Clinician's Commentary on Graham and Connelly[1]

As I spend more time digesting the information provided by Graham and Connelly,[1] it becomes evident that we, as clinicians, need to delve more deeply to effectively analyze and prescribe healthy activities for our clients of any age. While Statistics Canada reports that only 38% to 47% of Canadian older adults are sufficiently active to meet guidelines for health benefits, these figures are taken from data collected as "physical activity during leisure time."[2] In the rural older adult population described by Graham and Connelly's research, however, the percentage who are sufficiently active to meet the guidelines for health benefits may be underestimated, as the concept of leisure may be quite different from that generally accepted by younger generations.

The word "leisure" is defined as "unhurried ease," "freedom from the demands of work or duty," and "time free from the demands of work or duty, when one can rest, enjoy hobbies or sports."[3] In a rural community, even today, activity often starts before dawn and involves much physical work, so leisure would not traditionally involve additional physical activity at the end of the working day. Over the past few generations there has been a change in the concept of leisure, from leisure as rest to leisure as non-work activities, whether restful or physical (such as going to the gym). This transition may be less applicable in the rural population than in the urban population.

Particularly in rural communities, as Graham and Connelly describe, physical activity is everyday activity.[1] As technology has developed, less physical activity is required; for example, we have evolved from walking and horseback riding for the purposes of transportation and communication, to travelling by train, bus, car, truck, and airplane and communicating by telephone, computer, cellphone, and Skype. Most of this transition from physical to non-physical activity has developed over older adults' lifetimes. To a large degree, technology has removed necessity as a motivator for physical activity; instead, movement itself has become the purpose of physical activity.

It is difficult to change a concept ingrained when one is young. As Graham and Connelly describe, for the older rural Canadians in their study, the theme "*exercise is movement*" and "the sub-themes *enjoyable activity* and *past activity experience and present participation*" support this.[1] For a generation whose "past experience" involved purposeful activity or work from dawn until dusk, reported leisure activities may well be sedentary; their physical activity likely occurs during purposeful activities, such as walking to the mailbox, which would not be considered as leisure. This idea is supported by Graham and Connelly's report.[1] The older adult may see working out at a gym as purposeless repetitive activity; if that is the case, exercise for the sake of exercise is less likely to engage older adults, especially those from a rural community, than it is to engage a younger person who has grown up with the concept of physical activity for its own sake. This brings us to adherence and how to facilitate adherence to health-building exercise prescriptions for older adults. The importance of exercise and physical activity has been described for managing most chronic diseases, including chronic obstructive pulmonary disease,[4] and one of the difficulties for clients is maintaining their programmes once supervision is removed.[5] Achieving improved adherence to exercise regimens will improve the overall health of our communities. Motivational interviewing may help us to better understand our clients and thus prescribe activities that will be more meaningful to them.[6] Do our clients see retirement as the opportunity to do things they never had time for when working for their livelihood, or do they see it as finally having time to rest after working so hard all their lives? Understanding what motivates someone, along with their readiness to change (using Prochaska's stages of readiness for change),[7] will help us to know whether our intervention should address their readiness to incorporate exercise into their day-to-day lives through counselling and support, or whether we should focus on the exercise prescription.

In view of our ageing population and the increasing prevalence of chronic diseases such as diabetes, obesity, arthritis, and cardiovascular and cardiopulmonary conditions, maintaining physical activity is essential to optimizing the health of older adults.[8] As Graham and Connelly note, independence, a sense of community, and being with others are key concepts for getting our older adult clients' buy-in to the process of improving and maintaining their physical health and fitness.[1]

By incorporating interpretation of the Canadian Physical Activity Guidelines for Older Adults[9] along with the knowledge that purposeful activity—such as volunteer work, cleaning and gardening, and doing activities with others—may improve motivation and adherence, physiotherapists working with older Canadians may be able to achieve improved adherence to exercise programmes by including these features in the activity programmes we prescribe.

Graham and Connelly offer interesting food for thought, and their useful conclusions should be incorporated into physiotherapy practice. Improved interviewing can tease out and define the activities that are most relevant to physiotherapists' clients, which will help us counsel our clients on how to modify their activities to make them beneficial to their health.

Sylvia Jocelyn Carr, PT, MSc, BSc Phys Ther
West Park Healthcare Centre, Toronto

REFERENCES

1. Graham LJ, Connelly DM. "Any movement at all is exercise": a focused ethnography of rural community dwelling older adults' perceptions and experiences of exercise as self-care. Physiother Can. 2013;65(4):333–41. http://dx.doi.org/10.3138/ptc.2012-31
2. Statistics Canada. Physical activity during leisure time, 2010 [Internet]. Ottawa: Canadian Community Health Survey; c2010 [updated 2011 Jul 28; cited 2013 Jun 1]. Available from: http://www.statcan.gc.ca/pub/82-625-x/2011001/article/11467-eng.htm
3. Dictionary.com Unabridged [Internet] [cited 2013 Jun 16]. Available from: http://dictionary.reference.com/browse/leisure
4. Emtner MI, Arnardottir HR, Hallin R, et al. Walking distance is a predictor of exacerbations in patients with chronic obstructive pulmonary disease. Respir Med. 2007;101(5):1037–40. http://dx.doi.org/10.1016/j.rmed.2006.09.020. Medline:17085030

5. Brooks D, Krip B, Mangovski-Alzamora S, et al. The effect of postrehabilitation programmes among individuals with chronic obstructive pulmonary disease. Eur Respir J. 2002;20(1):20–9. http://dx.doi.org/10.1183/09031936.02.01852001
6. Miller WR, Rollnick S. Motivational interviewing: preparing people for change. New York: Guilford Press; 1991.
7. Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. J Consult Clin Psychol. 1983;51(3):390–5. http://dx.doi.org/10.1037/0022-006X.51.3.390. Medline:6863699
8. Public Health Agency of Canada. The economic burden of illness in Canada [Internet]. Ottawa: The Agency; c1998–2002 [cited 2013 Jun 6]. Available from: http://www.phac-aspc.gc.ca/ebic-femc/ebic-femc98/index-eng.php
9. Tremblay MS, Warburton DE, Janssen I, et al. New Canadian physical activity guidelines. Appl Physiol Nutr Metab. 2011;36(1):36–46, 47–58. http://dx.doi.org/10.1139/H11-009. Medline:21326376

DOI:10.3138/ptc.2012-31-CC