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Abortion

"No Big Deal": A Qualitative Study of Pharmacists' Perspectives on Dispensing Mifepristone for Medication Abortion

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A B S T R A C T

Introduction: Until December 2021, the United States Food and Drug Administration impeded abortion access by restricting pharmacists from dispensing mifepristone, one of two drugs used in medication abortion. This study aimed to explore pharmacists' perspectives on dispensing mifepristone.
Methods: We conducted semistructured interviews with pharmacists before and after participating in a pilot project where mifepristone was dispensed from their pharmacies. We thematically coded all interview transcripts, then summarized emergent themes related to pharmacists' support, comfort, experiences, and concerns around dispensing mifepristone.
Results: Between May 2018 and July 2020, we interviewed 29 pharmacists (22 at baseline and 15 at follow-up, with 8 completing both interviews) from 5 pharmacies. At both baseline and follow-up, interviewees strongly supported pharmacists dispensing mifepristone, feeling it would improve quality of care by providing more convenient medication abortion access and streamlined service delivery and take advantage of pharmacists' expertise and availability. All pharmacists interviewed at follow-up reported dispensing mifepristone except two who were willing but did not have the opportunity. Pharmacists experienced few challenges dispensing mifepristone. Their main concern was perceived discomfort that other pharmacists and pharmacy staff may experience, particularly in conservative areas or small pharmacies where pharmacists' refusal to dispense mifepristone could impede abortion access.
Conclusions: Most pharmacists supported dispensing mifepristone and were comfortable doing so after education on mifepristone and medication abortion. They dispensed mifepristone without difficulty, in a similar process as dispensing other medications. With the recent removal of U.S. Food and Drug

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Administration restrictions prohibiting it, our findings support the feasibility of pharmacists dispensing mifepristone.

Medication abortion provision in the United States is limited by the U.S. Food and Drug Administration's Risk Evaluation and Mitigation Strategy (REMS) for mifepristone, one of two drugs used in the treatment. Since its approval in 2000, the REMS has restricted where, how, and by whom mifepristone can be dispensed, despite the drug's safety and efficacy (Raymond, Shannon, Weaver, & Winikoff, 2013). In addition to its use for medication abortion, mifepristone together with misoprostol is the most effective medication regimen for the management of early pregnancy loss (Schreiber et al., 2018). Until a recent modification to the REMS announced in December 2021 (U.S. Food and Drug Administration, 2021), pharmacists were restricted from dispensing mifepristone, which was a long-standing barrier to increasing access to medication abortion services (Raifman, Orlando, Rafie, & Grossman, 2018). This modification built on a temporary suspension in 2020 of the REMS in-person dispensing requirement for mifepristone (American College of Obstetricians and Gynecologists v. United States Food and Drug Administration Memorandum Opinion, 2020), which allowed mifepristone to be dispensed by mail during the COVID-19 public health emergency. The most recent modification could expand mifepristone dispensing to include brick-and-mortar pharmacies.

Pharmacist dispensing of mifepristone has several potential benefits, including enabling clinicians who are unable to stock mifepristone in their own facilities to provide medication abortion services (Grossman, Grindlay, Altshuler, & Schulkin, 2019; Raifman et al., 2018). Furthermore, data from Australia and Canada show that pharmacist dispensing of mifepristone is safe and effective (Grossman & Goldstone, 2015; Norman & Soon, 2016; Schummers et al., 2022). Although a study of primary care providers found they were supportive of allowing pharmacists to dispense mifepristone for medication abortion (Rasmussen, Janiak, Cottrill, & Stulberg, 2021), research on pharmacists' attitudes regarding the practice is limited. Upon Canada's rule change to allow pharmacist dispensing, pharmacists were supportive of and willing to integrate it into their practice (Munro et al., 2021).

To evaluate the model in a U.S. context, we conducted a study under an Investigational New Drug application to the U.S. Food and Drug Administration in which pharmacists dispensed mifepristone to medication abortion patients. Mifepristone and other medications were dispensed from the pharmacy after receipt of a prescription from a clinician who had assessed patients for eligibility for medication abortion and counseled them on the treatment. An hour-long standardized pharmacist training was developed by the study team, including an overview of the abortion access landscape, review of the medications involved, REMS, and study procedures, and was delivered by the study investigators at each site. The study provided each pharmacy with a binder of reference materials, including key study and training information. The primary objective of this larger study was to evaluate the safety and effectiveness of pharmacist dispensing and to evaluate patient satisfaction (Grossman et al., 2021).

We also sought to evaluate the feasibility of the model by exploring pharmacists' perspectives and experiences dispensing mifepristone. We conducted surveys and interviews with pharmacists at study sites before the implementation of the study protocol to dispense mifepristone and again at the end of the study. We assessed pharmacists' knowledge of medication abortion and perspectives on mifepristone dispensing before and after implementing the protocol. Surveys reflected that pharmacists had higher knowledge levels at follow-up and were satisfied with pharmacy dispensing of mifepristone; these outcomes are published separately (Kaller et al., 2021). Here, we present findings from interviews with pharmacists. These data supplement the previously published pharmacists' survey responses by describing pharmacists' experiences dispensing mifepristone at their pharmacies and providing context to their support of, comfort with, and concerns around dispensing mifepristone.

Methods

Study Pharmacy Sites

We recruited six pharmacy sites for the study based on their affiliation with and proximity to clinical study sites providing medication abortion. The study sites were located in urban centers in California and Washington State. Four of the six pharmacies were affiliated with the clinical site's health system; two pharmacies were independent community pharmacies in close proximity to the clinical site.

Procedures

All pharmacists at participating pharmacies were required to participate in a training before dispensing mifepristone through the study. Pharmacists could choose not to participate in mifepristone dispensing and the associated training. Before the training, we invited all pharmacists to complete a baseline survey about their knowledge of medication abortion and perspectives on mifepristone dispensing, which they could complete regardless of their plan to participate in the training or intentions to dispense mifepristone. We also offered a follow-up survey at the end of the study to all pharmacists who had received the study training. We report survey data on interview participants' demographics and other characteristics here to describe the sample. Pharmacists could indicate in the baseline and follow-up surveys if they were interested in participating in a subsequent interview to share more about their thoughts on pharmacists dispensing mifepristone. We interviewed pharmacists at these two time points to assess changes in themes before and after mifepristone dispensing. Pharmacists could participate in only one or both of the baseline and follow-up interviews. Research staff conducted interviews over the telephone with pharmacists from five of the sites; interviews were conducted in person at one site.

Before the pharmacy began dispensing mifepristone, the baseline interview asked pharmacists, regardless of whether they planned to be or had been trained, how they felt about pharmacy dispensing of mifepristone at their site, including benefits, concerns, comfort, and training needs. The follow-up interview asked pharmacists who had received the study training about these same topic areas, as well as about their experiences with mifepristone dispensing at their pharmacies during the intervention.

Two authors (S.K., C.F.B.) and two research assistants conducted baseline interviews, aiming to interview pharmacists before their pharmacies began providing mifepristone. Two authors (S.K., T.G.) and one research assistant conducted the follow-up interviews in the final month of the study at the pharmacy, or earlier if a pharmacist was leaving the study pharmacy mid study. All interviewers had a background in abortion research and training on conducting interviews; none of the interviewers was a pharmacist or clinician.

Our sample size was determined by the number of pharmacists at the study pharmacies who were willing and available to participate in interviews. During each data collection period, the researchers conducted a preliminary analysis, determining that the interviews reached saturation addressing our study's research question. Pharmacists confirmed their consent to participate in the interview verbally before beginning the interview. Researchers conducting the interviews also asked pharmacists' permission to audio-record the interviews. The interviews were semistructured in nature and lasted 15–30 minutes. Pharmacists who completed an interview were remunerated with a $25 gift card for their participation, except for pharmacists at one institution whose institutional review board (IRB) of record did not allow for compensation. We transcribed audio-recordings of the interviews verbatim for analysis. The study was approved by the IRBs of Kaiser Permanente Northern California, University of Washington, and University of California, San Francisco, with approval from the IRBs of the University of California, Davis, and the University of California, San Diego, to rely on the University of California, San Francisco's IRB.

Analysis

We used a thematic approach to the interview analysis. Using the Dedoose qualitative data management software, two authors (S.K., M.M.) reviewed separate subsets of the baseline interview transcripts to generate a preliminary baseline codebook, consisting of both a priori codes developed from the interview guide and emergent codes that arose from the interviews related to pharmacists' support, comfort, experiences, and concerns around dispensing mifepristone. Then, the authors applied those codes to the remaining interviews, iteratively adjusting the codebook and previously reviewed transcripts as new themes emerged. After coding the transcripts, the two authors reviewed coded excerpts, summarizing common themes, notable outliers, and participant quotes that exemplified themes. The two authors met weekly during the analysis period to reflect on the coding and summary process, as well as the content of the themes, and to discuss how to resolve any discrepancies between the coders. We followed the same process for the analysis of the follow-up interviews, using the baseline codebook as a template to add to and modify. Three authors (S.K., M.M., T.G.) coded and summarized the coded excerpts from the follow-up interviews. After coding and summarizing baseline and follow-up transcripts, we then compared how themes applied similarly or differently to the baseline and follow-up interviews. We analyzed these differences across the two time points for all baseline and follow-up interviewees, rather than following trajectories only for the participants in both interviews. We also present the frequencies of key participant characteristics from the baseline and follow-up surveys, conducted using Stata 15 (StataCorp, College Station, TX).

Results

Participant Characteristics

We invited 72 pharmacists from 6 pharmacy sites to participate in the study training on mifepristone dispensing, a baseline survey, and a baseline interview. Among those invited, 56 participated in the training and 47 in the baseline survey. We completed baseline interviews with 22 pharmacists and follow-up interviews with 15 pharmacists, 8 of whom completed both interviews. Pharmacists who participated in the interviews represented five of the six study pharmacies. The sixth pharmacy was staffed by one study pharmacist who did not complete the surveys or interviews.

We conducted the baseline interviews between May 2018 and March 2019, before the pharmacies began dispensing mifepristone. One pharmacist was an exception, because they participated in training and data collection upon returning from parental leave after their pharmacy had begun dispensing for the study. We conducted 6 baseline interviews before the pharmacists participated in the mifepristone training as part of the study, 3 on the same day as the training, and 12 after the study training. One pharmacist who was interviewed did not subsequently participate in the training. We conducted the follow-up interviews between May 2019 and July 2020 in the final month that the pharmacy provided mifepristone for the study. There was one exception where a pharmacist was transferring away from the pharmacy and completed the follow-up survey and interview 7 months before mifepristone dispensing concluded at that site.

Table 1 shows the characteristics of participating pharmacists. Most were staff pharmacists, but there was also representation from pharmacy manager/owners and pharmacists in other roles. One pharmacy site (site A) had the largest number of interviewees at baseline and at follow-up; this was also the study pharmacy employing the most pharmacists and dispensing to the greatest number of patient participants. At the time of the baseline survey and interview, 22 pharmacists reported planning to dispense mifepristone, and 1 was unwilling owing to discomfort with abortion; this pharmacist did not participate in training. In the follow-up survey, 13 of the 15 pharmacists reported having dispensed mifepristone. Two pharmacists received training and were willing to dispense, but did not have the opportunity owing to low patient enrollment at the associated clinic site. None of the interviewees who participated in the training subsequently refused to dispense mifepristone. In the larger study, 4 (6%) of the 72 pharmacists invited to participate declined to be trained or to dispense mifepristone after training owing to discomfort with abortion (Kaller et al., 2021). We describe the larger sample of pharmacists and other reasons for declining training in the previously published article (Kaller et al., 2021).

Pharmacists' Support for Dispensing Mifepristone

Overall, at both baseline and follow-up, pharmacists expressed support for dispensing mifepristone, with many of

Table 1
Pharmacist Characteristics in a Study of Mifepristone Dispensing by Pharmacists ($N = 29$)

Sociodemographic Factors and Dispensing History	Baseline ($n = 22$)	Follow-Up ($n = 15$)
Gender identity		
Female	15	7
Male	7	8
Experience as a pharmacist, years		
< 5	6	4
5–9	5	5
10–19	4	2
≥20	7	4
Median (IQR)	10 (4–22)	6 (4–20)
Pharmacy site		
A	9	8
B	1	2
C	1	0
D	4	3
E	7	2
Role at pharmacy*		
Pharmacist, staff	17	10
Pharmacist, manager/owner	4	4
Pharmacist, other (resident, relief pharmacist)	2	1
Planned to dispense mifepristone		
Yes, I plan to dispense	21	–
No, I plan to refuse to dispense	1	–
Dispensed mifepristone		
Yes	–	13
No; willing to dispense but opportunity did not arise	–	2

* Pharmacists were able to mark more than one role.

them citing increased access to the medication as their main reason for support. They considered pharmacist dispensing of mifepristone to be more accessible, safe, and supportive of patients than having mifepristone only available from medication abortion providers. One pharmacist stated:

> I want to see the pharmacy as a more accessible point for patients; if we're able to dispense those medications and counsel patients on them, then I think it could improve the quality of care that we're able to provide.
>
> – Resident pharmacist at clinic-affiliated pharmacy, Baseline interview

Only one pharmacist we interviewed at baseline planned to decline to dispense mifepristone, for ethical reasons. They also felt the pharmacy may not be an appropriate place to counsel patients who have "second thoughts" about having a medication abortion or who have "emotional outbursts." This pharmacist, however, separated their personal decision not to dispense from the potential benefits on abortion access.

> If pharmacists' belief system or their experience in life doesn't make them hesitant, then I can see the benefits [of dispensing mifepristone]. Some of the remote areas with an [abortion] access issue…I can see why it's being studied, because there are areas where health care provider access is not there.
>
> – Staff pharmacist at clinic-affiliated pharmacy, Baseline interview

Pharmacists' Role in Medication Abortion Care

At baseline and follow-up, pharmacists described dispensing mifepristone as "a natural step" for pharmacists, given that they already dispense misoprostol and other medications prescribed in a medication abortion. Some interviewees felt that pharmacists are particularly well-suited to this role, given their focus on providing medication education. One pharmacist reasoned that assuming this role could free up providers' time to allow them to focus on other aspects of patient care:

> I think that pharmacists are really underutilized. And if we were to be able to dispense these medications, then we would not only be improving access of care to patients, but also reducing the burden on providers.
>
> – Resident pharmacist at clinic-affiliated pharmacy, Baseline interview

Another pharmacist felt that it could be beneficial for pharmacists to counsel patients on mifepristone because they could answer questions from a different perspective.

> If they have questions, we in the pharmacy may be looking at things a little differently than the clinic would be. And then provide possibly a different angle to a question they may have already asked.
>
> – Relief pharmacist at independent community pharmacy, Follow-up interview

Many also felt dispensing mifepristone would not be notably different from other medications and that dispensing it at the pharmacy would provide a convenient option for patients to receive all their medications for the abortion at one place. Some likened mifepristone dispensing to that of other medications, such as contraception and emergency contraception.

Pharmacists' Comfort with Dispensing

All pharmacists at baseline, except the one with moral objections to abortion, said they would feel comfortable dispensing mifepristone if they had enough knowledge to counsel patients adequately. One pharmacist shared how their comfort level depended on being prepared with the right information:

> What makes me comfortable is that I've educated myself enough to know the drugs and how they work. Putting in the time to obtain or refresh the knowledge makes me more comfortable.
>
> – Staff pharmacist at clinic-affiliated pharmacy, Baseline interview

At the end of the study, pharmacists overwhelmingly described a high level of comfort with mifepristone dispensing. They reported that the study training had been helpful to provide them with the information they needed to feel comfortable dispensing mifepristone.

During the follow-up interview, the two pharmacists who were trained but did not have the opportunity to dispense mifepristone said that they felt prepared and comfortable to do so.

Discomfort Among Other Pharmacy Staff

Although all the follow-up interviewees said they felt comfortable dispensing mifepristone, some mentioned other pharmacists who felt less comfortable or confident in dispensing the new medication. This theme came up both at baseline as pharmacists were anticipating dispensing and at follow-up after

their pharmacy had implemented the practice. One follow-up interviewee who was a manager at the pharmacy mentioned that some other pharmacists deferred to them to dispense mifepristone, "Other pharmacists were like, 'I don't even remember the training so you can do it.'" Another pharmacist suggested that pharmacists who declined to participate in the study might have been more comfortable if they had participated in the training:

> I feel like it's something that definitely pharmacists could do and they could get more training and feel more comfortable over time. It was just, maybe it was a new thing that they felt uncomfortable with.
>
> – Staff pharmacist at clinic-affiliated pharmacy, Follow-up interview

Four interviewees from three pharmacy sites mentioned witnessing at least one fellow pharmacist who was uncomfortable with dispensing the medication for religious or moral reasons and chose not to participate in the study training. One mentioned that some pharmacy technicians, who are often the first point of contact for patients at the pharmacy and play an important role supporting prescription processing, were not comfortable participating in mifepristone dispensing owing to religious reasons. Another interviewee explained how the pharmacy technician's role includes interacting with patients, processing and filling the prescription, and handling billing and payment, suggesting that "they need to be comfortable being part of that dispensing process."

Pharmacists' Experiences with Dispensing

During the follow-up interviews, pharmacists described their experiences either dispensing mifepristone personally or observing how mifepristone dispensing was implemented in their pharmacies. The main challenge pharmacists mentioned was other pharmacists' or technicians' discomfort or refusal to dispense and the impact on scheduling. Although pharmacists' refusal did not impact patients' ability to obtain the medications, the pharmacy had to coordinate to have a trained, willing pharmacist ready to provide the medication. One pharmacist recounted:

> The patient came down from her clinic appointment and then we knew that she was waiting. Some technicians and pharmacists refused to dispense the medication, so we had to have conversations with who was willing to discuss it [with the patient] and who was willing to fill [the prescription] and type it, and then get it to me so that I could verify it.
>
> – Staff pharmacist at clinic-affiliated pharmacy, Follow-up interview

Aside from this concern, pharmacists did not report experiencing many challenges. From a workflow standpoint, pharmacists described that dispensing mifepristone was "unremarkable" and "almost kind of boring."

The pharmacist we interviewed who dispensed mifepristone most frequently (approximately 25 times) thought that interactions with patients went smoothly and that patients felt comfortable. Another pharmacist who dispensed mifepristone three times shared:

> Yeah, they [patient interactions] were fairly quick, and nobody had any real questions. They were really well-informed. It may just be that the clinic there was doing a really exceptional job of that.
>
> – Relief pharmacist at independent community pharmacy, Follow-up interview

The main questions pharmacists reported receiving from patients were "pretty standard" questions about medication use. A pharmacist who was a pharmacy manager at a clinic-affiliated pharmacy dispensed mifepristone 10 to 15 times and said, "This is no big deal," about dispensing mifepristone. They noted that patients' questions were about "side effects, what medication to take first, what do I expect, what to take first, what follows, and those kind of things."

Some pharmacists described taking special care to be sensitive talking about abortion with patients and ensuring that counseling was private. They did not talk about this as a challenge, but rather a consideration they made. A pharmacist who dispensed mifepristone eight times reflected:

> Some of the people seemed like a little bit uncomfortable… I felt like I tried to make sure that they felt as comfortable as possible and just tell them the facts so that they just felt at ease being able to have a conversation with me. I felt like it was a good experience. But I made sure that there was a lot of privacy while counseling them.
>
> – Staff pharmacist at clinic-affiliated pharmacy, Follow-up interview

Additional Training and Practice

Many pharmacists mentioned that the training materials provided through the study were helpful to reference, especially when mifepristone dispensing was infrequent at their pharmacies. Some suggested that a periodic refresher training or other resources like a summary guide with main counseling points would be welcome for new or infrequently dispensed medications like mifepristone. A few pharmacists suggested that a sensitivity training on counseling abortion patients or values clarification training may support pharmacists who are less experienced with reproductive health care and abortion.

In addition to pharmacists reporting feeling more comfortable after receiving adequate training information, some pharmacists reported that the experience of repeated dispensing eased any concerns. These pharmacists shared that the more they dispensed, the more "routine" the process was, and the more at ease they felt dispensing.

Concerns About Expansion of Mifepristone Dispensing

Although most participants had a positive outlook on the potential success of pharmacists dispensing mifepristone, some interviewees at both baseline and follow-up mentioned concerns about its implementation. A few pharmacists anticipated less pharmacist support in conservative areas and difficulty with dispensing at smaller pharmacies:

> Smaller pharmacies are going to have a smaller pool [of pharmacists and pharmacy staff]. And whether it's

> technicians who are involved in data entry and filling, or it's a pharmacist involved in checking and counseling, I think you run into more challenges with a smaller staff in case somebody's opposed to dispensing it.
>
> – Pharmacist, manager/owner at clinic-affiliated pharmacy, Follow-up interview

Other concerns included lack of confidentiality for the patient. The one pharmacist who was not trained and did not dispense owing to personal beliefs about abortion expressed concerns:

> Why not give the medications right there [at the clinician's office] instead of delaying and picking up from pharmacy, and then what if the patient gets more questions, very intimate discussions? The pharmacy setup's not allowed that kind of intimate environment to re-address the issues, and I think the current setup is the best, and it is done right in the office.
>
> – Staff pharmacist at clinic-affiliated pharmacy, Baseline interview

A few pharmacists expressed a concern that chain pharmacies under pressure to meet quotas might compromise pharmacist training and patient counseling to save time. One stated:

> Their format is built more on volume now than service, actually. I hate to say that, but it kind of works that way.
>
> – Relief pharmacist at an independent community pharmacy, Follow-up interview

In contrast, a pharmacy manager who had worked at a large chain pharmacy in the past felt that scaling up would be largely uncomplicated, noting:

> I've worked retail for many years at a [large chain pharmacy], and I think it'll be fine. It was run very smoothly here. It was very unremarkable. I have no complaints or concerns from any of my staff.
>
> – Pharmacist, manager/owner at clinic-affiliated pharmacy, Follow-up interview

Pharmacists expressed some concerns about dispensing mifepristone at baseline that did not come up at follow-up, including concerns about legality of dispensing mifepristone and liability for pharmacists, negative media attention for pharmacies, and pharmacists lacking sufficient knowledge to properly dispense and counsel on mifepristone.

Discussion

Our study found that most pharmacists we interviewed supported mifepristone dispensing, mainly because it could increase access to abortion and because the experience counseling on and providing this medication was unremarkable. All pharmacists interviewed except one with ethical concerns about abortion were comfortable providing mifepristone with the necessary training and practice. At follow-up, all pharmacists who had the opportunity to dispense mifepristone described doing so with few challenges, in a similar process to dispensing other medications. A key concern pharmacists voiced was the potential discomfort of other pharmacy staff with providing a medication related to abortion. Although a willing pharmacist was always available to dispense mifepristone to patient participants in this study (Kaller et al., 2021), some pharmacists we interviewed speculated that there may be more pharmacist refusals and less privacy for patient counseling in conservative areas, pharmacies staffed by a small number of pharmacists, or large chain pharmacies.

The findings from these interviews are consistent with the larger sample of pharmacists from the study who shared their perspectives on mifepristone dispensing in surveys and provides additional nuance to those findings by more deeply exploring experiences from a subset of this group (Kaller et al., 2021). Pharmacists reported in follow-up surveys that improved access to abortion (86%), streamlined delivery of medications (84%), and expansion of pharmacists' role in providing reproductive health services (74%) were the top benefits of dispensing mifepristone at a pharmacy, similar to those interviewed when expressing their reasons for supporting the model. At follow-up, 89% were supportive of pharmacists dispensing the medication and 95% had an easy time implementing it. In the surveys, all pharmacists who participated in the study training except one reported dispensing or being willing to dispense mifepristone.

One of the strengths of our study is that U.S. pharmacists' experiences with pharmacist dispensing of mifepristone have not been previously explored qualitatively. The interviews with pharmacists provided an opportunity for them to describe their personal reasons for supporting or feeling concerned about dispensing mifepristone, and to share their experiences observing or participating in dispensing, providing depth to the previously published quantitative findings. Our sample was limited to self-selected pharmacists from clinic-affiliated and independent community pharmacies in states with permissive abortion policies. Pharmacists who were not interested in dispensing mifepristone may have felt less comfortable being interviewed. Additional research on attitudes in broader pharmacist populations, in other areas of the country, and with different types of pharmacies is needed. Owing to baseline interview scheduling, 12 pharmacists had already received the study training on mifepristone dispensing, which may have affected their attitudes toward the practice. However, the pharmacists expressed their initial views in the baseline interviews before they had dispensed mifepristone.

Implications for Practice and/or Policy

Pharmacists in our study mentioned the importance of training to feel comfortable providing and counseling on a new drug. In particular, some suggested that a sensitivity or values clarification training, similar to training used for new abortion providers, could support pharmacists in identifying their own attitudes toward abortion and more effectively counsel those seeking abortion (Freedman, Landy, & Steinauer, 2010; Turner, Pearson, George, & Andersen, 2018). As mifepristone dispensing is expanded into pharmacies, it will be crucial to incorporate training for pharmacists on medication abortion into preservice training, including pharmacy school curricula. Pharmacy technicians also play an important role supporting medication dispensing and should be included in training efforts. Beyond training, these study findings provide insight related to implementing the REMS policy change and, in particular, highlight the feasibility of dispensing mifepristone in pharmacies, including brick-and-mortar pharmacies.

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