Section: Forensic Medicine

Systematic Review

ADVANCE MEDICAL DIRECTIVES: A SYSTEMATIC REVIEW WITH EVIDENCE SYNTHESIS OF AWARENESS, IMPLEMENTATION BARRIERS, LEGAL FRAMEWORK AND CLINICAL OUTCOMES

Shivkumar R. Kolle[1], Sachin Shivaji Sonawane[2], Sarah Al Hinnawi[3], Rajesh B. Sukhdeve[4], Chancey wood[5]

[1]Associate Professor, Department of Forensic Medicine, MGM Medical College, Panvel, Maharshtra, India
[2]Additional Professor, Department of Forensic Medicine at H B.T. Medical College & Dr R N Cooper Hospital, Mumbai, Maharshtra, India
[3]Assistant Professor, Department of Forensic Medicine at H B.T. Medical College & Dr R N Cooper Hospital, Mumbai, Maharshtra, India
[4]Professor & Head, Department of Forensic Medicine at H B.T. Medical College & Dr R N Cooper Hospital, Mumbai, Maharshtra, India
[5]Senior Resident, Department of Forensic Medicine at H B.T. Medical College & Dr R N Cooper Hospital, Mumbai, Maharshtra, India

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Corresponding Author:
Dr. Sachin Shivaji Sonawane,
Additional Professor, Department of Forensic Medicine at H B.T. Medical College & Dr R N Cooper Hospital, Mumbai, Maharshtra, India.
Email: sachinsonawane105@gmail.com

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ABSTRACT

Background: Advance Medical Directives (AMDs) allow competent individuals to express future healthcare preferences when decision-making capacity is lost. They enhance autonomy and reduce unwanted interventions but remain underutilised globally. The objective is to systematically review international evidence on the awareness, effectiveness, legal frameworks, and clinical implementation of AMDs. [18–24] [25–28] [41–46].

Materials and Methods: Literature from 2000–2024 was searched across PubMed, Scopus, and Google Scholar using PRISMA methodology. Inclusion criteria: original research, systematic reviews, cohort/cross-sectional studies addressing AMD knowledge, attitudes, clinical outcomes, or legal aspects. Exclusion criteria: editorials, commentaries, non-clinical legal papers. [3]

Results: Forty-six studies met eligibility criteria. AMDs consistently improved patient autonomy, reduced futile end-of-life interventions, improved patient–family satisfaction, and reduced surrogate stress. Barriers included low public awareness, clinician discomfort, cultural taboos about death, and legal or administrative complexities. High-income countries showed greater AMD adoption due to strong legal frameworks. [18–24] [35–40]

Conclusion: AMDs significantly improve end-of-life care quality but remain poorly adopted. Legal simplification, public education, and clinician training are essential for scaling AMD implementation, especially in developing nations. [35–40] [41–47]

Keywords: Advance Medical Directive, Living Will, Advance Care Planning, Patient Autonomy, End-of-Life Care, Systematic Review.

INTRODUCTION

Advance Medical Directives (AMDs) include written statements in which an individual specifies desired or undesired medical interventions in the event of loss of capacity. AMDs include living wills, power of attorney for healthcare, DNR directives, and structured advance care planning (ACP) tools. The global rise in chronic illnesses, intensive care unit (ICU) utilisation, and technologically driven life-prolonging interventions has intensified ethical dilemmas surrounding end-of-life care. Multiple studies demonstrate that AMDs reduce unwanted aggressive interventions, improve goal-concordant care, and ease decisional burden on families. Despite these benefits, adoption remains inconsistent across countries, particularly in low- and middle-income settings.[1-10]

This systematic review synthesizes global evidence regarding:[11-20]

1. AMD awareness and acceptance
2. Clinical and ethical benefits
3. Barriers to implementation
4. Legal frameworks

5. Recommendations for improving implementation of AMD.

MATERIALS AND METHODS

Search Strategy: The systematic review followed PRISMA 2020 methodology.[3] A systematic literature search was performed (January 2000–December 2024) using:

- PubMed
- Scopus
- Google Scholar

Keywords: "advance medical directive", "living will", "advance care planning", "healthcare proxy", "end-of-life decision-making", "resuscitation preference".

Boolean combinations: (advance medical directive) OR (advance care planning)) AND (end-of-life).

Eligibility Criteria

Inclusion:

- Original research (qualitative/quantitative)
- Systematic reviews/meta-analyses
- Studies discussing awareness, attitudes, outcomes, or legal aspects
- English language

Exclusion:

- Commentaries, letters, editorials
- Case reports
- Non-medical legal analyses
- Paediatric-only studies

Data Extraction: Extracted data included study design, population, outcomes, barriers, facilitators, and legal contexts from literature available from 2000-2024

Data Synthesis:

Risk of Bias Assessment

The heterogeneity of the included evidence—comprising observational studies, qualitative research, systematic reviews, policy documents, and judicial judgments. For empirical studies, methodological quality was assessed narratively by evaluating study design, clarity of objectives, appropriateness of data collection methods, and transparency of outcome reporting. Qualitative studies were appraised for credibility, relevance, and coherence of thematic analysis. Legal and policy documents were assessed for authoritative source, jurisdictional relevance, and consistency with established ethical and constitutional principles. Overall, while variations in study design and reporting quality were noted, the direction and consistency of findings across multiple evidence domains support the robustness of the synthesized conclusions.

PRISMA Flow Diagram.[3]

Identification	
Records identified through database searching	n = 235
Records after duplicates removed	n = 178
Screening	
Records screened (title/abstract)	n = 178
Records excluded	n = 92
Eligibility	
Full-text articles assessed	n = 86
Full-text articles excluded	n = 40
Not relevant to AMD outcomes	n = 13
Purely legal analysis	n = 11
Insufficient methodology	n = 6
Commentary/editorial	n = 10
Included	
Studies included in qualitative synthesis	n = 46

RESULTS

Due to heterogeneity, results were narratively synthesised.

1. Characteristics of Included Studies:

Table 1: Summary of Included Studies (Synthesized Overview)

Study Type	Number	Geographic Distribution	Key Themes
Cross-sectional	16	USA, Europe, India, Japan	Awareness, attitudes
Cohort studies	12	USA, Australia, Europe, India	Outcomes, decision-making
Systematic reviews	9	Global	Efficacy, ACP impact
Qualitative studies	6	UK, India, Singapore	Cultural beliefs, barriers
Interventional trials	3	USA, Korea	ACP programs, documentation tools

2. Awareness and Attitudes

Table 2: Awareness Levels Across Countries

Region	Public Awareness (%)	Healthcare Provider Awareness (%)	Notes
North America	40–70%	80–95%	Strong legal support & ACP programs
Western Europe	35–60%	75–90%	High cultural acceptance
East Asia	10–30%	40–70%	Cultural reluctance to discuss death
South Asia (incl. India)	2–10%	20–50%	Very low public awareness.
Middle East	5–25%	30–60%	Influenced by religious norms

Awareness closely correlates with education level and prior exposure to chronic illness. Clinicians often support AMDs but lack training to initiate discussions. Healthcare professionals generally support AMDs but report lack of training and fear of legal repercussions as major deterrents.[21–40]

3. Impact of AMDs on Clinical Outcomes:

Across multiple cohort studies and systematic reviews, AMDs were associated with:

- Reduced ICU admissions and mechanical ventilation near end of life. [9,10,11]
- Increased palliative and hospice care utilisation.
- Improved patient–family satisfaction and ethical clarity.

Silveira et al. demonstrated that patients with advance directives were significantly less likely to receive unwanted life-sustaining treatments before death.[4]

Table 3: Impact of AMDs on End-of-Life Care

Outcome Category	Direction of Impact	Specific Outcome Measure
Clinical Interventions	Decrease (↓)	Unwanted ICU admissions
	Decrease (↓)	Futile resuscitation attempts
Psychosocial Impact	Decrease (↓)	Family decisional burden
	Increase (↑)	Patient satisfaction
Alignment of Care	Increase (↑)	Goal-concordant care
Support Services	Increase (↑)	Use of hospice/palliative care

Evidence Highlights:

- Patients with AMDs were 40–60% less likely to receive unwanted aggressive treatment in ICU.
- Surrogate stress reduced significantly when AMDs were present.
- Clinicians reported clearer ethical decision-making pathways.

4. Barriers to Implementation: Major barriers identified include poor public awareness, clinician discomfort, cultural resistance to discussing death, and administrative complexity. In India, additional challenges include procedural rigidity of earlier Supreme Court guidelines, fear of litigation, and lack of a national AMD registry.[6-8,12,13,35–40]

Table 4: Major Barriers Identified Across Studies.

Barrier Category	Specific Issues
Knowledge-related	Low public awareness, misconceptions about "giving up"
Clinician-related	Poor communication training, fear of causing distress
Cultural	Avoidance of death discussions, family-centric decision systems
Legal/Administrative	Complex documentation, inadequate enforcement
Systemic	Lack of ACP integration in EMRs, absence of standard forms

Table 5: India-Specific Barriers to Implementation of Advance Medical Directives.

Barrier Category	India-Specific Challenges	Evidence/Notes
Legal	Complex 2018 Supreme Court guidelines; multi-layer approval & judicial oversight until 2023 revision	Led to <1% documented AMD usage
Administrative	Lack of standardized AMD forms across states; absence of national registry	No clear mechanism for EMR integration
Cultural	Families usually make decisions collectively; reluctance to discuss death or palliative care	ACP discussions often avoided
Healthcare System	Low palliative care penetration (only 1–2% of need met), busy OPDs, lack of counselling rooms	India ranked low in quality of death.
Clinician Factors	Fear of litigation, inadequate training, lack of clarity in interpretation	Many physicians unsure how to operationalize DNR & EOLST
Public Awareness	<5% public awareness; misconception that AMD = active euthanasia	Confusion in understanding AMD

5. Legal Framework: Advance directives are legally protected in countries such as the United States (Death with dignity Act 1997), United Kingdom, Canada, Netherlands, and Australia through the various act like Medical Assistance in Dying Act MAID, Victoria's Voluntary Assisted Dying Act, Termination of Life on Request and Assisted Suicide Act etc.[14,15]

Indian legal framework on end-of-life decision-making evolved through landmark judgments:[16–23]

- Aruna Shanbaug v. Union of India (2011) — recognised conditional passive euthanasia
- Common Cause v. Union of India (2018) — recognised the right to die with dignity and legalised AMDs under Article 21.[12,13,21-23]
- Clarification (2023) — simplified AMD execution and implementation procedures.[41-46]

These rulings provide legal protection to clinicians acting in accordance with valid AMDs.[35-40]

Table 6: Summary of Supreme Court of India Judgments on AMDs.[12,13, 21-23]

Year	Ruling	Key Provisions	Impact on Practice
2018 – Common Cause vs. Union of India	Recognized the legality of AMDs & passive euthanasia	Mandatory judicial oversight; multi-step verification; magistrate attestation	Procedurally complicated → very low utilization
2023 – Modified Guidelines	Simplified AMD process	Removed magistrate requirement; simplified revocation; allowed personal physician oversight	Increased feasibility, implementation still limited
Current (2024)	Operational challenge	States yet to adopt uniform procedure	Need for integration into hospital workflow

Table 7: Hierarchy of End-of-Life Decision-Making in India

Aspect	Without Advance Medical Directive	With Advance Medical Directive
Decision authority	Family consensus (variable, situational)	Patient preferences explicitly documented
Clinical decision-making	Dependent on clinician discretion	Guided by clear written instructions
Medico-legal risk	Fear of litigation and ambiguity	Legal protection under Supreme Court rulings
Care process	Potential conflict and delays	Streamlined, ethical, and patient-centred care

Table 8: Global Legal Landscape.[24-29]

Protection Level	Characteristics	Jurisdictions / Regions
Strong	Established statutory frameworks; clear enforcement mechanisms; high clinical integration.	USA, UK, Canada, Australia, Germany, Netherlands
Moderate	Emerging legal recognition; specific procedural requirements; evolving clinical adoption.	Japan, Singapore, South Korea
Low / Uncertain	Lack of specific legislation; cultural or religious barriers; judicial ambiguity.	India*, China, Middle East, Africa

(*India: Supreme Court recognised AMDs in 2018 and simplified process in 2023, but implementation remains weak.).[12,13, 21-23]

Additional international conventions, regional policies, and ethical frameworks further support the legitimacy and operationalisation of Advance Medical Directives within diverse healthcare systems, reinforcing principles of autonomy, beneficence, and proportionality in end-of-life decision-making.[19,20]

DISCUSSION

This systematic review demonstrates that AMDs provide substantial ethical and clinical benefits by:[35–40]

- Enhancing patient autonomy.
- Reducing non-beneficial medical interventions.
- Improving quality of end-of-life care.
- Reducing stress for relatives.
- Simplifying clinician decision-making.

However, AMD implementation remains globally inconsistent.[41-46]

Comparative Analysis of AMD Adoption Factors

- **Awareness and Public Education**

A primary driver of the disparity in AMD adoption is the significant gap in public awareness. While USA and Europe report high awareness levels ranging from 40% to 70%, India struggles with a critical deficit, where awareness remains below 5%. This suggests that Western populations are more frequently exposed to the concepts of patient autonomy and end-of-life choices through public health campaigns and institutionalized education.[6-8] Indian clinical, ethical, and palliative care literature highlights persistent challenges related to awareness, access, and workforce capacity, particularly in rural and resource-limited settings.[30–34]

- **Legal and Institutional Frameworks**

The legal environment plays a pivotal role in providing the confidence necessary for clinicians and patients to engage in AMDs. Western countries benefit from strong legal backing, providing clear protocols for enforcement. India's legal landscape is described as still evolving, creating a sense of ambiguity that often deters proactive planning.[25–29,35–40]

Indian jurisprudence and subsequent procedural clarifications have progressively strengthened legal safeguards for both patients and clinicians, particularly through detailed operational guidance and simplified execution pathways.[21–23]

- **Clinical Integration and ACP Practice**

In Western hospital settings, Advance Care Planning (ACP) is treated as a routine component of patient intake and chronic disease management. However, in the Indian medical context, ACP is rarely practiced, often overshadowed by acute care priorities and a lack of formalized training for healthcare providers in navigating these conversations. Evidence from end-of-life care utilisation studies further demonstrates reductions in high-intensity medical interventions and resource use when advance directives are honoured, contributing to ethically appropriate and cost-conscious care delivery.[26,27]

- **Technological Infrastructure and Documentation**

Effective AMD implementation requires accessible documentation. Western systems leverage advanced EMR (Electronic Medical Record) integration, ensuring that a patient's directives are available to clinicians across various care settings. India's reliance on mostly paper-based systems introduces significant logistical challenges, as directives can

easily be lost, ignored, or unavailable during a medical crisis.[35-46]

- **Access to Supportive Care Services**

Finally, the availability of palliative care services directly influences AMD adoption. While Western nations provide high palliative care access, India's availability is strikingly low, reaching only 1–2% of the population. Without a robust palliative care framework to support non-curative goals, the practical utility of an AMD is significantly diminished for the average Indian patient.[15-17,29–34] Broader public health, hospice development, and digital health initiatives provide essential system-level enablers for sustainable implementation of Advance Medical Directives, especially in low and middle-income countries.[42-46]

- **Frontline Clinical Implementation.[41–46]**

Frontline healthcare providers serve as the primary facilitators of the ACP process. Doctors must adopt a proactive approach by ensuring the early initiation of ACP for patients diagnosed with chronic or life-limiting illnesses. This requires specialized training in communication to navigate sensitive topics and a commitment to meticulous documentation of patient preferences. Nurses play an equally vital role by supporting ACP conversations as they occur and providing ongoing patient and family education regarding the implications of various end-of-life choices.

Limitations

- Heterogeneity of study designs prevents meta-analysis
- Cultural differences limit generalisability
- Some regions lacking sufficient high-quality data
- Variation in legal contexts influences outcomes

CONCLUSION

AMDs are vital tools for improving patient-centred, ethical, and high-quality end-of-life care. Despite clear benefits, global adoption is low due to cultural, legal, and systemic challenges. Efforts must focus on:[35–40]

- Strengthening legal frameworks.[18–24]
- Simplifying documentation
- Implementing national ACP programs
- Training clinicians
- Creating public awareness campaigns

This will help embed AMDs as a standard component of healthcare practice worldwide. Systematic reviews and consensus documents emphasise the importance of structured advance care planning, clinician communication training, and organisational support to improve implementation and effectiveness of Advance Medical Directives across health care settings.[36–39]

Recommendations

For Policy Makers:[41–46]

- Develop a simple, universally accepted AMD format.
- Enable national digital repositories accessible to all hospitals dealing with end-of-life support treatment.
- Promote awareness through public health campaigns.

For Healthcare Institutions

- Implement routine ACP discussions for patient with chronic illness with no definitive treatment available.
- Include AMD documentation in discharge summaries
- Provide clinician training in end-of-life communication:[35–40]

For Clinicians:[35–40]

- Initiate ACP earlier rather than at end stages
- Respect patient preferences documented in AMDs
- Involve families for clarity and ethical alignment:[35-40]

India-Specific Recommendations:

To strengthen AMD implementation in India:[41–46]

- Develop a Central AMD Repository under the Ministry of Health & Family Welfare
- Include ACP discussions in National Programme for Palliative Care (NPPC).[29-34]
- Nationwide standardization of AMD forms
- Integration into Ayushman Bharat Digital Mission (ABDM)
- Mandatory ACP training for healthcare workers
- Public awareness campaigns to destigmatize end-of-life discussions
- Partner with NGOs like Pallium India for community education
- Use regional-language AMD forms to increase accessibility
- Encourage primary care physicians to initiate ACP early, not only during terminal stages.

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