

Medication Reconciliation Is Not Medication Continuity: A Pharmacist-Led Framework Linking Therapeutic Intent, Information Transfer, Patient Capability, and Post-Discharge Follow-Up Across Transitions of Care

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ABSTRACT

Medication reconciliation is central to safer transitions of care, yet an accurate discharge medication list does not ensure that intended medication changes remain understood, accessible, feasible, or clinically appropriate after discharge. To distinguish medication reconciliation from medication continuity and propose a pharmacist-led framework linking therapeutic intent, information transfer, patient capability, and post-discharge follow-up. This non-empirical model integrates evidence from transition-of-care, medication-safety, communication, patient self-management, pharmacist-intervention, and implementation research. Evidence-supported observations are separated from newly proposed relationships and failure states. Medication continuity is proposed as the longitudinal preservation or deliberate revision and enactment of therapeutic intent across care settings. Four interdependent conditions are distinguished: interpretable therapeutic intent, faithful transfer of the medication plan, sufficient patient or caregiver capability to perform medication work, and follow-up capable of detecting divergence and enabling correction. Pharmacists are positioned as medication-focused coordinators rather than sole owners of prescribing, supply, or patient behavior. Reconciliation should be treated as an essential transition process rather than proof of continuity. The proposed framework requires construct validation, prospective testing, context-sensitive implementation evaluation, and examination across heterogeneous patients and health systems.

Keywords: Medication reconciliation, Transitions of care, Medication continuity, Pharmacists, Medication safety, Self-management

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Introduction

Medication reconciliation is intended to identify and resolve discrepancies when medication information crosses care transitions, but evidence does not support treating successful reconciliation as equivalent to improved downstream outcomes. Systematic syntheses indicate that reconciliation more consistently improves medication-list or discrepancy-related process outcomes than subsequent clinical or health-service outcomes [1, 2]. This distinction matters because transition risk continues beyond the point at which the medication list has been checked. Medication errors and medication-related harm remain prevalent after patients move from hospital to community care [3]. Contemporary prospective evidence in hospitalized older adults likewise shows that medication errors can coexist with gaps in discharge planning at the point of transition [4].

The problem, therefore, is not simply whether the discharge list is technically accurate. A medication may be correctly added, stopped, restarted, held, or dose-adjusted yet subsequently be used differently because the purpose of the change is unclear, the information received by another clinician differs from that received by the

patient, the medicine cannot be obtained, the regimen exceeds available patient or caregiver capability, or no one detects emerging divergence. These events occur at different analytical levels: the medication or regimen, the patient and caregiver, clinicians and care teams, and the organizations or systems through which information, prescriptions, medicines, and responsibility move.

This article proposes medication continuity as a broader longitudinal construct: preservation, deliberate reassessment, and feasible enactment of therapeutic intent as a patient moves through admission, transfer, discharge, and early post-discharge care. Continuity in this formulation does not require an unchanged medication list. Appropriate initiation, deprescribing, temporary interruption, dose adjustment, substitution, or later restart may all be compatible with continuity when their rationale remains recoverable and subsequent action reflects deliberate reassessment rather than unintended loss of the plan.

The proposed model therefore links four conditions that reconciliation alone cannot guarantee: therapeutic intent, information fidelity, patient capability, and post-discharge follow-up. Pharmacists are positioned as medication-focused coordinators across these conditions, while prescribing authority, medication supply, primary-care follow-up, patient preferences, caregiver resources, and organizational infrastructure remain distributed responsibilities. The model is intended to organize failure detection and research questions, not to claim that these four conditions constitute a validated mechanism or that pharmacist leadership necessarily improves clinical outcomes.

Why medication reconciliation does not guarantee medication continuity

A reconciled list is a transition-state representation. Continuity is what happens to the intended regimen after that representation enters another clinical and practical environment. This separation is visible even when reconciliation itself performs well. A pragmatic pharmacist-led intervention reduced clinically important discharge medication errors, while related post-discharge evidence showed that unintentional patient-generated discrepancies could still arise after patients returned home [5, 6]. A successful discharge process therefore cannot be assumed to remain intact during subsequent medication use.

The distinction extends beyond medication-list accuracy. Nationwide pharmacy surveys in Germany identified problems in both medication-information transfer and continuous medication supply despite formal transition requirements [7]. These are analytically different failures: a perfectly transmitted plan may be impossible to enact if the medicine is unavailable, while an available medicine may be used incorrectly if the plan arriving at the next setting is incomplete or contradictory. Among patients with multiple long-term conditions, medication lists were also found to diverge after hospital discharge [8]. Such divergence is clinically important to detect, but it is not automatically an error; some differences can result from deliberate reassessment, new symptoms, adverse effects, or later prescribing decisions.

Accordingly, this article proposes that reconciliation should be understood as one continuity control point, not the endpoint of transition medication management. Continuity requires the medication plan to remain interpretable, transferable, obtainable, and executable over time. A discrepancy becomes a proposed continuity failure only when divergence is unintended, unexplained, clinically discordant with the intended plan, or not appropriately reassessed. This definition avoids converting every post-discharge medication change into an error while preserving attention to losses of therapeutic intent that an accurate discharge list cannot prevent.

Therapeutic intent across admission, transfer, and discharge

Medication information is insufficient when it records *what* changed but loses *why*, *for how long*, or *until what reassessment*. A systematic review of strategies for maintaining hospital-initiated medication changes in older adults found that post-discharge continuity generally depended on multicomponent and often multidisciplinary approaches [9]. The relevant object of continuity is therefore not simply the medication name and dose, but the clinical intention attached to its status.

Deprescribing illustrates this distinction. In the Shed-MEDS randomized trial, structured deprescribing allowed intentional medication reduction to persist from hospitalization through post-acute care [10]. Continuity in such a case means preservation of an intended discontinuation, not restoration of the preadmission regimen. Conversely, subsequent restart of a deprescribed medicine cannot automatically be classified as failure; post-discharge restart may represent deliberate clinical reassessment rather than accidental reversal [11]. Evidence concerning central nervous system medication deprescribing further shows that medication-change behavior is shaped by patient and clinician factors as well as clinical context [12].

The proposed implication is that every clinically meaningful medication transition should leave a recoverable intent statement: the medication action, the indication or therapeutic goal, whether the decision is temporary or continuing, the expected reassessment condition where applicable, and the person or service expected to resolve uncertainty. Therapeutic intent may evolve, but its evolution should be distinguishable from unexplained loss.

Table 1 translates this requirement into a medication-intent ledger that makes unresolved transition ambiguity visible rather than treating medication status alone as sufficient documentation.

Table 1. Preserving the reason for medication decisions across transitions: a therapeutic-intent continuity ledger

Medication/ therapy	Intended indication or goal	Status at transition	Intended duration or change	Responsible actor	Unresolved ambiguity
Continued therapy	Maintain established therapeutic goal	Continue	No planned change unless reassessed	Receiving prescriber/team	Is prior indication and monitoring plan still explicit?
Newly initiated therapy	Address newly identified need	Start	Continue to stated review point or goal	Initiating and receiving clinicians	Is indication and review expectation transferred?
Dose or formulation adjustment	Improve effectiveness, safety, or feasibility	Modify	Maintain new regimen unless reassessed	Prescriber with medication- support team	Is the reason for the change recoverable?
Temporary interruption	Manage time- limited clinical circumstance	Hold	Restart only when stated condition is met	Clinician responsible for reassessment	Who decides when the condition has resolved?
Intentional deprescribing	Remove treatment judged unnecessary or burdensome	Stop	Remain discontinued unless deliberately reconsidered	Prescriber and patient, supported by pharmacist	Would later restart represent reassessment or accidental reversal?

Note: The ledger is a proposed documentation and reasoning structure, not a validated instrument or patient-level prescribing protocol. Entries are illustrative intent states derived from the manuscript synthesis and should be adapted to the clinical context.

Information transfer and the fidelity of medication plans

Therapeutic intent can be clinically sound yet disappear during transfer. Communication interventions at hospital discharge have been associated with improved transition outcomes, although intervention content and effects are heterogeneous and individual components cannot be assumed to produce the downstream outcome independently [13]. Medication continuity therefore requires more than the existence of a discharge communication event. It requires sufficient information fidelity for the receiving patient, caregiver, pharmacist, prescriber, or service to reconstruct the intended medication plan.

Consumers and health professionals report recurrent problems in discharge medicine communication, including difficulties understanding or accessing information needed after transition [14]. Co-design work similarly treats medicine handover as a multifaceted coordination problem rather than a single-document task [15]. Pharmacist-prepared discharge medication management summaries provide a more specific example: they can improve communication of medication changes, although improved documentation itself does not establish that the plan will subsequently be enacted [16].

This article proposes five distinguishable information-fidelity failures. Omission removes a necessary medication-plan element. Contradiction gives different recipients incompatible instructions. Ambiguity transmits information without enough meaning to guide action. Timing failure makes correct information available too late for the required decision. Inaccessibility means that information exists but cannot be retrieved or meaningfully used by the person who needs it. These failures may originate in different locations and require different corrective ownership; collapsing them into “poor communication” obscures where recovery must occur.

Table 2 separates these failure modes by their point of introduction, the medication-plan element placed at risk, and the recovery responsibility they create.

Table 2. Where medication plans lose fidelity: transfer failures, detection points, and recovery ownership

Failure mode	Where introduced	Affected medication-plan element	Downstream continuity risk	Detection opportunity	Corrective owner
Omission	Documentation or handover	Drug, indication, change, monitoring, or stop instruction	Necessary action disappears	Reconciliation against prior and discharge sources	Originating team with pharmacist verification
Contradiction	Parallel records or messages	Dose, status, duration, restart/stop instruction	Recipients enact incompatible plans	Cross-source comparison or recipient query	Prescriber–pharmacist clarification
Ambiguity	Incomplete rationale or wording	Reason, temporality, reassessment condition	Action cannot be confidently interpreted	Patient or receiving-clinician teach-back/clarification	Originating clinician, supported by pharmacist
Timing failure	Delayed documentation/transmission	Any time-sensitive change	Action occurs before corrected plan arrives	Early receiving-setting review	Sending and receiving services
Inaccessibility	Technical, organizational, or practical interface	Existing medication information	Correct plan cannot guide care	Failed retrieval, missing record, patient report	Organization controlling access, with escalation by care team

Note: Failure categories and ownership assignments are proposed analytical distinctions. Corrective responsibility may be shared and must follow local professional scope, information-system design, and care pathways.

Patient capability and the work of post-discharge medication use

Even a clinically coherent and faithfully transferred medication plan remains inert until it can be enacted in everyday life. Older patients describe communication, participation, and medication-management challenges across transitions, indicating that the patient is not merely the recipient of a reconciled list but an active participant in reconstructing and performing the regimen [17]. Capability should consequently be treated as the fit between required medication work and the resources available to the patient or caregiver.

This fit is also temporally unstable. Longitudinal qualitative evidence in polymorbid patients with type 2 diabetes shows that medication understanding, management, and adherence can evolve during the weeks following discharge [18]. A patient who appears capable when instructions are first explained may encounter different difficulties when prescriptions must be obtained, dosing routines resumed, adverse effects interpreted, or apparently conflicting advice reconciled at home.

Observational work-system evidence associates post-discharge medication-management difficulty with multiple factors, including self-efficacy, medication-administration skill, transportation independence, caregiver availability, and regimen complexity, while a systematic scoping review shows that available measures incompletely represent medication self-management capability and frequently emphasize adherence or cognitive and physical skills [19, 20]. Capability therefore cannot be reduced to whether doses were taken. Adherence is an outcome or behavior of interest, but it does not by itself identify whether a person understood the plan, could obtain the medicine, possessed the physical skill to administer it, had appropriate support, or could respond to changing circumstances.

The framework consequently treats capability as task specific and potentially compensable. The appropriate question is not whether a patient is globally “capable,” but whether the required treatment work can be performed with the resources currently available. **Table 3** converts that distinction into a capability–task fit analysis for early post-discharge care.

Table 3. Matching post-discharge medication work to patient and caregiver capability

Post-discharge task	Cognitive, physical, or resource demand	Capability required	Mismatch signal	Compensatory support	Follow-up priority
Obtain medicines	Access, transport, payment/supply navigation	Ability or assistance to secure	Delay, partial supply, substitution	Pharmacy coordination,	Early when access is uncertain

		intended therapy	without clarification	caregiver or service support	
Interpret medication changes	Comprehension and comparison with prior regimen	Understand what changed and why	Continued use of stopped therapy or omission of new therapy	Plain-language explanation, teach-back, reconciled patient-facing plan	Early after complex changes
Administer regimen	Memory, dexterity, timing, device technique	Perform dosing regimen reliably	Missed, duplicated, mistimed, or technically incorrect administration	Simplification where appropriate, aids, caregiver training	Higher with complex administration
Monitor treatment	Symptom recognition and monitoring resources	Recognize expected effects and concerning change	Uncertainty about adverse effects or treatment response	Explicit monitoring and escalation instructions	Depends on medication and patient risk
Seek clarification or reassessment	Communication access, confidence, care navigation	Know whom to contact and when	Unresolved discrepancy or self-directed change	Named contact route and pharmacist-facilitated escalation	Urgent when plan is contradictory or clinically unstable

Note: Capability–task matching and follow-up priority are proposed reasoning functions, not validated risk scores. Support should be individualized and should not interpret every patient-initiated medication change as nonadherence or error.

Post-discharge follow-up and early detection of continuity failure

Discharge converts a controlled transition process into a period in which medication use unfolds under changing clinical, social, and access conditions. Follow-up is therefore proposed here not merely as another medication review, but as an opportunity to detect divergence between therapeutic intent and enacted treatment before that divergence becomes entrenched. In a matched cohort, participation in a post-discharge pharmacist clinic was associated with fewer 30-day readmissions [21]. Because the design was observational, this finding supports the plausibility of structured follow-up without establishing that pharmacist contact itself caused the difference. A clinically stable patient with a simple, well-understood regimen may gain little from intensive surveillance, whereas a patient facing recent changes, access barriers, uncertainty, or limited support may require earlier and more coordinated contact over time and setting.

Follow-up can also be valuable when its immediate endpoint is detection rather than utilization. A post-discharge pharmaceutical-care service provided a setting in which medication-related problems could be identified and addressed [22]. The proposed continuity function is consequently surveillance plus clarification, escalation, and correction: determining whether intended therapy was obtained and understood, whether new discrepancies have appeared, and whether changed symptoms or circumstances require clinician reassessment.

Effectiveness evidence should nevertheless remain calibrated. A scoping review identified recurring pharmacist-led components among studies that demonstrated reduced readmission, but its outcome-conditioned inclusion cannot estimate how often such interventions succeed overall [23]. A propensity score-matched community-pharmacy study likewise found a relatively small association with post-discharge outcomes that attenuated in sensitivity analysis [24]. Follow-up should therefore not be represented as a universally effective readmission-prevention mechanism.

The framework instead treats follow-up priority as conditional. Earlier contact may be more useful when therapeutic intent remains ambiguous, the regimen changed substantially, medication access is uncertain, capability–task mismatch is evident, or responsibility for reassessment is unclear. These priorities are proposed rather than validated thresholds. Follow-up should also remain responsive to patient preference and clinical trajectory: some patients require intensive clarification, whereas others can enact a well-specified plan with minimal additional workload.

The proposed pharmacist-led medication-continuity framework

The proposed framework joins four continuity conditions without assuming that their integration guarantees clinical benefit. This restraint is important because the large pragmatic PHARM-DC randomized trial did not significantly reduce 30-day unplanned hospital or emergency-department utilization overall, although a prespecified subgroup with low medication adherence and literacy showed a favorable signal [25]. The framework therefore treats pharmacist involvement as a potentially useful coordination architecture whose effectiveness is expected to depend on patient need, baseline services, intervention fidelity, and context.

Pharmacist leadership is defined functionally: reconstruct therapeutic intent, test information fidelity, identify capability–task mismatch, detect post-discharge divergence, and route problems to the actor able to resolve them. Qualitative PHARM-DC implementation evidence indicates that role clarity, workflow fit, communication, and resources shape delivery [26]. A dual-site CFIR analysis further shows that implementation determinants differ between settings [27]. Medication-reconciliation performance in MARQUIS2 also varied with multilevel intervention exposure and site conditions [28]. These findings support a multilevel design but do not validate the proposed continuity construct.

The model therefore operates across a temporal backbone—admission, intrahospital transfer, discharge, and home/community care—while keeping patient, regimen, clinician/team, and organizational conditions separable. Loss in one domain can constrain another: a faithfully transmitted instruction cannot preserve continuity if its therapeutic rationale is unknowable; an interpretable plan cannot be enacted when medication supply or patient capability is insufficient; and emerging divergence may persist when follow-up has no clear escalation route. These cross-domain dependencies are proposed relationships requiring empirical testing.

Figure 1 depicts why technically accurate reconciliation can remain compatible with downstream continuity failure and separates established transition vulnerabilities from the proposed integrative relationships.

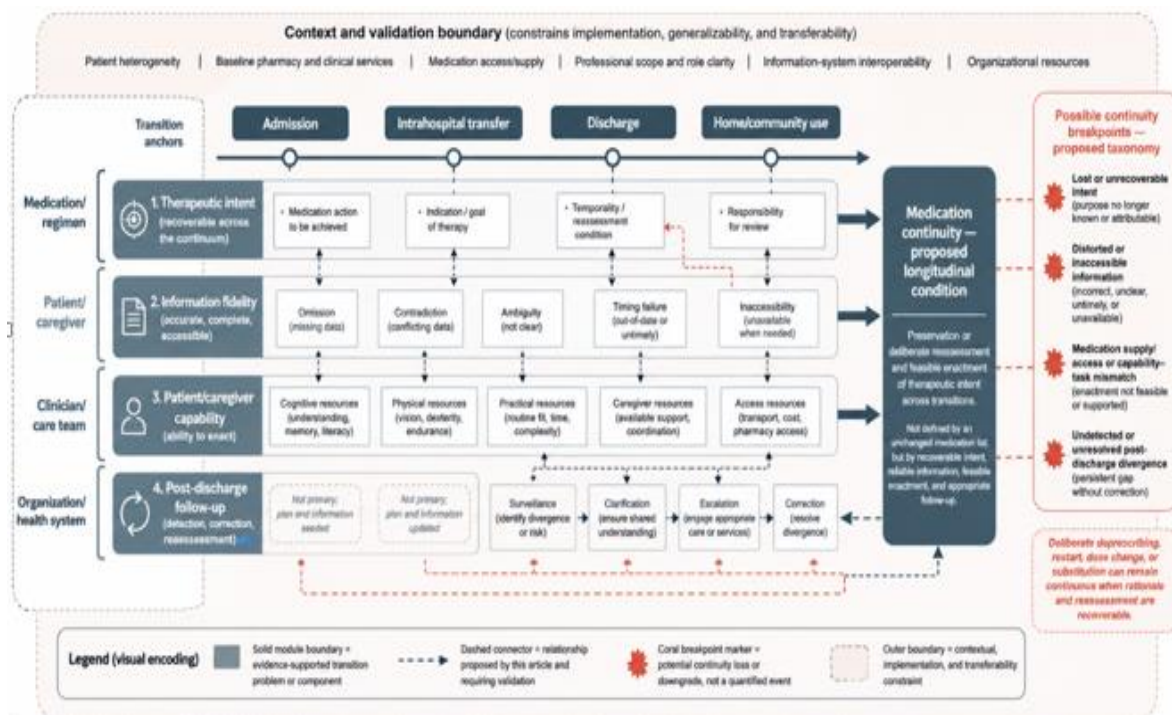


Figure 1. An accurate medication list can still fracture downstream: continuity requires recoverable intent, information, capability, and follow-up

Failure pathways across transitions of care

Continuity failure is best treated as a breakpoint with a recoverable provenance rather than as a single end-state category. Unintentional medication discrepancies have been associated with increased 30-day emergency-department visits among critically ill older adults [29]. The association supports clinical concern about some discrepancies but does not establish that discrepancies themselves caused subsequent utilization or that every discrepancy carries equivalent risk. The proposed taxonomy therefore classifies failure by where therapeutic coherence is lost, not simply by whether two lists differ.

A first pathway is intent loss: a medication action remains visible while its indication, duration, or reassessment condition becomes unrecoverable. A second is transfer distortion, in which the intended plan is omitted, contradicted, delayed, ambiguous, or inaccessible. A third is enactment mismatch, in which the plan exceeds available patient, caregiver, access, or supply resources. A fourth is recovery failure, in which divergence is detected late, cannot be escalated, or reaches an actor without authority or information to resolve it. These categories are proposed and can coexist.

System reliability also shapes whether breakpoints arise or are recovered. The MARQUIS2 multicenter quality-improvement study showed that a refined toolkit with mentored implementation improved medication-reconciliation process performance across hospitals [30]. At the tertiary-to-primary-care interface, qualitative evidence identifies information availability, role expectations, and service integration as important conditions for pharmacist-led reconciliation [31]. An observational pharmacist–doctor collaborative discharge model further demonstrates that changing role configuration has measurable workflow consequences [32]. These sources support attention to organizational interfaces without establishing the clinical effectiveness of the proposed breakpoint architecture.

Table 4 makes recovery explicit by linking each proposed breakpoint to a detection window, pharmacist response, necessary interprofessional dependency, and recovery endpoint.

Table 4. Recovering medication continuity after transition breakpoints

Breakpoint	Proximate cause	Detection window	Pharmacist action	Interprofessional dependency	Recovery endpoint
Intent loss	Reason, duration, or review condition unavailable	Before discharge or first downstream review	Reconstruct rationale; flag unresolved intent	Prescriber/initiating team confirms plan	Intent becomes explicit or is deliberately revised
Transfer distortion	Omission, contradiction, delay, ambiguity, inaccessibility	Handover through early post-discharge	Compare sources; clarify discrepancy	Sending/receiving teams and information access	One interpretable plan reaches relevant actors
Enactment mismatch	Treatment work exceeds capability, support, supply, or access	First real-world medication use	Identify mismatch; coordinate practical support	Patient/caregiver, pharmacy, prescriber, services	Intended regimen becomes feasible or is reassessed
Recovery failure	Divergence lacks timely ownership or escalation	Early follow-up or new clinical change	Detect, triage, escalate, document resolution	Actor with authority/resources to intervene	Divergence is resolved, accepted, or clinically reassessed

Note: Breakpoints and recovery endpoints are proposed analytical categories, not validated failure states or performance measures. Responsibility remains shared and context dependent.

Interprofessional interfaces and responsibility boundaries

A pharmacist-led framework should not be interpreted as pharmacist ownership of every continuity function. Discharge communication is inherently multistakeholder, and consumer and professional accounts show that the same medication information must remain usable across different recipients and settings [14]. Pharmacists can reconstruct medication histories, identify discrepancies, explain regimen changes, test patient understanding, and coordinate escalation; they cannot independently determine every therapeutic decision, guarantee supply, create primary-care capacity, or substitute for patient preference and informed choice.

Implementation evidence reinforces this boundary. PHARM-DC clinicians described role clarity, workflow fit, communication, and resources as important to intervention delivery [26]. At the transition to primary care, information access and role expectations constrain what pharmacist-led reconciliation can accomplish [31]. Collaborative pharmacist–doctor discharge reconciliation similarly redistributes operational work rather than eliminating professional interdependence [32]. The relevant unit of design is therefore the interface: who detects

a problem, who has authority to modify treatment, who communicates the decision, who can secure medication access, and who verifies that the new plan can be enacted.

Co-design evidence further indicates that medication handover requires coordinated components rather than a single actor or document [15]. Site-specific PHARM-DC implementation barriers and facilitators also differed [27]. Consequently, the proposed framework assigns pharmacists a medication-focused coordinating role while leaving prescriptive, diagnostic, organizational, supply, and patient-level responsibilities where appropriate to local scope and capability.

Responsibility should also be temporally explicit. A discharge instruction with no named reassessment owner can remain technically accurate while becoming clinically obsolete. Conversely, shared responsibility without an escalation endpoint can create diffusion rather than collaboration. The framework therefore favors recoverable ownership: each unresolved medication issue should have an identifiable next actor or service, while responsibility can transfer as the patient's setting and clinical state change. This is a design proposition requiring adaptation to professional regulation, staffing, information infrastructure, community-pharmacy models, and health-system organization.

Results and Discussion

The central argument is that medication reconciliation and medication continuity occupy different analytical levels. Reconciliation concerns the accuracy and resolution of medication information at a transition; systematic evidence supports stronger and more consistent effects on such process outcomes than on downstream clinical outcomes [1]. Continuity, as proposed here, concerns whether therapeutic intent remains interpretable, is transmitted with sufficient fidelity, can be enacted with available patient and caregiver resources, and is monitored sufficiently to permit deliberate correction or reassessment over time. Evidence that sustaining hospital-initiated medication changes often requires multicomponent strategies supports the need to look beyond a discharge list [9].

The framework does not imply that combining four domains will improve utilization or safety. The PHARM-DC randomized trial found no significant overall reduction in 30-day unplanned utilization [25]. That result is especially important because it resists a common conceptual shortcut: a more comprehensive pharmacist intervention should not be assumed to produce broad clinical benefit merely because its components appear individually reasonable. Baseline services, intervention fidelity, patient need, timing, and organizational context may alter what additional coordination can achieve.

Measurement is another constraint. Available tools incompletely cover medication self-management capability [19]. Post-discharge intervention effects can also be sensitive to analytical assumptions, as illustrated by attenuation in a community-pharmacy sensitivity analysis [24]. Meanwhile, associations between discrepancies and subsequent emergency use remain vulnerable to confounding and population specificity [29]. The proposed continuity construct therefore requires evidence that it adds explanatory or predictive value beyond existing measures such as reconciliation accuracy, medication discrepancies, adherence, health literacy, regimen complexity, and conventional transition outcomes.

Testing should proceed in stages. Construct development should first establish content and discriminant validity across patients, caregivers, pharmacists, prescribers, and other transition actors. Prospective observational work could then examine whether specified continuity breakpoints precede clinically meaningful divergence and whether their importance varies by medication risk, multimorbidity, cognitive or functional status, caregiver availability, and access conditions. Pragmatic evaluations should test targeted rather than automatically universal pharmacist involvement, measure intervention fidelity and workload, and distinguish process recovery from clinical outcomes. External validation across differently organized health systems is essential before any decision threshold, risk score, or implementation claim is justified.

Importantly, failure classification should remain medication- and context-sensitive: the same discrepancy may be trivial in one regimen but consequential in another, and the same capability limitation may be compensated by caregiver or service support in one setting but not another.

The framework is therefore most useful as a structured hypothesis about where continuity can fracture and where recovery might occur. Its value will depend on whether future studies can measure its domains reliably, demonstrate incremental usefulness, identify redundant components, and falsify relationships that do not survive prospective or cross-system testing.

Conclusion

Medication reconciliation remains an essential safeguard at transitions of care, but an accurate medication list is not evidence that the intended regimen will remain understood, available, feasible, clinically appropriate, or deliberately reassessed after discharge. This article proposes medication continuity as a longitudinal condition in which therapeutic intent is preserved or consciously revised, medication information remains usable across interfaces, treatment work fits patient and caregiver capability or is appropriately supported, and emerging divergence can be detected and recovered.

The framework gives pharmacists a medication-focused coordinating role across these conditions without assigning them sole responsibility for prescribing decisions, medication supply, patient behavior, or health-system access. It also treats medication change as potentially compatible with continuity: deprescribing, restarting, substitution, dose modification, or temporary interruption may preserve continuity when their rationale and reassessment remain recoverable.

The model remains conceptual. Its domains are not validated measures, its breakpoint taxonomy is not a proven causal mechanism, and no component should be interpreted as a universal predictor of harm or benefit. Patient heterogeneity, medication risk, caregiver resources, professional scope, organizational capacity, information infrastructure, and health-system design may alter both failure and recovery pathways. Future work must establish construct validity, temporal ordering, incremental usefulness, implementation feasibility, and external generalizability before the framework can support clinical decision rules or claims of improved medication-safety or utilization outcomes.

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