

Physical activity prescription: a critical opportunity to address a modifiable risk factor for the prevention and management of chronic disease: a position statement by the Canadian Academy of Sport and Exercise Medicine

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ABSTRACT

Non-communicable disease is a leading threat to global health. Physical inactivity is a large contributor to this problem; in fact, the WHO ranks it as the fourth leading risk factor for overall morbidity and mortality worldwide. In Canada, at least 4 of 5 adults do not meet the Canadian Physical Activity Guidelines of 150 min of moderate-to-vigorous physical activity per week. Physicians play an important role in the dissemination of physical activity (PA) recommendations to a broad segment of the population, as over 80% of Canadians visit their doctors every year and prefer to get health information directly from them. Unfortunately, most physicians do not regularly assess or prescribe PA as part of routine care, and even when discussed, few provide specific recommendations. PA prescription has the potential to be an important therapeutic agent for all ages in primary, secondary and tertiary prevention of chronic disease. Sport and exercise medicine (SEM) physicians are particularly well suited for this role and should collaborate with their primary care colleagues for optimal patient care. The purpose of this Canadian Academy and Sport and Exercise Medicine position statement is to provide an evidence-based, best practices summary to better equip SEM and primary care physicians to prescribe PA and exercise, specifically for the prevention and management of non-communicable disease. This will be achieved by addressing common questions and perceived barriers in the field.

INTRODUCTION

Non-communicable disease is a leading threat to global health. Physical inactivity is a large contributor to this problem; in fact, the WHO ranks it as the fourth leading risk factor for overall morbidity and mortality worldwide.¹ In Canada, at least four of five adults do not meet the Canadian Physical Activity Guidelines of 150 min of moderate-to-vigorous physical activity (MVPA) per week.^{2,3}

Prescription of physical activity (PA) is a key element of the multifaceted societal approach needed to address inactivity.^{4,5} Substantial evidence exists to support the benefits of exercise on at least 30 chronic diseases^{6–10} as well as the cost-effectiveness of exercise prescription in primary care,^{11,12} even for cardiovascular (CV) disease alone.¹³

Physicians play an important role in the dissemination of PA recommendations to a broad segment of the population. Over 80% of Canadians visit their doctors every year and prefer to get health information directly from their family physician.^{14,15} Unfortunately, most physicians do not regularly assess or prescribe PA as a part of routine care,^{16–18} and even when discussed, few provide specific recommendations.¹⁹

PA prescription has the potential to be an important therapeutic agent for all ages in primary, secondary and tertiary prevention of chronic disease. Sport and exercise medicine (SEM) physicians are particularly well suited for this role and should collaborate with their primary care colleagues for optimal patient care. We must act now to correct the general lack of knowledge and training in our medical schools and residency programmes surrounding PA guidelines and prescription^{20–23} as well. The purpose of this Canadian Academy and Sport and Exercise Medicine (CASEM) position statement is therefore to provide an evidence-based, best practices summary to better equip SEM and primary care physicians to prescribe PA and exercise, specifically for the prevention and management of non-communicable disease. This will be achieved by addressing common questions and perceived barriers in the field.

How effective is exercise prescription by primary care physicians?

Exercise prescription is effective at increasing PA levels^{24–26} and can generate positive clinical outcomes such as reduced blood pressure and glycosylated haemoglobin,^{27–29} as well as important positive effects on mental health,^{30–32} reducing risk of depression³³ and improving cognitive function in older adults with dementia and Alzheimer's

Definitions: *Physical activity* (PA), defined as 'any bodily movement produced by skeletal muscle', and *exercise*, which generally involves structured activity to improve a certain aspect of fitness,³⁴ confer benefits with respect to chronic disease. PA is further categorised as light, moderate and vigorous (table 1). *Sport* is one form of delivery of PA and exercise, but is not the focus of this statement.

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disease (AD).³⁵ From an effectiveness standpoint, the number needed to treat (NNT) for one person to achieve the recommended adult PA guidelines of 150 min of MVPA per week, though brief physician counselling is 12.³⁶ This is at least four-fold lower than the clinical effort to achieve a comparable health benefit of a smoker to quit smoking, which has an NNT of 50–120.²⁶

Challenges exist, such as time constraints, complex comorbidities, perceived the lack of patient engagement and a lack of physician training or education on particulars of PA counselling. Some promising examples exist, however, such as Courneya *et al*'s³⁷ study, eliciting high rates of adherence to exercise prescription in patients with cancer. Exercise prescription is cost-effective and can increase PA by 10% in relatively inactive patients,^{13 37 38 39} a number which recent Canadian evaluations have estimated could save ~2.1 billion dollars per year in healthcare and other costs if adopted at the population level.^{40 41}

Such counselling becomes even more effective in a range of situations in which: (1) there is an increased risk of chronic disease; (2) the encounter includes an individual assessment of needs, motivation, habits, preferences and barriers; (3) the message and goals are clear, simple and realistic; (4) valid behavioural change approaches are used and (5) proper follow-up, self-monitoring and social support are available.²⁶ Medical practitioners' own PA habits influence their practice of PA history-taking and exercise prescription as well.¹⁸

What are the key messages that should be given regarding the effective dose of exercise for the prevention and treatment of chronic disease?

In a landmark *British Medical Journal* paper examining the head-to-head effects of medication versus PA/exercise in chronic disease, Naci and Ioannidis⁴² from Stanford University made a strong case for equivalent or superior effect of the health benefits of PA. In particular, PA interventions were more effective than drug treatment among patients with stroke and were as effective as medications for the prevention of diabetes and secondary treatment of CV disease. PA can be as effective as medications for the treatment of depression⁴³ and has a potent effect on cognitive function in dementia in patients with AD and in patients with a diagnosis of AD or non-AD dementia.³⁵

Several high-level systematic reviews have also identified risk reductions of 25–50% or more in most major chronic diseases for individuals who achieve 150 min of MVPA per week.^{9 26 44 45} A systematic review of nine cohort studies with a mean follow-up of 9.8 years⁴⁶ and two recent prospective studies on large population cohorts (661 137 adults in the USA and Europe and 204 542 adults in Australia, followed for 14 and 8 years, respectively) demonstrated clear dose–response effects of PA to overall mortality;^{47 48} each 10 min of MVPA accumulated per day led to a roughly 10% relative risk reduction in mortality, up to a 32–44% relative risk reduction at 150 min MVPA per week, depending on the amount of vigorous activity as a part of the MVPA. The dose–response effect appears to plateau at a 50–60% reduction at 3–5 times the guidelines (ie, 750 min/week), and there is no evidence of increased mortality at high levels of PA in generally healthy individuals.

Although this target of 150 min may seem out of reach for many who are sedentary, studies have shown significant benefits for those who complete even small amounts of PA. The biggest positive change in health risk is in going from inactive to somewhat active (ie, 75–90 min/week), resulting in a 15% reduction

in mortality risk.^{26 49} Simply reducing sedentary behaviour confers short- and long-term health benefits,^{50 51} as prolonged sedentary time is an independent predictor of adverse health outcomes in adults.⁵²

Long-term efficacy

Adherence to PA (as with other lifestyle modifications) tends to decrease at 1 year, but can be sustained when activity is repeated,⁵³ or combined with community supports.⁵⁴ The Diabetes Prevention Program (DPP) observed the maintenance of adaptations and reduced diabetes incidence 10 years following intensive support for PA during the study,⁵⁵ as was the case with a similar DPP in China^{56 57} which elicited reduced CV and all-cause mortality and incidence of diabetes at 20 years. The most cost-effective and practical option is brief PA counselling through primary care, which is proven effective at improving PA levels at 12 months following the intervention.²⁶ Multiple sessions may extend this time period even further,⁵³ as does exercise performed under supervision.⁵⁸

How can brief exercise assessment and prescription be integrated in primary care?

There is evidence that a 2–4 min intervention in primary care effectively promotes PA.⁵⁹ Asking two simple questions regarding current PA (the exercise 'vital sign', 'EVS') at each visit can further inform effective counselling: (1) 'On average, how many days/week do you engage in moderate or greater physical activity (like a brisk walk)?' and (2) 'On those days, how many minutes do you engage in activity at this level?'⁶⁰ Regular EVS monitoring can change physician behaviour and improve patients' risk of disease.⁶¹ If the physician has more time than that of a typical family practice appointment, motivational interviewing is an effective method to raise the possibility of any behavioural intervention.^{10 62}

A written prescription (which comprises exercise and lifestyle goals) is a crucial element to signal that PA and exercise can be therapeutic.⁶³ For patients with stable conditions, general practitioners can provide customised exercise prescription. Incorporating discussions surrounding the use of advanced technology⁶⁴ is discussed later in this article. Healthy patients are encouraged to join community-based programmes and may exercise independently without supervision. PA guidelines should also be prominent in the waiting room.

Physicians who do not have training in exercise prescription may refer to skilled allied health professionals and to appropriate community-based resources. Follow-up is crucial, however, to signal the clinician's conviction, determine the patient's progress, solve problems, help identify social support, fine-tune the dose and reset goals.

What terminology and examples can be used to describe PA intensity to patients?

Effective counselling requires physicians to clearly explain to their patients what is meant by terms like MVPA and advise on ways to limit sedentary behaviour. Different PA intensities are described in [table 1](#).

Activities that correspond to any given level of intensity will change with the degree of an individual's CV fitness; for example, once a previously untrained patient has been regularly active at a moderate intensity through walking for several weeks, what counts as brisk at first may become a lighter intensity exercise ([boxes 1–3](#)).

Table 1 Descriptors of physical activity

Intensity	Objective measures	What patient feels*	Typical examples
Sedentary	<1.6 METs <40% HR _{max} <20% VO ₂ max	▶ At rest with limited added movement	▶ Sitting and reading ▶ Watching TV ▶ Driving a car
Light	1.6–3.0 METs 40–55% HR _{max} 20–40% VO ₂ max	▶ Active ▶ No noticeable change in breathing/ sweating ▶ Can be sustained for 1 hour or more	▶ Slow walking (eg, around the house) ▶ Light work while standing (eg, cooking, washing dishes) ▶ Playing an instrument
Moderate	3–6 METs 55–70% HR _{max} 40–60% VO ₂ max	▶ Increased breathing and sweating, but ▶ Still able to maintain a conversation ▶ Can sustain activity for 30–60 min	▶ Brisk walk ▶ Low movement racquet games (eg, doubles tennis, recreational badminton) ▶ Water aerobics ▶ Resistance exercise ▶ Mowing the lawn
Vigorous	6–9 METs 70–90% HR _{max} 60–85% VO ₂ max	▶ Feeling 'out of breath' ▶ Increased sweating ▶ Can be difficult to maintain a conversation ▶ Can sustain activity for up to 30 min	▶ Jogging ▶ Hiking ▶ Swimming with effort ▶ Higher movement racquet games (eg, singles tennis and squash) ▶ Field/ball games (eg, soccer and basketball) ▶ Cross-country skiing ▶ Shovelling
High	≥9 METs ≥90% HR _{max} ≥85% VO ₂ max	▶ Feels like giving 100% ▶ All-out bursts of between 1 and 2 min ▶ Intensity cannot be sustained for more than 10 min	▶ Training/competing in most competitive sports ▶ Racing or any all-out activity (eg, running, rowing, swimming, skiing and high-intensity intervals)

*These descriptions do not generally apply for symptomatic patients with chronic obstructive pulmonary disease. MET values for high-intensity activity may not be achievable for many patients with chronic disease, in which case HR_{max} or VO₂max values are advised. HR_{max}, theoretical maximal heart rate: usually estimated as (220–age)×0.9; MET, metabolic equivalent of task (1 MET=the energy to lie/sit quietly); VO₂max, maximal oxygen uptake (adapted from Norton *et al*).⁶⁵

Box 1 Key messages for patients during the discussion of the health benefits of physical activity

- ▶ Exercise is more effective than medication for the treatment of stroke and as effective for the secondary prevention of coronary heart disease and diabetes.
- ▶ A 150 min of moderate-to-vigorous physical activity (MVPA) accumulated per week can reduce the risk of most major chronic diseases by 25–50%.
- ▶ A 15 min of MVPA per day (or 75 min/week) is associated with a ~15% relative mortality risk reduction, and benefits increase with the dose.

Box 2 Practical steps for immediate exercise prescription

- ▶ Ask about physical activity (PA) at every consultation.
- ▶ A written prescription building towards accumulating 150 min/week is crucial—it takes just 30 s to do this.
- ▶ Encourage the patient to measure (eg, pedometer and smart phone) and record their PA (paper and mobile app).
- ▶ Refer on as appropriate—consider appropriate physicians, physiotherapists, clinical exercise physiologists, kinesiologists and certified fitness instructors.
- ▶ Follow-up with the patient to chart progress, set goals, solve problems, and identify and use social support.

What are the safety considerations prior to initiation of an exercise prescription?

For healthy patients, a gradual progression towards regular MVPA is safe and recommended. Participation in light to moderate exercise confers very little risk and can be 'self-administered', akin to an over-the-counter medication.⁶⁶ For those with stable asymptomatic CV, metabolic or renal disease, medical clearance is not needed for patients already active, but recommended for those who are inactive. Although these two categories represent the majority of patients in a typical primary care practice, physicians are often concerned with CV risk in patients with more serious conditions.

Self-screening instruments such as the Physical Activity Readiness Questionnaire (PAR-Q+)⁶⁷ or the American College of Sport Medicine (ACSM) health screening guidelines⁶⁸ direct people to a physician for further evaluation when current symptoms suggestive of CV, metabolic or renal disease or complex comorbidities are present. In these cases, the physician should evaluate the clinical condition of the patient through a history

and physical examination that will focus on contraindications to exercise. Patients with unstable angina, uncharacterised arrhythmias or decompensated heart failure should not perform vigorous exercise before their conditions stabilise. Physical examination should focus on significant clinical signs, such as a heart murmur, pulmonary overload or severe hypertension (resting blood pressure >200/110 mm Hg), which can indicate potential heightened risk.^{36 69}

The estimated prevalence of complications requiring hospitalisation (including serious arrhythmias), acute myocardial infarction or sudden cardiac death (SCD) during or immediately after a stress test are ≤0.2%, 0.04% and 0.01%, respectively.⁷⁰ Vigorous intensity exercise acutely, albeit transiently, increases CV events.⁷¹ In a prospective study of sport-related SCD in the general population, however, the incidence of SCD was estimated to 4.6 per million population per year or 0.00046%.⁷² Based on these numbers, it can be concluded that the gradual progression towards MVPA by a sedentary patient with stable chronic conditions and a normal history and physical is

associated with such a low rate of CV events that further formal CV testing is not indicated.

High-intensity interval training

Recently, high-intensity interval training (HIIT) has been promoted based on several systematic reviews,^{73–74} showing greater benefits on CV fitness compared to lower intensity continuous training. HIIT involves alternate bursts of short, intense PA interspersed with recovery periods and appears to be safe for rehabilitation of patients with coronary artery disease and heart failure,⁷⁵ although there are conflicting opinions in the literature as to its effectiveness and safety for population-level exercise.⁷⁶ For patients considered at higher CV risk, therefore, stress testing is advised.

Is it safe to prescribe exercise if my patient has osteoarthritis or other comorbidities?

Several recent systematic reviews demonstrate that aerobic and resistance exercise will not result in increased pain or disability in patients with osteoarthritis.^{78–81} In fact, both types of training generally reduce pain and increase function; further supporting the expert consensus recommendations that PA should be a part of management.^{82–84}

Regarding individualised adaptation of exercise prescription to specific chronic disease, the reader is referred to the free online textbook provided by the Swedish Institute of Public Health¹⁰ and two recent review articles.^{9–85} In general, as mentioned earlier, if the patient has one or two stable chronic diseases and is otherwise healthy, PA can be self-administered, with a gradual progression towards the adult PA guidelines.

Which tools can help patients adopt active behaviours?

While the ubiquity of mobile phones and wearable technology may present a simpler method for clinicians to assess and promote active behaviours in primary care, the evidence in this area is still underdeveloped.⁸⁶ Meta-analysis of pedometer use demonstrates average increases of over 2000 steps in participants' steps per day.⁸⁷ Step count targets for adults, using a guide of 100 steps/min as 'moderate intensity', are in the range of roughly 7100–11 000 steps per day, with <5000 steps a day leading to adverse health outcomes;⁸⁸ therefore, this can represent a significant improvement.

Data extraction may be time-consuming for patient and clinician, however, which may explain low levels of user adoption, despite the benefits of many PA monitors. Individuals using wearable technology to improve their health exhibit the most consistent usage when tracking is simple and automatic.⁸⁹ Other technologies that may improve adherence to PA are text messaging⁹⁰ and 'exergames'.^{91–92} Advances in the field of mobile apps for PA monitoring for health will inevitably continue and become more user-friendly for patients and doctors. Physicians are encouraged to be flexible and creative in their adoption of new devices to this end.

How can exercise professionals contribute to the implementation of an active lifestyle?

The role of exercise professionals through physician referral of patients must be carefully considered, so that an additional burden of treatment such as added costs for the patient or ease of access limitations do not raise barriers to integration of daily PA. Avoiding these and other potential obstacles is of particular concern for lower socioeconomic groups; medical professionals must be aware that those most at risk of disease are often the least able to afford the cure. In most cases, physicians

Box 3 Key messages regarding cardiovascular safety

- ▶ For generally healthy individuals, moderate exercise is safe. If inactive, begin with lower intensity and progress in duration and intensity over time.
- ▶ Progression towards recommended volumes of moderate-to-vigorous physical activity (MVPA) can be prescribed to patients with chronic disease. If inactive initially, a normal clinical evaluation is recommended. If already active, medical clearance is recommended before engaging in vigorous activities.
- ▶ Initiation of high-intensity physical activity, such as high-intensity interval training, should be preceded by establishing a 'base fitness level' over several weeks through regular MVPA.⁷⁷

should feel enabled to prescribe PA without referral, assuming appropriate safety considerations are made and gradual introduction of PA for the sedentary patient is advised. Nevertheless, physicians are encouraged to identify potential partners within their communities (eg, local recreation centres, sports programmes and walking/running groups) to build effective networks for patient referral and/or direction when desired.

Exercise professionals and other PA facilitators can be important members of an integrated approach to design and delivery of interventions, although experts point to the lack of evidence and sustainability for exercise referral schemes.^{93–96} Referral to a qualified exercise professional is most indicated for patients with conditions classified as high risk of morbidity and mortality associated with the lack of PA (CV disease and type 2 diabetes), as well as special populations that would benefit from PA but have difficulty engaging due to low motivation or safety concerns (patients with cancer, epilepsy or pulmonary disease). In many patients with chronic disease such as diabetes, exercise programmes are most effective when supervised.⁹⁷ Therefore, the role of the exercise professional is to ensure safety and adaptation to ability level of the patient and to ensure accountability for maximal treatment efficacy.

It is important to remember that patient empowerment is essential and the physician must communicate his or her belief that the patient is capable of change. Considerations should be made for the education and awareness-building for the patient, family and support network as a part of the total programme.

CONCLUSION

Primary care providers, and particularly SEM physicians, have an important opportunity to make PA an integral component of the prevention and treatment of chronic disease. It is the position of the CASEM that all SEM and primary care physicians should include PA assessment and prescription as part of routine healthcare for patients, and this should be a priority for training and education at every level of medicine.

Recommendations from physicians influence patient engagement and improve the likelihood of adoption. CASEM further recommends that clinicians lead by example and integrate PA into their own lives, for their own health and well-being, and to provide further credibility and empathy for the challenges patients face.

Physical inactivity is and will remain one of the gravest threats to public health for this and future generations of Canadians unless a catalyst for change can be found. With a simple prescription for PA, front-line physicians have one more tool to bring about real change in the lives of Canadians. With the evidence summarised in this review, the message is clear that PA prescription works and costs less than relying on the alternatives alone. The time to act is now.

Author note This position statement has been endorsed by the following nine sport medicine societies: Australasian College of Sports and Exercise Physicians (ACSEP), American Medical Society for Sports Medicine (AMSSM), British Association of Sports and Exercise Medicine (BASEM), European College of Sport & Exercise Physicians (ECOSEP), Norsk forening for idrettsmedisin og fysisk aktivitet (NIMF), South African Sports Medicine Association (SASMA), Schweizerische Gesellschaft für Sportmedizin/Swiss Society of Sports Medicine (SGSM/SSSM), Sport Doctors Australia (SDrA), Swedish Society of Exercise and Sports Medicine (SFAIM), and CASEM.

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