<table>
<thead>
<tr>
<th>Article no.</th>
<th>Year</th>
<th>Author/Country</th>
<th>Aims</th>
<th>Age of the participants in years (Mean age)</th>
<th>Sample size (Female/Male)</th>
<th>Characteristics of the participants&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Data collection</th>
<th>Data analysis&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Relevant results of importance extracted from the article</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>2022</td>
<td>Brown EL et al./England</td>
<td>To explore factors influencing Shared Decision Making from the perspectives of older patients with multimorbidity and GPs, to inform improvements in personalized care</td>
<td>65-84 (Unknown)</td>
<td>8 (7/1)</td>
<td>With 2 long-term health problems (n = 3) With 3 long-term health problems (n = 4) With ≥4 long-term health problems (n = 1)</td>
<td>Focus group interview</td>
<td>Braun and Clarke’s (2006) thematic analysis</td>
<td>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</td>
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<tr>
<td>P2</td>
<td>2021</td>
<td>Nilsen ER et al./Norway</td>
<td>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</td>
<td>72-87 (77.9)</td>
<td>8 (6/2)</td>
<td>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)</td>
<td>Semi-structured individual interview</td>
<td>Gadamer’s (1990) hermeneutic approach</td>
<td>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</td>
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<tr>
<td>P3</td>
<td>2019</td>
<td>van Bussel E et al./Netherlands</td>
<td>To explore older peoples’ experiences, preferences, concerns and perceived involvement regarding hypertension management</td>
<td>74-93 (81.1)</td>
<td>15 (10/5)</td>
<td>With ≥2 chronic conditions in addition to hypertension (n = 8) With &lt;2 chronic conditions, in addition to hypertension (n = 7) High education (n = 7) Middle education (n = 4) Primary education (n = 2)</td>
<td>Semi-structured individual interview</td>
<td>Braun and Clarke’s (2006) thematic analysis</td>
<td>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</td>
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</table>
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)
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.

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)
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.

To gain knowledge about conversation processes and patient influence in formulating the patients’ goals.

67-90 (80)
Living in own private home (n = 8)
Married (n = 5)
Widow (n = 3)

Semi-structured individual interview

Vaismoradí’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

- **Participants:** 75-86+ (Unknown) 30 (26/4)
  - Asian (n = 1)
  - White (n = 29)
  - High education (n = 23)
  - Middle education (n = 5)
  - Primary education (n = 2)

**Methods:** Focus group interview

**Analysis:** Immerison/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

- **Participants:** 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)

**Methods:** Semi-structured individual interview

**Analysis:** 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)

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)

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.
### Supplementary Table 4. Intra-studies characteristics.

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Authors</th>
<th>Title</th>
<th>Age Group</th>
<th>Sample Size</th>
<th>Characteristics</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>P11</td>
<td>2014</td>
<td>Bynum JPW et al. / USA</td>
<td>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</td>
<td>80-93 (84)</td>
<td>29 (17/12)</td>
<td>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)</td>
<td>Semi-structured individual interview</td>
<td>Constant comparative method</td>
</tr>
<tr>
<td>P12</td>
<td>2012</td>
<td>Sheridan NF et al. / New Zealand</td>
<td>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</td>
<td>55-75+ (Unknown)</td>
<td>42 (21/21)</td>
<td>From minority ethnic groups (n = 32) Living with family (n = 33) Living alone (n = 6) in residential care (n = 3)</td>
<td>In-depth interview</td>
<td>Street’s (2009) communication model</td>
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</tbody>
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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.