

The Non-Adherence Label

Byron Batz, Ph.D.

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THE NON-ADHERENCE LABEL

As the American health care system has diminished its capacity to ask the right questions, it has drifted toward interventions that are inevitably ineffective, inefficient, and costly.

Pharmaceutical companies unveil new medications as if they were modern miracles, inviting viewers to ask their doctors about them. Yet the “ask” that follows is rarely an inquiry. It arrives in the clinics as a demand shaped by advertising, not understanding. Physicians allotted ten hurried minutes, become less guides through complexity and more gatekeepers under pressure.

There is no space to explore how drugs work, what risks accompany their benefits, what long-term consequences might unfold, or whether gentler, more appropriate alternatives exist. In these compressed encounters, curiosity collapses into consumption, and the shared work of discernment is replaced by a transaction neither patients nor doctors truly chose.

Once the clinicians, pressed for time and faced with patients whose minds are already made up, sign the prescription with multiple refills, the rest of the process unfolds almost automatically; patients arrive at the pharmacy expecting relief, not complexity. The brand-name copay is shockingly high, even with insurance. Pharmacists explain that the cost is tied to the drug being new, non-formulary, or both. Patients bring the medications home and take the first dose, then the second, then the third.

Often, one of three broad outcomes appear; side effects emerge, the ones never discussed, never asked about, or never understood; adverse effects appear, rare but real; nothing happens at all, no harm, but also no improvement, revealing that the medication was never aligned with the patients’ conditions or biology.

As a result, patients often decide to skip doses, stop early, double up, or abandon the medications entirely.

Sometimes patients do everything “right.” They take the medication as prescribed. They follow the plans. And then, without warning; copays are suddenly far higher than before. Or

the medications are no longer covered at all. Or the refills require new appointments with doctors for authorization renewal. Or the insurers have quietly moved the drug to a different tier. Or medications slip into shortage when demand rises faster than pharmacies can supply them.

Patients feel caught in a structural ambush, discovering that the system they assumed was stable is in fact ever-changing, opaque, and indifferent to continuity.

Patients are expected to be consistent even when; the price is inconsistent, the coverage is inconsistent, the communication is inconsistent, the rules are inconsistent.

The unfilled refills become evidence of a system's design that makes discontinuation more likely than adherence. **Stopping the medication, in many cases, is not a failure of discipline. It is a rational response to an irrational structure.**

Patients' initial desires were shaped by advertising. Clinicians' decisions were shaped by time pressures. Pharmacists' explanations were shaped by formulary rules. Patients' experiences were shaped by situations or biology. Stopping medications was shaped by real life's volatility.

The shift from non-compliant to non-adherent was framed as a move toward gentler, less punitive language. But the underlying logic remained unchanged. Both terms perform the same function; they mark the patient as the point of failure. They erase the structural, financial, emotional, and informational forces that shaped the patient's choices.

Once the label is applied, the question shifts from "Why did this happen?" to "How do we correct the patient?" The system's response becomes operational rather than relational.

Costly, ineffective, inefficient interventions emerge; constant reminders, texts, calls, app notifications, automated messages. Relentless outreach; care coordinators, pharmacists, nurses, all tasked with "closing the gap." Adherence plans; flowcharts, dashboards, metrics, and performance indicators. Team meetings; groups of professionals discussing the patient as a problem to be solved.

Once the label is applied, the system begins to generate flawed explanations that protect its own architecture. The plan was sound; the patient deviated. The medication is effective; the patient failed to take it. The system provided access; the patient did not use it. The outreach was thorough; the patient ignored it.

The system keeps generating activity without generating understanding and results.

Patients are the only ones who know why the medication was stopped. Yet the system rarely asks them. Instead, it consults data dashboards, claims reports, pharmacy refill histories, predictive models, committee meetings, quality metrics.

A system that does not ask the right questions cannot produce the correct answers. It produces defective interventions. Therefore, interventions without sound inquiry become a form of institutional blindness.

When a system designs solutions without understanding causes, it reveals several things about itself; It is optimized for throughput, not reflection. It is structured around efficiency, not empathy. It is built to correct, not to comprehend. It is designed to protect its own logic, not to question it. It is more comfortable with labels than with stories.

This is why the non-adherent label is so powerful: it allows the system to stop asking the right questions.

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