

Article no.	Year	Author/Country	Aims	Age of the participants in years (Mean age)	Sample size (Female/Male)	Characteristics of the participants ¹	Data collection	Data analysis ²	Relevant results of importance extracted from the article
P1	2022	Brown EL et al./England	To explore factors influencing Shared Decision Making from the perspectives of older patients with multimorbidity and GPs, to inform improvements in personalized care	65-84 (Unknown)	8 (7/1)	With 2 long-term health problems (n = 3) With 3 long-term health problems (n = 4) With ≥4 long-term health problems (n = 1)	Focus group interview	Braun and Clarke's (2006) thematic analysis	The barriers to patient enablement for effective shared decision-making were illustrated by the following themes: medicolegal vulnerability, perceptions of time pressure, and a lack of continuity of care; the facilitators' themes that emerged: increasing consultation duration and improving continuity
P2	2021	Nilsen ER et al./Norway	To explore person-centered care provided to a group of older adults (65+) by understanding their experiences of care received, their participation in care and what matters to them during and after the transition process between hospital and home	72-87 (77,9)	8 (6/2)	Living in own house with a partner (n = 3) Living alone in own house (n = 2) Living alone in own apartment connected to a health center (n = 2) Living in a rented apartment connected to a health center with a partner (n = 1)	Semi-structured individual interview	Gadamer's (1990) hermeneutic approach	To facilitate shared decision-making, the older care recipients and their relatives must be adequately informed, empowered, and prepared. When discussing treatment and care options with older adults, it is important to talk to them in understandable and relatable language and encourage them to share their experiences. Additionally, it is important to clarify the person's existing knowledge of their own health issues
P3	2019	van Bussel E et al./Netherlands	To explore older peoples' experiences, preferences, concerns and perceived involvement regarding hypertension management	74-93 (81,1)	15 (10/5)	With ≥2 chronic conditions in addition to hypertension (n = 8) With <2 chronic conditions, in addition to hypertension (n = 7) High education (n = 7) Middle education (n = 4) Primary education (n = 2)	Semi-structured individual interview	Braun and Clarke's (2006) thematic analysis	Older people describe having little involvement in hypertension management, although they have several concerns. Reasons for not discussing the subject included low priority of hypertension concerns, reliance on GPs, or trust in GPs to make the right decision on their behalf. Interviewees would like to discuss tailoring treatment to their needs, deprescription of medication, and ways to reduce side effects. They expected GPs to be more transparent on treatment effects

P4	2019	Mitchell J et al./USA	To provide missing details on older African American men's first-hand experiences with primary care communication and participation, including their perceptions on how patient-provider communication, physician behaviors, and other health system factors influence the quality of their care	Unknown (65,9)	15 (0/15)	High education (n = 11) Primary education (n = 3) Retired (n = 10) Disabled (n = 1) With full or part-time employment (n = 4)	Semi-structured individual interviews conducted by phone	Thematic analysis	Two of the primary themes identified, perceptions of rushed care and racial or ethnic bias in care and communication, focused on important reasons for dissatisfaction with the primary care health experience. The theme regarding companions as a source of support highlighted how older African American men in the study viewed and valued the contributions of their significant others who accompanied them on medical visits. The final theme concerning participants' confidence, assertiveness, and self-advocacy, revealed the salience of men's self-perceptions and demonstrated how men in the study felt fully capable of speaking up for themselves during healthcare interactions
P5	2018	Doekhie KD et al./Netherlands	To openly explore the perspectives of patients, informal caregivers and primary care professionals on patient involvement in the decision-making process in primary care team interactions	62-98 (81,6)	19 (15/4)	With ≥2 chronic conditions (n = 18) With <2 chronic conditions (n = 1)	Semi-structured individual interview	Content analysis	Some patients feel limited in taking on an active role because of their interactions with professionals. They feel treated like passive bystanders in their own care process and that the professionals make decisions for them instead of with them. These patients want to be actively involved and feel obliged to express this explicitly. Other patients want to express their own opinions and wishes but hesitate to do so because of possible negative reactions. Patients sometimes feel that professionals do not always value their opinion, while in some situations, they feel they know best
P6	2017	Moe A et al./Norway	To gain knowledge about conversation processes and patient influence in formulating the patients' goals	67-90 (80)	8 (5/3)	Living in own private home (n = 8) Married (n = 5) Widow (n = 3)	Semi-structured individual interview	Vaismora di's (2016) content analysis	Challenges in the process were sometimes limited patient involvement, which led to ascribed goals formulated by the health worker. Patients' active participation in the conversations mainly varied with tactics or ways of professional leadership and communication skills used during conversations. When the personnel displayed active listening skills and allowed for patient participation in interactions, this led to patient-staff negotiations and clarification of rehabilitation goals. More often the staff limited

									and controlled patient participation when patients responded to ascribed goals formulated by the health worker. The findings highlight that patients' share in communication should be taken more into account than what is found. Dialogue where the health staff asked both open and clarifying questions and showed skills in active listening motivated patient participation
P7	2015	Crotty BH et al./USA	To identify how patients older than 75 years wished to share their health information with their caregivers and to understand how elders and families approached the spectrum of information sharing and control	75-86+ (Unknown)	30 (26/4)	Asian (n = 1) White (n = 29) High education (n = 23) Middle education (n = 5) Primary education (n = 2)	Focus group interview	Immersion/crystallization technique through an iterative process	The more independent elder participants had difficulty picturing themselves losing control of their decision-making capabilities and having to rely on their children. Throughout discussions, elders acknowledged the importance of keeping a sense of control of their health care and decision-making. Elders expressed a level of certainty in their decision-making abilities and did not want their family to hinder their sense of control. Control exerted regarding health information depended on the context of an elder's age and health status. Elders acknowledged that sharing all parts of their health information would be important during an emergency but would not be necessary or ideal daily. Elderly participants recognized that health information and decision-making are more likely to be shared as they age or as health issues arise
P8	2015	Hedman M et al./Sweden	To describe the meaning of autonomy and participation among older people living with chronic illness in accordance with their lived experience	65-84 (Unknown)	16 (7/9)	Urban setting (n = 10) Rural setting (n = 6) Living alone at home (n = 7) Living with another person at home (n = 9)	Semi-structured individual interview	Giorgi's (2009) descriptive phenomenological psychological method	The meaning of autonomy and participation emerged when it was challenged and evoked emotional considerations of the lived experience of having a chronic illness. The meaning of autonomy and participation was living a life apart, yet still being someone able as an older person living with chronic illness. The meaning of autonomy and participation was still being trustworthy and being given responsibility The meaning of autonomy and participation was being seen and acknowledged

P9	2014	Butterworth JE et al./England	To investigate the association between older patients' trust in their GP and their perceptions of shared decision making	65-95+ (Unknown)	20 (11/9)	With ≥1 chronic conditions (n = 14) Married (n = 7) Divorced (n = 3) Widow (n = 6) Never married (n = 2)	Semi-structured individual interview	Thematic analysis	Some participants expressed definite trust in a GP's opinion, particularly those who had experienced continuity of care. An explanation of this opinion was usually valued, however, and perceived by participants to represent patient involvement, augmenting their trust. The provision of patient choice as a method of involvement was frequently valued and expressed greater trust in a GP who provided a definitive view in respect of their care. Participants discussed trust in the context of factors that affected their preferences for involvement. The oldest participants acknowledged increasing awareness of their own health and self-confidence in older age, wishing for information about ever more complex healthcare requirements. Characteristics that facilitated their involvement in decisions about their health care were a patient-centered, caring, attentive, and holistic approach; appearing open and honest; and treating the patient as an equal.
P10	2014	Beverly EA et al./USA	To explore older adults' values and preferences regarding type 2 diabetes care	60-83 (71,3)	25 (14/11)	Range of health conditions, including diabetes among the participants = 2-7 High education (n = 13) Married (n = 15) Retired (n = 21)	Focus group interview	Content analysis	Some participants said that their physician had never explicitly asked them about their values and preferences for diabetes care and, as a result, had not seriously considered their values and preferences for care. Overall, participants valued a strong working relationship with their diabetes physicians. Further, older adults valued physicians who encouraged them to be involved in their own care and listened to their concerns. Interestingly, several participants discussed end-of-life decision-making preferences in three of the five focus groups. For them, diabetes care preferences that would allow them to maintain the quality of life they valued extended beyond immediate treatment decisions. These individuals said that it was their choice whether to continue with their treatments and it was their choice whether to be resuscitated

P11	2014	Bynum JPW et al./USA	To understand the level of participation of very old adults, understand the process by which participants experience medical decision making, and identify barriers to greater participation in their health care decision making, in particular those that may be modifiable	80-93 (84)	29 (17/12)	Black (n = 6) Non-Hispanic white (n = 23) Widow (n = 17) Married (n = 10) Divorced (n = 1) Single (n = 1) Middle education (n = 14) High education (n = 15)	Semi-structured individual interview	Constant comparative method	The differences in decision processes across the types of care, from surgery to routine testing, highlight the importance of whether the participants felt there were any options for them to consider or even any decision to be made. There were many instances in which the participant did not perceive a choice or even that a decision was being made. Many participants described low overall participation. Some explicitly stated that they did not participate. Several barriers in communication between the patient and physician could interfere with patients engaging in the decision process. Communication barriers precluded the possibility of information sharing and dissuaded participants from asking questions
P12	2012	Sheridan NF et al./New Zealand	To explore what poor older adults, who mostly belong to ethnic minority groups with high needs, say they want from clinicians and uncovered patient powerlessness and low engagement in primary care consultations	55-75+ (Unknown)	42 (21/21)	From minority ethnic groups (n = 32) Living with family (n = 33) Living alone (n = 6) In residential care (n = 3)	In-depth interview	Street's (2009) communication model	Few differentiated between seeing a nurse or doctor, and only one participant said a GP had made a home visit. Most participants described their relationship as 'very good', 'fine', or 'clinical', but their stories of interactions with either GPs or practice nurses revealed dissatisfaction. Being objectified and feelings of invisibility were expressed, as the practice nurses' lack of involvement. Repeatedly participants reported being upset at how they were spoken to and feeling unheard or disregarded. Cultural gestures were also seen to play an important part in revealing the subtext

¹Only those characteristics with the most relevant information for this meta-synthesis were extracted from each study.

²The terminology used by the authors in the denomination of the analytical process to be followed has been respected.

Supplementary Table 4. Intra-studies characteristics.