks and procedures involved in informed consent are frequently insufficient^{13–15}. Clear, complete, and understandable information is essential for meaningful consent^{8,15}. Consistent with this, our study found that most parents perceived consent as a compulsory formality intended primarily to protect medical personnel, rather than as a process supporting informed decision-making.

Previous studies indicate that preoperative information can reduce or increase parental anxiety depending on the context and communication method, highlighting the need to tailor information to each family's needs^{16–18}. In our study, most parents experienced fear and anxiety after consenting to anesthesia, often due to the emphasis on high risks or limited time to decide, which increased perceived pressure. However, some parents felt relieved when they understood the reasons, benefits, drawbacks, and potential advantages of the procedure, suggesting that clear, balanced communication can help alleviate anxiety in certain situations.

The study summarized parents' experiences, perceptions, and understanding of the informed consent process for GA into four themes: (1) misunderstanding of the reason for consent, viewing it as a formality (an official document offering legal protection to the doctor and anesthesia team), leading to feeling compelled rather than informed decision-making; (2) lack of understanding of explanations, due to poor recall of risks, benefits, and procedural details, compounded by fear and worry for their child; (3) parental anxiety, heightened by preoperative worries and uncertainty; and (4) barriers to asking questions, stemming from trust and confidence in the medical team, intimidation, or time constraints.

Recommendations to improve the consent process for EUA under GA^{8,13,14,16–18}

Based on the study's findings, the following

recommendations are proposed to enhance the anesthesia consent process for children undergoing EUA:

Clear and understandable information: Utilize simple, clear language to ensure parents fully comprehend the information, avoiding medical terminology that might cause confusion.

Avoid information overload: Provide only relevant and essential information to prevent overwhelming parents, reducing confusion and anxiety.

Consistent communication: Ensure all medical team members communicate consistently to avoid contradictions that could increase parental anxiety.

Demonstrate empathy and build trust: An empathetic approach by the anesthesia team helps alleviate anxiety and fosters trust, making the consent process more effective.

Allow sufficient time: Provide parents ample time to process information and make an informed decision without feeling rushed or pressured.

Encourage two-way communication: Enable parents to ask questions and actively participate in the conversation, helping them feel heard and confident in their decision.

Collaborative consent: Involving both parents and family members, as well as the medical team, in shared decision-making reduces parental stress and boosts confidence in care decisions.

Implementing strategies such as clear communication, empathy, allowing sufficient time, and fostering collaborative consent makes the anesthesia consent process more effective, decreases parental anxiety, and improves overall patient care.

The main limitation of this study is that it describes the types of experiences observed without evaluating long-term outcomes. Additionally, the single-center design limits the generalizability of the findings. Future research should employ multicenter designs and longitudinal approaches to

replicate these experiences and more accurately assess their lasting effects.

Conclusion

Parents of children with retinoblastoma experience anxiety, fear, and sometimes relief throughout the anesthesia informed consent process for EUA. Clear communication, empathy, and adequate time are essential to ensure informed decision-making. Healthcare professionals should provide comprehensive information and sufficient time for parents, fostering trust and confidence in their child's care.

IRB number

This study was approved by the Human Research Ethics Committee of Khon Kaen University in Thailand (HE671309).

Clinical trial registration number

This study was registered with the Thai Clinical Trials Registry (TCTR20240810006) on August 10, 2024.

Data availability

The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

Author contributions

Sutida Boonkamjad: Conceptualization, methodology, data curation, formal analysis, investigation, resources, project administration, validation, writing – original draft, writing – review & editing, and final approval of the manuscript.

Kholid Karunan: Conceptualization, Methodology, Formal analysis, Investigation, Project administration, Supervision, and final approval of the manuscript.

Darunee Sripadungkul: Conceptualization,

methodology, data curation, formal analysis, investigation, resources, project administration, supervision, visualization, writing—original draft, writing—review and editing, and final approval of the manuscript.

Kotchakron Palachewa: Conceptualization, data curation, methodology, validation, and final approval of the manuscript.

Laksanawadee Chairatana: Conceptualization, data curation, methodology, validation, and final approval of the manuscript.

Declarations

Artificial intelligence-based software (Perplexity) was used solely for grammar and language editing. Professional language editors at the Language Institute of Khon Kaen University also reviewed the final manuscript. No artificial intelligence tools were used for data analysis, content generation, or interpretation. The authors remain fully responsible for the accuracy and scientific content.

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Conflict of interest

All authors have no conflict of interest.

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Supplementary Table 1 Standards for Reporting Qualitative Research (SRQR)^a

No	Topic	Items	Page No
Title and abstract			
S1	Title	Concise description of the nature and topic of the study. Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
S2	Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	1
Introduction			
S3	Problem formulation	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	2–3
S4	Purpose or research question	Purpose of the study and specific objectives or questions	3
Methods			
S5	Qualitative approach and research paradigm	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale ^b	3
S6	Researcher characteristics and reflexivity	Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	3
S7	Context	Setting/site and salient contextual factors; rationale ^b	3
S8	Sampling strategy	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale ^b	3
S9	Ethical issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	3
S10	Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale ^b	3–5
S11	Data collection instruments and technologies	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	3–5
S12	Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	3–6
S13	Data processing	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts	4–5
S14	Data analysis	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale ^b	5–6
S15	Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale ^b	5
Results/findings			
S16	Synthesis and interpretation	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	6–7

Supplementary Table 1 (continued)

No	Topic	Items	Page No
S17	Links to empirical data	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	7–11
Discussion			
S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	11–14
S19	Limitations	Trustworthiness and limitations of findings	14
Other			
S20	Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	15
S21	Funding	Sources of funding and other support; role of funders in data collection, interpretation, and reporting	15

^aThe authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

^bThe rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.