



ORIGINAL ARTICLE

Knowledge of Palliative Care and Attitude towards Advance Medical Directives in Medical Community: A Cross Sectional Study in a Tertiary Care Center

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Abstract

Background: Palliative care focuses on relieving symptoms and stress from serious illnesses, aiming to improve the quality of life for both patients and their families. It is appropriate at any stage of illness and can be provided alongside curative treatment. Advance Medical Directives (AMDs) are legal documents that allow individuals to outline their medical treatment preferences if they become unable to communicate. This study was intended to evaluate the perception of the Medical Community in this institution about Advance Medical Directives and End of Life Care, generating novel insights.

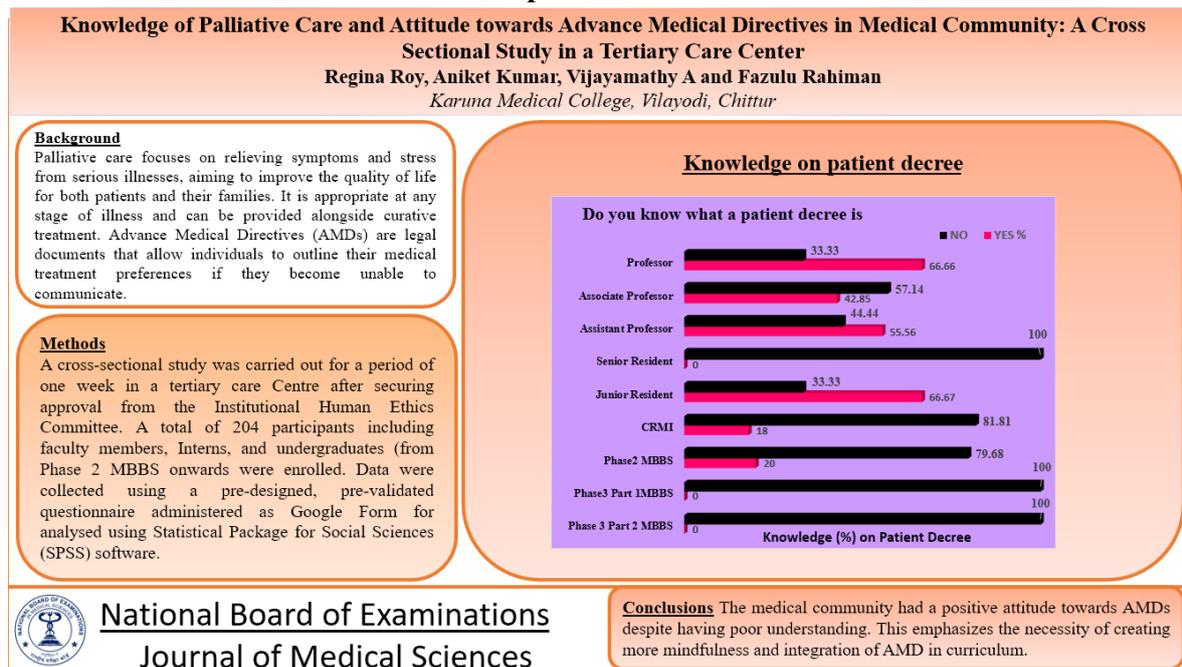
Objectives: The primary objective was to evaluate the attitude and knowledge of the medical community (including faculty, interns, and undergraduates) regarding palliative care and Advance Medical Directives (AMDs). The secondary objective was to explore perceptions about implementing palliative care into the Competency-Based Medical Education (CBME) curriculum. **Methods:** A cross-sectional study was carried out for a period of one week in a tertiary care Centre after securing approval from the Institutional Human Ethics Committee. A total of 204 participants including faculty members, Interns, and undergraduates (from Phase 2 MBBS onwards) were enrolled. Data were collected using a pre-designed, pre-validated questionnaire administered as Google Form for analysed using Statistical Package for Social Sciences (SPSS) software. Association between categorical variables was assessed by Chi-square test. The knowledge and attitude scores were correlated by Pearson correlation test.

Results: Of the participants, 78% were females. Fear of death was identified as their greatest concern in terminal illness by 47.09% of participants. 77.67% of the participants believed that once an AMD is signed it remains valid for life. 28.16% of the participants were of the impression that AMDs are a legal form of euthanasia. Integration of palliative care into Phase 1 of the CBME curriculum was supported by 37%. There was no statistical significance in the correlation of knowledge with attitude which was weak negative ($r = -0.108$; $p = 0.124$). **Conclusion:** The medical community had a positive attitude towards AMDs despite having poor understanding. This emphasizes the necessity of creating more mindfulness and integration of AMD in curriculum.

Keywords: Palliative care, Advance Medical Directive, Medical Community, Power of Attorney

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Graphical Abstract



Introduction

“Advance Medical Directive” is a healthcare document which is a type of “living will.” It is a common term for a document which articulates in advance your choices in the event you are physically and mentally incapacitated. Various types of directives are available such as living wills, powers of attorney for health care, etc. [1].

Advance directives are legal documents which empower people to disclose their decisions in advance as to what must be done or who will take decisions on their behalf, if a time comes when they are physically or mentally incapacitated [2]. Advance directives enable them to have more control over future care than is ordinarily possible [3]. Advance directives, particularly living wills, significantly improve the possibilities of getting healthcare according to the concerned patients' preferences when they lack decision-making capacity [4]. Danis et al. in the research concluded that advance directives for life-sustaining care are

effective when followed, but their effectiveness is limited by inattention and prioritization of other factors [5]. Advance Care Directives, as per Kermel-Schiffman and Werner bestow several benefits for the incapacitated person as well as his/her family and attending professionals [6]. The autonomy of the person is preserved ensuring respect for his value and treatment preferences. This leads to improved quality of life and life satisfaction at End-Of-Life stage (EOL). It also facilitates patient-centred EO care [6].

Palliative care concentrates on ameliorating symptoms and stress during serious illnesses, leading to improvement in the quality of life for both patients and their family members. Palliative care can be provided during the course and management of the illness. Palliative care teams are multidisciplinary, including doctors, nurses, social workers, and chaplains, who work in tandem to address physical, emotional, spiritual, and social needs [7]. AMDs, particularly during

palliative care, are essential for facilitating the values and preferences of the patient concerned [8]. Our study aimed to compile data about the attitude towards, knowledge about and preferences of a sample of health community regarding EOL care and AMD.

Objectives

To assess the knowledge and attitude of Medical Community in a tertiary care hospital regarding palliative care and Advance Medical Directives and to assess the Medical Community's perspectives on implementing palliative care in CBME curriculum.

Methods

A cross-sectional study was carried out over a period of one week from 19.11.2024 to 25.11.2024 in a tertiary care Centre after securing approval from the Institutional Human Ethics Committee (KMC/IHEC/36/2024 dated 30.10.2024) and only the participants who gave consent were included in the study. The study population included 204 participants from the medical community, consisting of Faculty members, Interns and Undergraduate MBBS students. STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) checklist was adhered while designing the study.

Data on attitude towards and knowledge about palliative care and Advance Medical Directives (AMDs) was collected using a pre-validated, predesigned questionnaire distributed through Google Forms (Annexure 1). Data on knowledge about palliative care of Palliative Care was collected using 12 questions addressing various aspects of palliative care and its effectiveness. Data on knowledge regarding Advance Medical Directives (AMDs) was compiled by means of 2-point Likert scale questions, 7 in number. Attitude towards AMDs was gauged using 10 items. Questionnaire was constructed based on previous literature [9,10].

Additionally, opinion of participants was compiled regarding the inclusion of palliative care in the CBME (Competency Based Medical Education) curriculum, specifically the initiation of training from Phase 1 of the MBBS course.

Data were analysed using SPSS software. Categorical variables were summarized using frequency distribution and Chi-square test was used to examine the association between them. Pearson's correlation coefficient was used to correlate the relationship between attitude and knowledge. The results were considered statistically significant if the p-value < 0.05.

Results

Table 1. Sample Characteristics

Professional status	n=204 (Percentage)
Phase 3 Part 2	5 (2.43)
Phase3 Part 1	1 (0.49)
Phase2	128 (62.14)
CRMI	44 (21.36)
Junior Resident	3 (1.46)
Senior Resident	1 (0.49)
Assistant Professor	9 (4.37)
Associate Professor	7 (3.40)
Professor	6 (2.91)
Gender	Percentage
Male	54 (26.21)
Female	150 (77.82)

The study involved 204 participants consisting of mostly Phase 2 MBBS

students 127 (62.14%). 78% of the total participants were females (Table 1).

Table 2. Knowledge on Palliative Care

Awareness and Knowledge of Palliative Medical Care	Most Common response	Awareness n (%)
In your opinion, what are the greatest fears of a patient who has been diagnosed with a terminal illness	Fear of death.	97 (47.09)
How much do you think people generally speak about death and dying?	About the right amount.	74 (35.92)
If you had a terminal illness, where would you like to spend the final stage of your life?	Home	160 (77.67)
If you had a terminal illness, where would you like to spend the final stage of your life?	Do not know	23 (11.17)
How do you rate your knowledge and awareness of palliative care in your state	Moderate	97 (47.09)
If you have already heard of palliative care, where did you find out about it?	Heard -work with patients on palliative	66 (32.04)

Please select the following sentence that in your opinion best describes palliative care	Improve quality of Life	105 (50.97)
Where and by whom do you think care is best provided to patients with a terminal illness	Family/Relatives	84 (40.78)
Among patients with the illnesses listed, who do you think should receive palliative care	Cancer-Fully Agree	158 (76.70)
	Kidney failure-agree	80 (38.83)
	Heart Failure-Fully Agree	58 (28.16)
	HIV AIDS-Fully Agree	74 (35.92)
	Chronic Lung Disease-Partly agree	66 (32.04)
	Dementia-Fully Agree	88 (42.72)
	Stroke-Fully Agree	79 (38.35)

Most of the participants (77.67%) said that they preferred to spend the final stage of their life at home if they had a terminal illness.

A sizable number of participants (76.70%) responded that patients with Cancer should receive palliate care (Table 2).

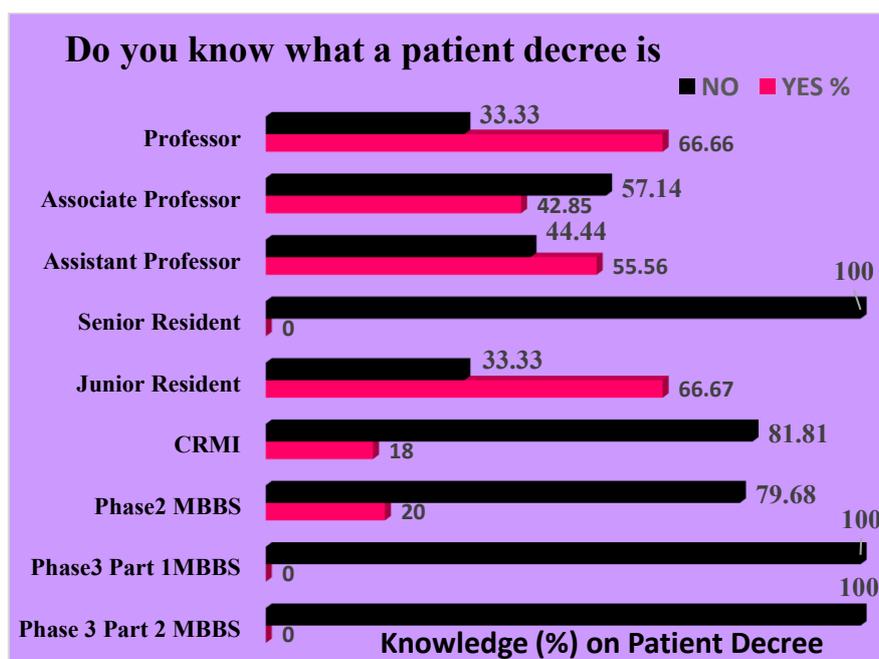


Figure 1. Knowledge on patient decree

Of the participants from the Medical Community, Professors (66.66%) and Junior Residents (66.67%) were most aware about patient decree.

The knowledge about patient decree was nil among Phase 3 Part 2 MBBS Students and Senior Residents (Figure 1).

A very high number of the participants (70.87%) did not consider AMD as the same as euthanasia (Table 3).

Table 3. Knowledge on Advance Medical directive

Knowledge on Advance Medical directive	Correct n(%)	Incorrect n(%)
Once signed Valid for life	160 (77.67)	44 (21.36)
AMD is the same as euthanasia	58 (28.16)	146 (70.87)
AMD reflects the values and preferences of citizens	177 (85.92)	27 (13.11)
AMD not be subjected to experimental treatments	161 (78.16)	43 (20.87)
family has to agree with the content of the AMD statement	154 (74.76)	50 (24.27)
family's opinion overrides that of the health care prosecutor.	125 (60.68)	79 (38.35)
If patient is unconscious, their family can change or cancel the content of the AMD.	102 (49.51)	102 (49.51)

Table 4. Descriptive statistics of the Attitude towards Advance Medical Directives

	Mean *SD ¹ (Standard Deviation)	Agree	Disagree	
1	AMDs are a useful tool for healthcare professionals when making decisions about EOL patients.	3.50(1.34)	66 (32.04)	23 (11.17)
2	AMDs are a legal form of euthanasia.	2.88(1.40)	39 (18.93)	49 (23.79)
3	Legalization of the vital testament did not contribute to human dignity.	2.70(1.25)	21 (10.19)	52 (25.24)
4	Death must be postponed, regardless of the person's condition.	2.50(1.32)	22(10.68)	66 (32.04)
5	EOL care should be provided based on the opinion of the health professional.	3.49(1.17)	49 (23.79)	16 (7.77)
6	EOL care should not be provided based on the patient's opinion.	2.75(1.31)	27 (13.11)	49 (23.79)
7	EOL care should be provided based on the opinion of the family.	2.93(1.27)	28 (13.59)	39 (18.93)
8	The vital testament is only important for elderly and sick people. *	2.65(1.32)	25 (12.14)	57 (27.67)
9	I do not make a Vital Testament because there is still little information available	3.09(1.27)	39 (18.93)	32 (15.53)

10	My family will make the EOL decisions for me, when necessary	3.05(1.25)	36 (17.48)	29 (14.08)
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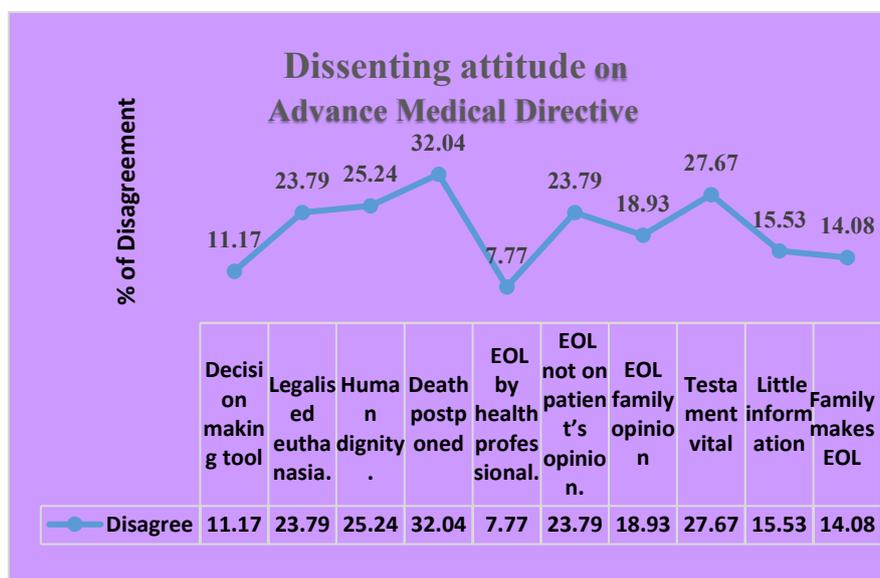


Figure 2. Dissenting attitude on Advance Medical Directive

Table 5. Correlation between knowledge and attitude (n=204)

Variable	Pearson correlation (r)	p value
Knowledge vs. Attitude	-0.108	0.124

Attitude and knowledge were not significantly correlated (Table 5).

AMDs have been perceived as useful for healthcare professionals in EOL decisions (M = 3.50, SD = 1.34), although some misconceptions persisted, such as equating AMDs with euthanasia (M = 2.88, SD = 1.40) or viewing them as undermining dignity (M = 2.70, SD = 1.25). Respondents were neutral in opinion about postponing death regardless of condition (M = 2.50, SD = 1.32). They expressed mixed views on whether EOL care should be given by professionals (M = 3.49, SD = 1.17), whether EOL care should exclude patient opinion (M = 2.75, SD = 1.31), or whether it should involve families (M = 2.93, SD = 1.27). The belief that vital testaments apply only to elderly or sick individuals was weak

(M = 2.65, SD = 1.32), while for lack of information (M = 3.09, SD = 1.27) and reliance on families for decisions (M = 3.05, SD = 1.25) (Table 4).

The study found that a participant's designation was statistically related to their opinion on two specific topics. The first is the belief that AMDs are a form of legal euthanasia (p = 0.0036). The second is the conviction that a patient's death should be delayed regardless of their condition (p = 0.0299). This indicates that professional level influenced attitudes towards ethical and decision-making aspects of EOL care.

The analysis showed significantly association between professional designation and attitudes toward several aspects of Advance Medical Directives. Different designations held distinct

viewpoints on end-of-life topics like euthanasia, extending life, the involvement of patients and their families in making decisions, and the importance of living wills. In contrast to this the usefulness of AMDs for healthcare professionals was acknowledged across various designations. They also held the belief that legalisation of vital testaments compromises human dignity.

Figure 3 depicts the perceptions of participants regarding the addition of palliative care in the CBME program. A majority of them (37.38%) agreed that palliative care should be introduced, while 24.27% partly agreed. An equal proportion (24.27%) remained neutral which showed indecisiveness. Only a minor portion of participants disagreed: 5.83% partly disagreed and 7.28% strongly disagreed. Overall, more than 60% of participants supported or partly supported the incorporation of palliative care into the CBME curriculum, reflecting positive inclination towards early exposure.

Discussion

The study was based on responses from 204 participants. Gender wise, females predominated (77.82%), while male participants constituted 26.21% of the total.

None of the Phase 3 Part 2 MBBS students and Phase 3 Part 1 MBBS students knew what is a patient decree. Regarding this, only 20% of Phase 2 MBBS students were aware, while 79.68% were not, while among CRMIs, 18% knew, and 81.81% did not. A higher proportion of Junior Residents (66.67%) knew about a patient decree, compared to 33.33% who did not. All Senior Residents reported non-awareness. More than half of the Assistant Professors (55.56%) were aware, while

44.44% were not. Among Associate Professors, 42.85% knew, and 57.14% did not. Two-thirds of Professors (66.66%) were aware, while 33.33% were not (Figure 1). Thus, awareness about patient decree was very low among MBBS students and CRMIs but higher awareness was seen among Junior Residents and Professors.

In this study, 47.09% of participants identified fear of death as their greatest concern in terminal illness, a finding consistent with prior reports that highlighted death-related anxiety as a major psychosocial worry in palliative care [11]. Only 35.92% felt that people speak about death and dying the “right amount,” indicating communication barriers similar to those documented by who noted that cultural reluctance often creates a barrier in EOL discussions Brighton & Bristowe [12]. A large proportion (77.67%) expressed preference to spend their final stage at home, aligning with global evidence that most patients value home-based care over institutional care [13]. However, 75.73% of the participants expressed unawareness about patient decrees or advance directives, reflecting poor awareness. This has been also reported in other Indian and international studies [14].

Knowledge about palliative care in this state was rated as “moderate” by 47.09%, while only 32.04% had prior exposure through direct patient care, suggesting limited training opportunities; which is similar to the findings of Rhee JY et al. [15]. The question on the purpose of palliative care was responded with “improving quality of life” by 50.97%. 40.78% of the participants opined that family/relatives are best able to provide care, reflecting the cultural expectation of family-centred caregiving in India [16]. With regard to disease-specific need for

palliative care, agreement was highest for cancer (76.70% fully agree), while for non-malignant conditions the responses were: kidney failure (38.83% agree); heart failure (28.16% fully agree); HIV/AIDS (35.92% fully agree); chronic lung disease (32.04% partly agree); dementia (42.72% fully agree); and stroke (38.35% fully agree). These results are similar in international literature, where palliative care is often perceived as cancer-focused, despite strong evidence supporting its benefits in non-cancer illnesses [17,18].

With regard to AMD, 77.67% of participants believed that once an AMD is signed it remains valid for life (Table 3). This shows that there is some understanding of its legal nature, but it also shows that it is not complete since revisions or updates of AMD are possible and recommended according to changing circumstances [19]. Misconceptions were also evident as 28.16% equated AMD with euthanasia, but 70.87% identified them as different concepts. This is in alignment with previous reports of confusion between end-of-life directives and assisted dying [20]. Similar to the findings of Song et al. [21], 85.92% of the participants felt that AMDs reflect the values and preferences of citizens which supports AMDs as a tool for patient autonomy.

The majority of the participants (78.16%) recognised that AMDs can protect patients from unwanted experimental treatments, consistent with the ethical principle of non-maleficence. Of the participants 74.76% felt that the family must agree with the content of an AMD and 60.68% believed that the opinion of the family can override the decision of the healthcare provider. This matches Indian studies where family-centric decision-making often over-rides individual

autonomy [14] in contrast to Western studies where patient directives are given legal priority [21]. Furthermore, 49.51% believed that families can change or cancel an AMD if the patient is unconscious, while an equal 49.51% disagreed, reflecting significant uncertainty and lack of clarity regarding legal authority.

Taken together, these findings show that while respondents broadly recognize AMD as a tool for autonomy, misconceptions still persist regarding its validity, distinction from euthanasia, and the legal authority of families. Similar challenges in public and professional understanding have been reported globally [21] underscoring the need for educating the stake holders to clear the policy in the Indian context.

In this study, only 11.17% did not agree that AMDs are a useful tool for healthcare professionals in decision making regarding end of life, indicating that their utility is broadly recognised (Table 4 and Figure 2). 23.79% of the participants mistakenly considered AMDs as a legal form of euthanasia which reflects the same misconception documented in other studies where the concepts of euthanasia and advance care planning were found confused [19]. Disagreement was found from 25.24% on the statement that legalizing the vital testament contributes to human dignity, suggesting the prevalence of ethical uncertainties around its perceived value.

In answer to the questions pertaining to life-prolonging measures, 32.04% believed death must always be postponed regardless of condition, reflecting a tendency toward aggressive treatment approaches, which has also been reported in other Indian contexts where cultural and religious beliefs emphasize life preservation [14]. Only 7.77% disagreed

that EOL care should be guided by healthcare professionals, showing trust in medical expertise. Conversely, 23.79% disagreed with the statement that patient opinion should not guide EOL care, reflecting that there is no proper understanding about the role of patient autonomy. This is consistent with other studies showing family- and physician-dominated decision-making in Asian societies [22].

Family involvement was evident, with only 18.93% disagreeing that decisions regarding end-of-life care should be determined by the family's wishes. A number of participants (14.08%) endorsed the family as the ultimate decision-makers, emphasising the cultural dominance of family-centred care in India [16]. A sizable proportion (27.67%) felt that AMDs were only important for the elderly or sick, showing limited understanding of their broader applicability across all ages. About 15.53% admitted they would not make a vital testament due to lack of adequate information. This points to educational gaps, also reported in other low- and middle-income settings [23].

Overall, these findings suggest that while AMDs are generally viewed as useful and dignity-preserving, some misconceptions prevail regarding their link with euthanasia, their relevance beyond the elderly and the role of family versus patient autonomy. International studies also highlight cultural factors, unclear laws, and insufficient awareness are major impediments to using AMDs, consistent with these trends [24].

The correlation coefficient ($r = -0.108$) shows a very weak negative relationship between attitude and knowledge suggesting that as knowledge scores increased, attitude scores tended to

decrease slightly, but the association was minimal. The observed relationship is not considered statistically significant because its p-value of 0.124 exceeds the commonly accepted significance threshold of $p < 0.05$.

The study found that participants' knowledge of palliative care did not significantly change their attitudes. Past research has indicated that awareness and attitudes towards palliative care are influenced more strongly by cultural beliefs, personal history, and experience with end-of-life care than by factual knowledge [11,14]. In this scenario, improving knowledge through education alone may not be sufficient to change attitudes. Interventions targeting the misconceptions employing communication skills, and cultural sensitivities are also essential.

In Germany, a questionnaire-based study among final-year medical students revealed that despite lacking sufficient knowledge and confidence in the field, the majority were in strong favor of including palliative care in their required medical curriculum [25]. A survey at Kasturba Medical College found that although students displayed good theoretical awareness, they lacked confidence in applying palliative care skills in practice, highlighting the need for early and experiential training [26]. Comparable gaps were observed in the United Arab Emirates, where more than half of recent graduates reported no formal palliative care teaching, but almost all considered such education essential in medical training [27]. Similar findings from other contexts affirms the importance of incorporating palliative care into the early stages of a medical education curriculum, as supported by the perceptions of the participants in the present study also.

Strengths

This was a pioneering study in this institution, addressing perceptions of AMDs and EOL care, generating novel insights. The study offers practical directions for integrating AMDs into medical education and public health strategies.

Limitations

The study was conducted in a single center which reduces wider applicability and the modest sample size reduces the strength of generalization.

Conclusion

This is the first comprehensive assessment from this tertiary care centre regarding views on advance medical directives (AMDs) and end-of-life (EOL) care. Its strength lies in addressing an underexplored area within a culturally sensitive context, offering baseline data that can guide both institutional practices and community initiatives. By identifying gaps in understanding and engagement with AMDs, the study provides actionable insights for curriculum development, policy planning, and health promotion. The study findings highlight opportunities to integrate AMDs into education and practice, ultimately supporting patient autonomy and dignified EOL care.

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Conflicts of interest

The authors declare that they do not have conflict of interest.

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ANNEXURE 1

Knowledge and attitude towards Palliative care and Advance Medical Directives among health professionals a cross sectional study.

QUESTIONNAIRE ON THE AWARENESS AND KNOWLEDGE OF PALLIATIVE MEDICAL CARE

1. In your opinion, what are the greatest fears of a patient who has been diagnosed with a terminal illness? (Please select three of the following options and rank them in order of relevance—1st, 2nd, 3rd)

- Fear of pain.
- Fear of death.
- Fear of no longer being independent.
- Fear of losing mental capabilities.
- Fear of loneliness.
- Fear of becoming disabled/immobile.
- Fear of financial burdens.
- Fear of being a burden to someone.
- I don't know.

2. What services do you think should be provided to people with a terminal illness and their families

- Help at home in case of pain and other symptoms. (a)
- Domestic care for the patient during the day. (b)
- Domestic care for the patient at night. (c)
- Complementary therapies. (d)
- Pastoral care. (e)
- A social worker that the patient and family could reach on the phone if necessary. (f)
- Assistance with household tasks, shopping, transportation etc. (g)
- Additional support at home to allow the family caregivers to have some free time and time for themselves. (h)
- Information and advice on financial aid. (i)
- Medical care in a hospice. (j)
- Medical care in hospital (k)

3. How much do you think people generally speak about death and dying?

- Too little. (a)
- About the right amount. (b)
- Too much. (c)

4. If you had a terminal illness, where would you like to spend the final stage of your life?

- At home. (a)
- In a hospital. (b)
- In a nursing home. (c)
- I don't know. (d)

5. Do you know what a patient decree is?

- Yes. (a)
- No. (b)

6. How do you rate your knowledge and awareness of palliative care in our federal state?

- (a) I know nothing about palliative care.
- (b) I have heard about palliative care.
- (c) I know a fair amount about palliative care.
- (d) I know a great deal about palliative care.

7. If you have already heard of palliative care, where did you find out about it?

- I have received palliative care myself. (a)
- A close friend/relative has received palliative care. (b)
- A distant relative/acquaintance has received palliative care. (c)
- A neighbour has received palliative care. (d)
- A friend or relative has told me about it. (e)
- I work with patients that receive palliative care. (f)

8. Please select the following sentence that in your opinion best describes palliative care.

- Palliative care hastens death. (a)
- (b)

Palliative care delays death.	(c)
Palliative care permits the patient to continue living an active life.	(d)
Palliative care calms the patient.	(e)
Palliative care improves the patient's quality of life.	(f)
I don't know.	

9. What do you think are the greatest needs of patients with a terminal illness that have reached the end of their lives? (Please select the following options and rank them in order of relevance—1st, 2nd, 3rd)

- Reduction in physical suffering.
- Specialist medical care.
- Home nursing care (medical and nursing services).
- Support for home-based caregivers.
- Professional psychological support.
- Spiritual support.
- I don't know.

10. What do you think are the greatest needs of family members that provide care to a patient with a terminal illness? (Please select the following options and rank them in order of relevance—1st, 2nd, 3rd)

- 24-hour specialist care.
- Home nursing care.
- Access to and availability of voluntary caregivers.
- Specially adapted residential facilities/hospices.
- Psychological care.
- Grief counseling.
- I don't know.

11. Where and by whom do you think care is best provided to patients with a terminal illness?

- At home by family/relatives. (a)
- At home by professional care workers. (b)
- In a hospice. (c)
- In hospital. (d)
- I don't know. (e)

12. Among patients with the illnesses listed in the table below, which do you think should receive palliative care? (Please mark one of the options for each illness.)

	5 (I fully agree.)	4 (I agree.)	3 (I partly agree.)	2 (I don't agree.)	1 (I don't agree at all.)	I don't know anything about this illness
Cancer						
Kidney failure						
Dementia						
Stroke						
Heart failure						
HIV/AIDS						

Chronic lung
diseases

Advance Medical directives (AMD)
Correct/Incorrect

Knowledge on AMD

1. The AMD, once signed, is valid for life
2. AMD and euthanasia mean the same thing
3. The AMD reflects the values and preferences of citizens when making therapeutic decisions at the end of their lives.
4. The AMD guarantees the citizen's choice to not be subjected to experimental treatments that are in experimental phase
5. The patient's family has to agree with the content of the AMD statement so it can be applied.
6. The family's opinion overrides that of the health care prosecutor.
7. When the patient is unconscious, their family can change or cancel the content of the AMD.

Attitude towards AMD 2 point Likert Scale

1. AMDs are a useful tool for healthcare professionals when making decisions about EOL patients.
2. AMDs are a legal form of euthanasia.
3. Legalization of the vital testament did not contribute to human dignity.
4. Death must be postponed, regardless of the person's condition.
5. EOL care should be provided based on the opinion of the health professional.
6. EOL care should not be provided based on the patient's opinion.
7. EOL care should be provided based on the opinion of the family.
8. The vital testament is only important for elderly and sick people.
9. I do not make a Vital Testament because there is still little information available
10. I don't want to think that I will eventually die or become disabled, to the point of not being able to make decisions.
11. My family will make the EOL decisions for me, when necessary

Please rate your opinion regarding in implementation of Palliative care in CBME curriculum and the commencement of the training from Phase 1 of MBBS course onwards