Georgia Advance Directive for Health Care

By: ______________________________  Date of Birth: ____________________________
(Print Name)  (Month/Day/Year)

This advance directive for health care has four parts:

**PART ONE—Health Care Agent.** This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

**PART TWO—Treatment Preferences.** This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

**PART THREE—Guardianship.** This part allows you to nominate a person to be your guardian should one ever be needed.

**PART FOUR—Effectiveness and Signatures.** This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

**PART ONE—Health Care Agent**

PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.

1. Health Care Agent

I select the following person as my health care agent to make health care decisions for me:

Name: ______________________________
Address: ______________________________
Telephone Numbers: ______________________________
(Home, Work, and Mobile)
2. Back-Up Health Care Agent

This section is optional. PART ONE will be effective even if this section is left blank.

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: __________________________________________
Address: ________________________________________
Telephone Numbers: ____________________________
(Home, Work, and Mobile)

Name: __________________________________________
Address: ________________________________________
Telephone Numbers: ____________________________
(Home, Work, and Mobile)

3. General Powers of Health Care Agent

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent’s authority includes, for example, the power to:
• Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
• Request, consent to, withhold, or withdraw any type of health care; and
• Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:
• My health care agent may refuse to act as my health care agent;
• A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
• My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

4. Guidance for Health Care Agent

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.
5. Powers of Health Care Agent After Death

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent’s power by initialing below.

________ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent’s power by initialing below.

Initial each statement that you want to apply.

________ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

________ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

________ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: ____________________________________________________________
Address: __________________________________________________________
Telephone Numbers: ________________________________________________(Home, Work, and Mobile)

I wish for my body to be:

________ (Initials) Buried

OR

________ (Initials) Cremated
PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

6. Conditions

PART TWO will be effective if I am in any of the following conditions:

Initial each condition in which you want PART TWO to be effective.

_________ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_________ (Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

7. Treatment Preferences

State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _________ (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _________ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) _________ (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

Initial each statement that you want to apply to option (C).

_________ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_________ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_________ (Initials) If I need assistance to breathe, I want to have a ventilator used.

_________ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.
8. Additional Statements

This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.

9. In Case of Pregnancy

PART TWO will be effective even if this section is left blank.

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_________ (Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE—Guardianship

10. Guardianship

PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.

State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.

(A) _________ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) _________ (Initials) I nominate the following person to serve as my guardian:

Name: __________________________
Address: _________________________
Telephone Numbers: ________________________
(Home, Work, and Mobile)
PART FOUR—Effectiveness and Signatures

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_________ (Initials) This advance directive for health care will become effective on or upon 
____________________ and will terminate on or upon ____________________.

You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:
- Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;
- Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
- Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

________________________________________________________________ __________________________
(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

________________________________________________________________ __________________________
(Signature of First Witness) (Date)

Print Name: _____________________________________________
Address: ______________________________________________

________________________________________________________________ __________________________
(Signature of Second Witness) (Date)

Print Name: _____________________________________________
Address: ______________________________________________

This form does not need to be notarized.
**PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)**

This is a Physician Order guided by the patient’s medical condition and based upon personal preferences verbalized to the Physician or expressed in an Advance Directive.

| Patient’s Name | _____________________________ | ____________________________ | ____________________________________ |
| (First) | (Middle) | (Last) |

<table>
<thead>
<tr>
<th>Last four digits of SSN:</th>
<th>______________</th>
<th>Date of Birth</th>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

### A CODE

**STATUS**

Check all that apply

- CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.
  - [ ] Attempt Resuscitation/CPR.
  - [ ] Allow Natural Death (AND) - Do Not Attempt Resuscitation.
  - Resuscitation Orders are to remain in effect during any surgical or invasive procedure.
  - When not in cardiopulmonary arrest, follow orders in B, C and D.

### B CODE

**Check One**

- MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.
  - [ ] Comfort Measures: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.*
  - [ ] Limited Additional Interventions: Includes Comfort Measures and medical treatment, IV fluids, and cardiac monitor as indicated. Does not include intubation or mechanical ventilation. *Avoid intensive care. Transfer to hospital if indicated.*
  - [ ] Additional Treatment: Includes Limited Additional Interventions, lab tests, blood products, dialysis. *Transfer to hospital if indicated.*
  - [ ] Full Treatment: Includes Additional Treatment and intubation, mechanical ventilation, and cardioversion as indicated. *Includes intensive care. Transfer to hospital if indicated.*
  - [ ] Additional Orders:

### C CODE

**Check One**

- ANTIBIOTICS
  - No antibiotics: Use other measures to relieve symptoms.
  - Determine use or limitation of antibiotics when infection occurs.
  - Use antibiotics if life can be prolonged.
  - Additional Orders:

### D CODE

**Check One**

- ARTIFICIALLY ADMINISTERED NUTRITION / FLUIDS
  - Where indicated, always offer food or fluids by mouth if feasible.
  - No artificial nutrition by tube.
  - Defined trial period of artificial nutrition by tube.
  - Long-term artificial nutrition by tube.
  - No IV fluids.
  - Defined trial period of IV fluids.
  - Long-term IV fluids.
  - Additional Orders:

### E CODE

**Check All That Apply**

- REASON FOR ORDERS AND SIGNATURES
  - To the best of my knowledge these orders are consistent with the patient’s current medical condition and preferences as indicated by:
  - [ ] My discussion with the Patient
  - [ ] My discussion with the Patient’s Authorized Representative
  - [ ] Verbal consent was given for an “allow natural death” order.

<table>
<thead>
<tr>
<th>Physician’s Printed Name</th>
<th>Physician’s Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>License No.</td>
<td>State</td>
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<table>
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<tr>
<th>Patient’s Printed Name</th>
<th>Patient’s Signature</th>
<th>Date</th>
<th>Phone</th>
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</table>

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<tr>
<th>Patient Authorized Representative’s Printed Name (if applicable)</th>
<th>Representative’s Signature (if applicable)</th>
<th>Date</th>
<th>Phone</th>
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</table>
DIRECTIONS FOR HEALTH CARE PROFESSIONALS

- This form should be completed by a health care professional based on the patient’s medical condition, and on the patient’s wishes, as expressed to the physician by the patient while in a competent condition, or in the patient’s advance directive, or by a representative of the patient acting with legal authority.
- This form should be signed by a physician, and also by the patient or a representative acting with legal authority on behalf of the patient.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms are valid.
- **Any incomplete section of POLST implies full treatment for that section.**
- Do not use a defibrillator (including AEDs) on a person who has chosen “allow natural death.”
- Always offer fluids and nutrition by mouth if medically feasible.
- Transfer the patient to a setting better able to provide comfort when it cannot be achieved in the current care setting (e.g., treatment of a hip fracture).
- A patient with capacity, or the authorized representative of a patient without capacity, may request alternative treatment.
- **Treatment of dehydration is a measure which prolongs life. A patient who desires IV fluids should indicate “Limited Additional Intervention” or higher level of care.**

SUBSEQUENT REVIEW OF THE POLST FORM

This form should be reviewed when (i) the patient is transferred from one care setting or care level to another (ii) there is substantial change in the patient’s health status, or (iii) the patient’s treatment preferences change. **If this POLST is voided, replaced, or becomes invalid, then draw a line through sections A though D, writes “VOID” in large letters with date and time, and sign by the line.** After voiding the form, a new form may be completed. **If no new form is completed, full treatment and resuscitation may be provided.**

<table>
<thead>
<tr>
<th>Date/Time of Review</th>
<th>Location of Review</th>
<th>Print Name of Reviewer</th>
<th>Outcome of Review</th>
<th>Physician Signature</th>
</tr>
</thead>
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<td>□ No Change</td>
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<td>No new form</td>
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</tbody>
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This form was prepared by the Georgia Department of Public Health pursuant to Official Code of Georgia Section 29-4-18(l). **O.C.G.A. § 29-4-18(8)(k)(3) provides:**

“**Any person who acts in good faith in accordance with a Physician Order for Life-sustaining treatment developed pursuant to subsection (l) of this Code section shall have all of the immunity granted pursuant to Code Section 31-32-10.**” **O.C.G.A. § 31-32-10 provides, in pertinent part:**

“Each health care provider, health care facility, and any other person who acts in good faith reliance ... shall be protected and released to the same extent as though such person had interacted directly with the [patient] as a fully competent person.”
Palliative Care (pronounced pal-lee-uh-tiv) is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

**1 WHERE DO I RECEIVE PALLIATIVE CARE?**

Palliative care is provided in a variety of settings including the hospital, outpatient clinics, home, hospice and long term care facilities.

**2 DOES MY INSURANCE PAY FOR PALLIATIVE CARE?**

Most insurance plans, including Medicare and Medicaid, cover palliative care. If costs concern you, a social worker or financial consultant from the palliative care team can help you.

**3 HOW DO I GET PALLIATIVE CARE?**

Ask for it! Tell your doctors, nurses, family and caregivers that you want palliative care.

**4 HOW DO I KNOW IF PALLIATIVE CARE IS RIGHT FOR ME?**

Palliative care may be right for you if you suffer from pain, stress or other symptoms due to a serious illness. Serious illnesses may include cancer, cardiac disease, respiratory disease, kidney failure, Alzheimer’s, HIV/AIDS, amyotrophic lateral sclerosis (ALS), multiple sclerosis and more. Palliative care can be provided at any stage of illness and along with treatment meant to cure you.

**5 WHAT CAN I EXPECT FROM PALLIATIVE CARE?**

You can expect relief from symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and difficulty sleeping. Palliative care helps you carry on with your daily life. It improves your ability to go through medical treatments. It helps you better understand your condition and your choices for medical care. In short, you can expect the best possible quality of life.

**6 WHO PROVIDES PALLIATIVE CARE?**

Palliative care is provided by a team including palliative care doctors, nurses and social workers. Massage therapists, pharmacists, nutritionists and others might also be part of the team.

**7 HOW DOES PALLIATIVE CARE WORK WITH MY OWN DOCTOR?**

The palliative care team works in partnership with your own doctor to provide an extra layer of support for you and your family. The team provides expert symptom management, extra time for communication and help navigating the health system.

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ADVANCE CARE PLANNING RESOURCES

There is a wealth of resources available to educate, explain, motivate and facilitate advance care planning and end-of-life conversations. Here are some useful ones that we have found.

**CDC Healthy Aging Program** – Free online course on advance care planning designed for public health and aging services professionals at: [http://www.cdc.gov/aging/advancecareplanning/care-planning-course.htm](http://www.cdc.gov/aging/advancecareplanning/care-planning-course.htm)

**National Health Decisions Day** -- April 16 each year. Website has wonderful short video promoting end-of-life conversations and documentation. [www.nhdd.org](http://www.nhdd.org)

**Consumer's Tool Kit for Health Care Advance Planning**, by the ABA Commission on Law and Aging. Download from [www.ambar.org/healthdecisions](http://www.ambar.org/healthdecisions)

**The Conversation Project**, begun by syndicated columnist Ellen Goodman; dedicated to helping people talk about their wishes for end-of-life care. Resources include the Conversation Starter Kit at: [www.theconversationproject.org](http://www.theconversationproject.org)

**The Go Wish Game** -- a card game created by the Coda Alliance. An entertaining way to think about what's important at the end of life. Can be played online at [www.gowish.org](http://www.gowish.org) and available for purchase at: [www.codaalliance.org](http://www.codaalliance.org)

**PREPARE.** Helps people prepare for medical decision making with multiple video aids. [www.prepareforyourcare.org](http://www.prepareforyourcare.org)

**Critical Conditions** – Published by Georgia Health Decisions. Detailed workbook with Georgia Advance Directive included. Available for download or purchase at: [www.georgiahealthdecisions.org](http://www.georgiahealthdecisions.org)

**The Coalition for Compassionate Care of California** – statewide collaborative focused on advanced care planning and POLST. Lots of resources, including POLST videos. [www.coalitionccc.org](http://www.coalitionccc.org)

**Compassion and Support** – from Rochester, NY’s Community-Wide End-of-Life/Palliative Care Initiative. Videos and materials on advance care planning and the NY MOLST. [www.compassionandsupport.org](http://www.compassionandsupport.org)

**Center to Advance Palliative Care** – General information, blog and provider directory. [www.getpalliativecare.org](http://www.getpalliativecare.org)

**Five Wishes** -- Published by Aging with Dignity. Advance directive guide. Available for purchase or download at: [www.agingwithdignity.org](http://www.agingwithdignity.org)
**Caring Conversations**, published by the Center for Practical Bioethics. Comprehensive workbook and advance directive. Available for purchase or download at:  
[www.practicalbioethics.org/resources/caring-conversations](http://www.practicalbioethics.org/resources/caring-conversations)

**Conversations on Death** – Boulder, Colorado community group.  
[www.conversationsondeath.org](http://www.conversationsondeath.org)

**Death Café** – Online bulletin board to advertise informal group discussions about death.  
[www.deathcafe.com](http://www.deathcafe.com)

**DOCUMENT REGISTRIES:**

- America Living Will Registry:  [www.alwr.com](http://www.alwr.com)
- U.S. Living Will Registry:  [www.uslwr.com](http://www.uslwr.com)
- MedicAlert Foundation:  [www.medicalert.org/join/advance-directives.htm](http://www.medicalert.org/join/advance-directives.htm)
- DocuBank:  [www.docubank.com](http://www.docubank.com)

**BOOKS:**

**Being Mortal: Medicine And What Matters In The End** (Metropolitan Books, 2014) by Atul Gawande.  

**The Best Care Possible: A Physician’s Quest To Transform Care Through The End of Life** (Avery, 2012) by Ira Byock  
[www.IraByock.org](http://www.IraByock.org)

**The Conversation: A Revolutionary Plan For End-Of-Life Care** (Bloomsbury, 2015) by Angelo Volandes  
[www.massgeneral.org/stoecklecenter/about/staff/volandes.aspx](http://www.massgeneral.org/stoecklecenter/about/staff/volandes.aspx)

**Knocking on Heaven’s Door** (Scribner, 2013) by Katy Butler.  

**Best Death Possible: A Guide For Dying Australians** (Palmer Higgs, 2013) by Sarah Winch  