Medications don’t always work like they should, transplanted organs are rejected, bacteria develop resistance to previously effective antibiotics, and physicians are hampered in their ability to judge the efficacy of treatments they have prescribed. What factors could account for these alarming trends in medicine? One significant factor is that patients and their families don’t always adhere to prescribed treatments. Haynes, Taylor, & Sackett, 1979. Why this is the case and what can be done about it is the subject of this book.

Before proceeding with this discussion of medical adherence in pediatrics, several caveats are in order:

1. **It is incumbent on medical providers that they are asking patients to adhere to regimens with demonstrated efficacy.** Providers need to remind themselves of the Hippocratic Oath: “I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous” (as cited in Cassell, 1991, p. 145).

2. **Providers need to abandon the “blame and shame” approach to dealing with medical adherence problems.** It is tempting to blame patients for adherence failures and shame them into changing their behavior. Providers need to share the blame (or better yet omit blame) and look at their own attitudes and behaviors which impact adherence. For example, failing to simplify regimens or minimize negative side effects can adversely impact patient adherence.

3. **Patients and their families are no longer (or maybe were never) satisfied with a passive role in their health care.** In fact, the term “compliance” lost favor in the literature because it implied for some an authoritarian approach to health care that required unquestioned obedience by patients to provider recommendations (Dimatteo & DiNicola, 1982). Comprehensive and effective health care requires a cooperative relationship between providers and patients and their families. It also acknowledges the following realities, particularly for treating persons with chronic illness:

   “Doctors do not treat chronic illnesses. The chronically ill treat themselves with the help of their physicians; the physician is part of the treatment. Patients are in charge of themselves. They determine their food, activity, medications,
visits to their doctors – most of the details of their own treatment” (Cassell, 1991, p. 124).

(4) Finally, children are not little adults. Pediatric adherence issues are arguably more complex than with adults because of the influences of family members and peers. There are also developmental processes and constraints that uniquely affect adherence for children and adolescents. Caution is in order when extrapolating from theoretical and empirical work with adults and applying this information to pediatric patients.

This volume is intended to give primary and allied health-care providers, researchers, and students an overview of the topic of medical adherence in pediatrics. Chapter 1 reviews definitions of adherence, types of adherence problems, and adherence rates to regimens for acute and chronic diseases. Chapter 2 is a review of the consequences of nonadherence and correlates of adherence. Chapter 3 reviews and critiques adherence theories, such as self-efficacy theory, and the clinical implications of these theories. Chapter 4 describes and critiques different measures of adherence such as assays, electronic monitoring, and self-report measures and also reviews measures of disease and health outcomes. Chapter 5 is a review of educational, organizational, and behavioral strategies for improving adherence. Chapter 6 concludes this book with a summary and critique of adherence intervention studies for acute and chronic pediatric diseases, meta-analyses of pediatric adherence intervention studies, and top ten ways pediatric medical adherence can be improved.

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