

Who Owns the Medication Question That Neither Profession Can Resolve Alone? Professional Jurisdiction, Reciprocal Dependence, and Clinical Follow-Through in Pharmacist–Prescriber Collaboration

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Abstract

Medication problems are often discussed as if they can be allocated by professional role: pharmacists identify medicine-related concerns, prescribers make prescribing decisions, and communication connects the two. That representation becomes inadequate when the problem itself crosses occupational boundaries. A pharmacist may hold medication-specific expertise without controlling diagnosis or prescribing authority; a prescriber may hold formal decision authority without possessing the same medication-use information, patient contact, or implementation knowledge. This article develops Shared-Jurisdiction Theory to explain how such medication questions become jointly owned, how reciprocal dependence shapes their resolution, and why collaboration cannot be judged by communication or recommendation exchange alone. Drawing on contemporary evidence concerning pharmacist–prescriber relationships, scope expansion, professional boundary work, integrated practice, recommendation uptake, and implementation, the theory distinguishes formal scope, claimed jurisdiction, practical authority, reciprocal dependence, and clinical follow-through. Shared jurisdiction is proposed as a conditional state arising when resolution requires consequential contributions from both professions and responsibility cannot yet be legitimately transferred to one actor. Its success depends on whether dependence is recognized, authority and information can be mobilized, and follow-through remains attributable until the medication problem is resolved, transferred, or explicitly left unresolved. The theory therefore predicts that apparently similar collaborative encounters may produce different accountability and resolution states. It offers a problem-centred basis for studying pharmacist–prescriber collaboration without assuming that more contact, clearer roles, or broader scope necessarily produces jointly accountable care.

Keywords: Professional jurisdiction, Pharmacist–prescriber collaboration, Reciprocal dependence, Medication problems, Clinical follow-through, Interprofessional care

Introduction

Pharmacist–prescriber collaboration is commonly justified by the complexity of medication use and the possibility that complementary expertise can improve medication safety. Yet evidence describing collaborative

medication-safety work also shows that information barriers, misconceptions about roles, practice arrangements, and uneven opportunities for interaction can obstruct the translation of professional expertise into coordinated action [1]. At the same time, pharmacists' movement into explicitly clinical roles has required continuing identity work: being designated a clinician, or performing clinically oriented tasks, does not automatically settle how other professionals recognize pharmacists' authority or how pharmacists themselves position their work [2]. These observations point to a problem that is deeper than whether two professionals communicate.

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Interactions between pharmacists and general practitioners can involve negotiation over discretion, expertise, responsibility, and the acceptable limits of intervention [3]. For medication problems that can be solved entirely within one profession's legitimate authority and information base, such negotiation may be peripheral. The harder cases are those in which the clinical question itself is distributed. A pharmacist may detect a potentially unsafe or suboptimal regimen yet lack the diagnostic information or prescribing authority required to resolve it. A prescriber may retain formal authority while relying on a pharmacist for medicine-specific interpretation, adherence knowledge, interaction assessment, monitoring information, or practical knowledge of how the regimen is being used. The practical question is then not simply who performs which task. It is who owns the unresolved medication problem while resolution still depends on the other profession.

This article develops Shared-Jurisdiction Theory around that question. It treats the medication problem, rather than the professional role, as the primary unit of analysis. The theory separates formal scope from jurisdiction over a particular problem; distinguishes possession of expertise from practical authority to act; conceptualizes reciprocal dependence as problem-specific reliance on resources controlled by the other profession; and defines clinical follow-through as the relational work required to move from identification or recommendation to implemented, monitored, and accountable resolution. The central claim is conditional: a medication question enters shared jurisdiction when neither profession can legitimately and practically complete its resolution alone, but shared jurisdiction is sustained only while consequential dependence remains and responsibility has not been validly transferred.

From professional roles to professional jurisdiction

Descriptions of professional roles provide necessary information about what pharmacists and prescribers are expected or permitted to do, but role descriptions alone do not determine who has jurisdiction over a concrete medication problem. Expanding pharmacists' scope has altered expectations regarding clinical services, prescribing-related activity, and participation in treatment decisions, while also exposing continuing ambiguity about how these roles are interpreted in practice [4]. Work on non-medical prescribing makes the distinction sharper: legal authority can expand without eliminating the wider professional structures through

which medicine, prescribing, and clinical responsibility have historically been organized [5]. Formal permission therefore changes the set of actions that may be legitimate, but it does not by itself determine who is accepted as having the right to define a problem, make the consequential decision, or remain responsible for what happens next.

Jurisdiction is used here in a problem-specific sense. It refers to the socially and organizationally recognized claim to define, decide, or direct action on a medication problem. This differs from scope, which concerns permitted activity, and from expertise, which concerns knowledge or capability. A pharmacist may have strong medication expertise and a defensible claim to identify a problem while still lacking accepted authority to alter therapy. A prescriber may hold final prescribing authority yet depend materially on the pharmacist's information or interpretation. These distinctions matter because interprofessional relations can remain asymmetric even when both actors are nominally collaborating. Pharmacists have described forms of medical dominance, resistance, or encroachment in interactions with doctors, indicating that the capacity to contribute does not always carry equivalent authority to shape the decision [6].

Jurisdiction is also enacted rather than merely possessed. Pharmacists transitioning into general practice have been shown to develop professional identity through boundary crossing, repeated participation, and learning within another professional environment [7]. Such experiences suggest that the practical legitimacy to participate in consequential decisions may be built through situated interaction. Relationship research similarly shows that physician-pharmacist collaboration often requires active maintenance, familiarity, and sustained recognition of the other profession's contribution [8]. The relationship may also be asymmetric: one party can invest more effort in initiating and sustaining the connection because it depends more heavily on access to the other.

Shared-Jurisdiction Theory therefore begins with a separation. Formal role answers what a professional is generally authorized or expected to do. Claimed jurisdiction concerns the professional's assertion that a problem falls within its legitimate competence. Practical authority concerns whether the actor can actually mobilize the decision rights, information, institutional backing, and access needed to act. A medication problem becomes theoretically interesting when these elements are distributed rather than aligned within one profession.

Medication questions that cross occupational boundaries

A cross-boundary medication question is not simply a case involving two professionals. It is a medication problem for which consequential elements of resolution are distributed across professional boundaries. Evidence from pharmacists working in general practice shows that the contribution of pharmacy is strongly conditioned by context, integration arrangements, and the mechanisms through which pharmacists gain access to patients, records, clinicians, and decision processes [9]. Evaluations of clinical pharmacy in general practice likewise identify practical opportunities alongside implementation constraints, indicating that placement within a clinical setting does not eliminate the need to negotiate how pharmacists' contributions are used [10]. Qualitative work with general practitioners and pharmacists similarly shows that integration involves continuing negotiation around role boundaries, trust, and expectations [11].

The distribution can take several forms. In opioid-related care, pharmacists and primary-care physicians may each hold information relevant to safe treatment while working under heightened clinical and regulatory constraints [12]. In chronic non-cancer pain management, collaboration can be required because medication risk, therapeutic goals, patient behaviour, prescribing decisions, and monitoring needs are not controlled by a single actor [13]. Point-of-care testing illustrates a different boundary: the pharmacist may perform or interpret a test and identify a treatment-relevant issue, whereas the next clinical action can depend on a physician relationship or collaborative agreement [14]. These are not identical clinical problems, but they reveal a common structure: the medication question cannot be understood by asking only which profession "owns medicines."

Medication-assisted treatment for opioid dependence shows the structure still more clearly. Pharmacists, prescribers, and patients describe interdependent responsibilities within treatment delivery, with practical success depending on how those responsibilities are coordinated under local regulatory and service conditions [15]. Community pharmacists can also initiate changes by expressing professional judgement to prescribers. In a Japanese study, greater assertive expression was associated with pharmacist-initiated prescription changes, although the cross-sectional design does not establish that assertiveness itself caused those changes [16]. The important theoretical point is that initiating a clinically consequential action does not necessarily mean possessing final authority over the problem.

The cross-boundary unit is therefore defined by the distribution of four resources: problem-relevant expertise, decision authority, information required for judgement, and capacity to implement or sustain the action. The configuration may vary from case to case. A pharmacist may hold expertise and patient-use information, a prescriber the authority to alter therapy, and both may depend on the other for a safe resolution. Alternatively, a pharmacist with prescribing authority may still depend on diagnostic assessment, laboratory access, specialist escalation, or information that remains under another professional or organizational domain. Cross-boundary status is thus not a permanent characteristic of a drug, disease, or profession. It is a property of the unresolved problem under a particular set of authority and information conditions.

The distinction can be expressed as a set of problem types without implying that the types occur with known frequencies.

Table 1. Cross-boundary medication questions classified by what neither profession controls alone

Proposed cross-boundary problem type	Medication-problem trigger	Pharmacist contribution that may be indispensable	Prescriber contribution that may be indispensable	Primary jurisdictional tension	Reciprocal-dependence pattern	Unresolved ownership risk
Therapeutic-change question	Existing regimen appears ineffective, unsafe, duplicative, burdensome, or otherwise	Medication-specific assessment; interaction/adverse-effect interpretation; use-pattern or	Diagnostic interpretation; therapeutic prioritization; prescribing decision	Expertise may identify the need for change while formal decision authority lies elsewhere	Pharmacist depends on prescriber action; prescriber may depend on pharmacist	Recommendation is issued but no actor remains responsible for determining whether change occurred

	in need of modification	adherence knowledge			medication intelligence	
Monitoring- dependent medication question	Safe continuation or adjustment requires clinical or laboratory reassessment	Identification of medicine-related monitoring need; interpretation of medication-specific risk	Ordering/access to diagnostic information; clinical interpretation; treatment decision	The professional identifying risk may not control the information needed to settle it	Each actor controls a different part of the evidentiary chain	Monitoring is requested but responsibility for obtaining, reviewing, and acting on it is unclear
High-risk controlled- therapy question	Treatment involves substantial safety, regulatory, dependence, or misuse concerns	Dispensing history; medication-use information; interaction/risk assessment; continuity observations	Diagnosis; prescribing authority; broader treatment plan	Regulatory and professional authority can be concentrated while risk information is distributed	Safe action depends on combining prescribing authority with medication-use intelligence	Responsibility is displaced to “the other professional” when risk escalates
Test- or service- triggered treatment question	Pharmacy-based testing, screening, or medication review identifies a clinically actionable concern	Detection, assessment, counselling, initial interpretation	Confirmation, diagnosis, prescribing or escalation when beyond pharmacist authority	Detection and action may sit in different jurisdictions	The value of the pharmacist’s finding depends on a reachable decision route	A finding is communicated without accepted ownership of the next step
Longitudinal treatment- maintenance question	Treatment requires repeated adjustment, adherence support, monitoring, or coordination	Recurrent patient contact; practical knowledge of medicine use; medicine optimisation	Ongoing clinical reassessment; prescribing changes; management of underlying condition	No single encounter completes the problem	Dependence persists over time and can shift between professions	Each encounter is completed, but the unresolved longitudinal problem is not
Legitimate -transfer question	One profession can complete resolution after receiving adequate information and formally accepting responsibility	Accurate problem definition and transfer information	Accepted ownership plus authority/resources to complete action, or the reverse when transfer is toward the pharmacist	Whether referral constitutes a true transfer of jurisdiction	Dependence can end if transfer is complete and accepted	A nominal handoff is mistaken for completed transfer

Note: These are proposed analytical types derived from the manuscript’s evidence base. They do not represent prevalence estimates, validated categories, or a claim that all cross-boundary medication questions require joint decision-making.

The table highlights why “role clarity” is an incomplete solution. A medication question can have clear professional roles and still remain unresolved if the necessary resources are split and no one has accepted responsibility for closure. Conversely, shared jurisdiction does not require every decision to be jointly made. A legitimate transfer can terminate shared jurisdiction when the receiving professional accepts the problem and has sufficient information, authority, and practical capacity to resolve it.

Reciprocal dependence in problem resolution

When a medication problem crosses professional boundaries, dependence is created by the distribution of resources required for resolution. This dependence is reciprocal when both professions control something consequential that the other cannot simply substitute. Studies of community pharmacists and primary-care professionals show that collaborative relationships are built around access, familiarity, recognition of

competence, and practical opportunities for interaction [17]. Physicians themselves describe trust through components such as cooperation, professional respect, competence, communication, and relationship quality [18]. These conditions matter because dependence that is not recognized may be experienced as interruption, encroachment, delay, or unnecessary consultation rather than as a legitimate feature of medication problem-solving.

Reciprocal dependence is not synonymous with equal power. One profession may control the formal decision while the other controls information without which the decision is materially weaker. Local collaborative arrangements between general practitioners and community pharmacists show that progress can be incremental and dependent on organizational support and alignment between stakeholders [19]. Embedding a non-dispensing pharmacist within general practice can alter access and team relationships, but it does not automatically transform collaboration. Mixed-method evidence has shown qualitative gains in integration while quantitative collaboration measures may remain unchanged where baseline collaboration is already high or implementation is incomplete [20]. The implication is important: structural proximity may change the opportunity to collaborate without guaranteeing that jurisdiction or dependence has been reconfigured.

A qualitative synthesis of general practitioners' views similarly suggests that role definition, professional relationships, and service configuration shape how pharmacists are incorporated into general practice [21]. Broader pharmacy literature on interprofessional education and collaborative practice supports the importance of understanding other professions and developing collaborative capabilities [22]. Yet learning to collaborate is not the same as recognizing shared jurisdiction over a live problem. Stakeholder syntheses in long-term-condition care further show that pharmacists, other health professionals, and patients do not necessarily interpret the pharmacist's role in the same way [23]. Dependence can therefore be objectively present while remaining professionally unacknowledged.

Shared-Jurisdiction Theory treats reciprocal dependence as a conditional relational mechanism. It is activated when the unresolved medication problem requires a contribution that one profession cannot legitimately or practically replace. The mechanism is strengthened when each actor recognizes the other's indispensable contribution and can access it without prohibitive

friction. It is weakened when authority asymmetry allows one actor to disregard the other's information, when the pharmacist's recommendation can be ignored without reassessment, when the prescriber cannot access the pharmacist's observations, or when organizational arrangements make consultation too difficult for the problem's urgency. Dependence is thus neither inherently collaborative nor inherently beneficial. It creates an obligation to coordinate only to the extent that the missing resource is genuinely consequential for resolution.

Clinical follow-through as relational work

The most consequential difference between an exchange and a resolved medication problem lies after the recommendation is made. Evidence on prescriber uptake of pharmacist recommendations shows that implementation depends on factors beyond the technical correctness of the recommendation itself [24]. A pharmacist can identify a concern, formulate an appropriate recommendation, and communicate it successfully while the medication problem remains unchanged. Conversely, a prescriber may accept the recommendation but implementation, monitoring, patient communication, or reassessment may still be incomplete. Treating "recommendation made" or even "recommendation accepted" as resolution therefore truncates the clinical process.

Outcome evidence reinforces the need for caution. A systematic review and meta-analysis of pharmacist-physician collaboration in primary care found an overall association with lower hospital readmission, including a stronger estimate for 30-day readmission, but certainty was low and the estimate among randomized controlled trials was attenuated and crossed the null [25]. This pattern does not negate collaboration; it demonstrates that contact between professions cannot be assumed to produce a stable causal effect independent of intervention design, implementation, context, and follow-through. The analytical task is to identify what must occur between collaborative activity and a completed clinical outcome.

Follow-through is also organizational. A meta-synthesis of pharmacists integrating into ward-based multidisciplinary teams identified expertise recognition and interpersonal relationships as facilitators while hierarchy, workload, and conflicting goals could impede integration [26]. A systematic review of medication-review implementation similarly showed that success

depends on multiple implementation domains rather than the existence of a technically appropriate service alone [27]. Although these settings differ from community pharmacist–prescriber collaboration, both bodies of evidence indicate that the dyadic exchange is nested within work systems that can enable or interrupt completion.

Clinical follow-through is therefore defined here as the relational work required to maintain attributable responsibility from problem recognition through decision, implementation, monitoring when required, and explicit closure or legitimate transfer. “Attributable” does not mean that one individual must perform every action. It means that responsibility for the unresolved state cannot disappear merely because a message has been sent, a recommendation recorded, or a referral initiated. Follow-through may be performed sequentially by different actors, but the transition in responsibility must remain intelligible.

This definition also prevents shared jurisdiction from becoming synonymous with permanent co-ownership. Shared jurisdiction should end when the problem is resolved or when jurisdiction is validly transferred. A transfer is valid when the receiving actor accepts responsibility and has sufficient information, authority, and capacity to complete the required action. If those conditions are absent, a nominal handoff may create the appearance of role completion while leaving the underlying medication question unresolved. The theoretical concern is therefore not endless collaboration. It is preventing gaps between professional contribution and clinical closure.

Development of a shared-jurisdiction theory

Existing measures of pharmacist–physician collaboration are valuable because they demonstrate that collaborative practice is multidimensional and can be operationalized rather than treated as an undefined positive relationship [28]. Shared-Jurisdiction Theory addresses a different analytical question. It does not ask only whether collaboration is strong. It asks what happens to jurisdiction over a medication problem when no single profession currently controls every consequential resource needed for resolution.

The theory has four linked components. First, a jurisdictional claim occurs when a professional identifies a medication problem as falling within its legitimate competence and seeks to define or influence its resolution. Second, practical authority concerns whether

that actor can actually make or secure the consequential decision. Third, reciprocal dependence exists when resolution requires non-substitutable information, expertise, authority, or implementation capacity controlled by the other profession. Fourth, clinical follow-through determines whether responsibility remains attributable until the problem is resolved or validly transferred.

Shared jurisdiction is proposed to arise when these conditions overlap: the medication problem is consequential; both professions possess a necessary contribution; neither can legitimately and practically complete resolution alone; and responsibility has not yet been transferred to a single actor capable of closure. This state does not imply equal authority. Nor does it require every step to be negotiated jointly. It describes a temporary allocation problem in which the unresolved clinical object exceeds one profession’s current jurisdictional resources.

Consensus work on collaborative practice between general practices and community pharmacies reinforces the practical importance of agreed principles and concrete collaborative actions [29]. Shared-Jurisdiction Theory uses such conditions as enabling infrastructure rather than as its endpoint. Clear contact routes, mutual knowledge, trust, information exchange, escalation rules, and agreed ways of working can reduce friction. They do not settle the medication question unless they result in a jurisdictional arrangement through which the needed decision and subsequent follow-through actually occur.

The central theoretical distinction is between shared contribution and shared jurisdiction. Shared contribution exists whenever both professions add useful information or work. Shared jurisdiction is narrower: both contributions are consequential to resolution, and the unresolved problem remains jointly dependent until a legitimate settlement occurs. Settlement can take several forms. One profession may assume full jurisdiction after receiving the necessary contribution from the other. The two professions may continue under complementary jurisdiction, with differentiated authority and explicit follow-through responsibilities. Jurisdiction may remain contested if both claim authority or reject the other’s claim. It may become nominally transferred but practically unresolved if the recipient does not accept ownership. Or accountability may diffuse if each actor treats its own communication task as completion.

This formulation generates a different way to evaluate collaboration. Communication frequency, professional

satisfaction, role clarity, trust, co-location, and recommendation acceptance remain important variables, but none alone demonstrates that the medication problem has a responsible pathway to closure. The observable object is the trajectory of the problem: who defined it, who possessed relevant information, who could authorize

action, who depended on whom, whether responsibility was accepted, what action followed, who monitored the consequences, and whether the problem was explicitly resolved or validly transferred.

The resulting structure is represented in **Figure 1**.

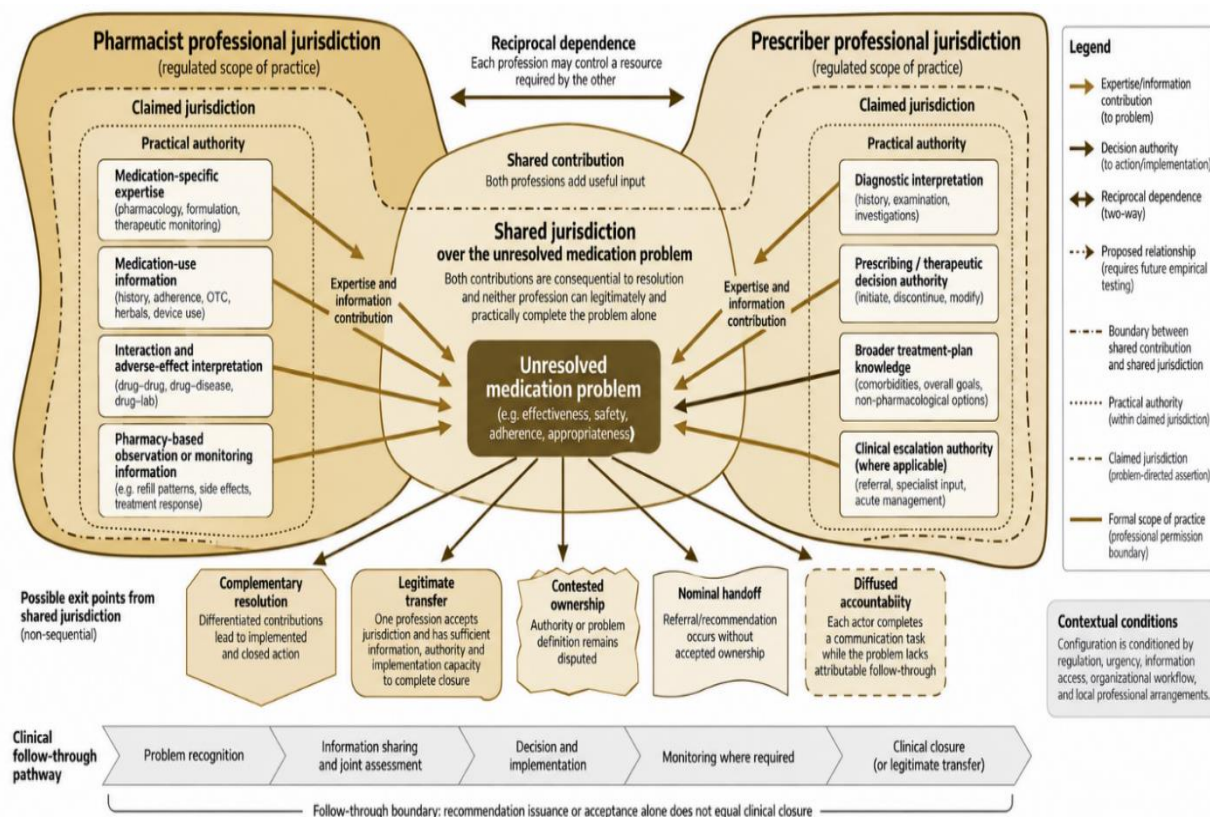


Figure 1. How an unresolved medication question enters, moves through, and exits shared jurisdiction

Configurations of jurisdiction, dependence and follow-through

Shared jurisdiction does not imply one stable collaborative arrangement. Similar levels of pharmacist–prescriber contact can conceal materially different distributions of authority and accountability. General practitioners may express willingness to collaborate with community pharmacists while routine interaction remains limited, demonstrating that positive orientation toward collaboration is not equivalent to enacted joint responsibility [30]. What matters for the unresolved medication problem is how jurisdiction, dependence, and responsibility for subsequent action combine.

Professional positioning can also differ among the actors involved. In antibiotic-related interactions, pharmacists,

general practitioners, and patients may assign different significance to pharmacy expertise and prescribing authority [31]. Such variation creates several possible settlements. One professional may legitimately assume jurisdiction after receiving information from the other. Both may continue to exercise complementary jurisdiction because each retains a consequential contribution. Authority may remain contested. A recommendation or referral may create only a nominal handoff because responsibility has not been accepted. In other cases, each professional may continue waiting for action by the other, producing reciprocal deadlock. These configurations are analytically distinct even when all contain communication.

Table 2. Jurisdiction–dependence–follow-through configurations in unresolved medication problems

Proposed configuration	Jurisdictional arrangement	Dependence pattern	Follow-through responsibility	Observable settlement of the medication problem	Accountability vulnerability
Complementary resolution	Different but mutually recognized jurisdictions contribute to one resolution	Reciprocal and acknowledged	Explicitly allocated across required stages	Decision implemented and problem closed or reassessed	Low when transitions in responsibility remain visible
Accepted jurisdiction transfer	Initial problem crosses boundaries, then one profession explicitly assumes sufficient jurisdiction	Dependence decreases after required knowledge/resources are transferred	Receiving professional accepts responsibility for completion	Problem exits shared jurisdiction	Transfer can fail if information or authority is incomplete
Sustained shared follow-through	Neither profession can yet replace the other's consequential contribution	Continuing reciprocal dependence	Responsibility remains differentiated but jointly attributable	Problem remains under active coordinated management	Repeated interaction can obscure who must trigger the next action
Contested ownership	Professional claims to define or control the problem conflict	Dependence may be present but incompletely acknowledged	Follow-through remains disputed	Decision is delayed, challenged, or fragmented	Each profession may defend its boundary rather than secure closure
Nominal handoff	One actor communicates or refers the problem without an accepted transfer of jurisdiction	Required dependence persists despite apparent transfer	Sender may regard its role as complete while receiver has not assumed responsibility	Problem remains clinically open	Communication is mistaken for transfer
Reciprocal deadlock	Each profession requires action, information, or authorization from the other	Reciprocal dependence is recognized but cannot be mobilized	Neither actor can or does initiate the next consequential step	Problem persists despite repeated contact	Responsibility circulates without effective authority
Diffused accountability	Both professions contribute, but no actor remains responsible for closure	Interdependence is fragmented into discrete tasks	Follow-through becomes unattributable	Individual tasks may be completed while the underlying problem remains unresolved	Completion of professional tasks substitutes for completion of the clinical problem

Note: These configurations are proposed theoretical distinctions. They are not validated clinical categories, prevalence estimates, or a hierarchy from inferior to superior collaboration.

The configurations also show why a single normative preference for “shared care” would be inappropriate. Accepted transfer may be safer and more efficient than continuing co-management when one professional has acquired all information and authority required for closure. Conversely, transfer is inadequate when the

receiving actor lacks a resource still controlled by the other profession. The relevant question is whether the jurisdictional settlement fits the structure of the medication problem.

Figure 2 represents these settlements as reversible relational states rather than stages of development.

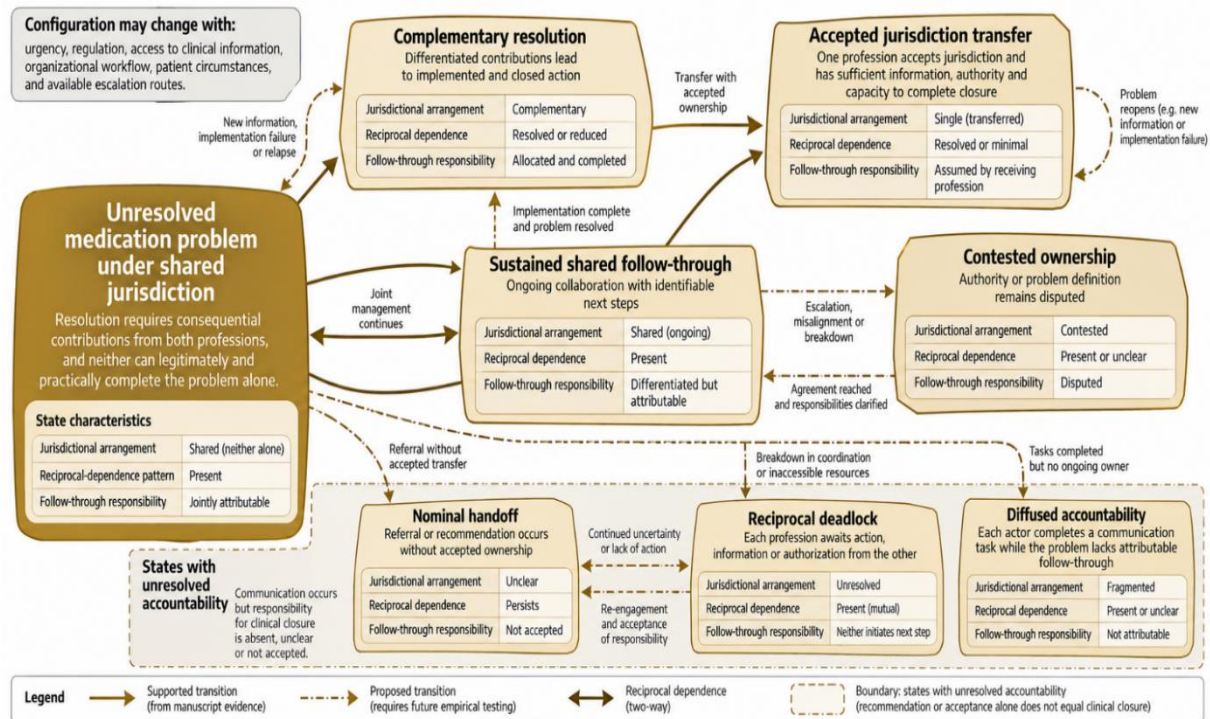


Figure 2. Alternative settlements of shared jurisdiction and their follow-through consequences

Propositions for pharmacist–prescriber collaboration

Shared-Jurisdiction Theory generates tests that differ from asking whether clinicians communicate frequently or report satisfactory relationships. First, when a medication problem genuinely requires consequential contributions from both professions, explicit responsibility for follow-through should distinguish effective shared jurisdiction from otherwise similar collaborative encounters in which responsibility becomes diffuse. This predicts variation even among cases with comparable communication intensity.

Second, reciprocal dependence should become clinically useful only when the resources creating that dependence are recognized and practically accessible. Trust may facilitate consultation, but it cannot substitute for inaccessible clinical information, unavailable prescribing authority, or an absent escalation route. Likewise, expanded professional scope should alter jurisdictional settlement only when formal permission can be translated into usable authority.

Third, recommendation acceptance should be treated as an intermediate event rather than the final indicator of collaboration. Pharmacist-initiated changes and prescriber uptake demonstrate clinically meaningful interaction [16, 24], yet the theory predicts that stronger

evidence of successful shared jurisdiction will require observation of implementation and, where relevant, monitoring and reassessment. Outcome evidence already cautions against assuming a uniform effect of collaborative interventions [25].

Fourth, legitimate transfer should be empirically distinguishable from nominal referral. Transfer is predicted to reduce reciprocal dependence only when the recipient accepts ownership and possesses the information, authority, and practical capacity required for resolution. If those conditions are absent, the medication problem should remain within shared jurisdiction even if one profession regards its own task as complete.

These propositions are deliberately conditional. They require empirical testing at the level of medication problems rather than validation through global measures of professional collaboration alone.

Practice and organizational implications

The practical implication is not that pharmacists and prescribers should jointly manage every medication problem. Organizations should instead make it easier to identify when a problem has crossed a jurisdictional boundary and who remains responsible for its next consequential step. Useful infrastructure includes

accessible clinical information, explicit routes for pharmacist-initiated escalation, mechanisms for prescribers to respond or transfer responsibility, and documentation that records whether the problem is awaiting a decision, implementation, monitoring, or closure.

Service design also needs to account for context. Integration of pharmacists into Aboriginal community-controlled health services, for example, has been shaped by interacting personal, service, community, and system factors [32]. Such evidence cautions against treating one organizational arrangement as universally transferable. The same formal pharmacist role may function differently when access to prescribers, information systems, community relationships, staffing, geography, or local governance changes.

For measurement, organizations should avoid treating numbers of recommendations, referrals, contacts, or accepted interventions as complete indicators of cross-professional medication management. Those measures can remain useful, but Shared-Jurisdiction Theory adds a different question: did the unresolved medication problem acquire an identifiable route to closure? Audits could therefore distinguish recommendation issuance, acceptance, implementation, monitoring allocation, accepted transfer, and explicit resolution without converting these stages into an unsupported composite score.

Results and Discussion

Shared-Jurisdiction Theory relocates the analysis of pharmacist–prescriber collaboration from fixed professional roles to the trajectory of an unresolved medication problem. Existing research establishes that professional boundaries are negotiated [3], that jurisdiction and medical dominance remain relevant as scopes expand [5], and that collaborative relationships depend on active recognition and maintenance [8]. Evidence also shows that role integration varies by context [21], that implementation conditions can obstruct theoretically valuable collaboration, and that patient-level outcomes are not uniformly improved across all collaborative arrangements [25]. The theory developed here connects these observations by asking who possesses the resources needed to move a specific problem toward clinical closure.

Its principal contribution is the distinction between shared contribution and shared jurisdiction. Many

clinical encounters contain useful contributions from several professions. Jurisdiction becomes shared only when both contributions remain consequential and neither profession can yet legitimately and practically complete resolution alone. This distinction avoids two opposing errors: assuming that any interprofessional contact constitutes shared care, and assuming that all difficult medication problems should remain permanently co-owned.

The strongest alternative explanation is that trust, role clarity, co-location, or general collaboration quality accounts for the same phenomena. These factors are important, but they do not fully specify what happens when one actor holds relevant expertise while another controls a necessary decision, or when a communicated recommendation lacks an accepted route to implementation. Shared-Jurisdiction Theory therefore treats relational quality as an enabling condition whose consequences depend on the configuration of authority, information, dependence, and follow-through.

The theory also has important limits. Some medication questions fall clearly within one profession's practical jurisdiction and do not require reciprocal dependence. Emergency conditions may require immediate unilateral action. Protocols can legitimately preallocate authority. Effective transfer may end shared jurisdiction rapidly. Conversely, organizational barriers can dominate the dyadic relationship so strongly that professional willingness cannot overcome missing information systems, unavailable referral routes, workload, or regulatory constraints. Professional positioning can also remain contested across clinicians and patients [31], while service-level constraints vary across institutional and community contexts [32].

The proposed theory therefore requires prospective empirical evaluation. Studies should follow medication problems longitudinally, identify which actor controlled relevant expertise and authority at each point, observe whether responsibility was accepted after referral or recommendation, and determine whether implementation and monitoring occurred. Such designs could test whether jurisdiction–dependence–follow-through configurations predict resolution more effectively than communication frequency or general collaboration scores. They could also establish whether the configurations proposed here require revision across settings in which prescribing authority, pharmacist access to clinical records, professional regulation, or service organization differ substantially.

Conclusion

The medication question that neither pharmacist nor prescriber can resolve alone is not automatically owned equally by both professions. It enters shared jurisdiction when resolution requires consequential resources distributed across them and no valid transfer has yet concentrated sufficient authority, information, and responsibility in one actor. Reciprocal dependence creates the need for coordinated action; it does not guarantee that coordination will occur. Clinical follow-through determines whether professional contributions become a resolved medication problem or dissolve into fragmented tasks and uncertain accountability.

The strongest answer to the title question is therefore conditional. Ownership should follow the structure of the unresolved problem. It may remain shared while indispensable contributions and responsibility are distributed, transfer legitimately when one actor can complete closure, or fail when communication occurs without accepted responsibility. Pharmacist–prescriber collaboration is consequently better judged by how jurisdiction and follow-through are organized around the medication problem than by professional contact alone.

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