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Finding The Clinical Exercise Physiologist's Collective Voice During the COVID-19 Pandemic

Because of the COVID-19 pandemic, shelter-in-place mandates; quarantines for those who test positive, have been exposed, or who have symptoms; and restrictions on travel, dining out, recreational pursuits, and exercise facilities, etc., have been implemented to different degrees throughout the world since March 2020. For many, the stated purpose was to “flatten the curve,” which was believed to mean controlling the rate of transmission of the SARS-CoV-2 infection so that the health care system would not become overwhelmed. While there is ongoing political, scientific, and public debate as to the success of such measures, there is also evidence that these actions may have unintended long-term consequences. These include students falling behind in school and a contraction of the economy.

Another potential unintended effect that may not manifest immediately is an environment that promotes a physically inactive lifestyle. This has been recognized by the World Health Organization, which developed recommendations for physical activity when at home (1). Even though other businesses deemed *essential* have been allowed to remain open, mandated closing of exercise facilities (considered nonessential) have hampered many people's ability to remain physically active. For instance, in the United States, many of the 36,000 membership-based exercise facilities with over 60 million memberships have been shuttered since mid-March. Additionally, most senior living housing (independent and assisted-living individuals), including memory care and medical/commercial fitness facilities, have severely restricted access to both recreational and exercise pursuits in an attempt to limit potential spread of the SARS-CoV-2 infection. These facilities have also furloughed *nonessential* staff to limit the amount of potential exposure to infected individuals. Unfortunately, this has included clinical exercise physiologists and other exercise professionals who serve a variety of persons by providing supervision in facility exercise areas or by providing in-room exercise support.

Indeed, it is premature to fully understand the benefits and drawbacks of these mitigation processes, and one can

speculate that there may be benefit of reducing the rate of infection spread. However, it is likely that because of the situation far fewer individuals are gaining the benefits of regular physical activity and exercise. While this is unfortunate and may have lasting effects in the future with respect to risk and current management of chronic disease, it may be most immediately detrimental to the elderly, especially those who have chronic disease. In addition to limiting exercise and physical activity opportunities, many senior living facilities are also socially isolating their residents, keeping them from interacting with family, friends, and other residents (i.e., dining in the confines of their rooms) (2). For all individuals, but particularly the elderly, the known benefits of exercise on reducing risks of immobility, depression, anxiety, and frailty are well documented (3).

In the United States, there have been limited voices concerning the need for reopening exercise and physical activity facilities. Much of it has come from individual facility owners who see their livelihoods being lost. Some, in protest, have reopened against local government orders. And many have adapted to the situation by offering outdoor options. However, even in my state of Michigan, which is in the northern climate of the United States, there is hot and humid weather (over 90°F [32°C] and > 80% humidity for most of the months of June and July) to contend with and is of concern when it comes to participant safety. But there are some voices of authority calling for *gyms* to remain open because they realize they help people remain healthy. For instance, the governor of Florida has controversially allowed health clubs and fitness facilities to remain open. Also, many clinic-based programs in the United States (cardiac, pulmonary, cancer rehabilitation) have reopened and are using highly enhanced mitigation processes to keep patients safe. To date (July 2020), an internet search revealed no reports of exercise/fitness facility closure due to the transmission of COVID-19.

The benefits of exercise and fitness are well known and described (4). This can be a unique time for the collective

clinical exercise community to develop a voice related to the risks and benefits of keeping exercise facilities and other physical activity and exercise options available, even during a pandemic. As demonstrated by the clinical facilities that deal with individuals with a higher risk for infection and poor outcome, exercise accommodations can operate safely when provided the opportunity and when they have access to expert guidance. The American College of Sports Medicine (ACSM) recently published a document on its website with an embedded Call for Action for developing physical activity resources during COVID-19 (3). Exercise & Sport Science Australia (ESSA) is active in governmental affairs related to exercise facilities and has a COVID-19 menu

selection on their homepage with specific focus items including supporting the health and well-being of all Australians and supporting individual business owners. And the Canadian Society of Exercise Physiology (CSEP) has resource links available to its members. While specific plans and recommendations must be tailored to local happenings (e.g., infection rate, hospitalizations, case mortality rate), there is a need to develop guidance for the practicing clinical exercise physiologist in order for them to be equipped with the knowledge needed to influence decision-makers about the harm that long-term closures of exercise facilities may inflict on society. As often stated, “the cure cannot be worse than the problem.”

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