Debate & Analysis

Conversations about sitting:
are we and should we be telling patients to sit less?

CONVERSATIONS ABOUT SITTING

Eat well. Eat moderately. Exercise regularly. These are messages we hear and repeat as doctors. But how often do we advocate sitting less in our health promotion information and lifestyle advice? Sedentary behaviour is defined as any waking behaviour with low energy expenditure equivalent to ≤1.5 metabolic equivalents (METs).1 Less than 1.5 MET is thought to be the amount of energy we use when resting. Not surprisingly, sitting is the commonest sedentary behaviour. The UK 2011 Start Active, Stay Active document2 advises avoiding lengthy periods of sitting. It should, therefore, perhaps be entering conversations in the consultation room. Yet are we facilitating this and are we equipped to? Do we know the detrimental effects of the inconspicuous pastime of sitting? Even if being sedentary is detrimental, will advice from the primary care team change this behaviour?

NEGATIVE OUTCOMES OF SEDENTARY BEHAVIOUR

There has been a dramatic societal change increasing our likelihood of spending time being sedentary. Older adults are thought to be particularly vulnerable to spending prolonged time being sedentary. A meta-analysis of 22 studies utilising objective measures by Harvey et al reported that older adults (aged ≥60 years) spend an average of 9.4 hours daily being sedentary, equating to 65–80% of their waking day.3

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above which risk of death increases.6-11 More work will be needed to clarify this.

What might an intervention in primary care look like? A feasible brief intervention (<20 minutes) might consist in raising the issue of sedentariness, screening patients regarding their level of sedentariness [several brief, validated questionnaires exist],12 providing feedback on current levels, and advice on strategies for behaviour change, reinforced with leaflets or web pages. Similar approaches targeting smoking have led to small effects at the individual level but potentially important changes at the population level; the overall impact of an intervention at a population level is determined by its effectiveness and importantly also by its reach.13

What effective behavioural change techniques have been evaluated and could these potentially be used in primary care? A recent review of 26 interventions targeting sedentary behaviour in adults found that the most frequently used techniques were setting behavioural goals, providing unspecified forms of social support, self-monitoring of activity, and altering the environment to be more conducive), with few studies focused on motivation (for example, education or information giving). Of the commonly trialled interventions, brief advice including goal setting (standing while watching TV once per day, a ‘reduced TV watching prescription’) and opportunity reminders (providing a ‘standing’ prompt card to be put on the sofa and lending activity monitors) could be feasible in a primary care setting.
Is there any evidence that we can make a difference with a brief intervention that is feasible in primary care? There has been little research on brief interventions of this type, but there is promising evidence of potential effectiveness of longer interventions consisting of multiple contacts. Two recent meta-analyses suggest such interventions have reduced sedentary time but not increased physical activity.\(^\text{16,17}\) Gardner et al. reviewed 26 trials of interventions targeting sedentary behaviour in adults and found 39% of interventions were very promising (significant reductions in at least one sedentary behaviour indicator).\(^\text{11}\) However, only seven studies (27% of all studies) were in a community, non-workplace setting and none involved brief interventions that could be feasibly carried out in a single consultation. Similarly, in their meta-analysis of 34 studies, Martin et al. reported that interventions reduced sedentary time by 22 minutes/day [95% CI = −35 to −9 min/day, n = 5868],\(^\text{19}\) although none of these interventions was brief. Although small, these changes could potentially translate to important effects at the population level.

**CHALLENGES TO DELIVERING ADVICE**

Although there is limited evidence suggesting that we can change behaviour with brief interventions regarding physical activity, we still continue to give advice on this. In the same way, should we be waiting for evidence for the effectiveness of brief interventions regarding sedentariness before we start delivering advice about this harmful behaviour? The task of doing this is made harder with the limited guidance ... in an increasingly time-constrained primary care environment.

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**REFERENCES**


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