

The epidemic has gone global: can Exercise is Medicine help quell the tide?

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The epidemic is physical inactivity and the resultant chronic diseases. Since inactivity is hard to measure, we tend to focus on its sibling, obesity. The physical inactivity epidemic seemed to start in the USA in the 1970s. And, if there's one thing the USA is not shy about, it's about sharing its supersized and sedentary culture (actually, there's not much the USA is shy about.). Now the USA, with two-thirds of its adults overweight or obese, is feeling the hollow pride of a country that set sail, got several islands in the South Pacific to jump on board, but then realised that the trip had ill-intended consequences. Like infectious epidemics, physical inactivity is spreading. Canada, New Zealand, Australia, much of South America and much of Europe have populations where over half of adults have a body mass index (BMI) above 25 (the cut-off for overweight). Globally, there are over 1 billion adults with a BMI above 25. To stress that obesity is a global problem, the WHO has coined the term, 'globesity'.

To try to tackle the epidemic, in 2007, the American College of Sports Medicine (ACSM) under the leadership of Dr Robert Sallis, MD trademarked the phrase, 'Exercise is Medicine' (EIM). The EIM initiative is a call to healthcare providers. The central tenets of the original charter of EIM were that physicians in the USA first assess physical activity during every patient visit (similar to vital signs of pulse and blood pressure), and second give physical activity a central role in the prevention and treatment of disease. If you think that this is an easy task, consider that the US

government was unable to institute the metric system! (Despite that, it thinks that it can rebuild entire countries.)

And now, just like the obesity epidemic, EIM has gone global. Linked with the recent annual meeting of ACSM in Baltimore, was the Inaugural World Congress on EIM. The turnout was impressive, nearly 6000 participants, including over 1200 from 60 countries outside the USA! From this we learnt that Sweden and Norway have for some years adopted this concept for a variety of medical conditions and have been using a physician's guide to prescription of exercise (an English language version is imminent).

How are we supposed to assess physical activity during the office visit? The EIM charter is linked with an action guide for healthcare providers (see below), but does not get too specific. The study from Boon *et al* in this month's BJSM (see page 741) found that two physical activity questionnaires correlated slightly with an objective measure (accelerometry), but the questionnaires tended to overestimate the amount of physical activity actually done. How are we supposed to counsel our patients? EIM offers some suggestions (eg, write a prescription, like it were a medicine!), but again, EIM keeps provider options open. If you think EIM is too vague, consider the alternative. Consider an initiative which tries to be global and yet has a 'one-size-fits all' brand and approach. This would fly in the face of the individualistic personalities of healthcare providers, cultural differences in physical activity patterns (see van Sluijs *et al* article in this month's issue, page 747), differences in national healthcare systems, and the 'self-correcting nature of science' (as elegantly discussed by Brian J Whipp, FACSM in his captivating keynote address at the World Congress on EIM).

So, what is the point of EIM if it doesn't specifically direct us in the 'how'? Some

believe that EIM's strength is as a lobbying tool to get new policies implemented (eg, government buy-in and then \$\$\$, and then the behavioural changes that go along with \$\$\$). Accessibility is a key to facilitate changes in individuals. Indeed we know that typically people change their activities and behaviours not when they are told to, but rather when the social context guides them to do so. Governments can enable change throughout society and for them this is so much easier if the sums add up. This speaks to the critical importance of economic analyses for physical activity and health – something that BJSM sees as critically important for our field to progress. A recent systematic review concluded that interventions aimed at increasing physical activity in adults can be a cost-effective means of resource allocation.¹

While cost-effectiveness is certainly a reality given what makes the world tick, it should not be a necessity for what makes sports medicine practitioners tick. Healthcare providers around the world are beholden to a higher calling than simply what governments deem acceptably reimbursable. Governments change. We hope that we don't change our clinical practice and beliefs because of politics. EIM is a call to us to lead a fundamental change in healthcare focused on prevention and treatment of disease through exercise. '[We] must be the change [we] wish to see in the world' (Mahatma Gandhi).

For more about the World Congress on EIM global initiative with links to a semislick video, the EIM charter and the EIM healthcare providers' action guide, visit <http://exerciseismedicine.org/global.htm>.

And listen to Robert Sallis' podcast on the BJSM home page – <http://bjsm.bmj.com>.

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