4.2% of women with no prior scarring needed additional intervention (aOR 1.7, 95% CI 0.87–3.2).
Conclusions: We did not find a significant association between uterine scarring and medication abortion using the current evidence-based regimen, although our findings do not rule out the possibility of a modest association. Overall, our findings support the continued provision of this regimen to women with uterine scarring. This is the largest sample size in which this association has been studied, and our findings are consistent with previous studies of other regimens.

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P21

UNDERSTANDING AND RESPONDING TO WOMEN'S REPRODUCTIVE HEALTH NEEDS IN OKLAHOMA

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Objectives: We aimed to conduct evidence-based advocacy informed by the policy landscape in Oklahoma and Oklahoma women's experiences accessing reproductive health care.
Methods: We first examined state-level policies and outcomes specific to the health and socioeconomic well-being of women and children and determined how those policies and outcomes related to the number of state-level abortion restrictions. We then conducted in-depth interviews with Oklahoma women who recently had abortions about their experiences with abortion, pregnancy, maternal and child care, and other health care. In-depth interviews were recorded, transcribed and analyzed thematically. Findings were shared with state-level advocates to develop a plan for responding to women's unmet needs.
Results: The state policy and outcomes analysis showed that Oklahoma heavily restricts abortion, has few policies in place that support women's and children's health, and performs poorly on indicators of women's and children's health and socioeconomic well-being. In-depth interviewees described difficulty accessing health insurance, primary health care and abortion services in contrast to the relative ease with which they described accessing prenatal and child health care. To address these issues, advocates called for collaborative efforts by stakeholders focused on improving abortion access, social determinants of health, and women's and children's overall health.
Conclusions: These data highlight the need for Oklahoma policymakers to focus on evidence-based policies known to support women's and children's health instead of abortion restrictions, which have no health benefits and can be harmful to women. It also highlights the need to consider women's abortion care needs in the context of their broader health care needs.

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P22

OFFENSIVE DEFENSIVE MEDICINE: THE ETHICS OF DIGOXIN INJECTIONS IN RESPONSE TO THE PARTIAL BIRTH ABORTION BAN

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Objectives: Since the Supreme Court upheld the partial birth abortion ban in 2007, more U.S. abortion providers have begun performing intraamniotic digoxin injections prior to uterine dilation and evacuations. These injections can cause medical harm to abortion patients. Our objective was to perform an in-depth bioethical analysis of this procedure, which is performed mainly for the provider's legal benefit despite potential medical consequences for the patient.
Methods: Several kinds of situations in medicine when medical risk or harm to a patient can be ethically justified were analyzed. First, patients may be ethically subjected to risk for the benefit of others, as in the cases of organ donation or public health measures. Second, patients may be subject to medical risk to avoid a rare but catastrophic outcome, such as exposing a patient to CT radiation to rule out an unlikely but devastating intracranial hemorrhage. Finally, patients may face risk because of providers' compliance with a restrictive law, such as when laws mandating parental consent for abortion result in diminished access for patients.
Results: While examples exist in medicine where patients are ethically subjected to medical risk, they differ from the case of digoxin injection in important ways. These injections lack the potential to benefit third parties; do not help prevent rare but catastrophic outcomes; and represent direct, medical harm not mandated by law.
Conclusions: Digoxin injections subject patients to risk to preserve the availability of legal abortion in their community; whether such a tradeoff can be ethically condoned requires explicit discussion among physicians and patients.

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P23

FIRST-TRIMESTER MEDICAL ABORTION VERSUS SURGICAL ABORTION: A COMPARISON OF EFFICACY AND COMPLICATIONS

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Objectives: To compare the efficacy and complication rates of medical abortion versus surgical abortion up to 9 weeks' gestation.
Methods: We performed an historical cohort study comparing outcomes of first-trimester medical abortion versus surgical abortion at Planned Parenthood, Los Angeles from November 2010 to August 2013. Data were collected through electronic medical record review from 30,147 women with pregnancies at or less than 63 days' gestation seeking termination. Charts were reviewed for complications occurring within the immediate postabortion period (within 8 weeks). These included unanticipated aspiration, ongoing pregnancy and other adverse events (emergency room presentation, hospitalization, perforation, transfusion, infection). Chi square test and logistic regression were used to compare the primary outcomes between cohorts.
Results: Social, demographic and clinical characteristics were similar in the medication abortion and surgical abortion groups. Unadjusted rates of ongoing pregnancy were low in both groups at 0.39% for medication abortions and 0.17% for surgical abortions ($p<.0001$). The medication abortion group was more likely to undergo an unanticipated aspiration for persistent bleeding or ongoing pregnancy, (1.63% vs. 0.51% of the surgical abortion group, $p<.001$). These rates were unchanged after we controlled for age, gravidity, parity, body mass index and gestational age. There was no difference in other adverse events between the two groups.
Conclusions: Medication abortion and surgical abortion at or prior to 63 days' gestation are both safe and effective. Women should be offered both options when seeking pregnancy termination up to 9 weeks' gestation.

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