B eing sedentary is a way of life for many health professionals who have been in practice, as is true for those in many other professions. Meetings, grand rounds, charting, dictation, outpatient interaction, classroom teaching, and medical conferences result in hours with little movement and much less moderate to vigorous physical activity (MVPA) at the level recommended by the Physical Activity Guidelines for Americans.

As Lesser et al,1 recently pointed out, health professionals have called for changes in the food environment in their communities, and yet little attention has been paid to the nutrient-poor quality of the food where physicians work, meet, and learn. Just as problematic, and despite its minimal cost and proven value to health, essentially no attention has been directed toward incorporating short bouts of physical activity into the organizational routine during meetings, conferences, and other ordinary, daily medical professional gatherings.2

Reintegrating fitness and movement into the daily lives of health professionals is as critical as attending to the quality of their diets. Emerging data suggest that physical activity bouts as short as 3 to 5 minutes may contribute to positive organizational and individual health outcomes,3 as well as the possible independent benefits of disrupting sedentary time. Ten-minute bouts of physical activity have been counted toward the 30-minute daily accrual of MVPA since federal recommendations were updated in 1995.

Abundant Opportunities

With an estimated 40,000 accredited continuing medical education events in the United States, more than 9000 residency programs, and tens of thousands of research meetings annually funded by the federal government and by foundation grants,1 opportunities abound for incorporating brief and energizing bouts of physical activity into organizational routine. A Canadian study showed that 55% of male physicians (n=2121) and 25% of female physicians (n=1092) were either overweight or obese, and most did not meet recommended MVPA levels.5

A smaller study of physicians (N=498; 67% male and 33% female) in the United States reported that 53% were obese or overweight6; and in the national Women Physicians Health Study, only 49% (n=4501) met recommended MVPA levels.6 While comprehensive data on physician MVPA levels in the United States is lacking, the high rates of overweight and obesity in this group suggest less than optimal MVPA considering that overweight is closely correlated with physical inactivity.

The Institute of Medicine’s standing committee on childhood obesity prevention has recommended that health care professionals be role models for patients and provide leadership in community policy advocacy efforts. Overweight physicians have been found to be less likely to counsel their patients about obesity and exercise.5,6 Conversely, a doubling of physical activity counseling behaviors has been demonstrated among nonphysician practitioners who have begun practicing physical activity in the workplace.7 Physicians are beginning to accept their nonclinical responsibilities to be role models and advocates, although most of these activities have been directed toward the food environment.8

Exercise Breaks

Encouraging people to be more active on a regular basis can foster the daily personal and professional decisions necessary to increase communitywide physical activity participation. Some have argued that policy change precedes social norm change. History suggests otherwise, however, such as the imposition of smoking bans as an organizational and regulatory practice change, influencing social norms and expectations long before legislative mandates and, ultimately, influencing population smoking rates. Like smoking bans, structurally integrated time for MVPA is within the decisional latitude of most leaders, including physicians and health center administrators.

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Simple measures such as instituting structured group exercise breaks at certain times of day or during meetings, re-engineering buildings to encourage medical personnel to avoid riding elevators in favor of taking the stairs, or limiting physician parking to more distant spaces could help to integrate some physical activity into health care professionals’ daily routine. In this era of information technology and social media dissemination, leaders may readily be able to institute approaches for incorporating MVPA in their venues after exposure to the intervention concept. Such default or opt-out organizational policies and practices may generate the visibility and political will supporting active-by-design public policy to make the critical but difficult and costly built environmental investments necessary for long-term sustainability.9

Improving Physical Activity Habits and Patterns

Society is replete with opportunities for reintegrating physical activity into daily life. Audiences in appropriate settings are ubiquitous. Refreshments are often offered at work, religious, and social functions and gatherings, and increasingly include nutrient-rich food and beverage choices. Yet there is little attention to the problem of keeping people stationary for long periods, and there is not much support for systematically interrupting prolonged sitting. Attendees or guests could be refreshed with brief activity bouts; such activity episodes are less expensive to provide and at least as important to health and well-being as nutrient-rich foods.

Activity breaks are becoming increasingly popular. One example is the concept of a 10-minute structured group exercise break. This could include a dance- or sports-themed movement break scientifically designed to maximize enjoyment and energy expenditure, while minimizing injury risk and perceived exertion in the average sedentary overweight adult. This concept has been adopted by many local health departments, clinics, and nonprofit agencies, particularly in California. For example, the Orange County Health Care Agency offered a formal county attorney opinion validating the use of paid time for one 10-minute activity break each day.9 Through collaboration with a wellness campaign of the California League of Cities and a health advocacy group, 39 cities have adopted policies advocating activity breaks in meetings or events lasting an hour or longer.9 In addition, several corporate initiatives have adopted activity breaks as part of their worksite wellness programs, including the Henry Ford Health System in Detroit, Michigan, and a Kaiser Permanente regional medical center in Torrance, California. Within the past year, the First 5 Los Angeles County Commission adopted the most rigorous activity break policy to date for all of its meetings, specifying both the duration and intensity of activity.

Conclusion

Simple and quick episodes of MVPA can be incorporated into the workplace without disrupting workflow or productivity. Given the value of regular physical activity to health, the medical profession should lead the way in adopting such practices.

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