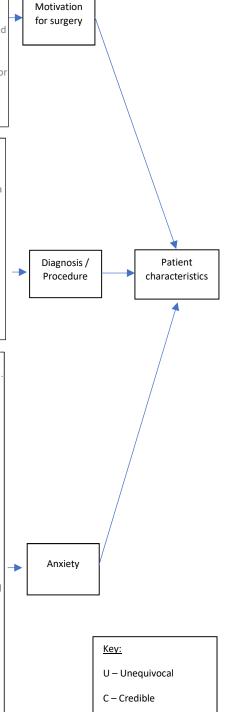
Findings Categories Synthesis

- Surgery had different meaning for patients depending on their circumstances. (U)
- The majority of patients make or develop a clear preference for a decision before meeting a surgeon. (U)
- Cultural belief in surgical care Nearly all of the patients came to the surgeon with a
 pre-established belief that surgery is required for cure. Support for this belief came
 from friends or family. (C)
- Distrustful participants articulated a background of suspicion about the efficacy of surgery and the intentions of surgeons. Ultimately their perception of untreated gallbladder disease outweighed their misgivings about cholecystectomy. (U)
- Unquestioning patients decided to undergo operative treatment as soon as the diagnosis of cholelithiasis was made. (U)
- Managing expectations and fear. (U)
- Patients are aware of risk and viewed risk in general as an inescapable part of life and something which they encountered on a daily basis. (U)
- The concept of readiness for surgery and surgery as last resort as perceived by the
 patient or the physician was also important and often brought up as the threshold for
 decision-making. (U)
- Previous personal experience with surgery, including non-orthopaedic procedures, also played a role in patients' preferences about knee surgery. (U)
- In addition to classifying the tumour as benign and malignant patients sought information about tumour biology, aetiology and anatomy of the brain (U)
- A malignant diagnosis changed information seeking behaviour. (C)
- Cultural belief in surgical care Nearly all of the patients came to the surgeon with a
 pre-established belief that surgery is required for cure. Support for this belief came
 from friends or family. (C)
- Resignation to risk of treatment patients expressed the view that analysing risks
 was irrelevant to their decision. They had to accept the risk and burden of surgical
 treatment to escape a miserable death. (U)
- Communicating information Preoperative information helped prepare the patient and the surgeon for difficult intraoperative and postoperative decisions and developments. (U)
- The importance of the patient condition certain conditions created more anxiety and more negative comments than others. (NS)
- Belief in expertise rather than medical information. Patients considered themselves
 unqualified to process the diagnostic and prognostic information presented to them
 Regardless of their level of education or career success, they felt incapable of
 making suggestions or decisions about their care because they lacked expertise and
 felt psychologically debilitated by anxiety and fear. (U)
- Communicating information Preoperative information helped prepare the patient and the surgeon for difficult intraoperative and postoperative decisions and developments. (U)
- Managing expectations and fear. (U)
- Some patients did not want technical information. (U)
- Fear may inhibit patients' desire for survival information. (U)
- A number of fears were also identified: fear of a lengthy recovery, fear from complications and from anaesthesia, concerns about longevity of prosthesis, and worries about how the surgery may affect their other health problems. (U)
- Surviving Uncertainty while patients were facing the possibility of losing their life, doctors had to cope with the risk of taking or harming the life at stake when trying to save it. This conflict was often resolved through the doctor discussing the risk and possibilities leading to an agreement often based on the doctor's recommendation.
 (U)
- Information-sharing and risk communication. During interviews, may participants
 discussed how medical terminology and surgical jargon can confuse and frighten
 patients. Some doctors demonstrated their ability to simplify and adapt their
 language to a level that is understandable to a lay person. (U)
- Patient engagement: a number of doctors reflected on the challenges of engaging
 patients in the consent process. Patients in an emotionally charged state would find
 it difficult to process and retain information, some doctor also discussed that they
 sometimes were required to consent patients who were less searching than others
 wanting either to sign the consent form without acknowledging information or
 deferring the decision to the doctor. When faced with disengaged patients many
 doctors in our study reported that they attempted to continue to provide



NS - Not substantiated

Findings Categories Synthesis

- Patients differed in scope and content of information they desired. (U)
- A malignant diagnosis changed information seeking behaviour. (C)
- Patients wanted to be allowed to view their own imaging with the surgeon. (U)
- All but one patient wanted to know about the risk of major complications as to make her own judgement about the balance of risks. Knowing about this would have made them less frightened if a major complication did arise and allowed people to make appropriate contingency plans should a complication arise. (U)
- Some patients did not want technical information. (U)
- Information about post-operative recovery and QOL was identified as important to all but four patients. (C)
- Survival information was desired by patients. (U)
- Fear may inhibit patients' desire for information. (U)
- Helpful/Unhelpful information Most women expressed the importance of having trust
 and confidence in the surgeon and office staff and of having support from family and
 friends. Women found looking at before and after photos useful, some internet sites
 etc. (C)
- Communication and information almost all patients wished to be told the truth about
 their condition and to be given details about their diagnosis, treatment and long-term
 implications. Patients felt that they were not as involved in consultation with surgeon as
 they would like. (NS)
- Patient engagement: a number of doctors reflected on the challenges of engaging
 patients in the consent process. Patients in an emotionally charged state would find it
 difficult to process and retain information. Some doctor also discussed that they
 sometimes were required to consent patients who were less searching than others
 wanting either to sign the consent form without acknowledging information or
 deferring the decision to the doctor. When faced with disengaged patients many
 doctors in our study reported that they attempted to continue to provide information
 to ensure they comply with their legal requirements. (U)
- Consent as a decision to trust surgeons preferred to discuss the operation simply and directly with patients and families, attending to the signals of comprehension and concern. (U)
- Patients exhibited three distinct decision-making styles. (U)
- Although many patients expressed a desire for partnership in decision-making, others preferred a more passive role. (U)
- Negotiating responsibility some patients explicitly said that the doctors should decide
 for them. Doctors however, handed the responsibility back to patients. Others were
 aware of their responsibility and right to choose a potentially dangerous treatment. (U)

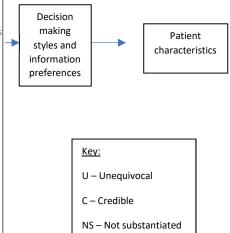


Figure 2: Patient characteristics synthesised finding.