

Feeling fine isn't the test

A short book about stopping your medicine when you feel better and taking it when you remember

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First edition

Written by AI with human guidance. It can contain mistakes, which later editions correct.

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Before you start

This is a short book and you can read it in two or three sittings. It's about one habit, and the habit has two shapes. The first is stopping a medicine because you feel better, or because you feel fine, or because you never felt anything and can't see what it's for. The second is the slow version, where the tablet that was every morning becomes most mornings, then when you think of it, then when you find the packet. Nobody decides to do either. They happen in the gap between a prescription and a life.

I'm going to argue three things. The first is that the habit makes sense from the inside. Feeling better is what treatment is for, so stopping when you feel better looks like the natural end of it. A tablet for something you can't feel is hard to believe in. A missed day that changes nothing looks like proof that the tablet does nothing. The second is that the feeling you're using as your test is the wrong instrument, and there's research on why. For some medicines you feel fine because you're taking them, and the feeling ends when the medicine does. For others you'd feel exactly the same with or without them, because the thing they treat has no symptoms until it does something serious. And for a short course, feeling better on day four says nothing about what the prescriber intended for day seven. The third is practical, and it's the whole method. Take it the way the prescription says, and if you want to change that, stop that, or you've been skipping it, the next step is a conversation with the person who prescribed it or a pharmacist, not a quiet decision on your own. Chapters 20 to 22 cover how.

This book never tells you to stop a medicine, to take less of one, or to take more. It never tells you your prescription was right, either. That's a question for the prescriber, and the book's point is that it should be asked there and not settled by the drawer.

Three cautions.

If you're taking a medicine for a mental health condition and you've been thinking about stopping it, the NHS says not to stop suddenly or without talking to your doctor first, because stopping can bring withdrawal symptoms and some of them look like the illness coming back. Chapter 10 is about this. If you or someone you know is in a mental health crisis, the NHS has urgent help and you don't need to finish the book first.

If you've been skipping a medicine for days or weeks and you're about to restart it after reading this, ring a pharmacist first. Some medicines are restarted differently after a gap, and a pharmacist can tell you in a minute whether yours is one.

If the reason you're not taking a medicine is that you can't afford it, can't get to the pharmacy, or can't manage the number of tablets, that isn't a habit and it isn't a fault. Chapter 23 says who can help.

The notes at the back give my sources and their limits. Where I'm giving my own reasoning and not a finding, I'll say so.

The half-empty packet

There's a packet of blood pressure tablets in the kitchen drawer. It was a month's supply and it was dispensed in March. You took them every morning for the first fortnight, then you had a weekend away and forgot, and the fortnight after that they were most mornings, and now they're a thing you notice when you're looking for the batteries. You felt nothing when you started them and you feel nothing now. There's a check-up you've been meaning to book, and part of the reason you haven't is that you'd have to explain the packet.

Somewhere else in the house there's a preventer inhaler that only gets used when your chest is tight, which the leaflet says is not what it's for. There's an antidepressant that you've been halving for six weeks because you feel so much better, and you haven't mentioned it at the surgery. There's a strip of antibiotics with three left, from a chest infection that cleared on day four. There's a thyroid tablet that's taken at seven some mornings and at eleven on others and not at all when the morning gets away from you.

These are invented, but I'd guess at least one of them is close. Some words. **The quiet stop** is stopping a medicine without telling the person who prescribed it. **The fade** is the slower version, from every day to most days to when you remember. **The feeling-fine test** is deciding whether to take a medicine by how you feel, which is the habit's engine and the thing this book takes apart. **The silent ones** are medicines for conditions with no symptoms, so you feel the same with or without them until something serious happens. **The holding ones** are medicines that hold a condition down while

you take them, so feeling fine is what taking them looks like. **The short ones** are courses with a planned end. **The conversation** is the talk with the prescriber or a pharmacist that any change should start from. **The hook** is the fixed daily event a dose is tied to. And **the leaflet** is the folded paper in the box, which turns out to answer most of the questions in this book.

Before you go on, do one thing. Find every medicine you've been prescribed and count what's left against the date it was dispensed. Don't take anything, don't throw anything away, and don't feel anything about it yet. Just write down the gap between what should be gone and what is. That number is the subject of this book, and it's more common than the drawer makes it feel.

Why stopping seems sensible

Nobody stops a medicine for no reason. Stand in the reader's kitchen and the reasons line up, and I want to give each one its due before the book starts arguing with any of them.

You feel better. That's what the medicine was for, and it's worked, and continuing to take something for a problem that's gone feels like wearing a plaster after the cut has healed. Or you feel fine, and you've felt fine throughout, and a tablet for a thing you can't feel is hard to keep believing in. You missed a day or a week and nothing happened, which looks like an experiment with a clear result. You don't like the idea of depending on a chemical. The side effects are real and unpleasant, and the illness they're treating is invisible. The doctor was brisk and never said what would happen if you didn't take it. And the tablet is one more thing in a morning that already has too many things in it, so it drops off the list the way anything without a consequence drops off a list.

These are honest. Research on what people believe about their medicines finds the same two forces in most of them. In a study of 324 patients with four different long-term conditions, Horne and Weinman found that most believed their medicine was necessary, but over a third also had strong concerns about it, mostly about dependence or long-term effects. When concerns outweighed the sense of necessity, people took less of it. A later review of 94 studies pooled that pattern across more than 25,000 patients and found it held. Nobody in those studies was careless. They were weighing something, and the weighing came out against the tablet.

So the habit isn't stupidity and it isn't defiance. It's a reasonable person using the only instrument they've been given, which is how they feel, to judge something that instrument can't measure. The next chapters go through the beliefs one at a time. Most of them are half right, and the half that's wrong is the half that matters.

"I feel better, so it's done its job"

This is the belief that stops antidepressants at three months, preventer inhalers in the summer, and the tablets for an ulcer as soon as the pain has gone. It's the most natural belief in the book, and for a lot of medicines it's exactly backwards.

The holding ones work by holding. A preventer inhaler keeps the airways from being inflamed, and while it's doing that you have no symptoms, and the absence of symptoms is the medicine at work. An antidepressant that has started to lift your mood is doing so in the present tense, and the NHS says you'll usually carry on taking it for at least six months after you feel better, because feeling better at month three is where the treatment is, not where it ends. Levothyroxine for an underactive thyroid replaces a hormone your body isn't making, and the NHS page says plainly that you'll usually take it for the rest of your life to stop the symptoms coming back. For all of these, "I feel better" and "it's working right now" are the same sentence.

The trouble is that the feeling doesn't come with a label saying which. When you had a headache and took a painkiller and it went, the medicine had finished. That's the model most of us carry, because it's the medicine most of us take most often. The holding ones don't behave like that, and nothing about the feeling tells you so. A study of 405 adults with asthma found that adherence to preventer inhalers ran at about half, and that each 25 percent increase in the time spent without the inhaler doubled the rate of hospital admission for asthma. Those people weren't ignoring symptoms. They'd stopped because they didn't have any.

So the question to ask isn't "am I better" but "is this one of the ones that finishes, or one of the ones that holds". The leaflet usually says, the pharmacist always knows, and chapter 20 is about asking. Feeling better is good news. It just isn't an instruction.

"I feel fine, so I don't need it"

The silent ones are harder, because here the feeling isn't misleading you. It's simply not connected to anything. High blood pressure, the NHS says, does not usually cause any symptoms, and many people have it without realising. High cholesterol is the same. You felt fine before the diagnosis, you feel fine on the tablet, and you'd feel fine for years off the tablet, and none of those three feelings tells you anything about the pressure in your arteries or the state of their walls.

This is the belief with the biggest numbers behind it. A study of 4,783 patients prescribed a once-a-day blood pressure tablet, with their dosing recorded electronically, found that about half had stopped taking it within a year. On any given day the ones still taking it missed about one dose in ten. Nearly half of them had at least one run of three or more missed days in a year, which the researchers called a drug holiday. Nobody in that study could feel their blood pressure. That's the point. Nothing was telling them to take it, and nothing told them they'd stopped.

What the tablet is doing is measured in decades, not mornings. A review of 44 studies with nearly two million participants found that about 60 percent of people took their heart and blood pressure medicines well enough to count as adherent, and that those who did had lower rates of heart attack and stroke and lower death rates than those who didn't. The researchers estimated that a considerable share of cardiovascular events in Europe, around nine percent, could be put down to poor adherence alone. Chapter 13 says what those numbers can and can't tell you about one

person. For now the point is simpler. Feeling fine is the normal state of someone with high blood pressure, on the tablet and off it. It's the one test that can't distinguish them.

The right instrument is a cuff, not a feeling, and the NHS says many pharmacies will put one on your arm for free if you're over forty. Chapter 16 is about using it.

"I missed a few days and nothing happened"

This looks like an experiment. You forgot the tablet on Tuesday, then Wednesday, then it was the weekend, and by Monday you had a result. Nothing happened. The blood pressure didn't announce itself, the mood held, the chest was fine. If the tablet mattered, surely five days without it would have shown you.

The trouble with the experiment is that it has no readout. For the silent ones there was never going to be a signal, because the condition doesn't produce one, so five silent days are what you'd get from a tablet that was doing everything and from a tablet doing nothing. For the holding ones the effect often outlasts the last dose by days or weeks. An antidepressant doesn't stop working the morning after, and inflamed airways take time to become inflamed. So the five days measured nothing, and the feeling of having tested it is the only result you got.

There's a second problem that I'd want you to know about even though it's less common. Blaschke and colleagues, reviewing decades of electronically recorded dosing, noted that intermittent lapses in taking a medicine are a potential source of harm in their own right, through rebound effects when a drug is stopped and through what they called recurrent first-dose effects when it's restarted. In plain words, for some medicines the off-and-on pattern is worse than either steady taking or a proper stop. That's my summary of their point, and which medicines it applies to is exactly the kind of thing a pharmacist can tell you and a feeling can't.

So what did the missed week show? That you didn't feel anything, which you already knew you wouldn't. What it didn't show is anything about the medicine. If you want an actual result, the cuff, the blood test and the peak flow meter give one, and the person who prescribed the medicine can read it. That's a better experiment, and the next chapter is about the fear that stops people asking for it.

"I don't want to depend on it"

Of the concerns people report about their medicines, this is one of the two big ones, and the researchers who measured it found that over a third of patients with long-term conditions held it strongly. The word underneath is dependence, and it carries a smell from somewhere else. Dependence is what happens with alcohol, with nicotine, with the tablets people can't come off. Taking something every day for years sounds like the start of that, and stopping sounds like the way to prove you're not.

But the word is doing two jobs. Dependence in the sense that matters, the sense book 11 in this series is about, means the substance has changed what your body expects, so that stopping produces craving and the substance itself has become the problem. Needing a medicine is different. Someone with an underactive thyroid depends on levothyroxine the way someone short-sighted depends on their glasses. The glasses haven't done anything to the eyes. Taking them off doesn't prove independence, it proves the eyes were short-sighted all along, and the same is true of most of the silent and holding ones.

There's a real version of the worry and it deserves a straight answer. Some medicines do produce withdrawal symptoms when stopped, and antidepressants are the clearest case, which is why chapter 10 gives them their own chapter and why the NHS says to reduce them gradually with a doctor. That's a reason for a planned stop, not a quiet one. The one thing the dependence worry argues

for is the thing the habit skips, which is a conversation about whether the medicine is still the right one and how a change would be done.

I'd put it this way. The person who takes the tablet every day and reviews it once a year with the prescriber is less dependent on it, in every sense that matters, than the person who takes it on and off and never asks. The first one has a decision. The second has a drawer.

"I'd rather not put chemicals in my body"

This one is held sincerely and it's worth being fair to it. Nobody wants to take something they don't need. A tablet a day for the rest of your life is a large thing to accept, and accepting it feels like conceding something about your body that you'd rather not concede. The wish to be someone who doesn't need medicine is a wish for health, and there's nothing wrong with it.

Two things, though. The first is that the condition is a chemical too. High cholesterol is a substance in your blood. An underactive thyroid is a shortage of a hormone. Depression, whatever else it is, is happening in a body. The choice was never between chemicals and no chemicals. It's between the ones your body has arrived at on its own and one more, chosen by someone who's seen what the others do.

The second is that this belief is a good reason to have the conversation and a poor reason to have the quiet stop. If you'd rather not take a statin, that's a legitimate thing to say to a GP, and the NHS statins page itself lists other medicines for people who can't or won't take one. If you'd rather try to bring your blood pressure down by other means first, prescribers hear that every day, and the NHS page on high blood pressure puts lifestyle changes before tablets. What you can't do from the drawer is find out whether your case is one where that's safe. The quiet stop takes a real preference and turns it into an unmonitored experiment on the one body you've got.

So keep the preference. Say it out loud, to the person who can act on it. The reader who says "I'd rather not, what are my options" gets options. The reader who stops and says nothing gets a repeat prescription in the post and a check-up they're avoiding.

"The side effects are worse than the illness"

Sometimes they are, in the sense that the illness is silent and the side effects aren't. A statin that gives you aching legs is a daily cost against a benefit measured in decades. An antidepressant that flattens your appetite or your sex life is asking a lot for a mood you can no longer remember being bad. The side effects are real and I'm not going to argue you out of feeling them.

Here's what the quiet stop gets wrong about them. The NHS statins page says that if you think your medicine is causing side effects you should talk to a doctor, who may prescribe a different statin or change the dose. That's not a polite formula. There are five statins on the NHS list and they don't all do the same thing to the same person. The antidepressants page says many side effects ease after a couple of weeks as your body gets used to the medicine, that you'll be seen every week or two when you start, and that if you're finding the side effects hard to manage you should talk to your doctor, who can discuss other options. The levothyroxine page says most of its side effects happen when the dose is too high and improve when it's changed.

In each case the side effect is information the prescriber needs, and the quiet stop is the one response that throws it away. Stop without saying anything and the record shows a patient on a statin who's doing fine. The next appointment, if it happens, starts from a false position. Say "the aching started in the second week and I've stopped taking them" and you've given the prescriber something to work with, and probably a different tablet by the end of the week.

There's also the Yellow Card scheme, which the NHS pages mention, for reporting a suspected side effect so that it's counted. You don't need it for the conversation. I mention it because a side effect that gets reported is a side effect that exists somewhere other than your kitchen, and that's the direction this book is pushing everything.

"I take it when I remember"

This is the fade, and it's the version that most readers will recognise even if they've never made a decision to stop anything. The tablet was every morning. Then a morning went wrong and it wasn't. Then it was most mornings, and then it was when you noticed the packet, and now taking it feels like an act of memory rather than a routine.

The scale of this is worth knowing, because it's easy to think you're unusually bad at it. The Cochrane review of interventions to improve adherence opens with the finding that people prescribed a medicine to take themselves typically take only about half the prescribed doses. Half. That's the average across conditions, across countries, across decades of studies. The reader who takes it four days in seven is doing about what everyone does. That's not comfort, exactly. It's a reason to stop treating the fade as a character flaw and start treating it as what it is, which is a design problem.

The design problem is that a daily tablet has no hook. It isn't attached to anything, it produces no feeling when taken and none when missed, and it competes with a morning that's full of things that do. Memory was never going to carry it, and the studies say memory doesn't. What does work, so far as anything does, is worth knowing too. A review of 771 trials of ways to improve adherence found modest effects overall, and found that the interventions that worked best were the ones built on habit and routine rather than

on information and persuasion. Knowing more about your tablet doesn't get it taken. Having a fixed place for it in a fixed minute of the day does, more often.

So the fade isn't cured by resolving to remember. It's cured by taking remembering out of it, and chapter 21 is the method. For now, the thing to see is that "when I remember" is a system, and it's the system most people are running, and it delivers about half.

"I'm better now, so I'll come off the antidepressant"

This gets its own chapter because the stakes are different and because the NHS is unusually direct about it. You'll usually carry on taking an antidepressant for at least six months after your symptoms improve. Talk to your doctor if you want to stop. And in bold on the page, do not stop taking an antidepressant suddenly or without talking to your doctor first.

The reason is withdrawal. The NHS lists the symptoms, and they include headaches, feeling sick, sweating, dizziness, sleep problems and strange dreams, feeling restless or anxious or tearful, and sensations like an electric shock in the head. Most people get some symptoms when coming off, some get none, and for some they're severe, start weeks or months later, and last for months. The best recent count I've found is a 2024 review of 79 studies covering 21,002 patients, which put the rate of at least one discontinuation symptom at about 31 percent after stopping an antidepressant against about 17 percent after stopping a placebo, and the rate of severe symptoms at about three percent against under one. An earlier review of 24 studies found higher rates and longer durations, and the two disagree on the size but not on the existence of the thing.

Here's the part that matters for the feeling-fine test. The NHS page says that some withdrawal symptoms can feel like your condition coming back. So the reader who stops at three months, feels dreadful a week later and concludes the depression has returned may be reading withdrawal as relapse, and the reader who feels dreadful and concludes the tablet was propping them up may be

right about that too. From the inside you can't tell. Horowitz and Taylor argued in 2019 that the short tapers guidelines used to recommend, two to four weeks, showed little benefit over stopping outright, and that tapers over months down to very small doses did better. The NHS now says the plan will usually run over several weeks or months.

None of that is an argument against coming off. It's an argument about how. The doctor who agrees a plan with you can slow it down if the symptoms bite, or go back up a step and try again later, which the NHS page says explicitly. The quiet stop has none of those options. It has a bad week and a guess about what the bad week means.

"My chest is fine, so the inhaler can wait"

Asthma is the cleanest case of the holding ones, because the two inhalers look alike and do opposite jobs. The reliever, the NHS explains, is for when you get symptoms. The preventer is for every day, to stop the symptoms happening, and the NHS is explicit that you shouldn't be given a blue reliever to use on its own. Some people now have a single inhaler that does both jobs, and the instructions for those come with the inhaler. But the reader with two inhalers who uses the preventer only when the chest is tight has turned it into a second reliever, and it's a poor one, because that's not what it does.

The study I mentioned in chapter 3 is the one to hold onto here. Of 405 adults with asthma in one American health system, adherence to preventer inhalers ran at about half. Each 25 percent increase in the time spent without the preventer doubled the rate of asthma hospital admissions. The researchers estimated that if there'd been no gaps in use, about 60 percent of the admissions in the study period wouldn't have happened. Those admissions came from people whose chests were fine right up until they weren't, which is what asthma does.

The feeling-fine test fails here in a specific way. A well-controlled chest feels like a chest that doesn't need anything. It feels that way because of the preventer. Stop, and for days or weeks the feeling continues, because inflammation builds slowly. Then a cold or a cold morning or a cat arrives, and the reliever is being used three times a day, and the NHS says that needing your inhaler more often

is a reason to see a GP. The fine chest and the bad night are the same story with a gap in the middle, and the gap was the preventer in a drawer.

The NHS says you should have a check-up at least once a year and that it will include checking you're using your inhalers correctly. That's a conversation with a nurse who's heard "I only use it when I need it" a thousand times and can explain, without any disapproval, why the sentence has the medicines the wrong way round.

"Four days and I'm better, the rest can go in the drawer"

The short ones are different, and the honest thing is to say that the advice around them has changed and to be precise about what it's changed to.

For years the message was to always finish the course, because stopping early would breed resistant bacteria. In 2017 a group of infection specialists led by Martin Llewelyn argued in the BMJ that the course-completion message wasn't well supported and that the link between stopping early and resistance runs, if anything, the other way. Spellberg and Rice, reviewing the trials in 2019, counted more than 45 randomised comparisons of shorter against traditional courses across pneumonia, urinary infections, skin infections and others, and found no difference in cure rates. A study of 931,015 antibiotic prescriptions in English general practice found that for most common infections a substantial share of courses were longer than the guidelines recommended, adding about 1.3 million days of antibiotics. So the old dogma is going, and courses are getting shorter by design.

Here's what that does not mean. It does not mean you should stop when you feel better. The current NHS advice is to take antibiotics as directed on the packet or the leaflet, or as your GP or pharmacist instructed. The reason is that the shortening is happening at the prescriber's end. A five-day course written in 2026 is already the shorter course. The prescriber chose its length for your infection, and day four of five isn't a judgement you can improve on from the sofa, because feeling better and being clear of the infection aren't

the same event, and the day they diverge varies by infection. If you feel better and you'd like to stop, ring the surgery or ask a pharmacist. For some infections the answer will be yes, and it will be a yes from someone who knows which infection it was.

The other half of this chapter is the drawer. A review of 46 studies found that people took about 62 percent of their antibiotics as prescribed and that about 29 percent later used leftovers, for the next sore throat or the next child. That's the most dangerous thing the drawer does, because the leftover is the wrong antibiotic at the wrong dose for an infection nobody's diagnosed. The NHS says unwanted medicines go back to the pharmacy. Not the bin, not the toilet, and not the drawer.

"It's only a blood pressure tablet"

The tablet is small and the condition is invisible, and it's easy to conclude that whatever it's doing is small too. So this chapter is about what the numbers say and, just as carefully, what they don't.

The review of 44 studies I mentioned in chapter 4 found that people who took their blood pressure medicines well, meaning at least 80 percent of doses, had about a fifth lower rate of cardiovascular disease than those who didn't, and for statins about 15 percent lower. Deaths from any cause were lower too, by more. A broader review of 63 studies across many conditions found that the difference in outcomes between high and low adherence was about 26 percent overall. These are large effects for a small tablet.

Now the caution, because it's the honest one and you'd find it anyway. In 2006 Simpson and colleagues pooled 21 studies of adherence and death, including eight where some participants had been given a placebo, and found that people who took their placebo reliably also died less often than people who didn't. Taking your tablets well, in other words, goes along with being the kind of person who does other things well too, and part of the benefit in the adherence studies is that, not the tablet. Researchers call it the healthy adherer effect and it's real.

What it doesn't do is rescue the drawer. The placebo takers weren't healthier because of the sugar pill. They were healthier because they did the things, and taking the tablet was one of the things. Meanwhile the trials that got these medicines licensed, which compared the medicine to placebo in people taking both properly,

are where the benefit of the tablet itself was shown. Both are true. The tablet does something, and the person who takes it reliably tends to be doing other good things, and neither is an argument for taking it on Tuesdays.

So it's only a blood pressure tablet in the sense that it's small, and cheap, and boring. What it's for isn't any of those.

"I'll double up tomorrow"

Here the leaflet earns its keep, because the NHS advice on missed doses is short and it's the same across most of the medicines in this book.

If you forget a dose, check the leaflet. If you're not sure, ask a pharmacist or a GP. In most cases you take the missed dose as soon as you remember and carry on as normal, but if it's nearly time for the next dose, you skip the one you missed and take the next one at the usual time. And then the line that's on the antibiotics page, the levothyroxine page and most of the others. Do not take a double dose to make up for a missed one.

The reason people double up is that it feels like repairing the mistake. The tablet was owed, so pay it back. But the body isn't a ledger. Two doses close together mean a higher level of the drug than the prescriber intended, and the NHS antibiotics page says the risk of side effects goes up when doses are taken closer together than recommended. For most medicines one accidental extra dose is unlikely to do serious harm, and the pages say so. For some it matters more, and the leaflet will say. The rule is the same for all of them. Missed is missed. Move on to the next one.

This is also where the fade does its quiet damage, because a person taking a tablet when they remember is making this decision several times a week without knowing they're making it. Was it this morning or yesterday. Take one now and one tonight to catch up. The reader who has a hook, in chapter 21's sense, rarely has to

think about a missed dose, because a missed dose becomes visible.
There's a compartment still full. And when there is one, the answer
is already written down in the box.

"The doctor never said why"

Sometimes that's true. Appointments are short and a prescriber can explain the dose and forget to explain the point. The reader leaves with a name and a frequency and no picture of what the tablet is standing between them and. Then the tablet gets weighed against side effects, cost, and the wish not to take it, with nothing on the other side of the scales.

The research on beliefs says this gap matters more than most things about a medicine. In the 94-study review of the necessity-concerns framework, a stronger sense that the medicine was personally necessary went with higher adherence, and stronger concerns went with lower, and the effect held across countries and across ways of measuring it. Necessity isn't a fact about the medicine. It's a belief about the medicine that the patient either has or doesn't, and a prescriber who never said why has left it to chance.

Here's what to do with the gap. Ask. Not at the next annual review, but this week, and not necessarily the doctor. The NHS says that when you're prescribed a medicine for the first time, a pharmacist may be able to give you up to three appointments, in person or by phone, to answer your questions, help you use it safely and check it's right for you. That service exists because the gap in this chapter is common enough to need one. And for a medicine you've been on for years, the questions are the same and the pharmacist is still the person standing nearest to the answer. What is this for. What happens if I don't take it. How long is it for. What should I do if I miss one.

I'd suggest one more question that isn't on any list. What would tell us it's working. For the holding ones the answer will be a feeling. For the silent ones it will be a number, and chapter 16 is about getting that number yourself.

"I know my body better than a leaflet does"

You do, in the sense that counts. You know when you're low, when your chest is tight, when the tablet makes you sick, when your sleep has changed. No leaflet knows any of that, and a prescriber who dismisses it is doing a bad job. The book has spent several chapters saying that these feelings are information and should be taken to the conversation, not thrown away.

What you don't know from the inside is your blood pressure, your cholesterol, or your thyroid hormone level, because they don't feel like anything. That's not a failure of self-knowledge. It's just what those things are. The person who trusts their body to tell them whether the silent ones are needed is asking their body a question it has no way of answering, and the silence they get back isn't a no.

So the honest version of this belief is to know your body with instruments where instruments are the only way. The NHS blood pressure page describes home monitors and says a GP may ask you to use one over a few days. Pharmacies do free checks for the over-forties. Levothyroxine comes with regular blood tests, the NHS says, to check you're on the right dose, and being on the wrong dose has side effects of its own. A peak flow meter tells you how your airways are doing before your chest does. These are the readouts the missed-week experiment in chapter 5 never had.

There's a nice thing that happens when you have a number. The tablet stops being an act of faith. You take it, the reading comes down, you stop, over weeks it goes back up, and now the medicine

has done something you can see. That's the feeling-fine test replaced with a test that works, and it converts a lot of people who couldn't be argued into a tablet by any leaflet.

"Half a tablet is a fair compromise"

The quiet reduction is the quiet stop's more thoughtful cousin. You didn't stop. You cut the dose, or you take it every other day, because the full dose felt like too much and stopping felt like too little, and halfway seemed sensible. The prescriber doesn't know.

The problem is what that does to everything the prescriber does next. Levothyroxine is the clearest case. The dose is set by blood tests, the NHS says, and adjusted until the level is right. If you're taking half, the test comes back low, and the prescriber raises the dose, and now you're prescribed more than you need and taking half of that, and the next test is being read against a dose you're not on. Blood pressure works the same way. The GP sees a reading that hasn't come down on the tablet, and adds a second tablet, when the first one was never really being taken. The quiet reduction doesn't just hide from the prescriber. It feeds them a wrong number and they act on it.

Some of that hiding isn't even deliberate. Research on self-reported adherence finds that people tend to overestimate how well they're taking their medicines when asked, and that self-report is good at confirming that someone is taking it and poor at catching that they aren't. So when the nurse asks "and you're taking the tablets alright" and you say yes, you're doing what most people do, and the record stays clean, and the treatment gets adjusted around a patient who doesn't exist.

None of this means half a tablet is never the right dose. It often is. Antidepressant tapers go down in steps, blood pressure tablets come in several strengths, and a prescriber who hears "the full dose makes me dizzy" will frequently say let's try half. The compromise is fine. Making it in secret is the part that breaks the system. Say "I've been taking half" and you've told the truth to the one person for whom it changes the plan.

What the quiet stop costs

Let me put the costs in one place, since they're spread through the book.

There's the outcome cost, which is the one the studies measure. About a quarter's difference in outcomes between high and low adherence across conditions, a fifth fewer cardiovascular events among people who take their blood pressure tablets well, a doubling of asthma admissions for each quarter of the year spent without the preventer. With the healthy adherer caution from chapter 13 applied, these are still the difference between a treatment that's happening and one that isn't.

There's the cost to the next appointment, which chapter 19 takes on its own, and which I think is the least noticed.

There's the cost of the medicine itself, dispensed and not taken, which is money the health service spent on you and which you'd never have burned in cash. I'm not going to put a figure on it, because the figures I've seen are estimates and the point doesn't need one.

There's the withdrawal cost, for the medicines that have one, and the rebound cost for the ones where on-and-off is worse than either.

And there's the cost you'd notice first if you looked, which is the low hum of a thing undone. The packet in the drawer isn't neutral. It's a small daily reminder that you're not doing something you agreed to do, and a reason to put off the check-up, and a subject

you've learned to steer around at the surgery. Book 20 in this series, Get it looked at, is about the appointment people avoid. This one is about the tablet, and the two habits feed each other, because the packet is the reason for the avoidance and the avoidance is what keeps the packet in the drawer.

Set against all of that is what the habit gives you. A morning with one fewer thing in it, and the feeling that you're not the sort of person who needs tablets. Those are real. They're just small, and they're the same size every day, while the costs compound.

What it does to the appointment

Imagine a GP with ten minutes and a screen. The screen says you've been on a blood pressure tablet since March. The reading today is high. The screen's story is that the tablet isn't working, and the sensible next step on that story is a second tablet, or a higher dose, or a different one. The true story is that the tablet's been in a drawer since April, and the reading today is just what your blood pressure is. Ten minutes go on the wrong problem, you leave with a prescription for a medicine you didn't need, and the packet that started it all is still in the drawer.

This is the cost that the feeling-fine test hides best, because it doesn't fall on you in the moment. It falls on the quality of every decision made about you from then on. The prescriber is steering by a map that says you're taking the tablets, and every turn they make is taken from a position you're not in. Blood tests get read against doses you're not on. Side effects get attributed to the wrong thing. A medicine gets called ineffective when it was never tried.

I think this is why the conversation in chapter 20 is the book's whole method and not one tip among several. Nothing else fixes the map. You can take the tablets from tomorrow and the map is still wrong about the last five months. You can stop for good and the map still shows you on them. Only telling the prescriber what actually happened puts the appointment back on the real problem, and the real problem is usually smaller than the invented one. "I stopped because they made me dizzy" is a ten-minute problem with a known solution. "The tablets aren't working" is a year of escalating doses.

It helps, I think, to notice that the prescriber has heard it before. Half of all doses go untaken, across every condition anyone has studied. Nobody in a surgery is surprised by a drawer. What they can't work with is a drawer they don't know about.

The conversation

Here's the method, and it's one sentence long. Any change to a prescribed medicine, whether stopping it, cutting it, restarting it after a gap, or admitting you've drifted, starts with telling the prescriber or a pharmacist. Everything else in this chapter is about making that sentence easier to act on.

Who. A pharmacist for most of it. The NHS says pharmacists can advise on how to use your medicine, on worries about side effects, and on any other questions, and can refer you to a GP if they can't help. There's no appointment, no ten-minute limit and no screen. For stopping an antidepressant, for anything involving a dose change, and for anything the pharmacist sends you on to, the prescriber.

What to say. The true thing, in one sentence, before anything else. "I've been taking these about four days a week since the spring." "I stopped these in May because they made my legs ache." "I've been halving the dose for six weeks and I feel fine." "I'd like to come off this and I want to do it properly." Lead with the fact, not the apology, and don't explain until asked. The fact is what they need, and the apology is what you need, and only one of them helps.

What to ask. Chapter 15's four questions, and the fifth. What is this for. What happens if I don't take it. How long is it for. What do I do if I miss one. What would show us it's working.

What to expect. Not disapproval, mostly. A prescriber who hears "I stopped because of the aching" hears a solvable problem. A pharmacist who hears "I've been skipping it" hears the most common sentence in their week. What you'll often get is a change, to the tablet, the dose, the time of day, or the plan, and occasionally an agreement that yes, you can stop, done this way. And you'll sometimes get a no, with a reason, and the reason is the thing you were missing.

When. This week. Not at the annual review, because the annual review is the appointment the drawer has been making you avoid. The pharmacy is open tomorrow.

The hook

The second half of the method is for the fade, and it's about design rather than resolve.

Pick the hook. One fixed thing you do every day without deciding to. The kettle in the morning. Brushing your teeth. The alarm going off. The dose is tied to that, always, so that the trigger for taking it is the event and not the memory of the event. The NHS levothyroxine page says to try to take it at the same time each day, and for that one there's a further rule about an empty stomach, which is exactly the sort of detail the leaflet holds.

Put it where the hook is. The packet lives next to the kettle, the toothbrush, the phone charger. Not in a drawer, not in a bathroom cabinet, not in a bag. If you can't see it at the moment of the hook, the hook doesn't fire. For medicines that need to be kept away from children or heat, the leaflet says so, and the hook moves to where the packet can safely be.

Make the miss visible. A weekly organiser with a compartment per day turns "did I take it" from a memory question into a glance. Pharmacies sell them for a few pounds and some will fill them for you. A phone alarm is a hook too, but a single alarm is easy to swipe, so the organiser is the check on it.

Expect it to take weeks. In a study of 96 volunteers forming a daily habit, the behaviour became automatic on a rising curve over weeks to months, and a single missed day didn't set the process back. That's the research on habits in general, and it's the most

useful thing to know about a tablet. The first fortnight will feel like effort. It stops feeling like effort, and the review of 771 adherence trials found that building the medicine into routine did more than any amount of information about it.

Two hooks for two doses. If it's twice a day, the second hook is a second event, the evening meal or the front door being locked. Not "twelve hours later", because nothing happens at twelve hours later.

The fade is what happens to a medicine with no hook. A hook isn't willpower. It's what removes the need for any.

The decision

Here's the rule, in one sentence you could say out loud. I take it the way the prescription says, and any change starts with a conversation, not a quiet stop.

That has three parts, and each one answers a belief from the book. The prescription, not the feeling, sets the dose and the days, because for the silent ones the feeling measures nothing and for the holding ones it measures the medicine working. Any change means all of them, stopping, halving, skipping, restarting, and the fact of having drifted, because a change the prescriber doesn't know about is a wrong map. And the conversation is the method, because it's the only thing that fixes the map and because the people on the other end of it are the ones with the options.

Then three when-then plans, which research on carrying out intentions finds work better than intentions alone.

When I feel better and think about stopping, then I ring the pharmacy or the surgery before I skip a dose, and say what I'm thinking and why.

When I notice a side effect, then I write down what it is and when it started, and I say it out loud to a pharmacist or the prescriber that week, and I keep taking the medicine until they say otherwise, unless the leaflet says to stop and seek help.

When I find I've missed a dose, then I check the leaflet, take it or skip it as the leaflet says, never double, and if the organiser shows more than a couple of empty days I ring a pharmacist before I

restart.

What to expect. The first conversation is the hardest and takes about four minutes. The hook takes a few weeks to feel like nothing. The silent ones will go on feeling like nothing, and the number, from the cuff or the blood test, is where you'll see them working. You'll still miss days. The organiser will show you, the leaflet will tell you what to do, and none of it will be a secret from anyone, which is the whole change. This is my expectation and not a finding. The rule hasn't been tested as a package. Its parts have.

The holiday, the new prescription, six tablets a day, the cost, and when it's more than forgetting

The holiday. A fortnight away with the packet at home is the commonest way a fade starts. Count out the days before you go, into an organiser or a labelled bag, and put them with the passport. If you've already come back and the packet's been untouched for two weeks, ring a pharmacist before restarting. For most medicines the answer is just start again. For a few the restart is done differently, and the pharmacist will know which.

The new prescription. The first month of a new medicine is where the quiet stop most often happens, because the side effects arrive before the benefit and there's no habit yet. This is what the pharmacy's help with new medicines is for. The NHS says you can have up to three appointments with a pharmacist, in person or by phone, to ask questions and check the medicine's right for you. Take the first one in the first week.

Six tablets a day. If you're on several medicines, the fade is as much about the pile as about any one tablet. Ask a pharmacist for a review of all of them together. Sometimes times can be lined up, a twice-a-day can become a once, or a tablet you've been on for years turns out to be one nobody would start you on now. That's a conversation, not a drawer, and it's the reason pharmacists ask to see everything you take.

The cost. If you're not collecting a prescription because of what it costs, say so at the pharmacy. There are ways to pay less for regular prescriptions in England and some people don't pay at all, and the

pharmacist can tell you which apply to you. Not taking a medicine to save the charge is a decision the prescriber needs to know about, because they may be able to change what's prescribed.

The repeat. Running out because the repeat wasn't ordered is admin, and book 60 in this series, It can be done today, is about the heap that kind of task lands in. Order the repeat when you open the last strip, not when you take the last tablet.

Children's medicines. The NHS levothyroxine page says that if you forget a child's dose you should talk to a doctor or pharmacist rather than apply the adult rule, and it points to the Medicines for Children website. The same goes for most children's medicines. The leaflet rules in this book are written for adults.

When it's more than forgetting. If you're missing doses because you can't keep track of days, because you're low most of the day most days, or because the thought of the tablets brings on something closer to dread than boredom, that isn't a hook problem and the NHS says to see a GP. Say what's happening with the medicine as part of the same visit. It's the kind of thing they'd rather know.

When you've stopped again

You had the conversation, you set up the hook, it worked for six weeks, and then a bad month came and the organiser has been full since the tenth. Or you never quite had the conversation, you just started taking them again, and now you've stopped again and you're back where the book found you.

The first thing is the safety line from the preface. If it's been more than a few days, ring a pharmacist before you restart. For most medicines they'll say just start again, and the call took a minute. For the few where a restart is done differently, the call is what prevents the problem.

The second thing is the map. A lapse you tell the prescriber about is a data point. A lapse you hide is another five months of wrong appointments. The sentence is the same as in chapter 20 and it's no harder the second time. "I stopped again in August." That's all.

The third thing is to look at which belief did it, because the lapse nearly always has one behind it. If you stopped because you felt fine, that's chapter 4 and the answer is a number, not a feeling. If you stopped because you felt better, that's chapter 3 and the question is whether this is one of the holding ones. If it was side effects, that's a conversation you've probably still not had, and a tablet you've probably not been offered. If it faded, the hook failed, and the fix is a different hook or a more visible packet, not a firmer resolution.

What a lapse doesn't mean is that you're the kind of person who can't take tablets. The kind of person who can't take tablets is most people, half the time, and the studies say so. The people who look good at it have a hook and a pharmacist they talk to. Those are things you set up, not things you are, and both can be set up again on a Tuesday.

The packet, counted

Go back to the drawer. The packet is still there and the count from chapter 1 is still true. Nothing in this book has changed the number of tablets in it, and that's right, because the book's argument was never that you should take them. It was that you should stop deciding about them by a feeling that can't decide, and start deciding with the person who can.

So here's the one action. Take the packet, and whatever else you counted, to a pharmacy this week, and say the sentence. "I've been prescribed these and I've been taking them about half the time, and I'd like to know what to do." You'll get one of a small number of answers. Take them, and here's how to make that easier. Stop them, and here's how. Go and see the prescriber, and here's what to tell them. Every one of those is better than the drawer, and every one of them is a decision that's yours, made with the facts instead of around them.

The tablet is small. The feeling of fine is real. They just have nothing to say to each other, and the sooner you stop asking one about the other, the sooner the medicine can get on with whatever it was prescribed to do, or stop, properly, with everyone knowing.

Notes

These notes give my sources and their limits. This book is not medical advice and does not replace the leaflet in your medicine box or the advice of a pharmacist, GP or other prescriber. Nothing in it tells you to stop, reduce, restart or change any medicine. If you're thinking of doing any of those, the book's one instruction is to talk to the person who prescribed it or a pharmacist first. If you're in a mental health crisis, the NHS has urgent help lines and you should use them. NHS pages were read on 26 September 2026 and give guidance for England. Research papers were read as abstracts unless stated otherwise, and where I give a sample size or a figure it comes from the abstract or the full text I read and not from memory.

The kitchen drawer, the packet from March, the halved antidepressant, the inhaler used only when tight, the three antibiotics left, the eleven o'clock thyroid tablet, the weekend away, the aching legs and the GP with ten minutes and a screen are all invented examples and not reports of anyone.

Chapter 2. Horne and Weinman, "Patients' beliefs about prescribed medicines and their role in adherence to treatment in chronic physical illness", *Journal of Psychosomatic Research* 47, 1999, pages 555 to 567. 324 patients across asthma, renal, cardiac and oncology groups, cross-sectional, self-reported adherence. 89 percent believed their medicine necessary, over a third had strong concerns, and the 17 percent whose concerns outweighed necessity reported lower adherence. Horne, Chapman, Parham, Freemantle, Forbes and Cooper, "Understanding patients'

adherence-related beliefs about medicines prescribed for long-term conditions: a meta-analytic review of the Necessity-Concerns Framework", PLoS ONE 8, 2013, e80633. 94 studies, 25,072 patients. The authors note few prospective studies with objective adherence measures. PubMed gives the 1999 authors as R Horne and J Weinman, so I've used surnames.

Chapter 3. NHS pages on antidepressants, at least six months after symptoms improve, and on levothyroxine, usually for the rest of your life. Williams, Pladevall, Xi, Peterson, Joseph and Elston Lafata, "Relationship between adherence to inhaled corticosteroids and poor outcomes among adults with asthma", Journal of Allergy and Clinical Immunology 114, 2004, pages 1288 to 1293. 405 adults aged 18 to 50 in one American health maintenance organisation, retrospective, adherence from pharmacy claims. Each 25 percent increase in time without the inhaler was associated with a doubling of asthma hospitalisation rate after adjustment, and the authors estimated 60 percent of the 80 admissions would not have occurred with no gaps. The claim that "I feel better" and "it's working" are the same sentence for the holding ones is my interpretation.

Chapter 4. NHS high blood pressure page, no symptoms usually. Vrijens, Vincze, Kristanto, Urquhart and Burnier, "Adherence to prescribed antihypertensive drug treatments: longitudinal study of electronically compiled dosing histories", BMJ 336, 2008, pages 1114 to 1117. 4,783 patients from 21 phase IV studies, 30 to 330 days long. About half stopped within a year, about 10 percent of scheduled doses omitted on any day, 43 percent of omissions part of runs of three or more days, almost half of patients with at least

one such run a year. Chowdhury, Khan, Heydon, Shroufi, Fahimi, Moore and colleagues, "Adherence to cardiovascular therapy: a meta-analysis of prevalence and clinical consequences", European Heart Journal 34, 2013, pages 2940 to 2948. 44 prospective studies, 1,978,919 participants, 60 percent with adherence of at least 80 percent. Relative risks of cardiovascular disease 0.85 for statins and 0.81 for blood pressure medicines with good against poor adherence, all-cause mortality 0.55 and 0.71, and about nine percent of cardiovascular events in Europe attributed to poor adherence. These are observational associations, see chapter 13.

Chapter 5. Blaschke, Osterberg, Vrijens and Urquhart, "Adherence to medications: insights arising from studies on the unreliable link between prescribed and actual drug dosing histories", Annual Review of Pharmacology and Toxicology 52, 2012, pages 275 to 301. The abstract says intermittent lapses are potential sources of toxicity through rebound effects or recurrent first-dose effects. Which medicines this applies to is not in the abstract and I don't claim it for any particular one. The claim that the missed week measured nothing is my reasoning from the absence of symptoms in the silent conditions and the NHS statements about them.

Chapter 6. Horne and Weinman 1999 as above for the dependence concern. The earlier book on nicotine referred to is The cigarette does nothing. NHS antidepressants page on gradual reduction. The glasses comparison is mine.

Chapter 7. NHS statins page, which lists alternatives for people who cannot take statins, and NHS high blood pressure page, which describes lifestyle changes and says when medicine is usually prescribed. The rest is my argument.

Chapter 8. NHS statins page, reviewed 5 May 2026, on talking to a doctor who may prescribe another statin or change the dose, and on the Yellow Card scheme. NHS antidepressants page on side effects easing after a couple of weeks and on review every one to two weeks at the start. NHS levothyroxine page on side effects mostly from too high a dose.

Chapter 9. Nieuwlaat, Wilczynski, Navarro, Hobson, Jeffery, Keenanasseril and colleagues, "Interventions for enhancing medication adherence", Cochrane Database of Systematic Reviews 2014, CD000011. 182 randomised trials. The abstract opens with the statement that people typically take only about half their prescribed doses and concludes that current methods are mostly complex and not very effective. Conn and Ruppert, "Medication adherence outcomes of 771 intervention trials: systematic review and meta-analysis", Preventive Medicine 99, 2017, pages 269 to 276. Standardised mean difference 0.29, larger effects for habit-based and behavioural than cognitive interventions, and for face-to-face delivery by pharmacists. Publication bias was present. The claim that the failure is a design problem is my interpretation of these.

Chapter 10. NHS antidepressants page, section on stopping or coming off, reviewed 12 June 2025. Henssler, Schmidt, Schmidt, Schwarzer, Bschor and Baethge, "Incidence of antidepressant discontinuation symptoms: a systematic review and meta-analysis", Lancet Psychiatry 11, 2024, pages 526 to 535. 79 studies, 21,002 patients, incidence 0.31 after antidepressant and 0.17 after placebo, severe 0.028 against 0.006. PubMed lists an erratum for this paper which I have not read. Davies and Read, "A systematic review into the incidence, severity and duration of antidepressant

withdrawal effects: are guidelines evidence-based?", *Addictive Behaviors* 97, 2019, pages 111 to 121. 24 studies, weighted incidence 56 percent, with seven of ten studies on duration finding a significant proportion beyond two weeks. The two reviews use different methods and I've reported both. Horowitz and Taylor, "Tapering of SSRI treatment to mitigate withdrawal symptoms", *Lancet Psychiatry* 6, 2019, pages 538 to 546. A review and argument, not a trial.

Chapter 11. NHS asthma page on the types of inhaler, on not being given a reliever alone, on needing your inhaler more often as a reason to see a GP, and on yearly check-ups. Williams and colleagues 2004 as above.

Chapter 12. NHS antibiotics page, take as directed on the packet or leaflet or as instructed by a GP or pharmacist. Llewelyn, Fitzpatrick, Darwin, Tonkin-Crine, Gorton, Paul, Peto, Yardley, Hopkins and Walker, "The antibiotic course has had its day", *BMJ* 358, 2017, j3418. I could not read this article from a free source and have characterised its argument only in general terms from the title and from the later papers that cite it. Spellberg and Rice, "Duration of antibiotic therapy: shorter is better", *Annals of Internal Medicine* 171, 2019, pages 210 to 211, read in full from the author manuscript in PubMed Central. More than 45 randomised trials and two meta-analyses with no difference in efficacy between shorter and traditional courses. Pouwels, Hopkins, Llewelyn, Walker, McNulty and Robotham, "Duration of antibiotic treatment for common infections in English primary care: cross sectional analysis and comparison with guidelines", *BMJ* 364, 2019, 1440. 931,015 consultations, 2013 to 2015, about 1.3 million days beyond

guideline durations. Kardas, Devine, Golembesky and Roberts, "A systematic review and meta-analysis of misuse of antibiotic therapies in the community", International Journal of Antimicrobial Agents 26, 2005, pages 106 to 113. 46 articles, mean compliance 62.2 percent, mean use of leftovers 28.6 percent. NHS pharmacies page on disposing of unwanted medicines. The statement that the answer for a given infection may be yes is my inference from the trials and is not advice to stop.

Chapter 13. Chowdhury and colleagues 2013 as above. DiMatteo, Giordani, Lepper and Croghan, "Patient adherence and medical treatment outcomes: a meta-analysis", Medical Care 40, 2002, pages 794 to 811. 63 studies, 26 percent outcome difference between high and low adherence. Simpson, Eurich, Majumdar, Padwal, Tsuyuki, Varney and colleagues, "A meta-analysis of the association between adherence to drug therapy and mortality", BMJ 333, 2006, page 15. 21 studies, 46,847 participants, good adherence to placebo associated with an odds ratio for mortality of 0.56. The reconciliation of the two is my reasoning.

Chapter 14. NHS antibiotics page and NHS levothyroxine page on missed doses and on not doubling up, and on an extra dose being unlikely to cause serious harm for those medicines. Other medicines may differ and the leaflet governs.

Chapter 15. Horne and colleagues 2013 as above. NHS pharmacies page, "Help with new medicines", up to three appointments with a pharmacist. The fifth question is mine.

Chapter 16. NHS high blood pressure page on home monitoring and free pharmacy checks for people aged 40 or over. NHS levothyroxine page on regular blood tests to set the dose. The claim that a number converts people is my observation and not a finding.

Chapter 17. NHS levothyroxine page on dose set by blood tests. Stirratt, Dunbar-Jacob, Crane, Simoni, Czajkowski, Hilliard and colleagues, "Self-report measures of medication adherence behavior: recommendations on optimal use", *Translational Behavioral Medicine* 5, 2015, pages 470 to 482. Self-reports tend to overestimate adherence and have high specificity but low sensitivity. The account of what a quiet reduction does to a prescriber's decisions is my reasoning.

Chapter 18. DiMatteo 2002, Chowdhury 2013, Williams 2004, Blaschke 2012 as above. No figure is given for wasted medicine because the figures I found were estimates I couldn't verify. The earlier book on avoided appointments is Get it looked at.

Chapter 19. Nieuwlaat 2014 as above for the half of doses. The rest is my reasoning.

Chapter 20. NHS pharmacies page on advice from a pharmacist about how to use your medicine and worries about side effects. The scripts are mine.

Chapter 21. NHS levothyroxine page on the same time each day and an empty stomach. Lally, van Jaarsveld, Potts and Wardle, "How are habits formed: modelling habit formation in the real world", *European Journal of Social Psychology* 40, 2010, pages 998 to 1009, as verified for earlier books in this series. 96 volunteers, 82

with usable data, time to plateau 18 to 254 days, a single missed day did not materially affect formation. Conn and Ruppar 2017 as above.

Chapter 22. Gollwitzer and Sheeran, "Implementation intentions and goal achievement: a meta-analysis of effects and processes", *Advances in Experimental Social Psychology* 38, 2006, pages 69 to 119, as in earlier books. The rule hasn't been tested as a package.

Chapter 23. NHS pharmacies page on help with new medicines and on prescription medicine for some conditions. NHS levothyroxine page on children's missed doses and the Medicines for Children website. The earlier book on small tasks is *It can be done today*. I have not given the current prescription charge or the details of prepayment certificates and exemptions because I couldn't verify them for this edition, and the pharmacist can. NHS guidance on seeing a GP for persistent low mood, as in earlier books.

Chapter 24. The advice to ring a pharmacist before restarting after a gap is my generalisation from the NHS pages' repeated instruction to ask a pharmacist when unsure, and from Blaschke 2012 on restart effects. It is not a claim about any particular medicine.

Looked up and not used. Osterberg and Blaschke, "Adherence to medication", *New England Journal of Medicine* 353, 2005, pages 487 to 497, a well-known review, no abstract available, not cited. Haynes and colleagues, the 2008 edition of the Cochrane review, superseded by the 2014 update. Burnier and Egan, "Adherence in hypertension", *Circulation Research* 124, 2019, a review whose

abstract adds nothing beyond Vrijens 2008. Groot and van Os 2020 on tapering strips, a questionnaire study with a self-selected sample, not cited. Spellberg 2016 in JAMA Internal Medicine, no abstract, replaced by the 2019 paper. The NHS pages for the New Medicine Service by that name and for stopping antidepressants at their old addresses returned page not found and were replaced by the pharmacies page and the antidepressants page respectively.