e-ISSN 2594-2166 Medicina y ética, vol. 36 núm. 3, july-september, 2025

# Medical knowledge and application of advance directives for decision-making

# Conocimiento médico y aplicación del documento de voluntades anticipadas para la toma de decisiones

***Jorge Augusto Moncaleano Sáenz****
San Ignacio University Hospital, Pontifical Xavierian University, Bogotá, Colombia

***Martha Patricia Rodríguez Sánchez*****
San Ignacio University Hospital, Pontifical Xavierian University, Bogotá, Colombia

***Catalina Hernández Flórez*******
San Ignacio University Hospital, Pontifical Xavierian University, Bogotá, Colombia

* Family Medicine Resident, Department of Preventive and Social Medicine, San Ignacio University Hospital, Pontifical Javeriana University, Bogotá, Colombia. Email: moncaleanos_ja@javeriana.edu.co https://orcid.org/0000-0002-6712-8039

** Internal Medicine Physician and Nephrologist, Department of Internal Medicine, Renal and Transplant Unit, San Ignacio University Hospital, Pontifical Javeriana University, Bogotá, Colombia. Email: mprodriguez@husi.org.co https://orcid.org/0000-0001-5902-2894

*** Internal Medicine Physician, Department of Internal Medicine, School of Medicine, Pontifical Javeriana University, Bogotá, Colombia. Email: catalina.hernandez@javeriana.edu.co https://orcid.org/0000-0003-2438-6545

CÓMO CITAR: Moncaleano Sáenz, J. A., Rodríguez Sánchez, M. P., Hernández Flórez, C., Gómez Restrepo, C., Ruiz Parra, A. I., González González, C. A. (2025). Medical knowledge and application of advance directives for decision-making. *Medicina y ética, vol. 36, núm. 3.* DOI: https://doi.org/10.36105/mye.2025v36n3.03

***Carlos Gómez Restrepo*****
Faculty of Medicine, Pontifical Xavierian University,
Bogotá, Colombia

***Ariel Iván Ruiz Parra******
Department of Gynecology and Obstetrics, National University Hospital of Colombia, National University of Colombia,
Bogotá, Colombia

***Camilo Alberto González González*******
Colombia University Clinic, Sanitas University Foundation,
Bogotá, Colombia

https://doi.org/10.36105/mye.2025v36n3.03

## Abstract

This study investigated the knowledge, applicability, and barriers related to advance directives (DVA) among healthcare professionals at the San Ignacio University Hospital in Bogotá, Colombia. Quantitative surveys were applied, which will be followed by semi-structured interviews to assess the understanding and experiences of doctors regarding the DVA. The results showed that 79.2% of participants recognize the

**** Dean of the Psychiatrist Program, Faculty of Medicine, Pontifical Javeriana University, Bogotá, Colombia. Email: cgomez@javeriana.edu.co https://orcid.org/0000-0002-9013-5384

***** Gynecologist and Obstetrician, Bioethicist, Department of Gynecology and Obstetrics, National University Hospital of Colombia, National University of Colombia, Bogotá, Colombia. Email: airuizp@unal.edu.co https://orcid.org/0000-0001-7158-4742

****** Internist and Nephrologist, Department of Internal Medicine, Renal and Transplant Unit, Clínica Universitaria Colombia, Sanitas University Foundation, Bogotá, Colombia. Email: camilo.gonzalez@javeriana.edu.co https://orcid.org/0000-0001-8213-4595

**Reception: 16/12/24 Acceptance: 25/03/25**

importance of planning medical wishes, and 92.5% know that doctors must respect the DVA by law. However, only 75% would recommend it, and only 67.9% are aware of the moral obligation to transfer the case to another professional if they do not want to follow the patient's wishes. A gap in knowledge of the process and barriers such as lack of time and training in communication were identified. The findings highlight the need to improve training and resources to incorporate the DVA into clinical practice.

*Keywords*: barriers, knowledge, healthcare professionals, advance directives.

## 1. Introduction

In Colombia, the legal framework supporting advance directives was defined through Law 1733 of 2014, which regulates palliative care for patients suffering from advanced, chronic, and irreversible diseases (1–4). Several countries have implemented laws regulating advance directives, such as South Korea since 2018 (5), France in 2016 (6), and Canada in 2016 (7). These legislations reflect a growing recognition of the importance of advanced decisions in healthcare, highlighting the need for healthcare professionals to be well-informed and trained in this area.

Recent research in Germany has shown a significant increase in the signing of advance directives among patients in intensive care units, indicating a global trend towards the acceptance and use of these documents in clinical practice (8,9). This type of data emphasizes the importance of training doctors in the implementation of DVAs, aligning with the study's objectives. The effective implementation of advance directives can improve the quality of life of patients in the final stages of life, allowing their wishes to be respected and ensuring they receive the care they prefer (10–12). This is an issue of international interest, as many healthcare systems aim to improve end-of-life care.


https://doi.org/10.36105/mye.2025v36n3.03

Despite these advances, there is still a gap in the effective implementation of advance directives, due to insufficient training and awareness among medical professionals (13–19). The increasing complexity of medical decision-making (MDM), particularly in the context of advanced chronic diseases, requires a deeper understanding of advance directives and their implementation in clinical practice (20–22).

The main objective of this study is to identify the knowledge and applicability of the advance directive document (DVA) among doctors with different levels of training. The study aims to assess how this knowledge influences medical decision-making for patients with advanced chronic diseases or those in the final stages of life and to determine whether healthcare professionals are informed and prepared to implement advance directives in their clinical practice.

The study is based on bioethical principles, highlighting patient autonomy and informed medical decision-making, which have gained greater importance since the 20th century with the evolution of legal frameworks that protect patients' rights in healthcare (22–24).

This research used a mixed methodological design, applying quantitative surveys in the first phase. In the second phase, additional institutions across the country will be included, where new surveys and semi-structured interviews will be conducted to validate the results regarding the current state of knowledge and the barriers healthcare professionals face in applying advance directive documents. The results will allow for the development of strategies to improve the integration of advance directives into clinical practice, aiming for assertive decisions for patients in the final stages of life.

## 2. Materials and methods

This is a mixed exploratory phenomenological study. Two methodologies were implemented in two phases of development: a quantitative phase to characterize the knowledge and applicability of the DVA. Participants in the first phase of the study were doctors from


https://doi.org/10.36105/mye.2025v36n3.03

clinical and surgical areas, attending physicians, educators, and first- and second-year specialty residents at the San Ignacio University Hospital (HUSI).

## 3. Inclusion and exclusion criteria

Residents in the following specialties:

- Internal medicine
- Second specialty in internal medicine
- Family medicine
- Geriatrics
- Oncological surgery
- Obstetrics and gynecology

Specialist doctors and faculty in the following areas:

- Internal medicine
- Second specialty in internal medicine
- Family medicine
- Geriatrics
- Oncological surgery
- Obstetrics and gynecology

Exclusion criteria

- Refusal to participate in any phase of the study, including the semi-structured interview for convenience sampling.
- Professionals from medical or surgical areas who are not currently practicing professionally.
- Participants with incomplete registration of the information subject to study.

To achieve a comprehensive understanding of the topic, responses to self-administered surveys were analyzed. These surveys took approx-


https://doi.org/10.36105/mye.2025v36n3.03

imately 5-10 minutes to complete and were conducted through the institutional RedCap® platform at the San Ignacio University Hospital (HUSI).

For the second qualitative component, semi-structured interviews will be conducted with two focus groups randomly selected and interviewed virtually after obtaining informed consent. This phase will involve doctors from medical and surgical areas and will explore personal perspectives on the application of the DVA and the barriers related to this topic, leading to the coding, categorization, and final triangulation of the information.

## 4. Ethical aspects

This research was approved by the Institutional Research and Ethics Committee of the Faculty of Medicine at Pontificia Universidad Javeriana and the San Ignacio University Hospital, with the approval number **FM-CIE-0193-24**. Participants in both groups agreed to participate in the study after being informed about the objectives and characteristics of the study, and they signed the informed consent form.

## 5. Results of component I: application of surveys

### 5.1. *Sociodemographic variables*

This research explored the knowledge, attitudes, and barriers regarding the advance directive (AD) document among general practitioners and specialists from various medical and surgical disciplines. Of the 63 surveys collected, 10 were discarded due to incomplete completion, leaving 53 surveys for analysis.

The sample included participants ranging in age from 25 to 65 years, with a median age of 38 years and an age range of 25 to 65 years. The female gender predominated (64.2%). The educational level of partici-


https://doi.org/10.36105/mye.2025v36n3.03

pants was mostly composed of first and second-year medical specialty residents and medical specialists, with a minority of participants from the surgical field (9.4%).

Regarding the educational level of participants, as seen in Table 1, the majority were doctors and residents in first and second-year medical specialties (28.3%), followed by medical specialists with first specialties (2.6%) and second specialties (20.8%). Only 20.8% were from the surgical field (specialists or residents in first or second-year specialty training).

**Table 1.** Main sociodemographic variables of Participants in the DVA Survey at HUSI

| Characteristic | Result |
|---|---|
| Median age (range) – years | 38 (25-65) |
| Female sex – n (%) | 19 (35.8) |
| Medical area – n (%) | 38 (71.7) |
| Surgical area – n (%) | 11 (20.7) |
| Place of practice – n (%) | |
| Outpatient consultation | 24 (45.3) |
| Medical hospitalization | 17 (32.1) |
| Surgical hospitalization | 5 (9.4) |
| Emergency room | 7 (13.2) |
| Professional level or degree – n (%) | |
| General practitioner | 4 (7.5) |
| Resident in 1st or 2nd medical specialty | 15 (28.3) |
| Resident in 1st or 2nd surgical specialty | 4 (9.4) |
| Specialist in 1st medical specialty | 12 (22.7) |
| Specialist in 1st surgical specialty | 4 (7.5) |
| Specialist in 2nd medical specialty | 11 (20.8) |
| Specialist in 2nd surgical specialty | 3 (5.7) |

**Source:** prepared by authors.


https://doi.org/10.36105/mye.2025v36n3.03

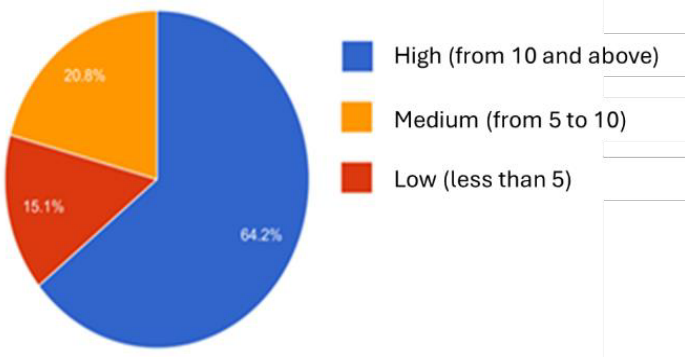
The results obtained according to category and item evaluated are detailed below.

### 5.1.1. *Care for Chronic Diseases at the End of Life*

*How often do you treat patients with advanced chronic diseases or those in the final stages of life?*

As shown in Graph 1, 64.2% of respondents reported a high frequency of care (10 or more patients), 15.1% reported a moderate frequency (between 5 and 10 patients), and 20.8% reported a low frequency (fewer than 5 patients).

**Graph 1.** Distribution of relative frequencies of care for patients with advanced chronic disease or at the end of life




**Source:** prepared by authors.

### 5.1.2. *Professional Practice*

*What is your area of practice?*

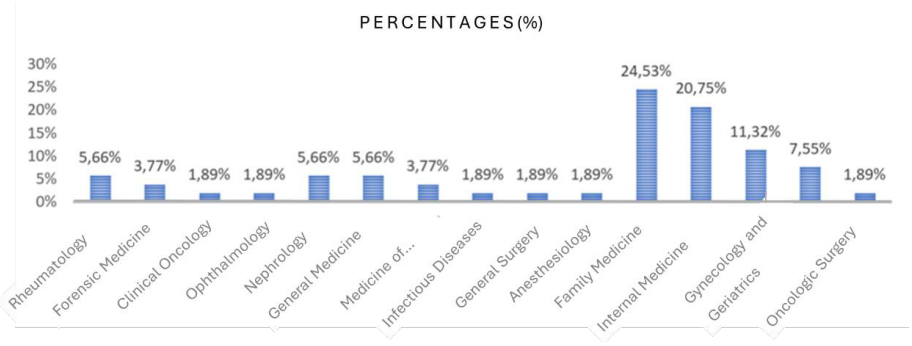
Table 1 shows that for the outpatient consultation scenario, 45.3% was reported, 32.1% for medical hospitalization, 13.2% for emergency care, and 9.4% for surgical hospitalization.


https://doi.org/10.36105/mye.2025v36n3.03

*What is your specialty?*

Regarding the medical or surgical specialty of the respondents, with participation from 13 specialties, as shown in Graph 2, the largest percentage was family medicine (24.5%), followed by internal medicine (20.7%) and obstetrics and gynecology (11.3%). Fourth, residents or specialists in geriatrics (7.55%).

**Graph 2.** Participants by Specialty




**Source:** prepared by the authors.

*What is their professional experience time?*

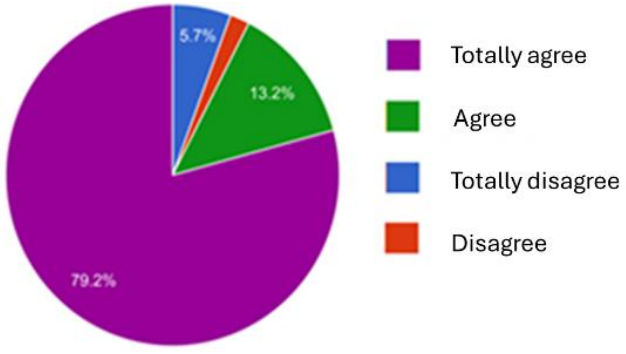
The range of professional practice varied from 1 to 40 years of experience, with an average of 11.53 years and a median of 38 years.

*Do you think planning the patient's medical wishes is appropriate?*

As shown in Graph 3, the majority fully agreed (79.2%). Only 7.6% did not consider the planning to be appropriate. The professionals who disagreed had an average age of 31.5 years and were from the specialties of anesthesiology, geriatrics, internal medicine, and emergency medicine.


https://doi.org/10.36105/mye.2025v36n3.03

**Graph 3.** Planning the patient's medical wishes

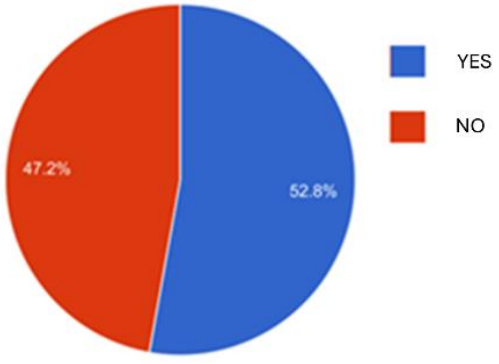



**Source:** prepared by authors.

*Has any patient asked you for information about the VAD?*

Only slightly more than half of the participants (52.8%) reported having been asked for information about the VAD, as shown in Chart 4.

**Graph 4.** Request for information from the doctor regarding the DVA




**Source:** Prepared by the authors.

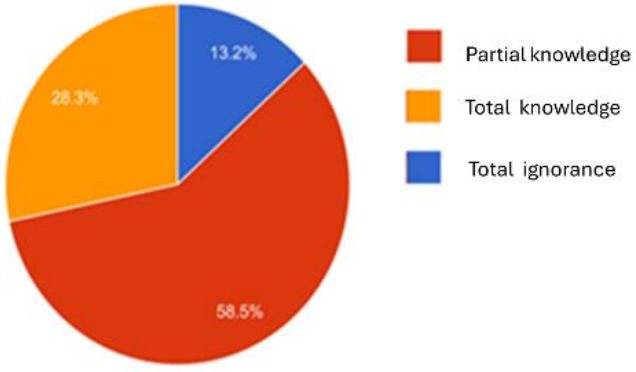

https://doi.org/10.36105/mye.2025v36n3.03

5.1.3. *Medical Knowledge of the DVA. Specific questions about understanding the DVA*

*How well do you know the DVA?*

As shown in Graph 5, the majority (58.5%) reported partial knowledge of the DVA, followed by total knowledge with 28.3%. Only 13.2% reported complete ignorance of the DVA, and these participants were specialists in general medicine, internal medicine, family medicine, gynecology and obstetrics, ophthalmology, and general surgery, with an average age of 38.42 years.

**Graph 5.** Knowledge of DVA




**Source:** prepared by authors.

*Does the DVA rest on the patient's right to autonomy?*

All participants (53) stated that it is true that the DVA is based on the patient's right to autonomy.

*Can aspects contrary to current legislation be included in the DVA?*

The majority of respondents answered no (66%), and the remaining group answered "don't know" (32.1%).


https://doi.org/10.36105/mye.2025v36n3.03

*Is the treating physician legally obliged to respect the DVA?*

Yes, the majority responded (92.5%), and the rest of the respondents do not know (7.5%).

*Do you know how to create a DVA?*

More than half of the respondents (56.6%) stated that they do not know how to write a DVA.

## Application and attitudes towards the advance directives document

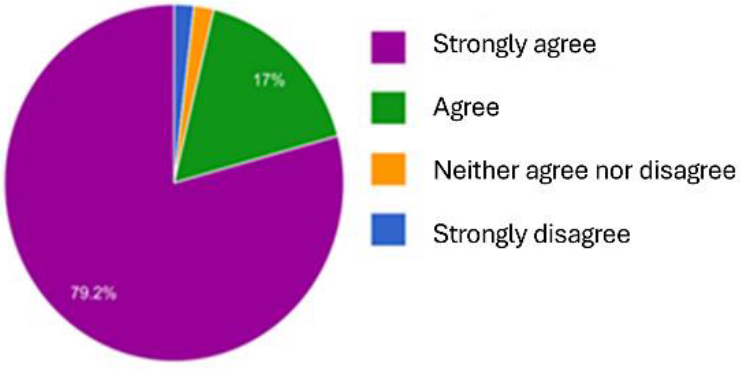
*Would you recommend that your patients use the DVA?*

Strongly disagree 1.9%, neither agree nor disagree 5.7%, agree 17%, strongly agree 75.5%.

*Would you write a DVA for yourself if you had to decide about your health?*

The majority (79.2%) expressed being totally in agreement. 17% agreed, while a small percentage (1.9%) indicated being totally disagreeing, or neither agreeing nor disagreeing (1.9%), as shown in Graph 6.

**Graph 6.** Would you write a DVA for yourself if you had to decide about your health?



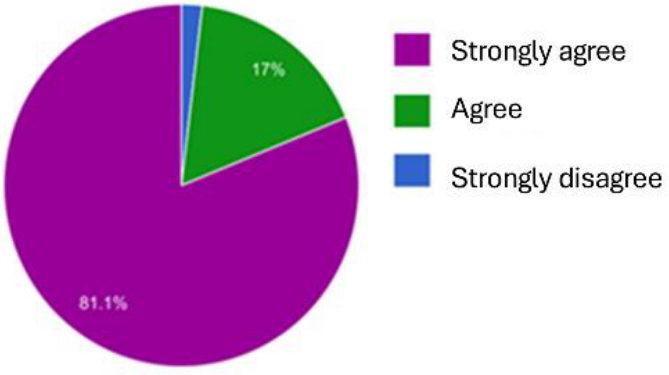

**Source:** prepared by authors.


https://doi.org/10.36105/mye.2025v36n3.03

*Does the DVA facilitate decision-making in the final stages of life for family members and healthcare professionals?*

Totally disagree 1.9%, agree 17%, and totally agree 81.1%, as shown in Graph 7.

**Graph 7.** Does the DVA facilitate decision-making in the final stages of life for family members and healthcare professionals?



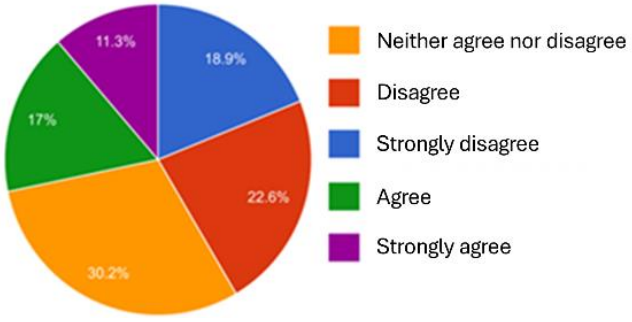

**Source:** prepared by authors.

*Do you think your chronic patients are well-informed about the progression of their illness in order to participate in clinical decision-making at the end of life?*

As shown in Graph 8, 41.5% of participants report being in disagreement.


https://doi.org/10.36105/mye.2025v36n3.03

**Graph 8.** Do you think your chronic patients are well-informed about the progression of their illness in order to participate in clinical decision-making at the end of life?

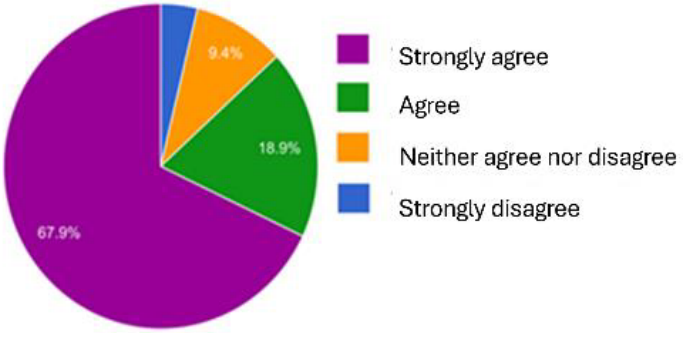



**Source:** prepared by authors.

*If the treating physician does not want to follow the patient's advance directives, does he or she have a moral duty to refer the patient to another professional?*

67.9% of respondents strongly agreed, 18.9% agreed, 9.4% had no defined position (neither agreed nor disagreed), and 3.8% strongly disagreed, as shown in Graph 9.

**Graph 9.** If the treating physician does not want to follow the patient's advance directives, does he or she have a moral duty to refer the patient to another professional?



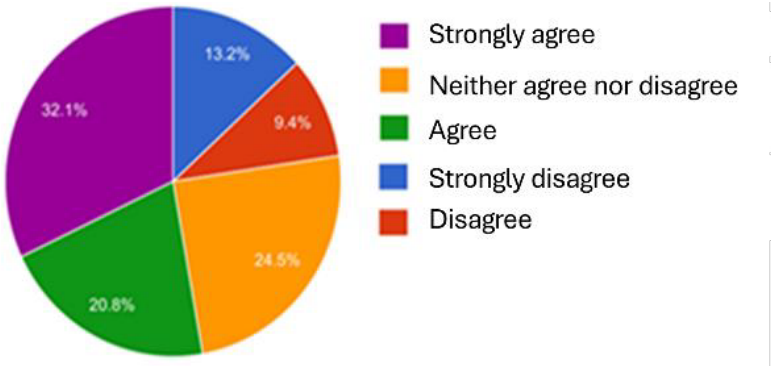

**Source:** prepared by authors.


https://doi.org/10.36105/mye.2025v36n3.03

*Do you prioritize advance directives over your professional judgment?*

As shown in Graph 10, respondents answered that they totally agreed 32.1% and agreed 20.8%. 22.6% disagreed with the statement, and 24.5% neither agreed nor disagreed.

**Graph 10.** Do you prioritize advance directives over your professional judgment?




**Source:** prepared by authors.

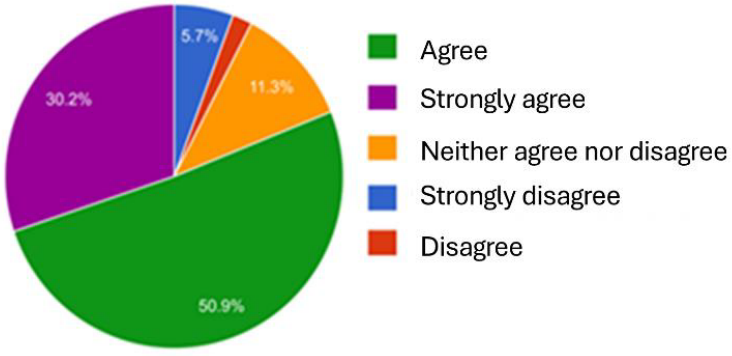
5.1.4. *Barriers encountered in its application in clinical practice*

*Is the time available for providing detailed information about advance directives to your patients limited?*

81.1% of participants agree that the available time for providing the necessary information about the DVA is limited, as shown in Graph 11.


https://doi.org/10.36105/mye.2025v36n3.03

**Graph 11.** Is the time available for providing detailed information about advance directives to your

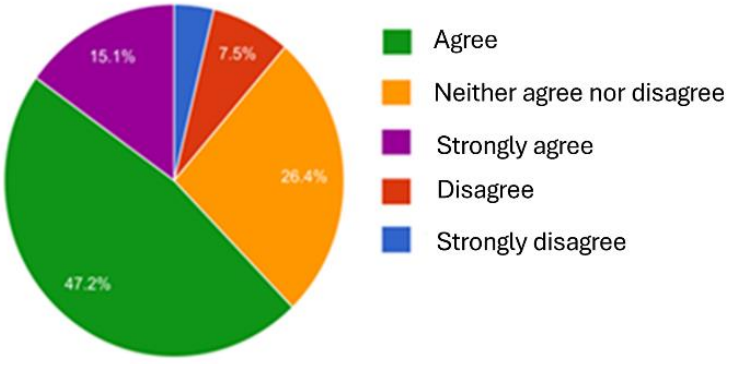



**Source:** Prepared by the author

*There are not enough support tools available to create the DVA*

As shown in Graph 12, the majority agreed (47.2%) and strongly agreed (15.1%).

**Graph 12.** There are not enough support tools available to create the DVA



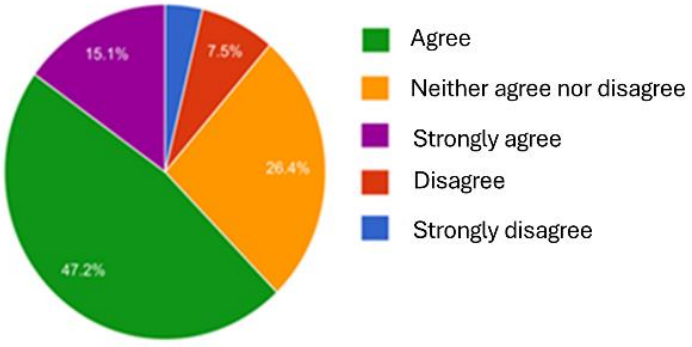

**Source:** prepared by authors.


https://doi.org/10.36105/mye.2025v36n3.03

*Do you think assertive communication training is insufficient?*

Agree, the majority (52.8%) and strongly agree (26.4%), as shown in Graph 13.

**Graph 13.** Do you think assertive communication training is insufficient?




**Source:** prepared by authors.

## 6. Second Stage of the Project:

- **Interviews:** Semi-structured interviews will be conducted with selected focus groups of medical and surgical professionals. During the interviews, participants will be presented with a clinical case of a patient with advanced malignancy and metastasis who had an advance directive (DVA). The experiences and opinions regarding the application of these advance directives (AD) in clinical practice will be explored.
- **Interview Structure:** This process will consist of four guiding questions designed to delve into the understanding of advance directives, the experiences of discussing them with patients and their families, and the challenges faced by doctors in implementing them.


https://doi.org/10.36105/mye.2025v36n3.03

- **Data Analysis:** The qualitative data collected from the interviews will be fully transcribed, edited, coded, categorized, and analyzed using the nVivo® software.

## 7. Discussion

Since their inception, advance directives (AD) have been widely promoted and supported globally as a fundamental part of planned care (25). Thus, several intervention studies have shown positive results, suggesting that both education and communication with the patient are effective strategies for encouraging the completion of advance directives (16–19). The individual perspectives of doctors, their beliefs, experiences, limited consultation times, and the duration of their relationships with colleagues and families can complicate the decision-making process, especially at the end of life (26,27).

It is crucial for healthcare professionals to fully understand their patients' values and preferences. This understanding can help bridge the gap between respecting autonomy and ensuring beneficence, as decisions should align with what the patient considers important in their care. Additionally, it should be recognized that patients' decisions can be revoked at any time, in respect of their autonomy. The implementation of an advance directive does not mean that the patient will be abandoned by the healthcare professional, nor that their right to receive dignified healthcare until the end of their life and at the time of their death will be denied (28–30).

The sample of doctors analyzed in this study had a median age of 38 years, with a predominance of women, and an adequate level of professional experience, allowing for exposure to requests for advance directives (DVA). On the other hand, it is important to highlight that most of the respondents work in outpatient clinics, with a small percentage in surgical hospital care (9.4%); however, the application of the DVA may be influenced more by the characteristics of the patients than by the clinical practice settings in which the


https://doi.org/10.36105/mye.2025v36n3.03

doctors work. It cannot be overlooked that time is a crucial factor for discussions with patients and their families on such sensitive topics as end-of-life decision-making, as evidenced in this study.

Greater professional experience allows for greater expertise in supporting end-of-life decisions and even in the correct application of the DVA. It also reduces professional moral distress and fears of facing difficult situations, potentially contributing to better planning of care processes, especially in end-of-life phases. This is in contrast to a lack of medical experience in this field or unfamiliarity with how to appropriately address patient desires or their advance directives (AD), which can generate limitations in guidance and assertive communication, regardless of the professional's age, their work area, and their level of experience in medical practice.

This study documented that more than 70% of the respondents fully agreed with the convenience of planning the patient's medical wishes, which represents the importance of respecting autonomy and the changes in medical practice that were historically guided by paternalistic medicine.

An interesting finding in this study was that 47.2% of respondents did not receive requests to apply the DVA, which may be related to the sense of well-being patients have or because they do not see the complexity of their illness as something that would lead them to make decisions or express their wishes openly and clearly in the short or medium term (31,32). There may also be other barriers preventing communication between the patient and their doctor due to the purely therapeutic focus of their pathologies without considering the advance directives.

A study conducted in Colombia in 2020 by Álvarez and Gómez found that 24% of doctors received one or more advance directives from their patients (33); however, it is noteworthy that a small group of respondents (7.6%) did not consider such planning appropriate. This subgroup includes professionals from various specialties such as anesthesiology, geriatrics, internal medicine, and emergency medicine, with an average age of 31 years.


https://doi.org/10.36105/mye.2025v36n3.03

Similarly, perceptions and knowledge of DVA can vary significantly depending on the practice environment. A significant percentage of participants (62.3%) responded that there are not enough tools for the clinical practice and application of the DVA. However, considering that participants who work in more than one clinical or surgical area were not included, this may limit the generalizability of the results obtained.

Regarding knowledge of the DVA, the majority expressed partial knowledge, while 31.5% indicated adequate knowledge, which represents a small proportion relative to the needs present during clinical practice. 13.2% of respondents who were unaware of the DVA, consisting of specialists in general medicine, internal medicine, family medicine, gynecology and obstetrics, ophthalmology, and general surgery, with an average age of 38 years, suggests that fieldwork with a comprehensive emphasis for healthcare professionals is needed to strengthen and facilitate the decision-making process for patients, especially in end-of-life phases.

Additionally, various studies have pointed out the lack of adequate training related to the dying process (34,35) and the research focused on examining patients' interests in end-of-life stages (34,36). Improving healthcare providers' training on the ethical principles of autonomy and beneficence can prepare them to navigate these conflicts. This includes understanding the legal obligations regarding the DVA and the moral duty to refer patients when their wishes conflict with the guidance of the healthcare professional in charge of their health.

A significant finding from this study is that the majority of participants (56.6%) indicated they did not know how to draft a DVA. In Spain, Simón Lorda and colleagues (37) reported in a study with doctors that explored their level of knowledge on the topic, measured on a scale from 0 to 10, where the average knowledge was 5.3 (SD: 2.4) in primary care and 5.2 (SD: 2.7) in specialized care. In the same country, a similar study by Ameneiros and colleagues (38) showed that knowledge of advance directives among primary care and specialized doctors averaged 3.8 (SD: 2.3) on a scale from 0 to


https://doi.org/10.36105/mye.2025v36n3.03

10. All this may indicate insufficient training and awareness among doctors about the DVA, and inconsistency in assessing patient wishes and the communication process in clinical relationships.

All the participants in this study recognized that the DVA is based on the patient's right to autonomy. However, there was variability in knowledge about the legality of including aspects contrary to current legislation in the DVA, with 32.1% of participants indicating that they were unsure whether this is possible, and a small group (1.9%) answered affirmatively. Although medical professionals generally have a higher level of knowledge than the general public, most do not have a detailed understanding of the DVA, its concepts, the current laws (including its binding nature in decision-making), and especially how to implement it in professional practice. This ranges from administrative aspects to the way they should act in specific clinical cases (39,40).

In contrast, the vast majority of respondents agreed that doctors are legally obligated to respect the DVA. However, the law is not binding on placing the DVA above medical judgment, as defined in article 14 of Resolution 2665 from 2018:

> Healthcare professionals should recognize advance directives as an exercise in autonomy by the individual who subscribes to them, and therefore, these must be considered in decision-making regarding the care and treatment of the person, without disregarding lex artis and the best interests of the patient"(3).

Improving the training of healthcare providers on the ethical principles of autonomy and beneficence can better prepare them to navigate these conflicts. This includes understanding the legal obligations related to advance directives (DVA) and the moral duty to refer patients when their wishes conflict with medical advice.

In Colombia, a study conducted by Álvarez and Gómez found that 54% of participants reported being unaware of the law regulating the DVA in Colombia, while 34.33% claimed to know the requirements that such a document must fulfill (33). This reflects that


https://doi.org/10.36105/mye.2025v36n3.03

ignorance about the DVA is a global phenomenon, with a significant gap for its full implementation in clinical practice. Monteiro and Gomes, in their review of the literature on the use of the DVA in Latin America, concluded that, despite growing interest, there is generally difficulty in adopting the DVA, regardless of the existing legislation (41). This suggests that healthcare professionals may not be fully aware of these advance directives, making their implementation in clinical practice challenging (41,42).

Seventy-five percent of participants in this study fully agreed on recommending the use of the DVA to their patients, indicating strong acceptance of this concept among the surveyed doctors and suggesting its potential integration into clinical practice. However, professional knowledge should be strengthened to ensure a more adequate and timely application of the DVA. In a review by Coleman, it was observed that doctors generally show positive attitudes toward advance directives. Respect for patient autonomy emerged as the main determinant of these attitudes (43).

The study published by Pablo Simón reveals a favorable attitude from doctors toward the usefulness of advance directives (37,44). Although doctors may agree with the concept of advance directives (45), they tend to prefer them less compared to their patients and use them infrequently (46). In the present study, 79.2% fully agreed on drafting a DVA for themselves, further reinforcing this positive trend. It is relevant to recognize that, although a minimal percentage of participants reported uncertainty or disagreement (1.9% each), this also represents an area for improvement within clinical practice teams to minimize moral distress and fears among professionals and improve outcomes in patient end-of-life decision-making.

Doctors may feel inadequately trained in shared decision-making processes and uncomfortable discussing advance directives; lack of confidence can contribute to their reluctance to advocate for these options and increase uncertainty and distress in medical practice, limiting the applicability of the DVA (47).

The results of this study indicate that 81.1% fully agreed that DVA facilitates the end-of-life decision-making process for patients,


https://doi.org/10.36105/mye.2025v36n3.03

their families, and healthcare professionals. However, it is striking that healthcare professionals perceive patients with chronic illnesses as not being well-informed about the progression of their disease to participate adequately in clinical end-of-life decision-making. A study conducted in Colombia on patients in end-of-life processes (48) found that 14% had signed their own advance directives and 24% had received one or more advance directives in the last year (33).

Promoting open dialogue between patients and doctors helps clarify expectations and individual preferences. This communication is essential for making informed decisions that respect the patient's autonomy while maintaining the medical professional's perspective on beneficence and good clinical practice. The results of this study also show that slightly less than half of the respondents disagreed with placing advance directives above their professional judgment, likely due to the conflict between the principle of patient autonomy and beneficence.

Beauchamp and Childress defined the principle of beneficence as the obligation to "help others achieve their important and legitimate interests" (49). In this line, following Diego Gracia, it is not considered that there is a real conflict between autonomy and beneficence since "they are closely related moral principles, and therefore of the same level […] What is beneficial is always beneficial to me. Beneficence is always in regard to my own religious, cultural, political, and economic value system" (50).

To achieve the patient's most important and legitimate interests, the physician must not only consider what is technically indicated for the patient's illness but also the patient's values and preferences. One cannot be beneficent without respecting the patient's autonomy, and in this context, rather than prioritizing the DVA over the physician's judgment, it should be considered as a fundamental part of clinical decision-making (28,29,31).

In the present study, we asked participants whether, in the case of a disagreement with the DVA, the physician has a moral duty to refer the patient to another professional. The results show that 67.9% completely agree, which reflects the care that professionals


https://doi.org/10.36105/mye.2025v36n3.03

have for their patients. The presence of participants with an undefined stance creates a potential risk in addressing the patient's desires and will. The shift toward prioritizing patient autonomy has given rise to ethical dilemmas; some physicians may feel their moral integrity is compromised when the patient's demands conflict with their professional judgment (51,52). The literature emphasizes that while physicians have the right to conscientious objection, they also have the duty to refer patients to other professionals who can provide the necessary, appropriate, and timely care with the responsibility, compassion, and mercy inherent in the medical act (53).

The most important barriers to discussing and applying the DVA found in this study were the lack of sufficient tools to create the DVA and the lack of time that physicians may have to familiarize themselves with advance directives and implement or promote their use (15,33). This limits their ability to provide detailed information about advance directives to their patients.

Proper documentation of patient preferences and decisions in medical history is an integral part of professional practice, and it is crucial as one of the tools for professional communication. It ensures that the patient's wishes are respected throughout their care journey, reinforcing the importance of autonomy while allowing healthcare providers to act in the best interests of the patient. Continuous education on ethical dilemmas and case studies can help healthcare professionals develop the skills to effectively address conflicts between autonomy and beneficence. This training can foster a culture of ethical awareness and sensitivity in medical environments.

Assertive communication is vital to obtain relevant information during patient interviews and shared decision-making processes, which are essential for understanding the patient's desires (54). Moreover, it encourages patients to plan their wishes clearly, which is crucial in professional practice (55). The training emphasizes both verbal and non-verbal tools, boosting self-confidence and responsibility in clinical settings (54). Assertive communication can lead to a reduction in medical errors and greater patient satisfaction, enhancing empowerment in their decisions (56). Patients who receive


https://doi.org/10.36105/mye.2025v36n3.03

assertiveness training may exhibit better decision-making abilities, particularly in emotionally stressful situations such as end-of-life care (57).

The limited training in the dying process and assertive communication with patients in the final stages of life is a recurrent and critical issue in healthcare. This implies that professionals need more robust training in communication skills to address the concerns, desires, or preferences of patients in an ethical, respectful, just, compassionate, empathetic, honest, and responsible manner at any point in their lives, even after death.

## 8. Limitations

The study primarily involved healthcare professionals from specific specialties, which may not represent the entire medical community, given that many professionals work in more than one clinical area. The representativeness of the sample and the generalizability of the results are affected by the lack of participation from professionals in surgical areas. Physicians working in different specialties could have diverse experiences and perspectives on the DVA that were not included in this study.

Survey application may lead to bias, as participants might overestimate their understanding or willingness to engage with the DVA, leading to inadequate perceptions of their knowledge on the assertive application of the DVA (response bias). Additionally, bias may occur if participants provide socially desirable answers rather than their true opinions (response bias).

## 9. Conclusions

The findings of this study suggest a critical need to improve the training and education of healthcare professionals regarding end-of-life


https://doi.org/10.36105/mye.2025v36n3.03

care and the application of the DVA, to ensure they effectively support patients in making informed decisions about their medical care.

The limited knowledge of the DVA and the lack of time in medical care imply the need to enhance education on this subject and improve healthcare processes.

There is interest and medical willingness to create a DVA for themselves, suggesting a positive attitude toward the concept of advance directives, in contrast to the lower actual frequency of DVA use in clinical practice. The study highlights the ethical and moral obligation of healthcare professionals to understand patients' desires and preferences and to accompany them in shared decision-making regarding their advance directives, without abandoning them at any point in their care process.

With the results of this work and in order to promote the integration of the DVA in clinical practice, several recommendations can be made:

- Improve training and education on the DVA for healthcare professionals to address knowledge gaps.
- Provide communication skills workshops to facilitate discussions about the DVA.
- Promote longer consultation times to allow for thorough discussions in special cases.
- Involve patients and caregivers in shared decision-making processes.
- Use multidisciplinary teams for comprehensive support.
- Periodically assess healthcare professionals' knowledge and attitudes toward the DVA.
- Create accessible resources about the DVA for patients.
- Encourage doctors to document patients' desires or preferences in the medical history and ideally confirm the completion of the DVA before reaching health conditions where decision-making capacity is compromised or the patient is in the final stages of life or dying.


https://doi.org/10.36105/mye.2025v36n3.03

Future research could focus on the effectiveness of specialized training modules on end-of-life care and the DVA for healthcare professionals. It is essential to evaluate the impact of continuous education on physicians' ability to discuss the DVA with patients during clinical practice encounters. Furthermore, methods to involve patients and caregivers in the shared decision-making process about the DVA should be explored.

## References


1. Ministerio de Salud y Protección Social. Leyes desde 1992 - Vigencia expresa y control de constitucionalidad [LEY_1733_2014] [Internet]. Congreso de la República; 2014. Available at: http://www.secretariasenado.gov.co/senado/basedoc/ley_1733_2014.html
2. Ministerio de Salud y Protección Social. RESOLUCION 971 DE 2021 [Internet. 2021. Available at: https://www.suin-juriscol.gov.co/viewDocument.asp?ruta=Resolucion/30043592
3. VLEX [Internet]. 2018 [cited 2022 jun 6]. Resolución número 2665 de 2018, por medio de la cual se reglamenta parcialmente la Ley 1733 de 2014 en cuanto al derecho a suscribir el Documento de Voluntad Anticipada - 25 de junio de 2018 - Diario Oficial de Colombia. Available at: https://vlex.com.co/vid/resolucion-numero-2665-2018-729891385
4. 2018 - CONSULTORSALUD - Nueva reglamentación sobre el Documento de Voluntad Anticipada: Resolución 2665 de [Internet]. [cited 2022 jun 6]. Available at: https://consultorsalud.com/nueva-reglamentacion-sobre-el-documento-de-voluntad-anticipada-resolucion-2665-de-2018/
5. Kim B, Choi J, Lee I. Factors Associated with Advance Directives Documentation: A Nationwide Cross-Sectional Survey of Older Adults in Korea. Int J Environ Res Public Health. 2022; 19.
6. Rwabihama JP, Belmin J, Rakotoarisoa DR, Hagege M, Audureau E, Benzengli H. Promoting patients' rights at the end of life in a geriatric setting in France: The healthcare professionals' level of knowledge about surrogate decision-makers and advance directives. Patient Educ Couns. 2020; 103(7):1390–8.
7. Zunzunegui MV. End of life care. Gac Sanit. 2018; 32(4):319–20.
8. Graw JA, Marsch F, Spies CD, Francis RCE. End-of-life decision-making in intensive care ten years after a law on advance directives in Germany. Medicina (Lithuania). 2021; 57(9).
9. Sprung CL, Ricou B, Hartog CS, Maia P, Mentzelopoulos SD, Weiss M. Changes in End-of-Life Practices in European Intensive Care Units from 1999 to 2016.



https://doi.org/10.36105/mye.2025v36n3.03

JAMA - Journal of the American Medical Association. American Medical Association. 2019; 1692–704.
10. Tierney WM, Dexter PR, Gramelspacher GP, Perkins AJ, Zhou XH, Wolinsky FD. The Effect of Discussions About Advance Directives on Patients' Satisfaction with Primary Care. J Gen Intern Med. 2001; 16(1):32–40.
11. Chambers C V, Diamond JJ, Perkel RL, Lasch LA. Relationship of advance directives to hospital charges in a Medicare population. Arch Intern Med. 1994; 154(5):541–7.
12. Brinkman-Stoppelenburg A, Rietjens JAC, Van Der Heide A. The effects of advance care planning on end-of-life care: A systematic review. Vol. 28, Palliative Medicine. SAGE Publications Ltd. 2014; 1000–25.
13. Low JA, Ng WC, Yap KB, Chan KM. End-of-life issues--preferences and choices of a group of elderly Chinese subjects attending a day care centre in Singapore. Ann Acad Med Singap. 2000; 29(1):50–6.
14. Tay M, Chia SE, Sng J. Knowledge, attitudes and practices of the Advance Medical Directive in a residential estate in Singapore. Ann Acad Med Singap. 2010; 39(6):424–8.
15. Wissow LS, Belote A, Kramer W, Compton-Phillips A, Kritzler R, Weiner JP. Promoting advance directives among elderly primary care patients. J Gen Intern Med. 2004; 19(9):944–51.
16. Pearlman RA, Starks H, Cain KC, Cole WG. Improvements in advance care planning in the Veterans Affairs System: Results of a multifaceted intervention. Arch Intern Med. 2005; 165(6):667–74.
17. Happ MB, Capezuti E, Strumpf NE, Wagner L, Cunningham S, Evans L. Advance Care Planning and End-of-Life Care for Hospitalized Nursing Home Residents. J Am Geriatr Soc. 2002; 50(5):829–35.
18. Tolle SW, Tilden VP, Nelson CA, Dunn PM. A prospective study of the efficacy of the physician order form for life-sustaining treatment. J Am Geriatr Soc. 1998; 46(9):1097–102.
19. Houben CHM, Spruit MA, Groenen MTJ, Wouters EFM, Janssen DJA. Efficacy of Advance Care Planning: A Systematic Review and Meta-Analysis. J Am Med Dir Assoc. 2014; 15(7):477–89.
20. Barnato AE. Emotion and Decision Making in the Clinical Encounter. En: Schwartz R, Hall J, Osterberg L. Emotion in the Clinical Encounter [Internet]. McGraw Hill Medical; 2021 [cited 2022 jun 6]. Available at: https://accessmedicine.mhmedical.com/content.aspx?bookid=3088&sectionid=257489697
21. Ruiz-Azarola A, Perestelo-Pérez L. Participación ciudadana en salud: Formación y toma de decisiones compartida. Informe SESPAS 2012. Vol. 26, Gaceta Sanitaria. Elsevier. 2012; 158–61.
22. Hall D, Beal E, A. Angelos P, Dunn G, Hinshaw D, Pawlik T. Ethics, Palliative Care, and Care at the End of Life. AccessMedicine, McGraw Hill Medical. Brunicardi FC, Andersen D, Billiar T, Dunn D, Kao L, Hunter J. Schwartz's Principles of Surgery [Internet]. McGraw Hill Medical. 2019 [cited 2022 jun 6]. Available at: https://accessmedicine.mhmedical.com/content.aspx?bookid=2576&sectionid=216218388


https://doi.org/10.36105/mye.2025v36n3.03

23. María Á, Flórez W. La Propuesta Bioética de Van Rensselaer Potter, cuatro décadas después. 2011; 27(66):70–84.
24. Matlock DD, Lum HD. Decision Making and Advance Care Planning: What Matters Most. En: Halter JB, Ouslander JG, Studenski S, High KP, Asthana S, Supiano MA. Hazzard's Geriatric Medicine and Gerontology, 8e [Internet]. New York, McGraw-Hill Education; 2022. Available at: accessmedicine.mhmedical.com/content.aspx?aid=1190903610
25. Xu C, Yan S, Chee J, Lee EPY, Lim HW, Lim SWC. Increasing the completion rate of the advance directives in primary care setting – a randomized controlled trial. BMC Fam Pract. 2021; 22(1).
26. Hov R, Hedelin B, Athlin E. Being an intensive care nurse related to questions of withholding or withdrawing curative treatment. J Clin Nurs [Internet]. 2007 [cited 2022 jun 11]; 16(1):203–11. Available at: https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2006.01427.x
27. Flannery L, Ramjan LM, Peters K. End-of-life decisions in the Intensive Care Unit (ICU) - Exploring the experiences of ICU nurses and doctors - A critical literature review. Australian Critical Care. Elsevier Ireland Ltd. 2016; (29):97–103.
28. Lima JS, Lima JGSR, Lima SISR, Alves HK de L, Rodrigues WF. Advance directives: patient autonomy and professional safety. Revista Bioética. 2022; 30(4):769–79.
29. Derler F. [Human dignity and autonomy in medicoethical decisions at the end of life]. Z Gerontol Geriatr [Internet]. 2024 [cited 2024 dec 14]; 57(7). Available at: https://pubmed.ncbi.nlm.nih.gov/38743165/
30. Berkman E, Clark JD, Lewis-Newby M. Do Not Resuscitate and Physician Orders for Life-Sustaining Treatment. Professional, Ethical, Legal, and Educational Lessons in Medicine [Internet]. 2024 [cited 2024 dec 14]; 232–9. Available at: https://academic.oup.com/book/58122/chapter/479625025
31. Clubb LE. Educating Health Care Professionals to Improve Communication in Advance Care Planning; 2018.
32. Owen L, Steel A. Advance care planning: what do patients want? Br J Hosp Med (Lond) [Internet]. 2019 [cited 2024 dec 14]; 80(5):263–7. Available at: https://pubmed.ncbi.nlm.nih.gov/31059340/
33. Álvarez Acuña AM, Gomezese Ribero ÓF. Advance Directives Document: Knowledge and experiences of healthcare professionals in Colombia. Colombian Journal of Anesthesiology. 2022; 50(2).
34. Santos de Unamuno C. Documento de voluntades anticipadas: actitud de los pacientes de atención primaria. Aten Primaria. 2003; 32(1):1–8.
35. Kessel Sardinas H. Paradojas en las decisiones al final de la vida. Med Clin (Barc). 2001; 116(8):296–8.
36. Callahan D. Death and the Research Imperative. New England Journal of Medicine. 2000; 342(9):654–6.
37. Simón-Lorda P, Tamayo-Velázquez MI, Vázquez-Vicente A, Durán-Hoyos A, Pena-González J, Jiménez-Zurita P. Conocimientos y actitudes de los médicos

en dos áreas sanitarias sobre las voluntades vitales anticipadas. Aten Primaria. 2008; 40(2):61–6.
38. Ameneiros-Lago E, Carballada-Rico C, Garrido-Sanjuán JA. Conocimientos y actitudes sobre las instrucciones previas de los médicos de Atención Primaria y Especializada del área sanitaria de Ferrol. Revista de Calidad Asistencial. 2013; 28(2):109–16.
39. Fajardo Contreras MC, Valverde Bolívar FJ, Jiménez Rodríguez JM, Gómez Calero A, Huertas Hernández F. Grado de conocimiento y actitudes de los profesionales ante el Documento de Voluntades Anticipadas: Diferencias entre distintos profesionales y provincias de una misma autonomía. Semergen. 2015; 41(3):139–48.
40. Jiménez Rodríguez JM, Allam MF. Conocimiento, actitud y planificación de la voluntad vital anticipada en el Distrito Sanitario Guadalquivir de la provincia de Córdoba. Medicina General y de Familia. 2015; 4(4):114–8.
41. Da Silva Fontes Monteiro R, Da Silva Junior AG. Directivas anticipadas de voluntad: recorrido histórico en América Latina. Revista Bioética [Internet]. 2019 [cited 2024 dec 12]; 27(1):86–97. Available at: https://www.scielo.br/j/bioet/a/j9xLqRQmYnpQWPPn87QfZHh/?lang=es
42. Tardelli NR, Fukushima FB, Palácio ASW, Forte DN, Mikelyte R, Filho MAC. EP01.013 Mapping the regulatory state of advance directives in Latin America: lessons learnt. BMJ Support Palliat Care [Internet]. 2023 [cited 2024 dec 14]; 13(Suppl 4):A56–A56. Available at: https://spcare.bmj.com/content/13/Suppl_4/A56.1
43. Coleman AME. Physician Attitudes Toward Advanced Directives: A Literature Review of Variables Impacting on Physicians Attitude Toward Advance Directives [Internet]. American Journal of Hospice and Palliative Medicine. SAGE PublicationsSage CA, Los Angeles. 2013 [cited 2022 jun 11]; (30):696–706. Available at: http://journals.sagepub.com/doi/10.1177/1049909112464544
44. Navarro Bravo B, Sánchez García M, Andrés Pretel F, Juárez Casalengua I, Cerdá Díaz R, Párraga Martínez I. Declaración de voluntades anticipadas: estudio cualitativo en personas mayores y médicos de Atención Primaria. Aten Primaria. 2011; 43(1):11–7.
45. Blondeau D, Valois P, Keyserlingk EW, Hébert M, Lavoie M. Comparison of patients' and health care professionals' attitudes towards advance directives. J Med Ethics. 1998; 24(5):328–35.
46. Hughes DL, Singer PA. Family physicians' attitudes toward advance directives. CMAJ. 1992; 146(11):1937–44.
47. Say RE, Thomson R. The importance of patient preferences in treatment decisions—challenges for doctors. The BMJ [Internet]. 2003 [citado 9 de diciembre de 2024]; 327(7414):542. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC192849/
48. Sarmiento-Medina MI, Vargas-Cruz SL, Velásquez-Jiménez CM, Sierra De Jaramillo M. Terminally-ill patients' end of life problems and related decisions. Rev. salud pública; 2012.

49. Holm S. Principles of Biomedical Ethics, 5th edn. J Med Ethics [Internet]. octubre de 2002 [cited 2024 dec 12]; 28(5):332.2-332. Available at: https://www.researchgate.net/publication/249530310_Principles_of_Biomedical_Ethics_5th_edn_Beauchamp_T_L_Childress_J_F
50. Gracia D, Júdez J. La deliberación moral: El método de la ética clínica. Med Clin (Barc) [Internet]. 2001 [cited 2024 dec 12]; 117(1):18–23. Available at: https://www.researchgate.net/publication/256811877_La_deliberacion_moral_El_metodo_de_la_etica_clinica
51. Pellegrino E. Patient autonomy and the physician's ethics. Annals. 1994; 27(3):171–3.
52. Fischkoff D, Prager K, Dastidar J, Dugdale L, Neuberg G, Nemeth S. Ethical Framework to Guide Decisions of Treatment Over Objection. J Am Coll Surg [Internet]. 2021 [cited 2024 dec 9]; 233(4):508-516.e1. Available at: https://pubmed.ncbi.nlm.nih.gov/34325018/
53. Diekema DS, Fallat M, Matheny Antommaria AH, Holzman IR, Katz AL, Leuthner SR. Policy statement - Physician refusal to provide information or treatment on the basis of claims of conscience. Pediatrics. 2009; 124(6):1689–93.
54. Eklics K, Fekete J, Szalai-Szolcsányi J. Improving Assertive Communication Skills in Simulated Medical Encounters. Porta lingua [Internet]. 2023 [cited 2025 feb 13]; (2):23–8. Available at: https://doi.org/10.48040/pl.2023.2.2
55. Hamilton IJ. Advance care planning in general practice: promoting patient autonomy and shared decision making. British Journal of General Practice [Internet]. 2017 [cited 2025 feb 13]; 67(656):104–5. Available at: https://bjgp.org/content/67/656/104
56. Calisto FMGF, Fernandes JGDM, Morais M, Santiago C, Abrantes JMV, Nunes NJ. Assertiveness-based Agent Communication for a Personalized Medicine on Medical Imaging Diagnosis. Conference on Human Factors in Computing Systems - Proceedings [Internet]. 2023 [cited 2025 feb 13]; Available at: https://dl.acm.org/doi/10.1145/3544548.3580682
57. Yani Syuhaimie Hamid A, susanti H, Indonesia U, Kesehatan Jiwa Nasional Rumah Sakit Jiwa Marzoeki Mahdi Bogor P. Assertiveness Training dalam Penurunan Risiko Perilaku Kekerasan pada Pasien Skizoprenia. Journal of Telenursing (JOTING) [Internet]. 2023 [cited 2025 feb 13]; 5(2):3249–57. Available at: https://journal.ipm2kpe.or.id/index.php/JOTING/article/view/7806
58. Reflexiones sobre el testamento vital (I y II): Versión resumida | Atención Primaria [Internet]. [cited 2022 ago 8]. Available at: https://www.elsevier.es/es-revista-atencion-primaria-27-articulo-reflexiones-sobre-el-testamento-vital-13042581
59. CRANE MK, WITTINK M, DOUKAS DJ. Respecting End-of-Life Treatment Preferences. Am Fam Physician. 2005; 72(7):1263–8.
60. Hildén HM, Louhiala P, Palo J. End of life decisions: Attitudes of Finnish physicians. J Med Ethics. 2004; 30(4):362–5.



https://doi.org/10.36105/mye.2025v36n3.03

61. Thompson TDB, Barbour RS, Schwartz L. Health professionals' views on advanced directives: A qualitative interdisciplinary study. Palliat Med [Internet]. 2003 [cited 2022 ago 8]; 17(5):403–9. Available at: http://journals.sagepub.com/doi/10.1191/0269216303pm784oa

## Annex 1

### Informed Consent

INTRODUCTION

This informed consent document is addressed to healthcare professionals from clinical and surgical areas, including both faculty and first- and second-year specialty residents, inviting them to participate in this research on "Medical Knowledge and Application of the Advance Directive Document" to contribute to future decision-making in advanced chronic diseases and end-of-life care processes. The project is being conducted by the Pontificia Universidad Javeriana and the San Ignacio University Hospital under the leadership of Dr. Martha Patricia Rodríguez Sánchez.

Before deciding whether to participate in the study, please read this document carefully, ask any questions you have to ensure that the study procedures are clear, and make an autonomous, voluntary, and free decision about whether to participate. If doubts remain after reading this document, they will be clarified. Therefore, you should feel completely free to ask about any aspect that helps you decide your participation. All necessary information will be provided before you are included in the study. If you wish to participate, you will need to confirm your decision by signing this consent, and you will receive a signed and dated copy.

GENERAL INFORMATION

Given the importance of understanding the medical community's opinion regarding advance directives (AD) and knowledge of the official document issued by the Ministry of Health and Social Protection (Resolution 2665 of 2018), this research aims to address the existing gaps related to physicians' knowledge of the advance directive document (DVA) in our context.


https://doi.org/10.36105/mye.2025v36n3.03

Therefore, the objective of this research is to determine the knowledge, work experience, applicability, and barriers associated with the advance directive document among physicians in various fields (whether clinical, educational, or administrative) and to evaluate its applicability according to the level of academic training in which they practice.

Additionally, the research will help establish data related to the frequency and timeliness of implementing the document, without waiting for the patient's clinical deterioration or progression to advanced stages of disease for its implementation.

Semi-structured interviews will be conducted with medical staff from different specialties such as Internal Medicine, Geriatrics, Family Medicine, and surgical areas, including participants from surgical oncology, gynecology, and obstetrics, from November 2023 to August 2024. The survey will be applied in two phases: in the first phase, the interview will be conducted via the RedCAP® platform, taking no more than 10 minutes. In the second phase, semi-structured interviews will be conducted either in person or virtually, based on a clinical case presented to the focus groups of residents.

Interviews will be fully transcribed, edited, coded, and analyzed using NVivo software version 12.0, ensuring the confidentiality of personal data. The study's results are expected to generate strategies that facilitate the application of advance directives, thereby aiding decision-making in high-complexity scenarios related to chronic or advanced diseases and end-of-life stages.

The identity of the research participants will be kept confidential. The data collected will only be used to achieve the objectives of this study, and any dissemination will occur in academic settings where only the results will be shared, with no identifying details about the participants being disclosed, ensuring confidentiality at all times.

This type of study does not present specific risks or benefits to either party; it is a study containing sensitive information, where the participant may withdraw from the study at any time without it


https://doi.org/10.36105/mye.2025v36n3.03

affecting them directly or indirectly. It is their choice, and all their rights will be respected. However, data collected up until that point will be part of the study unless the professional does not consent or requests that their information be removed from the database. A copy of the form will be provided to the participant.

The results are intended to be published in academic venues such as conferences, meetings, and scientific journals. If any participants are interested in obtaining further details about the results from the tools applied, they may request access.

## AUTHORIZATION

I have read the information provided and understood the explanations given to me in clear and simple language. I understand that I must participate in the first phase, which is a survey for this study, and that I may subsequently be selected for the second phase, which is a semi-structured interview based on a clinical case.

The researchers have allowed me to express all my observations and have clarified all the doubts and questions I raised regarding the study. I will be provided with a copy of this document. I have been informed that I will not be exposed to risks and that there are no benefits to me, and that I will not be compensated financially. I have been provided with the name of the researcher, who can be easily contacted using the name and address provided to me.

By signing this document, I freely and voluntarily consent to participate in the research "Medical Knowledge and Application of the Advance Directive Document" as a study participant, and I understand that I have the right to withdraw from this study at any time without being affected in any way.

If you have any questions regarding your participation in this study, you may contact Dr. Martha Patricia Rodríguez Sánchez at the following phone number: 3002076518. Email: mprodriguez@husi.org.co or the delegate president of the Institutional Ethics


https://doi.org/10.36105/mye.2025v36n3.03

Committee: Isabel Cristina Cuellar at 3208320 Ext 2770, Cra. 7 No 40-62, 8th Floor, Faculty of Medicine.

*Web Link*

https://redcap.husi.org.co/surveys/?s=CCKF9NDWF7HAN4KR

*QR Code*


https://doi.org/10.36105/mye.2025v36n3.03