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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

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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

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Abstract

This study investigated the knowledge, applicability, and barriers related to advance directives document (ADD) 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 ADD. The results showed that 79.2% of participants recognize

**** 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

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the importance of planning medical wishes, and 92.5% know that doctors must respect the ADD 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 ADD 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). This legislation reflects 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 ADD´s, 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. Despite these advances, there is still a gap

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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, 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 ADD 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 ADD. Participants in the first phase of the study were doctors from

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

3. Inclusion and exclusion criteria

Inclusion 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.

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To achieve a comprehensive understanding of the topic, responses to self-administered surveys were analyzed. These surveys took approximately 5-10 minutes to complete and were conducted through the institutional RedCap® platform at the 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 ADD 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 HUSI, 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 ADD 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

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participants 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 specialty (28.3%), followed by medical specialists with first specialty (2.6%) and second specialty (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 ADD 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.

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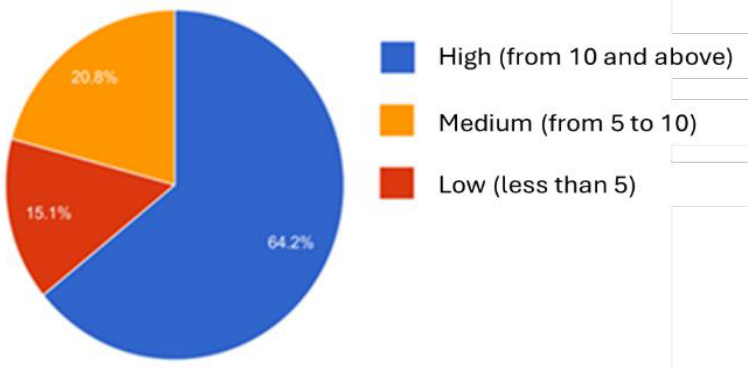
The results obtained according to category and item evaluated are detailed below.

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.

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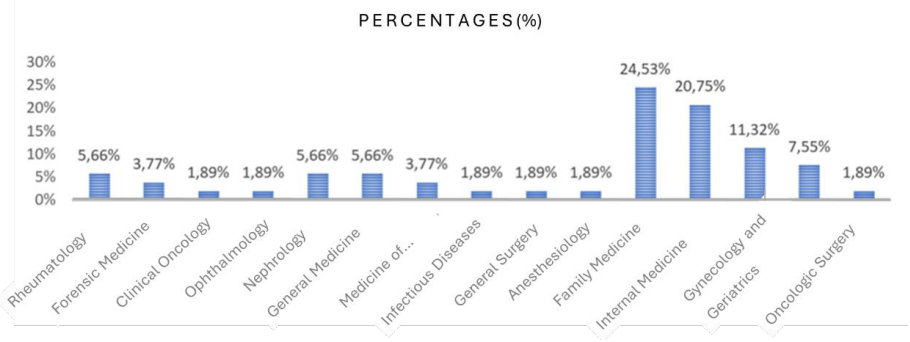
What is your specialty?

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.

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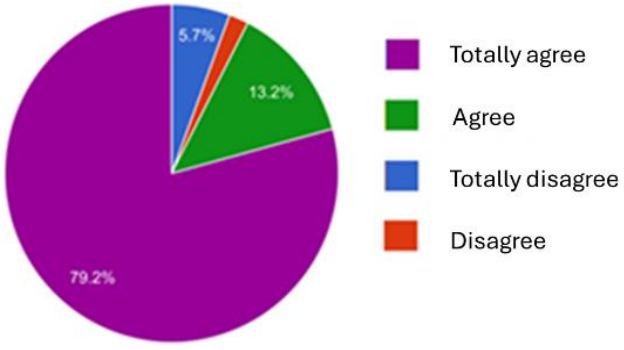
Graph 3. Planning the patient's medical wishes

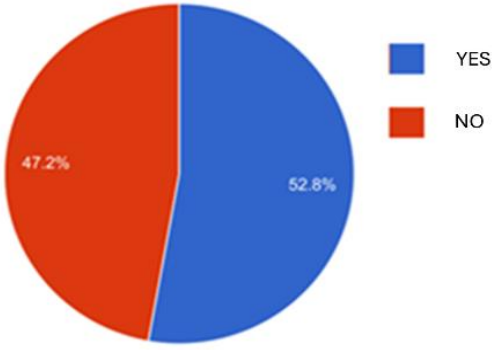


Source: prepared by authors.

Has any patient asked you for information about the ADD?

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

Graph 4. Request for information from the doctor regarding the ADD



Source: Prepared by the authors.

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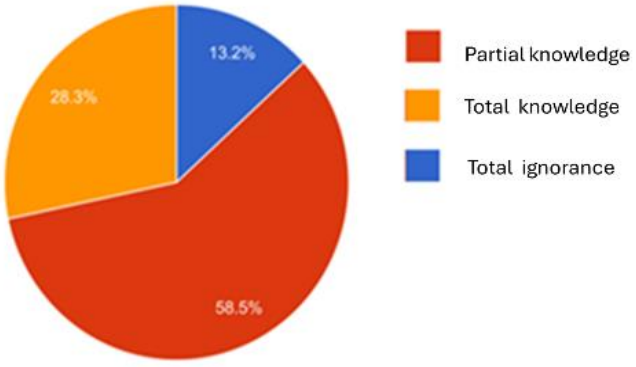
5.1.3. *Medical Knowledge of the DVA. Specific questions about understanding the ADD*

How well do you know the ADD?

As shown in Graph 5, the majority (58.5%) reported partial knowledge of the ADD, followed by total knowledge with 28.3%. Only 13.2% reported complete ignorance of the ADD, 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 ADD



Source: prepared by authors.

Does the ADD rest on the patient's right to autonomy?

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

Can aspects contrary to current legislation be included in the ADD?

Most 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 ADD?

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

Do you know how to create a ADD?

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

Application and attitudes towards the advance directives document

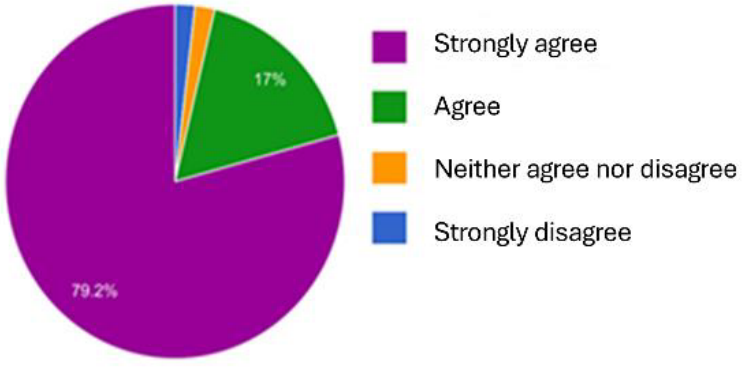
Would you recommend that your patients use the ADD?

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

Would you write a ADD 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 an ADD for yourself if you had to decide about your health?



Source: prepared by authors.

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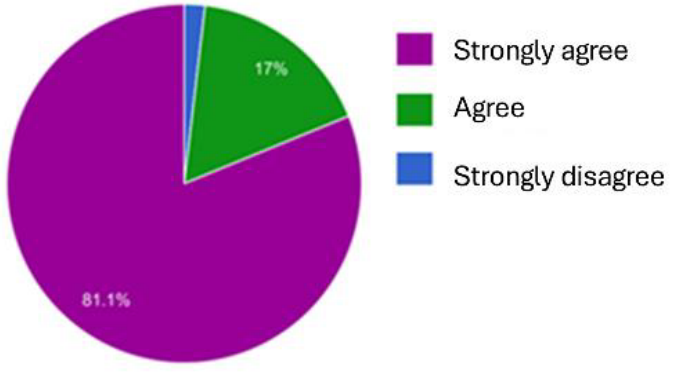
Does the ADD facilitate decision-making in the final stages of life for family members and healthcare professionals?

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

Graph 7. Does the ADD 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 to participate in clinical decision-making at the end of life?

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

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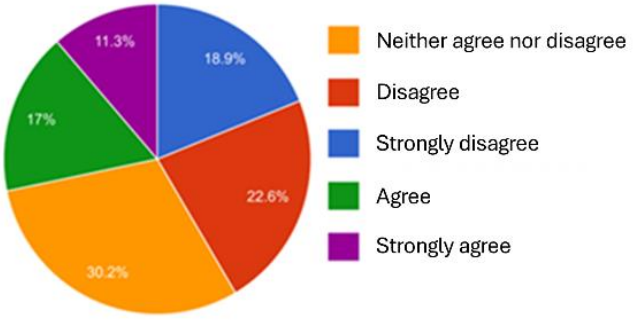
Graph 8. Do you think your chronic patients are well-informed about the progression of their illness to participate in clinical decision-making at the end of life?

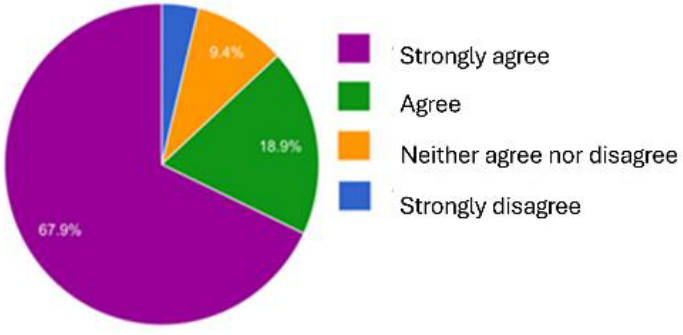


Source: prepared by authors.

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.

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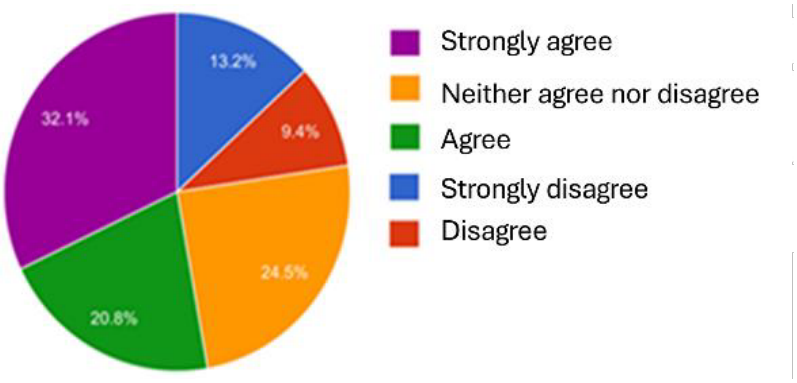
Do you prioritize advance directives over your professional judgment?

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 ADD is limited, as shown in Graph 11.

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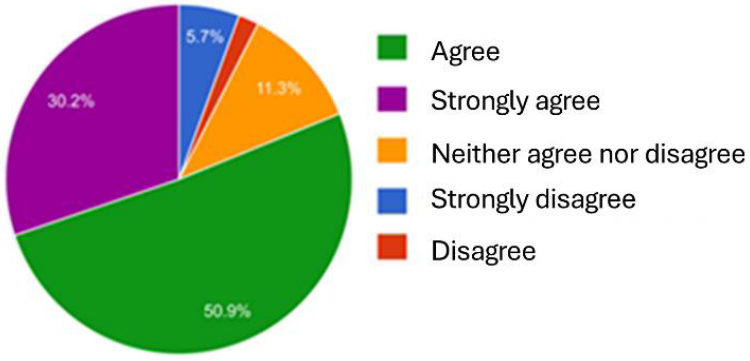
Graph 11. Is the time available for providing detailed information about advance directives to your

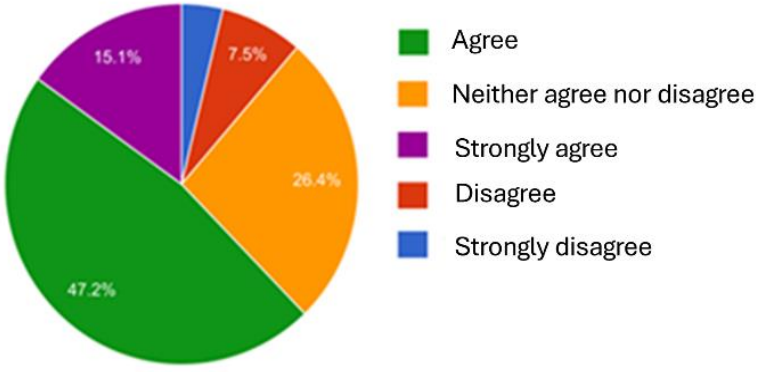


Source: Prepared by the author

There are not enough support tools available to create the ADD

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 ADD



Source: prepared by authors.

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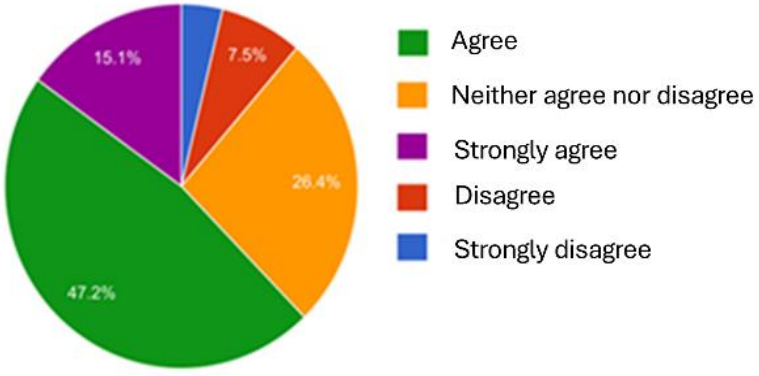
Do you think assertive communication training is insufficient?

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 ADD. The experiences and opinions regarding the application of these advance directives 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.

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

7. Discussion

Since their inception, advance directives have been widely promoted and supported around the world as a fundamental part of planned care (25). Several intervention studies have shown positive results, suggesting that both education and communication with patients are effective strategies for encouraging the use of advance directives (16–19). Physicians' individual perspectives, beliefs, experiences, limited time for medical care, and the duration of their relationships with colleagues and families can complicate the advance directive process, especially at the end of life (26,27).

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

The sample of doctors analyzed in this study had a median age of 38 years, with a predominance of women, and a level of professional experience that allows them to be exposed to requests for ADDs. On the other hand, it is important to note that most of the respondents work in outpatient clinics and a small percentage in surgical hospital care (9.4%); however, the application of ADD may be influenced more by the characteristics of the patients themselves than by the clinical practice settings in which doctors work. Greater

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professional experience allows for greater solidity in accompanying medical decision-making and even in the correct application of ADD, as it reduces the moral distress of professionals and reduces fears of facing difficult situations, favoring better planning of care processes. This is relevant because ignorance of the appropriate way to take into account the patient's wishes or advance directives can lead to limitations in guidance and assertive communication, regardless of the age of the professionals, their area of work and their level of experience in medical practice.

On the other hand, the present study documented that 79.2% of professionals stated that they totally agreed with the advisability of planning patients' medical wishes. Although this figure does not explicitly establish the frequency with which professionals receive advance directives from their patients, it is an indirect indication of the recognition of their importance and applicability in clinical practice. Furthermore, this finding represents the relevance of respect for autonomy and reflects decisive changes in medical practice, which historically was based on paternalistic medicine.

However, another interesting finding of this study was that 47.2% of respondents did not receive requests from patients to apply the ADD, which may be related to their patients' sense of well-being or because they do not consider the complexity of their illness as something that leads them to make decisions or express their wishes openly and clearly in advance (31,32). In addition, there may be other barriers that prevent patients from communicating with their doctors. In contrast to this finding, a study conducted in Colombia in 2020 by Álvarez and Gomezese found that 24% of the doctors surveyed had received one or more advance directives from their patients (33).

Regarding knowledge of ADD, the majority said they had partial knowledge, while 31.5% said they had adequate knowledge, which means that there is currently a need to further strengthen knowledge of this document and the importance of its application during medical care. The finding that 13.2% of respondents were unaware of

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ADD is not insignificant. This group included doctors from various specialties, with an average age of 38. This result implies that comprehensive fieldwork is required for healthcare professionals to strengthen and facilitate the patient's medical decision-making, especially at the end of life. Several studies have pointed to the lack of adequate professional training related to the dying process (34,35) and research examining the interests of patients in the final stages of life (34,36). Improving the training of doctors in the ethical principles of autonomy and beneficence allows several fundamental purposes to be achieved, both for doctors and healthcare personnel in general, as well as for their patients. This includes understanding the legal obligations regarding advance directives and the professional moral duty to refer patients when their wishes conflict with the guidance of the doctor in charge of their health; empowering patients through doctors trained in understanding patient autonomy; ensuring understanding of the risks and benefits before refusing or accepting treatment; and, most importantly, the professional must act as a guide in the process and not as an authority, which promotes person-centred care, reduces ethical risks and, ultimately, improves clinical outcomes and strengthens trust and human sensitivity during the provision of healthcare services.

In line with the above, a significant finding of this study is that most participants (56.6%) indicated that they did not know how to write advance directives. In Spain, Simón Lorda *et al.* (37) conducted a study exploring physicians' level of knowledge about ADD, measured on a scale of 0 to 10, in which the average knowledge score 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 conducted by Ameneiros *et al.* (38) showed that knowledge about advance directives among primary and specialized care physicians obtained an average of 3.8 (SD: 2.3) on a scale of 0 to 10. All of this could indicate insufficient training and awareness among doctors regarding ADAs, and inconsistency in the assessment of patients' wishes and desires, as well as assertive communication in clinical relationship processes.

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There was variability in knowledge about the legality of including aspects contrary to current legislation in ADAs, with 32.1% of participants indicating that they had no knowledge of this. Although doctors tend to have a higher level of knowledge about ADAs than the general public, most do not have a detailed understanding of the concept, current laws (including their binding nature in end-of-life care) and, especially, how to implement them in professional practice, ranging from administrative aspects to how they should act in specific clinical cases (39,40).

In contrast, most respondents agreed that doctors are legally obliged to respect ADDs. In this regard, the law is not binding in giving priority to ADDs over medical criteria, as defined in Article 14 of Resolution 2665 of 2018:

> Health professionals must recognize advance directives as an exercise of autonomy by the person signing them and, therefore, they must be considered when making decisions about the person's care and treatment, without disregarding lex artis and the best interests of the patient (3).

This includes understanding the legal obligations regarding ADDs and the moral duty to refer patients when their wishes conflict with medical advice.

In the study conducted by Álvarez and Gomezese, it was found that 54% of participants stated that they were unaware of the existence of the legal regulations governing ADDs, while 34.33% indicated that they were aware of the requirements that such documents must meet (33), reflecting that ignorance about ADDs is a global phenomenon, with a significant gap for their full implementation in clinical practice. Monteiro and Gomes, in their review of the literature on the use of ADDs in Latin America, concluded that, despite growing interest, there is generally difficulty in adopting ADDs regardless of current legislation (41). This suggests that healthcare professionals may not be fully aware of these advance directives, which may hinder their implementation in clinical practice (41,42).

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Seventy-five-point five percent of the participants in the present study strongly agreed with recommending the use of AD to their patients, indicating strong acceptance of this concept among the physicians surveyed and suggesting its potential integration into clinical practice; however, professional knowledge should be strengthened to generate a more appropriate and timely application of advance directives. In a review conducted by Coleman, it was observed that, in general, physicians show positive attitudes toward advance directives. Respect for patient autonomy emerges as the main determinant of these attitudes (43), which is consistent with what was documented in the present study, in which all respondents recognized that advance directives is based on the patient's right to autonomy. The study published by Pablo Simón et al. reveals a favorable attitude among physicians towards the usefulness of advance directives, like that reported in a study of primary care physicians conducted by Navarro Bravo B *et al.* (37,44). Although doctors may agree with advance directives (45), they tend to prefer them less than their patients and use them infrequently (46). In the present study, 79.2% strongly agreed with drawing up an ADD for themselves, further reinforcing this positive trend. It is important to recognize that, although a small 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 care. This may be secondary to the fact that doctors may feel inadequately trained in shared decision-making processes and uncomfortable discussing advance directives; lack of confidence may contribute to their reluctance to advocate for these options and increase uncertainty and distress in medical practice, limiting the applicability of advance directives (47).

The results of this study indicate that 81.1% strongly agreed that advance directives facilitate decision-making by patients, their families, and healthcare professionals in the final stages of life. However, it is striking that healthcare professionals perceive that patients with chronic diseases are not well informed about the progression

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of their disease to be able to participate adequately in clinical decision-making at the end of life. A study conducted in Colombia on patients in end-of-life processes (48) found that 14% had signed their own advance directives. This highlights the need to strengthen knowledge and education about the right to decide on the care we wish to receive at the end of life.

Encouraging open dialogue between patients and doctors helps to clarify individual expectations and preferences. This communication is essential for making informed decisions that respect patient autonomy while prioritizing 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 judgement, probably in relation to the conflict between the principle of patient autonomy and beneficence. In this regard, Beauchamp and Childress defined the principle of beneficence as the obligation to 'help others achieve their important and legitimate interests' (49). Along these lines, and following Diego Gracia, there is no real conflict between autonomy and beneficence, given that:

> They are closely related moral principles and therefore on the same level [...] Something that is beneficent is always beneficent for me. Beneficence is always beneficent with respect to one's own system of religious, cultural, political and economic values (50).

For the patient to achieve their most important and legitimate interests, the doctor must not only consider what they consider technically appropriate for the disease, but also the patient's values and preferences, since in this sense it would not be possible to be beneficent without respecting the patient's autonomy. In this context, rather than placing the ADD above the doctor's judgement, it should be considered as a fundamental part of clinical medical decision-making (28,29,31).

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In the present study, most participants agree that in the event of disagreement with the ADD, the doctor has a moral duty to transfer the patient to another professional, which is a representation of the care that the professional has for their patients. Having found participants with an undefined position creates a risk in attending to the wishes and desires of the patient. The shift in medical care towards prioritizing patient autonomy has given rise to ethical dilemmas; some doctors may feel that their moral integrity is compromised when a patient demands conflict with their professional judgement (51,52). Literature emphasizes that, while doctors have the right to conscientious refusal, they also have a duty to refer patients to other professionals who can provide the necessary care (53) in an appropriate and timely manner with the responsibility, compassion and mercy that the medical act confers on them.

This study explored the barriers perceived by professionals to the discussion and application of ADDs, including the lack of sufficient tools to carry out the ADD and the lack of time that doctors have during patient encounters to discuss the concept of ADDs, promote and implement their use (15,33), and thus provide detailed information about advance directives to their patients (33). Proper documentation of patient preferences and decisions in the medical record is part of professional practice and is vitally important as a tool for professional communication. This ensures that their 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. Continuing education on ethical dilemmas and case studies can help healthcare professionals develop skills to effectively address conflicts between autonomy and beneficence. This training can foster a culture of ethical awareness and sensitivity in medical settings.

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

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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 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 at a single healthcare institution, 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 ADD 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 ADD, leading to inadequate perceptions of their knowledge on the assertive application of the ADD (response bias). Additionally, bias may occur if participants provide socially desirable answers rather than their true opinions (response bias).

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9. Conclusions

The findings of this study suggest a critical need to improve the training and education of healthcare professionals regarding end-of-life care and the application of the ADD, to ensure they effectively support patients in making informed decisions about their medical care.

The limited knowledge of the ADD 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 ADD for themselves, suggesting a positive attitude toward the concept of advance directives, in contrast to the lower actual frequency of ADD 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 ADD in clinical practice, several recommendations can be made:

- Improve training and education on the ADD for healthcare professionals to address knowledge gaps.
- Provide communication skills workshops to facilitate discussions about the ADD.
- 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 ADD.
- Create accessible resources about the ADD for patients.

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- Encourage doctors to document patients' desires or preferences in medical history and ideally confirm the completion of the ADD before reaching health conditions where decision-making capacity is compromised or the patient is in the final stages of life or dying.

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

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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 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 ADD in our context.

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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, always ensuring confidentiality.

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 affecting them directly or indirectly. It is their choice, and all their

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rights will be respected. However, data collected up until that point will be part of the study unless the professional does not consent or request that their information be removed from the database. A copy of the form will be provided to the participants.

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

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