Licensure: Just the Tip of the Iceberg

Sedentary lifestyle (physical inactivity) is the fourth leading cause of death globally, and sedentarism is often coupled with other risk factors (or comorbidities) including smoking, poor nutrition, physical inactivity, obesity, cardiovascular disease, and metabolic syndrome (Duperly et al., 2014). The American College of Sports Medicine's (ACSM) "Exercise is Medicine" initiative was a vehicle that injected the idea that physical activity (PA) and active lifestyles are more than just leisure/pleasure--PA has many health benefits (Duperly et al., 2014). Individuals working in the clinical/non-clinical, health/fitness/wellness fields are uniquely positioned as experts to evangelize and prescribe PA.

Non-clinical health/fitness/wellness fields (e.g. personal trainers, strength coaches) should not be exempt from demonstrating basic, standardized knowledge and practical experience (applied knowledge) through tiered (or stepped) licensure. It is precisely because "fitness" is nebulous and the exercise dose-response is so individualized that health/fitness professionals need good foundational, evidence-based knowledge to ensure the safety of their clients (Davis, 2015). Tiered/stepped licensure similar to that of nursing would allow novices an entry point into the field while providing incentive for them to progress their career over time.

Requiring some type of standardized assessment of competency seems to make sense, but the execution of such a reform is complicated, starting with "the board". Who should dictate "the standards"? Davis noted that in Washington, D.C., physical therapists reside on the board responsible for enacting regulations for fitness professionals (Davis, 2015). However, physical therapists, physicians, and other clinicians' expertise lie in the symptomatic demographic. Clinicians may not necessarily be qualified to work with the varied asymptomatic demographic--it is impossible to know everything (Moffat et al., 2012). Davis (2015) noted that a board of "peers" would be more fair and relevant.

The discussion surrounding licensure may just be the tip of the iceberg. With a growing population of older adults, the obesity pandemic, and the effects of sedentarism a new "type" of clientele may likely emerge requiring a more collaborative approach between clinicians and non-clinicians in the health/fitness/wellness fields. Anemaet & Hammerich (2014) proposed a new collaborative framework for categorizing exercise prescription: "tissue healing; mobility; performance, initiation, stability, and motor control; performance improvement; and advanced coordination, agility, and skill" (p. 80). These categories may overlap and cover a range of both symptomatic and asymptomatic clients (Anemaet & Hammerich, 2014). This type of framework could foster collaboration between professionals and ensure a continuum of care for a client that may be "downgraded" from more acute issues.

References

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