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Strengthening Clinical Ethics Committees: An Examination of the Jurisprudence and a Call for Reform

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Increasingly, ethics conflicts in hospitals are adjudicated not through the judicial system but through hospital ethics committees. Ethics committees resolve disagreements over treatment plans, interpretations of do not resuscitate orders, and other medical issues, providing critical guidance to health care practitioners. The case law in some states, such as New Jersey, suggests that the recommendations of ethics committees ought to be binding on courts. In other states, such as Massachusetts and Florida, courts have ruled that ethics committee recommendations should be persuasive in court proceedings but not determinative. But even in these states, ethics committees can have great influence over right to die and other medical decisions.

Ethics committees offer many benefits. They can relieve congestion in the judicial system by resolving cases that do not involve cognizable legal claims. They can also respond to conflicts much faster than courts in cases requiring immediate attention. In particular, right to die cases—situations in which it is unclear whether to pursue further medical intervention even though refusing to do so will result in death—are well suited for ethics consultations because many of the legal questions around these conflicts have been resolved. Finding efficient mechanisms to resolve right to die conflicts is important; as the population ages, these situations sadly become more frequent. However, in order properly to utilize ethics committees to resolve right to die and other conflicts, states must enact requirements that will guarantee due process. States should regulate ethics committees to ensure that they have a clearly defined role in resolving right to die conflicts.

I. Why Care Now?

Most of the relevant case law on ethics committees and right to die issues comes from the late 1970's and early 1980's. However, the courts' lack of activity since then does not necessarily suggest that the problem has been solved satisfactorily. Instead, it may mean that private adjudicators and facilitators, including ethics committees, are resolving the bulk of these conflicts outside of court. However, as the population of the United States ages and as life support technology continues to improve, right to die

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controversies will become more and more frequent, increasing the chances that the ad hoc system will be overloaded and that mistakes will occur due to lack of oversight and regulation.

Furthermore, right to die decisions could play an important part in the ongoing effort to allocate scarce healthcare resources appropriately, and to curb the rising costs of healthcare. End-of-life care consumes a disproportionate amount of Medicare expenditures.¹ However, regional variations in end-of-life expenditures suggest that intensive health spending does not equal better survival rates and that people prefer less, rather than more, intensive treatments.² Strengthening the process by which people decide whether to continue end-of-life care would help ration expensive procedures by allowing those who do not value them to opt out. It may also help to reduce regional variation in end-of-life spending by making the decision to continue treatment incumbent on patients and ethics committees rather than the regional customs of local physicians.

Ethics committees arose when end-of-life care was rapidly becoming extensive and intrusive, and when it was not clear if patients could choose to forgo medical treatment, if proxies could make these same decisions, and if the state had a compelling interest to prevent the rejection of end-of-life care. As the demographics of this country gray and conflicts about an individual's right to refuse treatment occur over and over again, states should regulate ethics committees so the committees can better arbitrate situations and provide better evidence and guidance for courts facing these cases. A greater role for ethics committees is particularly appropriate since the right to refuse medical treatment at the end of life, or any other stage of life, has been widely accepted by the courts. Thus, the majority of cases presenting a right to die issue will likely revolve around ethical or interpersonal, not legal, considerations. For example, there may be doubt about the proper way to interpret an individual's wishes, about how the health care providers ought to properly communicate the prognosis to the family, or about which family member ought to make the decision. Refusing life-supporting treatment is a serious decision that oftentimes is best resolved within a forum that can bring together patients, families and health care providers in a non-adversarial setting. While a court can play that role satisfactorily, so too can an ethics committee, given the proper procedural safeguards.

II. *Quinlan and Saikewicz: Two Divergent Roles for Ethics Committees*

Although ethics committees existed before 1976, it was *In re Quinlan* that first brought them to prominence.³ Karen Ann Quinlan was a 22-year-old woman who was in a persistent vegetative state due to brain damage resulting from deprivation of oxygen for two 15-minute periods. Her father sought to be appointed as her guardian and to use that authority to discontinue all extraordinary medical procedures since there was no hope of

¹ Christopher Hogan et al., *Medicare Beneficiaries' Costs Of Care In The Last Year Of Life*, 20 HEALTH AFFAIRS 188, 190 (2001).

² See Jonathan Skinner & John E. Wennberg, *How Much is Enough? Efficiency and Medicare Spending in the Last Six Months of Life* 17–20 (Nat'l Bureau of Econ. Research, Working Paper No. 6513, 1998).

³ 355 A.2d 647 (N.J. 1976).

STRENGTHENING CLINICAL ETHICS COMMITTEES

recovery. However, the Attorney General of New Jersey, citing the state's interest in preserving life, blocked Mr. Quinlan's actions. The Supreme Court of New Jersey held that as Ms. Quinlan's guardian, her father could exercise her right to privacy by insisting that any life supporting apparatus be withdrawn and by allowing her to terminate by natural forces.⁴

The *Quinlan* court believed that the underlying problem was the lack of a pre-determined process for making such medical decisions. Moral theorist Susan Wolf describes the issue: As a result of "advances in medical technology, patients, families, caregivers, and courts now faced difficult life and death decisions, and with growing frequency. Yet there was no common agreement on how the decisionmaking process should proceed."⁵ As a result of the novel capacities of modern medicine to extend life despite brain damage, there was a new need to determine how a decision about whether to use such treatment ought to be made. While grappling with the question of how to weigh the individual's interest in discontinuing life support with the state's interest in preserving life, the *Quinlan* court referred to an obscure article written by a doctor in the *Baylor Law Review* calling for hospital ethics committees.⁶ The *Quinlan* court approvingly cited the article as a solution to the decision-making problem, which called for "an Ethics Committee composed of physicians, social workers, attorneys, and theologians, which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and safeguards for patients and their medical caretakers."⁷ The court further cited the article: "The concept of an Ethics Committee which has this kind of organization and is readily accessible to those persons rendering medical care to patients, would be, I think, the most promising direction for further study at this point."⁸ *Quinlan* viewed ethics committees as an appeals court for medical decision-making, an expert body a physician could consult with to confirm his treatment plan and to provide a defense against possible suits.

In some ways, *Quinlan* can be seen as the first in a wave of delegations of power from the courts to these private committees.⁹ *Quinlan* strongly suggested, albeit in dicta, that ethics committees ought to be taken seriously as decision-making bodies and that they should have the power to immunize physicians from liability for their actions by approving withdrawal of treatment. Thus, *Quinlan* legitimized the use of hospital committees to resolve the ethical conflicts that arose in the course of hospital business. However, *Quinlan* seemed to focus largely on the ethics committee's ability to confirm prognoses and to review the doctor's medical recommendations to make sure his medical recommendations were not clouded by personal biases. *Quinlan* did not discuss the

⁴ *Id.* at 671.

⁵ Susan M. Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798, 798 (1991).

⁶ *In re Quinlan*, 355 A.2d at 668 (citing Karen Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should be*, 27 BAYLOR L. REV. 6 (1975)).

⁷ *Id.*

⁸ *Id.*

⁹ Bethany Spielman, *Has Faith in Health Care Ethics Consultants Gone Too Far? Risks of an Unregulated Practice and a Model Act to Contain Them*, 85 MARQ. L. REV. 161, 161 (2001).

possibility that ethics committees could resolve ethical or moral issues. Still, *Quinlan* delegated to ethics committees both decision-making power and a possible power to provide immunity to health care providers.

Taking the *Quinlan* court's suggestion, hospitals have aggressively pursued ethics committees. By 1991, over half of all American hospitals had some sort of ethics committees.¹⁰ However, almost immediately there was a backlash to *Quinlan* in other courts. Most notably, the Supreme Judicial Court of Massachusetts rejected the delegation of authority to ethics committees in *Superintendent of Belchertown v. Saikewicz*.¹¹ The court held that although the right to refuse medical treatment extended to incompetent patients, courts ought to use the substituted judgment doctrine to decide if the patient would have elected to decline treatment. The *Saikewicz* court acknowledged the crucial role medical ethics ought to play in deciding right to die cases, finding it "advisable to consider the framework of medical ethics which influences a doctor's decision as to how to deal with terminally ill patients," and also recognized that "[t]he law lags behind the most advanced thinkers in every area."¹² However, *Saikewicz* firmly grounded the decision-making authority in the probate court, saying, "we reject the approach adopted by the New Jersey Supreme Court in the *Quinlan* case of entrusting the decision whether to continue artificial life support to the patient's guardian, family, attending doctors and hospital 'ethics committees.'"¹³ The court rejected *Quinlan* in strong terms: "We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established court of proper jurisdiction to any committee, panel or group, ad hoc or permanent."¹⁴ Instead, "consideration of the findings and advice of such groups . . . would be of great assistance to a probate judge faced with such a difficult decision."¹⁵ *Saikewicz* thus attempted to reduce ethics committee recommendations to simply another evidentiary component to be considered by the probate judge and not a separate legitimate mechanism for resolving these conflicts.

Much legislation on ethics committees seems to fall halfway between *Quinlan* and *Saikewicz*, offering an expanding role for ethics committees and implying that they should be the arbiter, while stopping short of granting them formal decision-making authority. Maryland requires hospitals to set up advisory committees and entrusts them with the duty to "offer advice in cases involving individuals with life-threatening conditions."¹⁶ Texas regulations establish ethics committees for the purpose of providing advice to physicians and other interested parties regarding treatment.¹⁷ Montana law provides immunity from civil and criminal liability for the actions of members of ethics committees.¹⁸ Arizona allows for a treating physician to make health care decisions for

¹⁰ Wolf, *supra* note 5, at 799.

¹¹ 370 N.E.2d 417, 434 (Mass. 1977).

¹² *Id.* at 423.

¹³ *Id.* at 434.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ MD. CODE ANN., HEALTH-GEN. § 19-373(a) (West 2009).

¹⁷ 25 TEX. ADMIN. CODE § 405.55 (2008).

¹⁸ MONT. CODE ANN., § 37-2-201(1) (West 2009).

STRENGTHENING CLINICAL ETHICS COMMITTEES

an incompetent patient after consulting with an ethics committee, provided no one close to the patient can be found to act as a health care proxy.¹⁹ Arizona also encourages infant care review committees, and protects its members from liability.²⁰ Although these statutes do not explicitly preclude courts from dealing with medical ethics issues, the limitations on liability seem to indicate that review of the actions of ethics committees by the judicial system is not a priority, giving them perhaps a *Quinlan*-esque autonomy from the courts.

III. The Benefits and Problems of Authoritative Ethics Committees

In many respects, transferring authority from the courts to state-mandated ethics committees is a reasonable response to the heavy caseload of most courts, the need for a quick resolution posed by medical conflicts, the frequent difficulty in articulating a legally cognizable claim for these cases, and the increasing number of these situations. As hospital creations, ethics committees are well suited to clinical crises. They can be staffed with specialists in medicine, medical ethics, and the relevant law, people with expertise that a generalist judge would be hard-pressed to approximate in such a time-sensitive situation. They can be set up to operate quickly, whereas quick resolution in the judicial system often requires sacrificing procedural safeguards, the very safeguards that may make courts preferable to ad hoc private committees in the first place. For example, in *In re A.C.*, the Court of Appeals for the District of Columbia was called upon to determine the proper decision-maker for a pregnant woman who was near death yet close to full term.²¹ By the time the appeal was heard, the mother and child had both died. The *A.C.* court noted “it would be far better if judges were not called to patients’ besides and required to make quick decisions on issues of life and death. Because judgment in such a case involves complex medical and ethical issues as well as the application of legal principles, we would urge the establishment—through legislation or otherwise—of another tribunal to make these decisions, with limited opportunity for judicial review.”²²

Ten years before *In re A.C.*, in *Satz v. Perlmutter*,²³ the Supreme Court of Florida acknowledged that the judicial system is ill-suited to adjudicate right to die cases for a different reason: “Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding.”²⁴ Unlike judicial forums, ethics committees are usually not designed to be adversarial. Instead, ethics committees use facilitation and mediation as their method of operation.²⁵ This is a clear advantage of ethics committees over courts in resolving complicated right to die issues, and it is one of the reasons that states have embraced

¹⁹ ARIZ. REV. STAT. ANN. § 36-3231 (West 2009).

²⁰ *Id.* § 36-2284.

²¹ 573 A.2d 1235, 1237 (D.C. 1990).

²² *Id.* at 1264 n.2.

²³ 379 So. 2d 359 (Fla. 1980).

²⁴ *Id.* at 360.

²⁵ Giles R. Scofield, *What is Medical Ethics Consultation?*, 36 J.L. MED. & ETHICS 95, 99–101 (2008).

ethics committees and urged hospitals to create them. Furthermore, ethics committees offer a way to resolve conflicts that “avoid[s] cumbersome court procedures and unwieldy litigation.”²⁶

Unfortunately, most of the relevant regulations impose very few procedural or structural requirements on ethics committees. This raises the worry that the voice of the patient might not be fully heard throughout the ethics consultation, especially if the interests of the hospital take precedence over the interests of the patient. Most of the members of ethics committees will be hospital staff or receive paychecks from the hospital.

Ethics committees should not be exempt from basic requirements of due process. It is in the best interests of the patients and committee members that ethics committees follow a set of standard procedures to ensure that the results are just and fair. Due process will benefit patients and families because they will be able to place trust in the decisions of the ethics committee. Due process requirements will also benefit ethics committees because their decisions will be seen as more legitimate. While it is unlikely that ethics consultants set out to abuse their authority, safeguards will provide peace of mind and prevent mishaps as ethics consultations continue to grow in number.

Unfortunately, few statutes require much by the way of due process. Maryland imposes some of the most detailed due process requirements for ethics committees, but even its requirements are disappointingly vague. Maryland requires each hospital to come up with a written procedure by which the advisory committee is called, requires a committee of at least four members, and mandates that the committee consult, when appropriate, with the patient’s family.²⁷ While this guidance is better than no guidance, the open-ended language requiring committees to consult patients and their families only “in appropriate cases” does not provide sufficient protections for patients dealing with *Quinlan*-inspired authoritative ethics committees.

The lack of due process requirements for ethics committees cannot be excused by the fact that ethics committees are still in their infancy. If ethics committees are accepted by the legal and medical ethics communities as reliable authorities, then they ought to be subject to procedural requirements. Simply providing vague procedural guidelines does not do enough to ensure that individuals will find their rights sufficiently safeguarded when seeking an ethics consultation. And providing immunity to ethics committee members does not necessarily produce better decisions. On the contrary, immunity ought to be minimized to provide pressure for ethics committee members to maintain best practices during the course of their duties.

IV. The Benefits and Problems of Advisory Ethics Committees

Many jurisdictions have shied away from the *Quinlan* approach of empowering ethics committees to take the responsibility of resolving medical ethics questions away from the courts. Following *Saikewicz*, other courts have also emphasized the importance of maintaining judicial control over this area of the law. In *Severns v. Wilmington*

²⁶ Janet Fleetwood & Stephanie S. Unger, *Institutional Ethics Committees and the Shield of Immunity*, 120 ANNALS OF INTERNAL MED. 320, 320 (1994).

²⁷ MD. CODE ANN., HEALTH-GEN. § 19-371, 19-372 (West 2009).

STRENGTHENING CLINICAL ETHICS COMMITTEES

Medical Center, the Supreme Court of Delaware required an evidentiary hearing to determine whether to remove life support.²⁸ Although the Wilmington Medical Center did not have an ethics committee, the rule in *Severns* would probably apply even in cases in which an ethics consultation had been sought. A New York state court also chose to follow *Saikewicz* and *Severns*, holding “that the neutral presence of the law is necessary to weigh these factors, and thus judicial intervention is required before any life-support system can be withdrawn.”²⁹ The logic behind this holding was that the courts in these situations best guard social interests, as opposed to private committees which can be more easily influenced. However, this case, *Eichner v. Dillon*, reserved a role for ethics committees by envisioning them as prognosis committees, delivering a confirmation of medical prognosis, not an ethical recommendation.³⁰ Massachusetts partially reaffirmed *Saikewicz* in *In re Spring*,³¹ which maintained that ethics committees should be consulted in right to die cases but that there should be no “delegation of the ultimate decision-making responsibility to any committee, panel or group, ad hoc or permanent.”³² All of these cases firmly emphasized the importance of judicial control over these issues. For these states, the recommendation of an ethics committee, at least on paper, is persuasive but not determinative.

Even in *Saikewicz*-influenced jurisdictions, there is still a pressing need for procedural regulations of ethics committees. First, not every conflict reviewed by an ethics committee makes it to the judiciary system. In those situations, a patient’s family may feel disempowered enough to forgo battling the hospital and doctors in the adversarial setting of the court. They may lack the resources to access the judicial system, or the psychological impact of the committee’s advice may carry so much weight that the decision will effectively be determinative.³³ Second, even when ethics committees issue non-binding decisions, their decisions hold significant weight and are often seen as authoritative.³⁴ Professor Susan Wolf argues that “a close reading of these opinions [relying on ethics committee recommendations as evidence] indicates that not only may the determination be received into evidence, but it may also be accorded some degree of deference by the court.”³⁵ Judges, such as the ones involved in *A.C.*, may feel that they are inadequately prepared to evaluate the recommendations of ethics committees. If judges do not feel properly educated in the complexities of right to die issues, they may simply rubber stamp ethics committee decisions. Furthermore, as the population ages and judges are faced with more and more of these disputes, they may not be as conscientious as they were in the late 1970’s and early 1980’s about evaluating each case. They may instead choose to rely on the ethics committee recommendations as an efficient and presumably fair way to resolve these situations. Therefore, the need for

²⁸ 421 A.2d 1334, 1349 (Del. 1980).

²⁹ *Eichner v. Dillon*, 426 N.Y.S.2d 517, 550 (N.Y. App. Div. 1980).

³⁰ *Id.*

³¹ 405 N.E.2d 115 (Mass. 1980).

³² *Id.* at 120.

³³ Wolf, *supra* note 5, at 809.

³⁴ *Id.* at 808–10.

³⁵ *Id.* at 809–10.

due process requirements is just as pressing in jurisdictions that follow *Saikewicz* as in jurisdictions that follow *Quinlan*.

V. Potential Solutions

For successful collaboration between ethics committees and the judiciary, ethics committees should serve as the first arbiters in right to die cases because they promise increased speed, reduced cost, and reliable expertise. However, removing all judicial oversight is inappropriate, since ethics committees remain private groups relatively unaccountable to the public. Further, for ethics committees to be attractive forums for patients, families, and doctors to resolve conflict, they must be strengthened by including due process requirements.

The need for due process requirements spans not only *Quinlan*-type jurisdictions, where courts appear to have delegated determinative decision-making authority to ethics committees, but also *Saikewicz*-type jurisdictions, where ethics committees still play a quasi-judicial role and derive significant authority from governmental institutions such as the legislature and the judiciary. The *Eichner* court remarked, “Common-law rights can be abrogated by statute in the exercise of the State’s police powers subject only to due process requirements.”³⁶ Since the recommendations of the ethics committees often receive their authority from the police power—the same power that allows legislatures to regulate do not resuscitate orders and courts to decide right to life cases in the first place—due process procedures are necessary in order to preserve the validity of ethics committees. While the authority they derive from state institutions is not the only justification for increased procedural protections, it serves as a reminder that courts ought to delegate procedural responsibilities along with this authority. Therefore, by tying the authority of ethics committees more closely to the police power, we can create a justification for judicial oversight of the procedural workings of ethics committees, which are still technically private groups despite the quasi-judicial function they serve.

To enact such a scheme, states would have to revise some of the regulations on ethics committees. For example, privilege statutes, which limit the discoverability of proceedings, records and files of the committee in civil actions, such as those in Maryland and Montana, can limit courts’ ability to review the recommendations of ethics committees. These statutes present a barrier for review of the inner workings of ethics committees by limiting the situations in which these records can be reviewed in a judicial proceeding. These statutes can also create a major obstacle for patients seeking to uncover any mistake or wrongdoing through judicial review of the documents generated by an ethics consultation.³⁷ Future statutes ought to facilitate judicial review of the records of ethics committees. The possibility of judicial review may provide incentive to practice good record keeping and good procedural practices.

In addition, statutes imposing only vague procedural requirements for ethics committees, such as the Maryland statute, ought to be revised to create a more standardized procedure for ethics committees in each state. Standardization would help make ethics committees accountable to patients and the populations they serve.

³⁶ *Eichner*, 426 N.Y.S.2d at 540–41.

³⁷ *Fleetwood & Unger*, *supra* note 26, at 323.

STRENGTHENING CLINICAL ETHICS COMMITTEES

Currently, ethics committees use a wide variety of procedures, which makes it difficult to construct a customary standard of care for these groups, restricting the ability of patients to show negligence or misconduct. With a meaningful and specific set of procedures, a patient might be able to show negligence should an ethics committee misuse its authority. Although ethics committees have rarely been named as defendants,³⁸ patients will benefit from the ability to police ethics committees in court.

The lack of standardized procedures also undermines the weight a court can ascribe to an ethics committee recommendation. Courts cannot delve into each ethics committee's operations to determine if that committee is run well or if patients and doctors have accepted their recommendations in the past. With procedural regulations in place, courts will be able to assume that ethics committees have followed approved procedures and that their recommendations are sound.

However, standardization will be useless if procedures are not carefully designed and implemented. A potential, though not ideal, solution to the lack of standard procedures could be patterned after Minnesota's *In re Torres*.³⁹ The *Torres* court required three ethics committees to submit reports on the procedures they would have used to determine the appropriate treatment for someone in that patient's condition.⁴⁰ Later, Minnesota law adopted the *Torres* court's approach, allowing county officials to request that ethics committees submit a report affirming that health care providers have followed the proper procedures on behalf of a ward.⁴¹ While this is better than having no procedural requirements at all, a superior approach would be for the legislature to impose specific procedures after a careful survey of the best practices of ethics committees around the country.

If ethics committees are increasingly becoming the final arbiter, then state legislatures should establish due process requirements for these committees. Left to their own devices, hospitals will inevitably err on the side of giving ethics committees more freedom and fewer constraints, often at patients' expense. They may jettison safeguards that they find cumbersome or burdensome, even when these procedures protect the interests of the patient. Without state regulation, the procedures set for ethics committees by ethics committees beg the question "who will guard the guards themselves?"⁴²

VI. Conclusion

Ethics committees are a useful forum for alternative adjudication of right to die controversies. They allow parties to avoid the expense and difficulties of the judicial system. They can help determine which patients value costly end-of-life care and which patients would view such extensive life support as an affront to their dignity. Considering the expense of end-of-life care, as well as the increasing portion of GDP spent on healthcare, strengthening the role of ethics committees in right to die issues may

³⁸ See *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127 (Cal. Ct. App. 2d Dist. 1986).

³⁹ 357 N.W.2d 332 (Minn. 1984).

⁴⁰ *Id.* at 335.

⁴¹ MINN. R. 9525.3055 (2009).

⁴² "Quis custodiet ipsos custodies." Juvenal, *Satire* 6.346-8 (G.G. Ramsay, trans., Loeb Classical Library 1918).

not only support ethical medical decision-making but may also help minimize the burden end-of-life care can put on the healthcare system.

Ethics committees can be used in two ways. First, they can be used as substitute arbiter for the overloaded judicial system. Second, they can be used as investigative tools for the courts, submitting well thought-out recommendations for each situation. However, without proper procedural due process, the usefulness of ethics committees will be limited. Regulations should establish standardized procedures for ethics committees so that negligent committees can be held accountable and so that courts can confidently rely on their recommendations. More importantly, these procedures ought not to come from the ethics committees themselves. Instead, the legislature should delegate authority to ethics committees by enacting legislation with clear and definite procedural requirements. Without this type of legislation, the usefulness and validity of ethics committees in providing guidance to courts in right to die cases will remain limited.

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