

# Seniors Prove Receptive on Exercise Counseling

*Physicians noted that 75% of their older patients cited lack of time as a perceived barrier to exercise.*

BY HEIDI SPLETE  
Senior Writer

WASHINGTON — When doctors talk about exercise, older adults listen, Shaun Nelson said at the annual meeting of the Gerontological Society of America.

A caring, empathetic physician who counsels patients aged 60 and older about exercise will probably make an impression, even if the doctor is not a paragon of fitness, said Mr. Nelson, an MPH candidate at the University of Illinois, Chicago, who conducted focus group interviews of 28 adults aged 60-74 years. As one woman noted during the interviews, "You like a doctor that seems to be worried about your welfare. ... I guess if they were [role models] it might be better. But to me, that really wouldn't be a factor."

Older adults are receptive to exercise counseling as a way to manage chronic pain and to avoid medication, Mr. Nelson said. One white male patient reported, "My cholesterol was up. And [the doctor] told me about it, and we set up a plan, again, to exercise more and to diet. Didn't even think of any type of drug—that wasn't even a consideration."

In general, women were more likely to view a doctor's persistence in exercise counseling as caring rather than nagging, were more likely to fit in exercise when

they could, and were more encouraged by qualitative benefits, such as better-fitting clothes. Men were more likely to view a doctor's persistent exercise counseling as nagging; were more likely to have a fixed schedule for exercise; and were encouraged by quantitative benefits, such as a lower blood pressure. Black patients were less likely to have a long visit with their doctors and were less likely to consider water exercise because of fear of water and not knowing how to swim; white patients were more likely to express concerns about repeated dressing and undressing, and having to find a place to park at a gym.

Mr. Nelson's work was part of a grant from the Robert Wood Johnson Foundation. The grant also supported studies of the physician perspective conducted by Daphne Schneider, M.D., of Cornell University, New York, and Karen Peters, Dr.P.H., of the University of Illinois, Rockford.

Dr. Schneider interviewed a convenience sample of 37 public and private sector physicians in urban and suburban areas about whether they discussed exercise with older patients. Sixty-two percent were family physicians; 35% specialized in geriatrics, and 33% were internists. Most of the doctors were white (70%), and 51% were women and the mean age was 46 years.

All the physicians reported that they counseled some older patients about exercise, and nearly a third of them said that they counseled all patients about exercise. However, the physicians' perceptions varied as to their roles as exercise advocates. Although most saw themselves as coaches/teachers, some saw themselves as authority figures whose words carried real weight with patients, and others said that the implementation of exercise recommendations would be better handled by a nurse-practitioner or trainer.

Physicians cited discussion of a patient's chronic condition, diagnosis of a chronic illness, or the possible need to start a new medication, as the best opportunities for exercise counseling. One physician told a diabetic woman that she might not need to use insulin if she could watch her diet and motivate herself to exercise.

"She came back 3 months later and her hemoglobin A<sub>1c</sub> was less than 7. She had been swimming every day, sometimes she rode a bicycle, and she was saying how she felt much better, and her sugars were better, and she was happy," the physician said.

Barriers to exercise counseling during an office visit included lack of training, lack of time, and lack of a reimbursement mechanism. One physician noted, the complicated medical histories of geriatric patients often push exercise counseling to the bottom of a list of issues to be addressed in an office visit. From a financial perspective, "taking more time and doing exercise counseling looks like an unaf-

fordable luxury," the physician recounted.

Physicians in rural areas have issues similar to their suburban counterparts regarding exercise counseling for seniors. Dr. Peters analyzed results of a mail-in survey returned by 11 family physicians and one nurse-practitioner aged 31-54 years from her ongoing study of exercise counseling in rural Illinois counties. All the physicians in the rural study said that exercise was relevant to their older patients, and 75% said they recommended exercise in the context of chronic disease management; 58% said they recommended exercise in the context of weight loss and in the context of a routine health and physical exam.

Half of the rural physicians viewed their roles as educational in terms of exercise counseling. In addition, 42% saw themselves in a support/advocate role. All the physicians said that they stress the frequency of exercise, and 83% said that they stress duration. The physicians noted that 75% of their older patients cited lack of time as a perceived barrier to exercise, and 42% cited joint pain as a barrier.

Rural patients also cited weather as a barrier—they didn't want to walk outside in winter due to icy walks and fear of falling, and any exercise facilities were far away and expensive.

Physicians should know that their senior patients take them seriously. Older adults are receptive to exercise counseling if it is presented in a caring and empathetic way, with attention to racial and gender preferences, according to the presenters. ■

## Physical Activity Is Tied to Continued Mobility in Elderly

BY KERRI WACHTER  
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WASHINGTON — Exercise, and to a lesser extent even daily activity, appears to be key to maintaining mobility in older adults, according to data presented at the annual meeting of the Gerontological Society of America.

"It's very clear that in these people—well-functioning people at baseline—phys-

ical inactivity increases the risk of functional mobility limitation about twofold versus those who exercise," said Marjolein Visser, M.D., of Vrije University Medical Center, Amsterdam. There is an intermediate risk for those who are active in daily living but do not regularly participate in structured exercise. "There is some benefit but not as great a benefit as for exercise."

In a study including 2,987 individuals aged 70-79 years, physical activity during

the last 7 days was assessed using a questionnaire that addressed duration and intensity of exercise, as well as daily living activity.

The data came from the Health, Aging, and Body Composition study, sponsored by the National Institute on Aging. To be included in this study, volunteers had to be free of disabilities affecting daily living and free of functional limitations. "This is important because it indicates that they were very likely to be physically capable of being physically active," Dr. Visser said.

Participants were categorized according to activity level. The exercise group (474 men, 251 women) got at least 1,000 kcal/wk of structured exercise. The active lifestyle group (666 men, 899 women) got about the same amount of total physical activity as those in the exercise group, but less than 1,000 kcal/wk came from structured exercise. The inactive group (303 men, 394 women) got little or no structured exercise and were not active in terms of daily living.

Patients were followed for an average of 4.5 years through an annual clinical exam and self-reports of level of difficulty walking a quarter of a mile and walking up 10 steps. Difficulty had to persist over at least two reports to result in a change of status. Mobility limitation was reported by 34% of men and 47% of women.

The inactive group had the most mobility limitation during follow-up, with

the intermediate group showing greater mobility, and the exercise group had the greatest mobility.

After adjusting for demographic, lifestyle, and health factors, inactive men and women had twice the risk of mobility limitation during follow-up, compared with those who exercised. Those with an active lifestyle had an intermittent risk.

The researchers also looked at associations between walking and mobility limitation among only the subjects who got little or no exercise.

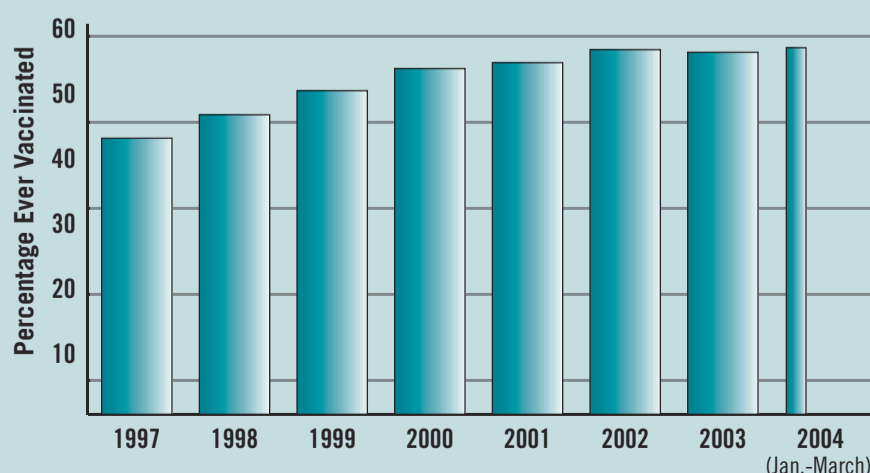
In this walking subgroup analysis, those who rarely walked (440 men, 649 women) had the highest risk of mobility limitation. Occasional walkers (247 men, 378 women) had an intermediate risk, while frequent walkers (282 men, 266 women) had the lowest risk.

The researchers also wanted to examine the relationship between activity and mobility is mediated muscle parameters. by muscle mass (at mid thigh), strength (knee extension), and muscle fat (mid thigh attenuation on a CT scan).

Those who received structured exercise had more muscle mass, less fat in their muscle, and more muscle strength than those with an active lifestyle. Inactive participants had the least muscle mass, the most fat in their muscle, and the least muscle strength. There was no association between walking activity and the muscle parameters. ■

### DATA WATCH

#### Pneumococcal Vaccination Rate Reaches 56% In Adults Aged 65 Years and Older



Source: Centers for Disease Control and Prevention