

the measures most responsive to deterioration in MS were self-reported scores in self-care, mobility and domestic life; distance walked and change in heart rate during a 6-minute walk test; 10-m walk test speeds, stride length and cadence; repetitive squatting; and box-and-block test scores. MS-specific measures have been developed in recent years. One is the Multiple Sclerosis Spasticity Scale (MSSS-88) that is used to measure spasticity from a patient's perspective (Hobart et al 2006). The Modified Fatigue Impact Scale (MFIS) is a modified form of the Fatigue Impact Scale (Fisk et al 1994) based on items derived from interviews with MS patients concerning how fatigue impacts their lives. This instrument provides an assessment of the effects of fatigue in terms of physical, cognitive and psychosocial functioning. The full-length MFIS consists of 21 items while the abbreviated version has five items. The abbreviated version can be used if time is limited but the full-length version has the advantage of generating subscales. Although these measures have been shown to be valid and clinically relevant, further research is needed to establish their reliability.

Coping with chronic illness and uncertainty can be very stressful. Schwartz and colleagues (1996) have developed and tested a *self-efficacy scale* specifically for MS. Self-efficacy is a term used to describe the degree of confidence an individual has in his/her ability to cope with a specific situation or condition. The test was found to have high internal consistency and test-retest reliability. This scale should be valuable in measuring the outcome of intervention in terms of enhancing the patient's wellbeing and

confidence. High self-efficacy in individuals with MS has previously been found to be associated with better adjustment and less psychological dysfunction (e.g., Schnek et al 1995).

The use of *integrated care pathways* (ICPs) appears to be useful in identifying key factors influencing outcome of intervention. An ICP is a document that details the interventions expected to occur during a specific period of clinical intervention (Rossiter & Thompson 1995). Several audits have shown that the introduction of ICPs in an inpatient setting resulted in decreased length of stay, a framework for identifying not just how many goals were achieved but also for identifying why goals were not met, and improved record keeping (Rossiter & Thompson 1996).

In summary, as Compston (1990) has pointed out, a clearer understanding of the epidemiological and biological factors that determine the geographical and anatomical dissemination of MS may provide a solution to this disease. The most exciting development in neurological rehabilitation for persons with MS is the impact of strengthening and aerobic training, with adequate temperature control, on strength and fitness, together with factors related to quality of life. Therapists are encouraged to become familiar with the literature on strengthening and aerobic training in order to prescribe effective exercise programmes. Other critical interventions include prevention of unnecessary limitations in activity and participation and advice on reducing unnecessary fatigue in everyday, social and vocational activities.

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