

The Drug as a Program Rather Than a Dose

ABSURD HEALTH INSTITUTE | 15 OCTOBER 2026 | III. Beyond targets and state-based pharmacology

Abstract

This concept paper examines the drug as a program rather than a dose. It develops an argument drawn from Beyond Targets, identifies the relevant biological or clinical mechanisms, and considers where that argument may fail. This is a narrative perspective, not a systematic review or an original clinical study.

The central problem

A medication order is commonly described by the substance, route, dose and frequency. Yet some treatments are inherently programs: initiation, monitoring, titration, support, co-treatment, adverse-event surveillance and exit criteria all influence outcomes. The proposed “drug as a program” framework makes that architecture explicit without pretending every medication needs a complex system. The unit of therapeutic design is the patient's trajectory under a specified intervention process.

Mechanisms and causal architecture

Treatment programs use feedback. Initial measurements establish risk; the intervention changes physiology; subsequent observations indicate whether to continue, adjust or discontinue. Some systems require ordered steps because one intervention changes tolerance to another. Refeeding after starvation, control of infection before immunosuppression and adjustment of medication in renal impairment are familiar examples where sequence matters. A state-based program could formalize when to strengthen, pause or de-escalate an intervention, using patient-important endpoints rather than arbitrary subjective milestones.

A discriminating example

Insulin titration, antihypertensive adjustment and many rehabilitation plans already embody programmatic care: an initial action, observation, adjustment and reassessment. The proposal is to generalize this clarity to other complex interventions, but not to produce labyrinthine schedules that patients cannot maintain. The simplest reliable feedback rule may be more effective than an elaborate theoretical architecture.

Competing explanations and limitations

Complexity creates hazards. Multi-step plans may reduce accessibility, introduce interactions, and overwhelm households with limited time or money. A program can also become an excuse to prolong ineffective care. Claims of “metabolic reprogramming” require clear physiological measurements; a memorable phrase does not establish a phase transition.

What evidence would change the interpretation?

A program is superior only if it improves outcomes over a simpler regimen at acceptable cost and burden. Its rules should be specified in advance: starting conditions, monitoring intervals, modification triggers, adverse-event thresholds and stopping criteria. Otherwise retrospective explanations can always be invented for success or failure.

Implications for medical interpretation

For the Institute, the concept is useful as a way to describe responsible longitudinal care. It complements evidence-based pharmacology and should never override established prescribing or emergency protocols.

Selected scientific reading

Barabási, Gulbahce & Loscalzo (2011), Network medicine: a network-based approach to human disease, Nature Reviews Genetics.

<https://doi.org/10.1038/nrg2918>

Drucker (2018), Mechanisms of action and therapeutic application of GLP-1, Cell Metabolism.

<https://doi.org/10.1016/j.cmet.2018.03.001>

Original source: Beyond Targets. All source books supplied by the author.

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