Proponent Testimony - HB 236

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My name is Geoff Mitchell. I am a retired emergency physician. I practiced emergency medicine in Ohio for nearly 40 years. Every working day of my professional life I spent much of my time caring for critically ill patients here in Ohio. I have cared for more than 100,000 generally sick Ohioans.

I am also a licensed attorney. I've practiced medical negligence law finished my career as medical school faculty, teaching law as well as medicine to post-graduate physicians. I have served on a university ethics committee and multiple hospital quality assurance committees.

I am here to testify in favor of HB236. Based upon my training and experience, I see no legitimate clinical reason why a patient should be denied the presence of an advocate over the course of his or her hospitalization.

Advocate is a rather formal, maybe even a sterile word. The advocates described in this bill are generally going to be a patient's loved ones: wives, husbands, sons, daughters, other relatives, life partners, best friends, and significant others. We are generally talking about the most important person in someone's life being present at a patient's most vulnerable time. We are talking about human relationships. The term advocate is used to encompass all of these human relationships.

History – Never an issue until COVID.

During COVID we began to see medicine was turning upside down. E.g:

1) We saw patients sent home from the emergency department without treatment. Inpatient end-of-life treatment with a ventilator and Remdesivir was largely ineffective.

2) Unlike every other previous infectious disease model, early, outpatient treatment was banned.

3) The ban on the presence of patient advocates was also part of this new, upside-down medicine during COVID. This was not progress. The banning of patient advocates is regression. It is barbaric. The banning of patient advocates is a violation of a most basic human right. It is an assault on human dignity.

This upside-down medicine during the COVID pandemic was accompanied by a precipitous drop in patients' trust in physicians and medicine. A recent JAMA article found that trust in physicians fell from 70% to 40% in four years. [1] This is horrific. It is a generational decline. Hospitals' bans on the presence of patient advocates is part of their contribution to this decline and distrust. This committee cannot fix this systemic failure. This committee can fix this one small part and make the world a better place.

The Experts who study patient isolation find that it is harmful.

In an article on precisely this subject, in the Journal of Bioethical Inquiry in the context of the COVID pandemic in 2020, entitled "An Ethical Framework for Visitation of Inpatients Receiving Palliative Care in the COVID-19." [2] The authors stated:

1) "**Human connection is universally important.**" (Zhou et al. 2020; Tran et al. 2020).

2) "**We recognize the importance of access to close family and friends during healthcare experiences. . . Isolation of hospital inpatients** is **associated with psychological harm and poorer patient safety . . .**" (Abad, Fearday, and Safdar 2010).

3) **"Visitor restrictions instituted in hospitals . . . led to significant distress and loss of dignity."** (Swedish registry study of hospitals and nursing homes).

4) **"Visitor restrictions place additional burdens on hospital staff."** (Rogers 2004).

I respectfully suggest that these are all reasonable lessons to be learned from the isolation policies imposed during the COVID pandemic.

Brief Comparison to Historical and Current Federal Law

Under federal law, 42 CFR § 482.13(h) – "Patient's rights," A hospital must:

(1) "**Inform each patient** (or support person [advocate], where appropriate) **of his or her visitation rights. . ."**

(2) "**Inform each patient** (or **support person** [advocate], where appropriate) of the **right**, **subject to his or her consent**, **to receive visitors** [advocates] **whom he or she designates . . ."**

(3) "**Not restrict, limit, or otherwise deny visitation privileges"** on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(4) "**All visitors enjoy full and equal visitation privileges** [advocate access] **consistent with patient preferences.**

Also under federal law, 42 CFR § 482.13(e) – "Patient's rights," "All patients have the right to be free from restraint or seclusion," of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff." **"Seclusion may only be imposed to ensure the immediate physical safety of the patient** . . . and must be discontinued at the earliest possible time." Denial of visitation is essentially seclusion. Seclusion is seriously frowned upon by federal law.

The question is, why in the world would hospitals want a policy denying patients' access to an advocate during such a trying time? Why in the world would a hospital want to place its patients in seclusion, in solitary confinement? Why are we even debating this issue?

In sum, I ask this committee and the Ohio Senate to pass HB 236. Based upon my training and experience, I see no legitimate reason, clinical or otherwise, why a patient should be denied access to their advocates over the course of hospitalization.

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[1] Trust in Physicians and Hospitals During the COVID-19 Pandemic, Roy H. Perlis, MD, MSc et. al., JAMA Network Open. 2024;7(7):e2424984. doi:10.1001/jamanetworkopen.2024.24984 (Reprinted) July 31, 2024 1/13.

[2] J Bioeth Inq. 2022 Feb 17;19(2):191–202. doi: 10.1007/s11673-022-10173-z.