

10/06/2025

To: The Honorable Jean Schmidt, Chair of the Ohio House Health Committee
From: Sara Zandvakili, Constituent from District 41, Toledo OH

Dear Chair Schmidt, Vice Chair Deeter, Ranking Member Somani, and members of the House Health Committee,

My name is Sara Zandvakili, and I am a fourth-year medical student at the University of Toledo College of Medicine and Life Sciences who is preparing for a career in Obstetrics & Gynecology. I write to you in opposition to House Bill 324, as I am deeply concerned that this bill does not promote patient safety in an evidence-based manner.

My first concern is that the bill directs the Director of Health to determine medications with “severe adverse effects” based on insurance claims and self-reported data, sources that are prone to bias. In medical school, we are taught to make decisions based on rigorous peer-reviewed clinical research and professional guidelines supported by controlled trials and clinical data from physician reports and patient charts. Making determinations about drug safety based on unverified or subjective data undermines the standards that guide our clinical decision-making and disregards medications where the benefits outweigh the risks.

Moreover, I am concerned that House Bill 324 is proposing an arbitrary 5% threshold to define these medications. Physicians are trained to recognize and counsel patients on all risks, including those that present in as few as 0.01% of patients. In order to practice patient-centered care, the care team employs shared decision-making¹, which entails educating patients about benefits, risks, and alternatives, including what happens without treatment. This conversation can be conducted in person or virtually via telehealth. Publishing a list based on an arbitrary percentage will not improve patient safety and instead oversimplifies complex clinical decisions that demand individualized attention.

While on my gynecologic oncology rotation, we counseled patients receiving chemotherapy for uterine and ovarian cancer. Patients are made aware of the many side effects, including rare but life-threatening autoimmune reactions such as hepatitis, pancreatitis, and thyroiditis. These risks are managed through routine monitoring, not avoided through restrictions on telehealth or contingent upon follow-up care. House Bill 324 will not prevent rare life-threatening complications and does not explain how the restrictions placed on prescribers will yield better health outcomes for patients.

I am also concerned that House Bill 324 aims to limit access to specific medications where the benefits far outweigh the risks. Will the Director of Health have the capacity to compare the risk of life-threatening events in patients on a given medication versus if they go untreated? I make this point out of concern for pregnant patients. Being pregnant physiologically puts a person at higher risk of life-threatening conditions like blood clots, infection, and organ dysfunction¹. For my patients seeking to terminate a pregnancy or treat early pregnancy loss, the benefits far outweigh the risk of cramping and bleeding from medication abortion using mifepristone or misoprostol^{2,4}. Additionally, for patients seeking to continue their pregnancies, antibiotics that

treats urinary tract infections must be prescribed promptly to prevent their quick progression to kidney infections and preterm labor³. Are pregnant patients going to be restricted in their ability to obtain their prescriptions because they cannot make in person appointments or schedule follow-up care? I urge you to consider how this will restrict accessible care. There are most definitely situations where close monitoring of patients with a physical exam are necessitated, and physicians already make recommendations for follow-up to patients who need it.

I respectfully urge the committee to oppose House Bill 324 and instead prioritize policies that support timely, evidence-based access to medications essential for improving health outcomes in Ohio.

Thank you for your time and consideration. I would be happy to follow-up with more information.

Respectfully Yours,

Sara Zandvakili
sara.zandvakili@rockets.utoledo.edu
513-675-8111

References:

1. Kaimal, Anjali et al. American Journal of Obstetrics & Gynecology, Volume 224, Issue 4, B16 - B23. [Society for Maternal-Fetal Medicine Consult Series #55: Counseling women at increased risk of maternal morbidity and mortality](#). 2021.
2. American College of Obstetricians and Gynecologists. [Updated Mifepristone REMS Requirements](#). 2024.
3. Mansour O, et al. [Prescription Medication Use During Pregnancy in the United States From 2011 to 2020](#). *Am J Obstet Gynecol*. 2024;231(2):250.e1–250.e16.
4. Food and Drug Administration. [Information about mifepristone for medical termination of pregnancy through ten weeks gestation](#). 2025.