Get active about physical activity

Ask, advise, assist: get your patients moving

Andrew Pipe, MD, DIP SPORT MED

The growing evidence of declining levels of physical activity and an increasing incidence of obesity in Canada is as depressing as it is daunting. The relationship between physical inactivity and development of an array of chronic illnesses is now well understood; a sedentary lifestyle is associated with a twofold increase in the risk of all-cause and cardiovascular mortality.[1,2]

A social revolution has transformed our society from one in which regular, daily physical activity was the norm to a community where a sedentary lifestyle is commonplace. In the past few years, the incidence of obesity among teenagers has doubled; the incidence of being overweight increased by 92% in boys and by 57% in girls between 1981 and 1996.[3] For more than a decade, Canadian children have expended 400% less energy than their counterparts did 40 years ago, and 60% of them do not meet fitness standards for their age group.[4] Almost two thirds of Canadians are physically inactive[5] and unable to enjoy the health benefits that accrue to those who are active in their daily lives.

An increasingly immobile community must be prepared to confront a rising incidence of disease and the associated pressures that will be placed on an already overburdened health system. Researchers calculate that 2.5% of total direct health costs in Canada ($2.1 billion) and 21 000 premature deaths were attributable to physical inactivity in 1999.[6] Conversely, and predictably, evidence shows that regular physical activity results in reduced risk of many common chronic diseases.[7] Health Canada now recommends an accumulation of at least 30 minutes of moderate physical activity on most days of the week.[8]

Changes in physical behaviour are complex

A complex interplay of social, economic, and environmental factors are responsible for the changes in physical behaviour that have swept the population over the last half-century. Automation and the mechanization of agriculture, suburban sprawl, the dominance of the automobile and an associated decline in walking, devaluation of physical education programs in our schools, and the amount of time our children sit in front of computer and television screens have all contributed to a culture of inactivity. Family physicians alone cannot make substantial changes in physical activity levels. But because epidemiologic realities are so compelling, family physicians must address this important public health issue. They can become advocates for public policies that facilitate physical activity, support development of recreational facilities and programs for all in the community (not just male adolescents), champion the development of high-quality physical education programs in local schools,[9] and advise patients of the importance of physical activity.

Haennel and Lemire (page 65) show evidence that supports promoting physical activity during our interactions with patients. But family physicians have been observed to advise only a few of their patients about physical activity, and patients at the highest risk for weight gain and poorer health outcomes—sedentary people and those from low socioeconomic backgrounds—are even less likely to receive counseling.[10] This is troubling when we consider that the mortality associated with low levels of physical fitness is "similar to, and in some cases higher than, the risk attributable to diabetes mellitus, high cholesterol levels, hypertension, or cigarette smoking."[11]

Traditionally, family physicians have had a strong commitment to interventions designed to prevent or ameliorate chronic disease. They have been especially vigilant in identifying and treating hypertension and hyperlipidemia and in identifying and counseling smokers. Perhaps physicians are skeptical about the effectiveness of providing advice or guidance regarding physical activity. As with many preventive initiatives, physicians might feel inhibited by a lack of expertise and time, frustrated by issues of remuneration, or impeded by

a perception that counseling initiatives are likely to be ineffective. It is true that some sophisticated primary care interventions designed to influence physical activity have yielded disappointing results. Recent investigations have compared interventions with "usual care." Usual care almost always consists of specific advice from a physician and provision of written materials.[12] There is reason to doubt that this is usual care (given the evidence cited above that reveals a low rate of counseling about physical activity). Thus it is not surprising that no appreciable benefit is evident when an intervention is compared with a standard of usual care, which itself reflects a significant departure from the norm and might on its own be a relatively powerful intervention.

In their review of the literature, Petrella and Lattanzio (page 72) conclude that family physicians can help improve physical activity levels among their patients. They point out that adding written materials to verbal advice, especially if provided in the form of a "prescription," might improve effectiveness. They also speculate that interventions designed to encourage patients to exercise might be more effective when coupled with simple evaluations to assess fitness capacity and guide exercise prescription. This is heartening news.

More active in addressing inactivity

Over the past 3 years, the College of Family Physicians of Canada has been urging its members to become more "active" in addressing physical inactivity by encouraging use of Canada's Physical Activity Guide and a "green prescription"[13]; and by adopting a Canadian version of PACE (Provider-based Assessment and Counseling for Exercise) developed in consultation with the Canadian Fitness and Lifestyle Research Institute. These endeavours and approaches are entirely in keeping with the conclusions reached by Petrella and Lattanzio.

Asking every patient about physical activity, recommending simple approaches to exercise for sedentary people, and providing specific guidance when asked is an approach that can be implemented easily and efficiently in most practices. This approach is similar to ones used to identify and influence smokers ("Ask, Advise, Assist"). Physicians should anticipate that such a strategy will, when consistently applied, sensitize patients to the need for exercise, affect their decisions, and subtly lead to increases in their personal physical activity levels. Coupled with changes in the social environment (that physicians can support and accelerate) we have a unique opportunity to address the issue of physical inactivity in Canada more effectively.

In the course of the Napoleonic wars, during the Battle of Marengo, French Marshall Desaix is reported to have told Napoleon: "This battle is completely lost, but it is only two o'clock. There is time to win another." We have lost an initial battle in the struggle against obesity and sedentary lifestyles; but there is time to wage and win another.

Dr Pipe *is an Associate Professor in the Department of Family Medicine and Division of Cardiac Surgery at the University of Ottawa in Ontario, and is Chair of the Physical Activity and Health Strategy Coordinating Committee of the College of Family Physicians of Canada.*

Correspondence to: *Dr A. Pipe, University of Ottawa Heart Institute, 40 Ruskin St, Ottawa, ON K1Y 4W7*

References

1. Blair SN, Kohl HW III, Paffenbarger RS Jr, Clark DG, Cooper KH, Gibbons LW. Physical fitness and all-cause mortality. A prospective study of healthy men and women. *JAMA* 1989;262:2395-401.
2. Kujala UM, Kaprio J, Sarna S, Koskenvuo M. Relationship of leisure-time physical activity and mortality: the Finnish twin cohort. *JAMA* 1998;279:440-4.
3. Tremblay MS, Willms JD. Secular trends in the body mass of Canadian children. *Can Med Assoc J* 2000;163:1429-33.
4. Fishburne G. The well being of children and youth. *Alta Counc Fitness Wellbeing Newslett* 1991;May:10.
5. Craig CL, Russell SJ, Cameron C, Beaulieu A. *Foundation for joint action: reducing physical inactivity.* Ottawa, Ont: Canadian Fitness and Lifestyle Research Institute; 1999.
6. Katzmarzyk PT, Gledhill N, Shephard RJ. The economic burden of physical inactivity in Canada. *Can Med Assoc J* 2000;163:1435-40.
7. Bouchard C, Shephard RJ, Stephens T. Physical activity, fitness and health. The consensus statement. In: Bouchard C, Shephard RJ, Stephens T. *Physical activity, fitness and health.* Champaign, Ill: Human Kinetics; 1994. p. 9-76.
8. Health Canada. *Handbook for Canada's physical activity guide to healthy active living.* Ottawa, Ont: Health Canada/Canadian Society of Exercise Physiology; 1999.
9. Pipe A. Getting active about physical education. *Can Fam Physician* 2001;47:235-7 (Eng), 243-5 (Fr).
10. Wee CC, McCarthy EP, Davis RB, Phillips RS. Physician counseling about exercise. *JAMA* 1999;282:1583-8.
11. Blair SN, Kampert JB, Kohl HW III, Barlow CE, Macera CA, Paffenbarger RS Jr, et al. Influences of cardiorespiratory fitness and other precursors on cardiovascular disease and all-cause mortality in men and women. *JAMA* 1996;276:205-10.
12. The Writing Group for the Activity Counseling Trial Research Group. Effects of physical activity counseling in primary care: the Activity Counseling Trial: a randomized controlled trial. *JAMA* 2001;286:677-87.
13. Swinburn BA, Walter LG, Arroll B, Tilyard MW, Russell DG. The green prescription study: a randomized controlled trial of written exercise advice provided by general practitioners. *Am J Public Health* 1998;88:288-91.