To: Chair Takumi
Vice Chair Ichiyama
Members of the Committee
Fr: Nanci Kreidman, M.A.
Chief Executive Officer
Re: HB 2425; Support

Aloha. Thank you for placing this Bill on the agenda for discussion and deliberation. We have learned so much about the crime of domestic violence these last 30 years. There are many and varied ways used to harass or control partners, that had not been considered domestic violence, by definition.

It is important for us to name the behaviors and hold abusers accountable for their perpetration of abuse, even when it doesn't leave a visible bruise.

This has the potential, of course, to arouse resistance and controversy. Those of us who have been working with survivors recognize the behavior included in this Bill, and have heard it described multiple times by many clients. It is clearly time to believe victims when they describe the lengths their abusers go to control them, isolate them, restrain them from contact with family and friends, withhold resources, threaten them, and harass them into obedience. It is when we face the dark and hidden behaviors that we can effectively address the epidemic we see at schools,

DOMESTIC VIOLENCE ACTION CENTER
ADDRESS: P.O. BOX 3198, HONOLULU, HI 96801-3198
LEGAL HELPLINE: (808) 531-3771
TOLL-FREE NEIGHBOR ISLAND HELPLINE: (800) 690-6200
WEBSITE: WWW.DOMESTICVIOLENCEACTIONCENTER.ORG
EMAIL: DVAC@STOPTHEVIOLENCE.ORG

businesses, medical settings, courtrooms, churches, community based organizations, therapists offices and domestic violence shelters.

We shall look forward to favorable action on HB 2425. Thank you.

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Barbara Gerbert, PhD
Joshua Gerbert, DPM

59-120 Laninui Drive
PO Box 44505
Kamuela, HI 96743

February 10, 2020

Dear Honorable Chair Senator Baker and Vice Chair Senator Chang

Position on HB2425: Support

My name is Joshua Gerbert, DPM, a board certified foot and ankle surgeon who practiced in San Francisco for 45 years before retiring to the Big Island 7.5 years ago. In my practice I had the occasion of seeing women who were coercively abused and discovered that there were no laws that protected them.

I am writing to express my support of Bill HB 2425 in that it is long overdue. The trauma these women experience are as severe as physical abuse.

Thank you for the opportunity to testify on this Bill.

Sincerely,

Joshua Gerbert, DPM, FACFAS
59-210 Laninui Drive
Kamuela, HI 96743

Position on HB 2425: Support

HB-2425
Submitted on: 2/10/2020 9:06:37 PM
Testimony for CPC on 2/12/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Eileen M Gawrys	Dr. eileen gawrys. board member, Domestic Violence Action Center	Support	No

Comments:

loha. Thank you for placing this Bill on the agenda for discussion and deliberation. We have learned so much about the crime of domestic violence these last 30 years. There are many and varied ways used to harass or control partners, that had not been considered domestic violence, by definition.It is important for us to name the behaviors and hold abusers accountable for their perpetration of abuse, even when it doesn't leave a visible bruise.This has the potential, of course, to arouse resistance and controversy. Those of us who have been working with survivors recognize the behavior included in this Bill, and have heard it described multiple times by many clients. It is clearly time to believe victims when they describe the lengths their abusers go to control them, isolate them, restrain them from contact with family and friends, withhold resources, threaten them, and harass them into obedience. It is when we face the dark and hidden behaviors that we can effectively address the epidemic we see at schools, businesses, medical settings, courtrooms, churches, community based organizations, therapists offices and domestic violence shelters.

We shall look forward to favorable action on HB 2425. Thank you.

HB-2425
Submitted on: 2/10/2020 3:17:15 PM
Testimony for CPC on 2/12/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
MARSHA H BOLSON	Individual	Support	No

Comments:

I would like to offer strong support for HB 2425 that amends the definition of domestic abuse to define and include coercive control between family or household members. It is well known that abuse of household and family members takes many, many forms. The inclusion of language that describes physical, verbal, psychological, economic and mental abuse tactics, as well as threats and intimidation, isolation and single or repeated hostile, malicious and scary acts will help to identify
and acknowledge coercive control as a major aspect of domestic violence.

Mahalo for the opportunity to express my support of this valuable legislation.

Marsha H. Bolson

HB-2425
Submitted on: 2/10/2020 4:46:12 PM
Testimony for CPC on 2/12/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Barbara Ota	Individual	Support	No

Comments:

Dear Honorable Chairs, Vice Chairs and Representatives of the CPC and JUD Committees,

I am Dr. Barbara Ota, DACM, DAc, a resident of the Big Island, current President of the Hawaii Acupuncture Association, and a long time advocate in my professional and private life to protect the public from the insidiousness and reality of domestic abuse in all its forms in our State of Hawaii. Please, support HB2425 and help in the protection for all members of our families. Thank you.

HB-2425
Submitted on: 2/10/2020 6:21:17 PM
Testimony for CPC on 2/12/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
kara england	Individual	Support	No

Comments:

Thank you placing this bill up for discussion it's important for our community !

Kara England

DATE: February 10, 2020

TO: Honorable Senator Baker, Chair and Senator Chang, Vice Chair

FROM: Barbara Gerbert, PhD

Professor Emeritus, University of California San Francisco

RE: HB2425

Hearing scheduled Wednesday, February 12, 2020 at 2:00 p.m.

Aloha. My name is Barbara Gerbert, PhD, and I am Professor Emeritus at the University of California, San Francisco (UCSF), as well as a constituent from Hawaiʻi Island, where I've lived since 2012.

I am writing in support of HB2425

My 40-year career at UCSF began with entrance into a doctoral program in 1975. I earned my doctorate in Health Psychology there in 1982, and I served as tenured faculty and Chair of the Behavioral Sciences Division until my retirement.

My passion and expertise is in domestic violence. My academic work as a professor at UCSF highlighted research studies of the important role that health care professionals (specifically physicians and dentists) play, in addressing domestic violence (DV). I also developed tutorials to improve health care professionals' response to DV, including the "AVDR" (Ask, Validate, Document, and Refer) method I developed, which was funded by the National Institutes of Health.

I have published over 120 peer-reviewed manuscripts, many on domestic violence and simple ways that health care professionals (HCP) can ask patients about domestic violence in their lives and validate their experiences, offering hope and always leaving the door open for further discussion. My research has shown that minor changes in HCP behaviors can lead to big changes in the environment for victims of abuse.

In 2015, I was driving toward Waimea from the Kona coast, listening to

National Public Radio. I heard a piece about a new law that had been enacted in England and Wales, targeting people who coercively control their intimate partner or other family members. Shortly thereafter, Scotland added this law to their legislation as well.

I immediately pulled over to the side of the road, with tears in my eyes, a rapid heartbeat, and chicken skin. I had just given a presentation on domestic violence at Tutu's House in Waimea, emphasizing the long-lasting harm of coercive control. My audience, to a person, had experienced coercive control themselves or to friends, family members, and co-workers. A law against coercive control, with all it entails, would be a godsend in Hawaiʻi!

I am very familiar with Scotland's groundbreaking work to alleviate DV. In 2009 Linda Borland, a police officer from Scotland's Violence Reduction Unit (VRU), contacted me, asking if she could use my AVDR (Ask, Validate, Document, and Refer) model. Not long after, Dr. Christine Goodall, an oral surgeon, updated me on Scotland's efforts to reduce violence, with AVDR as the centerpiece.*

Dr. Goodall, as the founder and head of Medics against Violence Scotland (MAVScotland) focuses on the role of health care professionals parallel to my focus. She also encourages health care professionals to work with all professions in preventing and reducing DV.

In England, Scotland, and Wales, it is illegal to coercively control an intimate partner. As a result, Scotland, once known internationally for high rates of violence, including gang violence, family violence, etc., is now a role model internationally for reducing violence. Glasgow went from being called the "murder capital of Europe" to an exemplar of non-violence.

The enactment of HB2425 would educate our Hawaiʻi citizens to the great burden that coercive control places on our people and our state, and abusers would learn that this abuse is not acceptable.

In my 7 years living fulltime in Hawaiʻi, I have observed the power of the family, the closeness and bonds of family, that create a warm, loving, kind, and gentle atmosphere. Once HB2425 is in place, programs can be implemented to heal, nurture, and enhance this natural warmth of that family culture here in Hawaiʻi—and help reduce coercive control and violence that destroy it.

Please VOTE YES on HB2425.

Mahalo,

Barbara Gerbert, PhD

Professor Emeritus

University of California San Francisco

barbara.gerbert@ucsf.edu

415-385-9831

*This very powerful 5-minute training video developed by MAVScotland and the Violence Reduction Unit of the Scottish Police emphasizes AVDR, which I developed and distribute internationally (copyright UCSF).

“Harder” https://m.youtube.com/watch?v=ay4dQy6vzPI

HB-2425
Submitted on: 2/10/2020 9:10:00 PM
Testimony for CPC on 2/12/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Jane Mayo	Individual	Support	No

Comments:

Mrs. Jane Mayo, 59-120 Hahalua Place

Kamuela, HI 96743-7813

February 10, 2020

Dear Honorable Chair Senator Baker and Vice Chair Senator Chang

Position on HB2425: Support

I am writing to express my support of bill HB2425.

I believe every household in HAWAII deserves to be free of coercive control. As the author of this testimony I plan to do my part to make it so. The enactment of this bill will help to reduce coercive control within the household by allowing it to be identified as domestic violence and dealt with in the same measures.

Thank you for the opportunity to testify on this Bill.

Sincerely,

Jane Mayo

Constituent, resident of District 9

Position on HB2425: Support

Shelby Loo
6th Grade Mathematics Teacher, NBCT
66-1803 Alaneo Street
Kamuela, HI 96743

February 10, 2020

Dear Honorable Chair Senator Baker and Vice Chair Senator Chang

Position on HB2425: Support

I am writing to express my support of bill HB2425.

I am a school teacher and contend with bullying in the classroom. It is often determined that these bullies are being raised in households where coercive control is occurring. I believe that through the enactment of HB2425, coercive control at home can be reduced and provide a better example to children of how to treat others, thus reducing bullying at school. This would increase peace and learning at school for all involved.

Thank you for the opportunity to testify on this Bill.

Sincerely,

Shelby Loo
6th Grade Mathematics Teacher, NBCT
Waimea Middle Public Conversion Charter School

Position on HB2425: Support

Michelle Harrison
Executive Housekeeper, Westin Hapuna
62-100 Kauna'oa Drive
Kohala Coast, HI 96743

February 11, 2020

Dear Honorable Chair Senator Baker and Vice Chair Senator Chang

Position on HB2425: Support

I am writing to express my support of bill HB2425.

Many families in Hawaii experience a close and loving environment within the home. Yet in other families, aggression and coercive control are exhibited and passed down from generation to generation as acceptable behavior. I have observed this in close friends, coworkers, and fellow church members. Enactment of this bill will help to reduce coercive control within the household.

Thank you for the opportunity to testify on this Bill.

Sincerely,

Michelle Harrison
Executive Housekeeper, Westin Hapuna Beach Hotel

Position on HB2425: Support

HB-2425
Submitted on: 2/11/2020 9:44:06 AM
Testimony for CPC on 2/12/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Patricia Cook	Individual	Support	No

Comments:

HB-2425
Submitted on: 2/11/2020 11:08:40 AM
Testimony for CPC on 2/12/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
May Lee	Individual	Support	No

Comments:

May Lee

645263 Hohola Drive Kamuela, HI 96743

—

February 11, 2020

Dear Honorable Chair Senator Baker and Vice Chair Senator Chang

Position on HB2425: Support

I work in law enforcement and have lived in Hawaii for about 14 years.

I am writing to express my support of bill HB2425.

Domestic Violence is a complex issue but at the heart of it is the need for power and control. Long before there is any physical abuse, there is emotional and controlling abuse. If we can stop domestic violence on this level, then maybe it won't escalate to physical injury and murder. Domestic violence tends to intensify over time, so stopping it early may be the key to victim safety.

Thank you for the opportunity to testify on this Bill.

Sincerely,

May Lee

Position on HB2425: Support

HB-2425
Submitted on: 2/11/2020 4:18:06 PM
Testimony for CPC on 2/12/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Dara Carlin, M.A.	Individual	Support	No

Comments:

Takeshi Uemura, MD
347 N. Kuakini St, HPM-9
Honolulu, HI 96817
Office: 808-523-8461

January 29, 2020

Dear committee on health,

My name is Takeshi Uemura. I am a physician and a faculty member of the department of geriatrics at the University of Hawaii School of Medicine. I am an assistant professor and board-certified in palliative medicine, geriatrics, and internal medicine. I work as a hospice medical director at Islands hospice and as an attending physician at Kuakini geriatric care and Manoa Cottage Kaimuki.

This testimony is addressed to COMMITTEE ON HEALTH (Rep. John M. Mizuno, Chair) for the hearing HB 2451 at 11AM of Friday, January 31, 2020.

This is my personal opinion and does not reflect the views or thoughts of the aforementioned institutions or organizations.

I am writing this testimony to express my opposition to most of the bills and my serious concerns over this bill from a viewpoint of a trained palliative care physician.

Please first allow me to write about my personal experience of Our Care, Our Choice Act (OCOCA) since my concern is based on this experience. I have experienced two cases, one as a hospice medical director, and the other as a prescribing attending physician. Since this testimony will be posted publicly, I will omit personal information and detailed clinical information to protect patient privacy.

The first case was a male patient in his 60s who had cancer with a local recurrence after curative intent therapy. I saw him as a hospice medical director when he was admitted to our hospice. It was noted that he had severe pain likely due to his cancer. He was taking an enormous amount of an opioid for the pain. At that point, he had been already prescribed with medication for medical aid in dying (MAID) by an oncologist. He stated that he did not want to die but he would take the medication if the pain could not be controlled. His story sounded very concerning to me since he had not received any high-quality palliative care before this prescription. The pain medication had been prescribed only by his oncologist. Since his pain was refractory, high-quality, specialized palliative care should have been involved in his care since it is beyond primary palliative care skills that oncologists could provide.[1] I, as a hospice medical director, tried my best to optimize his pain medications by rotating to a different kind of opioid and adding other agents. However, we did not have enough time to find the right regimen

before he proceeded to take the medication. I really wished he had been referred to specialty palliative care since there were measures that should have been done.

The second case was a female patient in her 90s. She was suffering from congestive heart failure and admitted to one of my nursing homes. She was bed-bound due to her deconditioning and heart failure but her mind was crystal clear. Although she had completed physical therapy at sub-acute rehab, her bed-bound status did not improve. This functional state was unacceptable to her who had enjoyed traveling the world and valued independence the most. Given her advanced state of heart failure, she requested OCOCA. Her request was very challenging to me since making prognosis on non-cancer condition is known to be likely inaccurate.[2] However, after lengthy discussions with the patient, family and other providers, I felt more comfortable that MAID is the right choice for her. Her reason for requesting MAID was due to loss of function and meaning in her life, both of which are difficult to treat with specialist palliative care or any other measures. Therefore, I proceeded with the process. The waiting period gave me time to process my emotional distress and to ensure I explore all the other possible options. A physician who had done MAID before provided the guidance to me. Without guidance, it would have been almost impossible to navigate all the procedures since the process was totally new to me. She died peacefully at her home, surrounded by her family, right after taking the medication. I was present at the moment. It was one of the most peaceful deaths I have ever seen.

These two cases raise several important points on this OCOCA.

- Lack of patients' access to high-quality palliative care
- Determining of terminal conditions and prognosis is very challenging especially if physicians are prescribing lethal medications
- The waiting period helps for ensuring other possible options explored
- Support and guidance from physicians who are experienced with OCOCA are crucial for physicians to feel safe and more comfortable to navigate this stressful process.
- MAID could be a reasonable option when ordinally palliative measures cannot address the suffering

Given these points, I would like to provide my opinion about the bill you will be discussing.

1. "Explicitly authorizes advanced practice registered nurses, in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority."

I strongly oppose this change. There are two reasons.

The first is the difficulty of making an accurate prognosis. Determining the condition of the disease as a terminal condition and whether the patient's prognosis is less than six months requires a deep knowledge of pathophysiology and available treatment options, and accurate

assessment of patient's functional status and trajectory of functional decline. This task is even challenging for physicians as stated above. Therefore, this task is beyond the scope of nurse practitioners' capabilities since their training is not intended to provide these skills. To my knowledge, there is no study that studied the accuracy of prognoses by nurse practitioners. Besides, under medicare, nurse practitioners are prohibited from certifying a terminal diagnosis or six months prognosis. ("Additionally, the Medicare Benefit Policy Manual, Pub. 100-02, chapter 9 has been updated to reiterate that designated hospice attending physicians who are nurse practitioners or physician assistants may not certify a hospice patient as terminally ill in accordance with section 1814(a)(7) of the Social Security Act, which requires that no one other than a medical doctor or doctor of osteopathy can certify or recertify terminal illness for the Medicare hospice benefit." [3]) Since the determination of a terminal condition and six months prognosis is an essential part of OCOCA, nurse practitioners should not be allowed to act as an attending physician or consulting physician.

The second is a lack of evidence that excluding nurse practitioners have been a barrier to fair access to MAID. To my knowledge, there has been no state-wide survey to identify what is causing an access barrier. Only anecdotal opinion. Such a change to laws regarding lethal medication should not be made without having solid data or evidence. Otherwise, it is as if you were granting permission for a new medication without a robust clinical trial. This is about lethal medications. We should have data. Not just an anecdote. Since other states do not allow nurse practitioners to act as attending physicians, they will ask us what was the rationale for that change. We do not want to say that it was only based on an anecdote.

2. "Reduces the mandatory waiting period between oral requests made by a terminally ill individual to fifteen days.

I am neutral about this change. I do not feel impelled need to shorten the period but also do not see actual harm. If the intention of the waiting period is to make sure the consistency of the patient's request, 20 days and 15 days should not make much difference in this regard.

3. "Allows the attending provider to waive the waiting period for terminally ill individuals not expected to survive the mandatory waiting period."

I oppose this change. There are two reasons.

Firstly, making an accurate prognosis will be challenging for this task. If physicians feel that patients would not live more than twenty days, that means patients are imminently dying. Other than by a recognition of imminent death syndrome, physicians cannot make prognostication with reasonable accuracy for less than 20 days. [2] The syndrome of imminent death is an irreversible process of dying and lasts as long as 14 days. [4] Since imminent death usually causes an altered mental status and difficulty of swallowing, it is questionable if patients who are actively dying can even maintain the capacity and swallow the medication. Also, if symptoms of imminent death are difficult to control with ordinal palliative care measures,

palliative sedation can be pursued instead of MAID to provide relief. [5] Therefore, there is no place for MAID in imminently dying patients.

Secondly, if the waiting period can be waived, there will be concerns that a few physicians who are very enthusiastic about this will abuse the system and prescribe lethal medication by using the justification of prognosis less than 20 days. Since there is no evidence about how to make an accurate prognosis for less than 20 days, you cannot prove the wrongness of this person's opinion about the prognosis for less than 20 days either. Therefore, this can increase the risk of abuse and misuse of the system.

We all want to provide good care to terminally ill patients that are suffering and MAID can be a valuable option for some of them. However, MAID should not be the only option. As a palliative care physician, I believe that it should be indicated only for terminally-ill patients who are suffering with symptoms that are difficult to treat with palliative care measures. In fact, states with years of experience of MAID such as Oregon or Washington, physical symptoms were not the reason for MAID requests in the majority cases. Instead, loss of functions and dignity were listed as the most common reasons, both of which are difficult to treat [6] There is a concerning lack of palliative care in this state. To my knowledge, only Queens medical center provides outpatient palliative care. The other hospitals provide only inpatient services and even their teams are understaffed. Some teams are only composed of nurse practitioners without physicians. There is no fellowship training program on palliative care in this state. As I have been trained in New York state where many palliative care fellowship programs exist, to my eyes, it is obvious that Hawaii lacks enough access to palliative care services. Therefore, I am deeply concerned that MAID is being used instead of high-quality palliative care. If you are providing only death to patients rather than helping them to live and manage their suffering, it is shameful as a society.

Rather than making the changes to the law, I suggest things listed below.

- Conduct a statewide survey to physicians to figure out whats barriers are for participating OCOCA
- Include reasons for MAID request in the follow-up report questioners to find out how often physical symptoms are the reasons
- Provide state support to distribute palliative care practice broadly statewide
- Create a system to provide support from physicians who have experience in OCOCA to attending physicians who are going through the process

Sincerely,

Takeshi Uemura, MD

References:

1. Quill TE, Abernethy AP. Generalist plus specialist palliative care--creating a more sustainable model. N Engl J Med. 2013;368: 1173–1175.

2. Brandt HE, Ooms ME, Ribbe MW, van der Wal G, Deliens L. Predicted survival vs. actual survival in terminally ill noncancer patients in Dutch nursing homes. J Pain Symptom Manage. 2006;32: 560–566.

3. for Medicare C, Services M, Others. Pub 100-02 Medicare benefit policy. 2013. Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R246BP.pdf

4. Syndrome of Imminent Death - Palliative Care Network of Wisconsin. In: Palliative Care Network of Wisconsin [Internet]. [cited 29 Jan 2020]. Available: https://www.mypcnow.org/fast-fact/syndrome-of-imminent-death/

5. Kirk TW, Mahon MM, Palliative Sedation Task Force of the National Hospice and Palliative Care Organization Ethics Committee. National Hospice and Palliative Care Organization (NHPCO) position statement and commentary on the use of palliative sedation in imminently dying terminally ill patients. J Pain Symptom Manage. 2010;39: 914–923.

6. Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. JAMA. 2016;316: 79–90.