

The Medication List as a Negotiated Clinical Record: A Conceptual Model of Information Ownership, Discrepancy Resolution, and Interprofessional Accountability across Transitions of Care

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Abstract

Medication reconciliation is commonly organized around identifying discrepancies between medication lists and producing an accurate record at transitions of care. Yet a documented list may conceal disagreements about prescribing intent, medication supply, actual patient use, and responsibility for unresolved uncertainty. These disagreements become consequential when information moves between professionals and organizations with different knowledge, clinical authority, and opportunities for verification. This article develops a conceptual model of the medication list as a negotiated clinical record, drawing on contemporary evidence concerning medication reconciliation, information provenance, patient participation, electronic documentation, and interprofessional care transitions. Negotiation is defined as a clinically accountable process through which competing medication claims are interpreted, verified, revised, or retained as explicitly unresolved. The model distinguishes information contribution from prescribing authority, documentary agreement from clinical verification, and discrepancy detection from accountable resolution. It further proposes that unresolved discrepancies require identifiable responsibility, a specified next action, and continuity of that responsibility during handover. Source provenance, temporal relevance, professional decision rights, and patient knowledge are integrated as interacting conditions of record authority. The resulting account provides a basis for examining medication-information workflows without presuming that a single source is universally correct or that electronic consistency demonstrates safe medication use. Its contribution is conceptual and requires subsequent evaluation in different clinical and organizational settings.

Keywords: Medication history, Electronic health records, Patient participation, Care coordination, Information provenance, Medication safety

Introduction

Medication lists connect prescribing decisions, dispensing activity, administration records, patient

knowledge, and the work of professionals who encounter a patient at different points in care. Their practical importance becomes especially apparent during admission, discharge, transfer between institutions, and subsequent community follow-up. At these points, an apparently straightforward medication entry may represent an earlier prescription, a recently modified order, an established home regimen, or a medicine that the patient no longer takes.

Medication reconciliation seeks to identify and address inconsistencies between medication information available at these encounters. Systematic evidence

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demonstrates that reconciliation interventions can reduce discrepancies, although effects on subsequent clinical outcomes are less certain and depend on the intervention and outcome examined [1]. Pharmacist-led reconciliation following hospital discharge provides a further illustration of the distinction between correcting medication information and achieving downstream improvements in healthcare utilization [2].

Implementation research indicates that reconciliation also depends on the organization of clinical work. The MARQUIS2 study examined a refined toolkit and mentored implementation across hospitals [3]. Its subsequent analysis highlighted variation associated with implementation sites and exposure to particular reconciliation practices [4]. These findings suggest that medication-list quality cannot be understood solely through the technical accuracy of an isolated entry.

A further difficulty concerns the definition of successful reconciliation. Studies of medication-use optimization at discharge employ different outcomes, complicating comparisons between documentation, medication use, and patient-level consequences [5]. A list may be complete without reflecting current use, electronically consistent without being clinically verified, or clinically reviewed while important uncertainty remains uncommunicated.

The central question is therefore how a medication list acquires sufficient authority to guide care when its contributing sources disagree. This article develops a conceptual account of medication reconciliation as a process involving information provenance, interpretation, negotiation, and responsibility. Its contribution concerns the conditions under which a medication claim becomes actionable and the accountability that remains when agreement cannot be achieved.

Why medication lists become inconsistent across care transitions

Medication discrepancies emerge partly because treatment and documentation change on different timelines. A prescription may be altered during hospitalization while the longitudinal electronic record continues to display the previous regimen. A discharge document may describe intended treatment before a community pharmacy has supplied it. A patient may resume an earlier medicine because the reason for discontinuation was not understood.

These situations have different implications despite potentially producing similar differences between lists. Observational research in critically ill older adults has examined unintentional medication discrepancies and subsequent emergency visits, emphasizing their clinical relevance in a particularly vulnerable population [6]. However, the presence of a discrepancy does not independently identify its cause or establish that it produced an adverse outcome.

Information continuity and medication supply constitute related but distinct problems. German hospital and community pharmacy surveys identified difficulties concerning information transfer and continuity of supply during hospital-to-home transitions [7]. Consequently, agreement between written lists cannot establish that the intended medicine is available to the patient.

Documentation introduces another source of uncertainty. A discharge summary may omit relevant medication information, while its recipient may lack access to the reasoning behind a treatment change. Research examining medication-information completeness in discharge summaries illustrates the importance of documentary content [8]. Qualitative accounts from healthcare professionals additionally reveal that discharge communication involves interacting organizational and professional demands [9].

These problems are not interchangeable. Missing information describes an incomplete representation; conflicting information describes incompatible claims; delayed communication concerns the timing of transfer; and an unfulfilled prescription concerns the relationship between an intended regimen and medication availability.

Patient experience introduces a further temporal dimension. A longitudinal qualitative study involving polymorbid patients with type 2 diabetes examined medication management, understanding, and adherence during the transition from hospital to outpatient care [10]. Medication use after discharge may reflect practical constraints, misunderstanding, deliberate choices, or subsequent clinical advice.

A discrepancy should consequently be understood in relation to the event and time it describes. Two sources may accurately represent different moments while appearing inconsistent when displayed together. Conversely, contemporaneous documentary agreement may conceal divergence between prescribed treatment and actual use.

The analytical task is to establish whether an apparent conflict reflects an error, an intentional change, an incomplete transfer, or genuinely unresolved uncertainty. This requires attention to source provenance before assigning authority to the resulting medication record.

Medication information sources, provenance, and claims of record authority

Medication information originates through different activities. Prescribing records document clinical decisions, dispensing records document supply-related events, administration records describe medicines given in particular settings, and patient accounts provide information about actual use. Their evidentiary value depends on the question being asked.

Qualitative research involving older people demonstrates that patients may differ in their understanding of which medicines should be reported during a medication history [11]. A patient account therefore requires careful elicitation, including medicines obtained outside the current prescribing system, without treating incomplete disclosure as evidence that patient knowledge lacks value.

Differences between electronic health record information and insurance claims further illustrate source-specific representation. Research comparing biologic medication information in EHR data and Medicare claims shows why records generated through different healthcare activities cannot automatically be treated as interchangeable [12]. Claims may establish recorded dispensing-related activity without establishing ingestion or the current prescribing intention.

Electronic documentation itself requires scrutiny. Research examining EHR-documented aspirin use in adult outpatients demonstrates the importance of assessing whether recorded medication status corresponds to actual use [13]. Interface design can also

affect the accuracy with which professionals perform complex reconciliation tasks [14].

Source provenance consequently involves more than identifying the database from which an entry originated. Relevant attributes include the originating actor, clinical event, date of observation, date of entry, medication action represented, and whether the information has subsequently been verified.

Patient participation can reveal information absent from professional records. In a randomized pilot, patient use of tablet computers contributed additional medication-list changes during hospital reconciliation [15]. Patients have also reported errors in their ambulatory electronic health record notes [16]. These findings support mechanisms for patient contribution and correction, while leaving clinical adjudication of medication changes with appropriately authorized professionals.

Three dimensions of record authority follow from these observations. Documentary authority concerns whether an entry faithfully represents its originating event. Clinical authority concerns whether the information has been interpreted and verified for a present treatment decision. Operational authority concerns whether the resulting instruction can be acted upon by the relevant professional or patient.

These dimensions may diverge. A historical order can be an authentic document without remaining clinically applicable. A patient's account can accurately describe use without establishing that the regimen should continue. A pharmacist's verified history can inform prescribing without independently conferring prescribing authority in every jurisdiction.

Information provenance should therefore remain visible when source claims are compared. The distinctions are developed in **Table 1** as proposed analytical categories for assessing medication information at a transition.

Table 1. Provenance-sensitive interpretation of medication information during transitions of care

Information source	Event and temporal relevance	Knowledge supported by the source	Uncertainty requiring interpretation	Verification and record responsibility
Current prescription or medication order	Authorized treatment decision at a specified time	Documented prescribing intent	Whether the order was subsequently changed, supplied, or followed	Confirm current intent with the authorized prescriber or designated clinical team
Longitudinal electronic medication list	Entries accumulated across encounters	Previously recorded medication status	Historical entries, delayed updates, and missing discontinuation information	Establish entry provenance and reconcile against current clinical decisions
Discharge medication documentation	Intended regimen at transfer	Treatment instructions communicated by the discharging service	Completeness, subsequent modification, receipt, and interpretation	Verify intended changes and establish a receiving professional where clarification is needed

Patient or caregiver account	Reported use within a stated period	Medicines actually reported as taken, omitted, or modified	Recall, terminology, timing, and interpretation of instructions	Elicit and document the account; submit clinically consequential differences for review
Dispensing or pharmacy record	Supply-related event within the recorded period	Dispensing history or recorded supply	Whether the medicine was collected, available, or used as prescribed	Confirm supply where relevant and communicate discrepancies requiring clinical decisions
Medication administration record	Recorded administration within a care setting	Documented doses administered or withheld	Whether the record reflects treatment outside that setting or later changes	Verify administration events and communicate unresolved inconsistencies at transfer

Note: The distinctions represent the article's proposed synthesis of source provenance and verification responsibilities. Source reliability is conditional on the clinical question, temporal relevance, and local professional authority. Documentary agreement alone does not establish actual medication use.

The medication list as a negotiated clinical record

Medication reconciliation involves several activities that should remain conceptually distinct. International work examining reconciliation terminology demonstrates the importance of defining the processes represented by that term [17]. Qualitative investigation of a pharmacist-led service connecting tertiary hospitals and primary care further illustrates the organizational and interpersonal work involved in transferring medication information [18].

A negotiated clinical record is defined here as a medication representation whose current authority arises through traceable consideration of relevant source claims, clinical interpretation, and accountable decisions about unresolved differences.

Negotiation does not imply that every participant possesses identical authority or that medication safety depends on consensus. It describes the process through which contributions from different actors are recognized, interpreted, challenged, and translated into a record that can guide subsequent care.

The patient contributes knowledge of actual medication use, experience, preferences, and practical constraints. Pharmacists may contribute structured medication histories, dispensing information, and assessments of medication-related problems. Prescribers determine treatment decisions within their professional authority. Nurses and other clinicians contribute administration information, observed responses, and handover knowledge according to their roles.

These contributions become clinically meaningful when disagreements can be examined without automatically privileging the latest electronic entry.

A negotiated record therefore requires distinctions between contributing information, verifying a claim, authorizing a treatment decision, and updating the record.

Responsibility for one activity does not necessarily confer authority over the others.

Participatory research concerning medication-support tools for older patients demonstrates the relevance of involving users in designing transitional-care information practices [19]. The present model extends that premise conceptually by distinguishing the ability to contribute information from the authority to revise treatment and the responsibility to communicate an unresolved concern.

Record ownership is consequently distributed across activities but must remain identifiable at each decision point. Shared participation cannot substitute for a named professional responsible for completing or escalating a clinically consequential task.

The model also accommodates disagreement that cannot immediately be eliminated. An account of medication use may conflict with a prescription while both accurately represent their originating events. Their coexistence becomes unsafe when the difference is hidden or treated as settled without clinical review.

Negotiation succeeds, in the conceptual sense advanced here, when the record communicates what is known, what remains uncertain, which treatment decision is currently authorized, and who must act next. Agreement between displayed entries is only one possible outcome of that process.

Discrepancy identification, interpretation, and resolution

Discrepancy identification begins when available sources contain incompatible information about a medicine, its intended use, or its recorded status. Electronic reconciliation tools can support comparison and the identification of differences, although their functions and evaluated outcomes vary [20].

Evidence from a randomized trial of digital information transfer between hospital discharge and primary care demonstrates the potential for shared medication information to reduce unintended prescription discrepancies in the studied setting [21]. Such findings concern defined interventions and outcomes; they do not establish that every difference identified electronically has been clinically resolved.

Identification must therefore be followed by interpretation.

An omitted medicine may represent incomplete documentation, intentional discontinuation, or a change unknown to the receiving service. A conflicting dose may reflect a recent adjustment or an outdated entry. Apparent duplication may arise from interchangeable formulations, simultaneous orders, or actual concurrent use.

Each interpretation requires information appropriate to the uncertainty involved. Documentary discrepancies may be clarified through source records, while questions about actual use require patient engagement. Suspected prescribing errors require a clinically authorized decision.

The model distinguishes four proposed states: detected, under clarification, resolved, and explicitly unresolved. These are conceptual classifications, not validated clinical outcome categories.

Detection establishes that an apparent conflict exists. Clarification involves determining its origin, clinical meaning, and relevance to current care. Resolution

requires an appropriate decision and completion of the necessary record or communication action. An explicitly unresolved discrepancy remains visible when the required evidence or decision is unavailable.

This final category is essential because agreement about an intended correction need not mean that the correction has been completed. A nonrandomized feasibility study involving older adults examined medication-list correction and medication use across care transitions, supporting attention to the practical distinction between identifying a problem and achieving a corrected record [22].

The importance of specifying outcomes is also apparent in systematic evidence concerning advanced medication reconciliation and medication errors or adverse drug events [23]. A successful documentary amendment should not be represented as demonstrated prevention of harm without appropriate outcome evidence.

Resolution consequently requires attention to both clinical and informational completion. A prescriber may authorize a change while an outdated list remains accessible elsewhere. Conversely, a record may be amended before the patient or receiving professional understands the new regimen.

An unresolved item should retain its evidentiary status, clinical significance, required verification, and responsibility for further action. The proposed analytical distinctions between discrepancy interpretation and subsequent disposition are specified in **Table 2**.

Table 2. Clinical interpretation and accountable disposition of medication-record discrepancies

Discrepancy unit	Uncertainty requiring interpretation	Necessary verification	Proposed record disposition	Continuing responsibility
Medicine omitted from a current list	Historical treatment, intentional cessation, or incomplete transfer	Establish recent prescribing intent and reported use	Restore, confirm discontinuation, or retain an explicit unresolved status	Designated clinician completes the treatment decision and communicates the outcome
Conflicting dose or frequency	Recent change, outdated instruction, or patient misunderstanding	Compare dated orders and clarify current clinical intent	Document the authorized regimen and supersede obsolete instructions	Authorized decision-maker and record-updating professional complete their respective actions
Medicine recorded as discontinued but reportedly taken	Difference between prescribing intent and actual use	Obtain the patient account and assess current clinical implications	Record actual use separately from the authorized treatment decision until clarified	Receiving clinical team arranges assessment and appropriate patient communication
Apparent therapeutic duplication	Concurrent treatment, substitution, or historical record persistence	Examine orders, indications, administration and	Clarify intended treatment and correct affected entries	Clinically authorized professional resolves the treatment question

		dispensing where relevant		
Prescription without confirmed supply	Difference between an intended regimen and medicine availability	Check dispensing, access, and patient circumstances	Record the supply concern without misclassifying it as prescribing discontinuation	Designated service or professional coordinates the next supply-related action
Unresolved question transferred between services	Incomplete evidence, unavailable decision-maker, or pending clarification	Identify the outstanding question and required source or decision	Preserve unresolved status with a recorded next action	Named receiving owner accepts follow-up or an explicit escalation route remains active

Note: This proposed disposition structure separates information verification, clinical decision-making, documentation, and handover. Professional responsibilities remain conditional on local scope of practice and organizational arrangements. “Resolved” requires completion of the relevant clinical and communication actions; it must not be inferred merely from matching electronic entries.

Interprofessional accountability and the ownership of unresolved discrepancies

Medication reconciliation involves overlapping professional contributions, but overlap does not establish who must act when information remains uncertain. Qualitative research examining nurses’ discharge responsibilities demonstrates the importance of understanding how reconciliation duties are interpreted within clinical practice [24]. Co-design research concerning medicines-information handover similarly identifies the need for coordination across the discharge process [25].

The proposed model distinguishes four responsibilities: information verification, clinical decision-making, communication, and continuing follow-up. These activities may be performed by different professionals, provided their relationship is explicit.

A pharmacist may identify a conflict and obtain an accurate medication history without having authority to change the underlying prescription. A prescriber may authorize a correction without directly updating every record used by subsequent providers. A nurse may

recognize a clinically important inconsistency during administration or discharge preparation and communicate it to the responsible professional.

Accountability therefore attaches to a specified action and its completion, not simply to the professional who first detects the problem.

Evidence concerning pharmacists in general practice illustrates the diversity of roles through which medication information can be transferred between secondary and primary care [26]. Role allocation must consequently reflect the receiving service’s actual capabilities, professional authority, and capacity to undertake follow-up.

An unresolved discrepancy requires an identifiable owner who accepts responsibility for arranging the next action. Transfer of information alone should not be interpreted as transfer of accountability. Where the receiving professional cannot accept the task, the originating service must retain or explicitly reassign responsibility through an appropriate escalation process.

Table 3 translates these distinctions into proposed responsibility allocations across transition points.

Table 3. Accountability for medication-information decisions and unresolved uncertainty across care transitions

Transition point	Information contribution	Clinical decision right	Required handover evidence	Owner of unresolved action
Admission	Patient, caregiver, pharmacist, nurse, previous records	Authorized treating clinician	Verified history, discrepancies, and source provenance	Designated admitting clinician or team
Inpatient medication modification	Prescriber, pharmacist, administering clinician	Authorized prescriber	Current order, reason for change, and affected records	Clinician responsible for the pending treatment decision
Discharge preparation	Discharge team and patient	Authorized discharging clinician	Intended regimen, completed changes, and outstanding questions	Designated discharging professional until responsibility is accepted
Hospital-to-community transfer	Discharging service, receiving clinician, community pharmacist	Appropriate authorized clinician	Medication changes, unresolved status, required action, and recipient	Named receiving professional following acknowledged transfer

Post-discharge clarification	Patient, caregiver, pharmacist, receiving team	Clinician authorized to revise treatment	New information, decision, updated record, and patient notification	Professional assigned to complete and communicate the correction
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Note: These are proposed functional allocations, not universal professional or legal rules. Local prescribing authority, institutional arrangements, and service availability determine the appropriate assignment.

Development of the negotiated medication record model

The preceding distinctions establish four interacting dimensions of the proposed model: information provenance, interpretation of competing claims, authorized clinical decision-making, and continuity of responsibility.

Evidence concerning pharmacist-led discharge interventions describes varied service configurations and outcomes [27]. Retrospective evaluation of post-discharge pharmacist follow-up further illustrates how transitional services can be examined against healthcare utilization outcomes [28]. Neither establishes the effectiveness of the conceptual model developed here.

The model instead specifies conditions under which medication information may become clinically actionable. Each relevant claim must be interpreted in relation to its originating event and temporal relevance. Conflicting claims require appropriate verification. Treatment decisions must remain attributable to an

authorized professional, and uncertainty must retain an identifiable action owner.

Institutional arrangements influence whether these conditions can be fulfilled. The Slovenian national seamless-care program provides an example of medication-related responsibilities embedded within a defined service and reimbursement structure [29]. Such arrangements cannot be presumed available in every health system.

Record authority is therefore conditional. It depends on the question being answered, the available evidence, the legitimacy of the clinical decision, and the ability to communicate that decision to affected actors.

Figure 1 integrates these dimensions into a proposed multilevel representation. Its central analytical distinction concerns the difference between having several apparently compatible records and possessing sufficient verified information to support a current treatment decision.

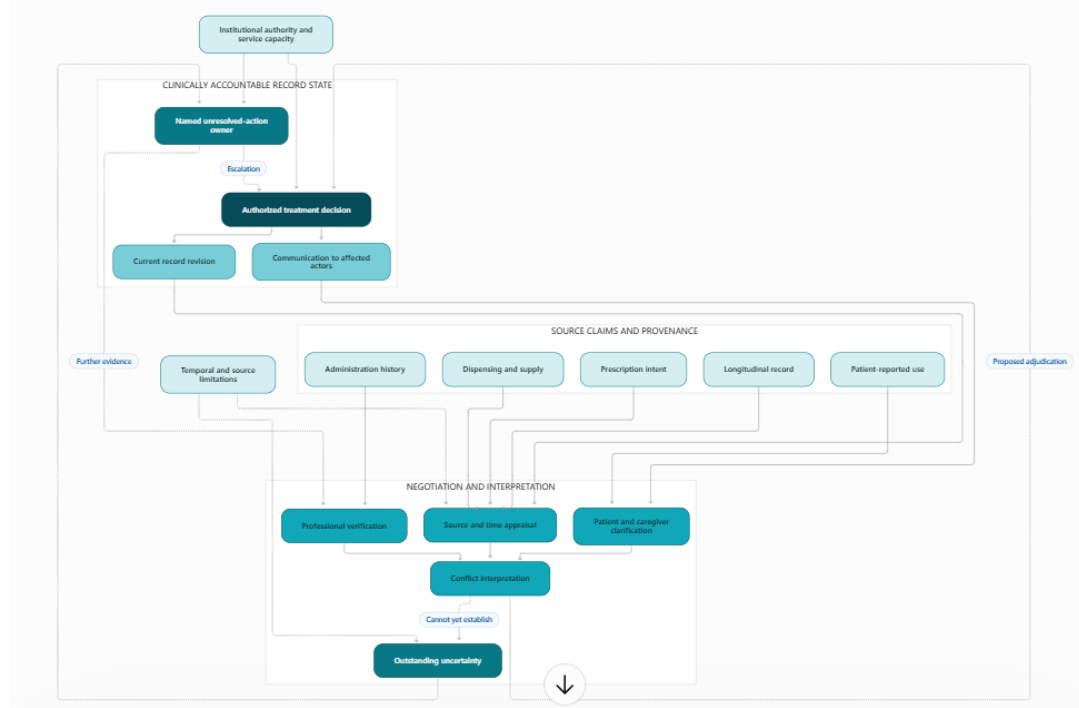


Figure 1. How competing medication claims acquire conditional clinical authority

Clinical and organizational implications for transitions of care

The proposed model directs attention to the clinical action associated with each medication-information difference. A reconciliation workflow should enable professionals to record source provenance, distinguish reported use from prescribing intent, and identify the authority required for a subsequent decision.

Qualitative research examining medicines support for people with chronic obstructive pulmonary disease describes needs spanning the period before and after discharge [30]. Prospective research involving vascular-surgery patients also illustrates the clinical contribution of pharmacist-led identification and management of drug-related problems [31]. These settings support the relevance of continuing medication review without establishing a uniform intervention for every population. Electronic systems could support this work by retaining the source and timing of medication claims, displaying unresolved status, and identifying the professional responsible for further action. These are proposed design requirements, not demonstrated performance characteristics.

Patient-facing information is equally important. Randomized research examining patient-centered discharge summaries supports evaluating how discharge information is communicated [32]. Within the present model, comprehensibility must be considered alongside opportunities for patients to report differences between documented instructions and actual use.

Organizationally, handover arrangements should specify when responsibility has been accepted and how an unanswered clarification request returns to the originating team. Evaluation should distinguish discrepancy detection, verified resolution, completed record correction, and continuity of follow-up. Each represents a separate aspect of the proposed model and should be measured independently in future studies.

Results and Discussion

The negotiated medication-record model provides a conceptual explanation of why agreement between medication lists may be insufficient for clinical continuity. Its central proposition is that record authority depends on source interpretation, legitimate clinical decisions, and accountable handling of unresolved uncertainty.

Implementation remains an important limitation. A process evaluation of a heart-failure medicines-at-transitions intervention illustrates the relevance of examining intervention delivery and organizational context [33]. A proposed accountability structure cannot be assumed to function simply because its responsibilities have been described.

Patient participation also raises questions of equity. Research evaluating hospital discharge instructions highlights differences in information quality and accessibility [34]. Opportunities to challenge a medication record may therefore depend on communication resources, health literacy, language support, and access to subsequent care.

Several competing explanations require investigation. Apparent reconciliation failures may arise from insufficient staffing, fragmented information systems, inadequate clinical communication, or differences in local authority rather than the absence of a negotiated-record process itself. Future empirical research should determine whether the proposed distinctions improve interpretation and accountability beyond existing reconciliation practices.

The model is deliberately bounded. It does not establish a universally authoritative information source, prescribe identical professional responsibilities across jurisdictions, or demonstrate improved patient outcomes. Its value lies in identifying specific relationships and responsibilities that can be examined through subsequent implementation and clinical research.

Conclusion

A medication list becomes clinically authoritative through the interpretation of source information, appropriate verification, authorized decisions, and accountable communication. Documentary agreement alone cannot establish that a regimen reflects current clinical intent or actual patient use.

The negotiated medication-record model distinguishes information contribution from decision authority and discrepancy detection from completed resolution. It further identifies continuing responsibility for unresolved uncertainty as a necessary consideration during care transitions.

These propositions offer a conceptual basis for designing and evaluating medication-information practices while preserving the distinct roles of patients, professionals, records, and healthcare institutions.

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