So! Who’s been doing their exercises?
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Many of us attend courses involving the development of exercise approaches to the management of neuro-musculoskeletal dysfunction, but suspect that our patients, often, do not comply with the advice. The efficacy of any exercise, regardless of the research rigour it may have been subjected to, can only be evaluated if the patients comply with the programme. Our concerns about exercise compliance is reflected in some of the literature where drop-out rates for physiotherapy programmes in general range from 30 to 64 per cent (Dishman 1986, Sluijs 1991). Whilst specific information relating to exercise compliance in neuro-musculoskeletal physiotherapy, particularly as home exercises, is sparse the available literature may provide guidelines for the enhancement of compliance. The literature addresses compliance in three categories: patient behaviour and beliefs, therapist/patient interaction and compliance enhancing strategies.

Personal factors related to gender and education were not significantly relevant, although Sluijs et al. (1993) did find that patients were more compliant as they aged. Three main factors were highlighted; (i) An important area expressed was the belief related attitudes, not only from the patients, but also from significant others. Patients already involved with sport complied better (Schneider et al. 1998; Rejeski et al. 1997), as did those whose family and friends supported the use of exercise for the rehabilitation (Carron et al. 1996; Ice et al. 1998). However, those who were sedentary, did not identify with exercise as a means to recovery, and presented with an external-locus of control were more likely to non-comply (Schneiders et al. 1998; Sluijs et al.1993; Slanker et al.1985). Fear-avoidance behaviour would possibly contribute to reduced compliance, although this has not been specifically addressed in the literature. This is widely regarded as a major barrier to the restoration of function and may be a factor in exercise where patients identify physical stresses as a harmful agent to their problem (ii) The patient-therapist relationship has been highlighted as a significant factor (Sluijs 1993). Positive feed-back from the therapist was significantly related to compliance, especially where the therapist demonstrated satisfaction and appreciated the patient's efforts. Therapists whose patients were more compliant incorporated the patient's ideas and demands, and they monitored and motivated the patient more frequently. Consequently, therapists who do not acknowledge a patient's efforts and undermine the problems by not listening to the patient, are less likely to promote compliance (iii) Whilst qualitative measures are not available to predict compliance failures and screen patients there are direct approaches and possible strategies to enhance patient compliance. Listening to the patient regarding attitudes to exercise, perceived barriers at home and alleviating fears relating to the painful dysfunction, may help therapists to encourage patients in their exercises (Sluijs 1998). Education relating to the benefits and function of the exercises will foster deeper levels of understanding. Often, the exercises designed to control segmental shear and gives reduce or resolve painful symptoms and may serve to motivate the patient with symptoms and may serve to motivate the patient with further exercise progressions. Minimising the numbers of exercises given (Henry et al. 1998), along with negotiating reasonable goals so that success can be positively reinforced. Strategies have also been considered to enhance compliance. Memory triggers such as the red dot prompts and incorporating the exercises within specific times of the day can help to in-still patterns of activity that will aid compliance. Patients may comply more if they know that regular progress checks are planned. Two studies addressing pelvic floor and back pain related therapeutic exercise using written and audio information have also been demonstrated to enhance compliance (Gallo and Staskin 1997; Schneiders et al. 1998). The use of bio-feedback devises such as real-time ultrasound and pressure bio-feedback units serve to motivate a patients involvement and enhance compliance.

Conclusion Beliefs and attitudes to exercise seem to influence rates of compliance most significantly. Demographic factors are not clear. The approach and strategies of the therapist strongly affect the potential for improved compliance. No screening tool is available to predict the factors that may determine the reasons why a patient would drop-out from a programme of exercise. More research is required to determine the issues relevant to home exercise programmes for patients dealing with neuro-musculoskeletal dysfunction.
References