Developing learning outcomes for an ideal MSc course in sports and exercise medicine

R Kordi, R G Dennick, B E Scammell

Objective: To develop learning outcomes for an ideal MSc in sports and exercise medicine.

Methods: Twenty nine learning outcomes were developed based on the learning outcomes, aims, and objectives of current sports medicine courses, occupational standards, and other related data. Using a Likert scale, the opinion of MSc/Dip course directors in the United Kingdom, Ireland, Australia, New Zealand, and South Africa as well as teachers, graduates, and students of the MSc/Dip course at the University of Nottingham were surveyed. An email questionnaire listing the 29 learning outcomes was sent to the subjects. A mixed reminder via email or mail was used. The results were treated as ordinal data, and reliability and internal consistency of the questionnaire was tested using Cronbach’s coefficient α.

Results: Response rates were high (75% course directors, 79%, 54%, and 78% University of Nottingham teachers, graduates, and students respectively). The questionnaire was highly reliable (α>0.8). The total scores of all but one of the respondents were above the midpoint (>87, possible range 29–145). Most course directors (>80%) agreed or strongly agreed with each of the learning outcomes, except two. Most of the other subjects also agreed or strongly agreed with the learning outcomes, with few exceptions.

Conclusion: The results suggest that there is a consensus among subjects that the final listed learning outcomes should be included in an ideal MSc in sports and exercise medicine.

METHODS

Listed learning outcomes

A literature search showed no previous work on defining learning outcomes for a sports medicine MSc course on which we could base our questionnaire. Therefore 29 learning outcomes were developed based on the following six basic areas, especially from current MSc courses (table 3).

- The aims, learning outcomes, and objectives of the current MSc/Dip courses in the United Kingdom.
- MSc/Dip in sports medicine and other postgraduate sports medicine courses in other countries.
- The syllabus of the examination for the Diploma in Sport and Exercise Medicine of Great Britain and Ireland run by the intercollegiate academic board of sports and exercise medicine in the University of Edinburgh. The syllabus of the diploma in sports medicine of the Society of Apothecaries of London.
- Related data and articles that show policies and directions such as the “Sport and exercise medicine: policy and provision” published by the BMA.
- Occupational standards in the field of sports medicine such as the “Team physician consensus statement”, which is a statement of different important institutions involved in sports medicine in the United States, and “Doctors’ assistance to sports clubs and sporting events,” published by the board of science and education of the BMA.
- Short term sports medicine courses in the United Kingdom.

Written learning outcomes are broad educational outcomes that cover the main points addressed in the above basic data. The phrase “sports and exercise medicine” instead of “sports medicine” was used because the latter may refer to only professional athletes, whereas the former covers all aspects and levels of physical activities and health. A total of 29
learning outcomes were defined, which included seven key and cognitive skills.

**Attitude measurement**

Subjects were asked to what extent they agreed that each listed learning outcome should be an outcome of an ideal MSc sports and exercise medicine course. A five point Likert scale was used: 1, strongly disagree; 2, disagree; 3, neutral; 4, agree; 5, strongly agree. A “don’t know” choice was allowed for lack of knowledge or attitude towards the learning outcome. It was dealt with as missing data in the analysis.

**Subjects**

The opinion of teachers, experts in the field, and the needs of students can provide basic information for course development and the writing of learning outcomes. Among experts in sports medicine, the attitudes of the directors of MSc/Dip sports medicine courses listed in tables 1 and 2 were sought. For the opinions of teachers and students, the teachers, graduates (graduated in 1999–2002), and current students of the course at the University of Nottingham were evaluated.

**Email survey**

Subjects were sent an email requesting their opinions of the learning outcomes and directing them to an online questionnaire via a hyperlinked web address embedded in the email. In the case of non-response, an email was sent as a reminder two weeks later. A second reminder was sent by mail one week after the first reminder.

### Table 1  MSc/Dip in sports medicine offered by universities in Australia, New Zealand, Ireland, and South Africa

<table>
<thead>
<tr>
<th>University</th>
<th>Country</th>
<th>Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Queensland</td>
<td>Australia</td>
<td>MSc/Dip in sports medicine</td>
</tr>
<tr>
<td>Edith Cowan University</td>
<td>Australia</td>
<td>MSc in medicine (sports medicine)</td>
</tr>
<tr>
<td>University of Canberra</td>
<td>Australia</td>
<td>MSc/Dip in sports medicine</td>
</tr>
<tr>
<td>University of New South Wales</td>
<td>Australia</td>
<td>MSc/Dip in sports medicine</td>
</tr>
<tr>
<td>University of Otago</td>
<td>New Zealand</td>
<td>Diploma in sports medicine</td>
</tr>
<tr>
<td>University College, Cork</td>
<td>Ireland</td>
<td>MSc/Dip in sports medicine</td>
</tr>
<tr>
<td>University of Dublin Trinity College</td>
<td>Ireland</td>
<td>MSc/Dip in sports medicine</td>
</tr>
<tr>
<td>University of Cape Town</td>
<td>South Africa</td>
<td>MPhil degree in sports medicine</td>
</tr>
</tbody>
</table>

### Table 2  MSc/Dip in Sports medicine and related courses offered by universities in the United Kingdom

<table>
<thead>
<tr>
<th>University</th>
<th>Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universities of the City of Glasgow</td>
<td>MSc/Dip in medicine and science in sport and exercise (MSc/Dip in medicine, science or therapy)</td>
</tr>
<tr>
<td>Sheffield Hallam University</td>
<td>MSc in sport injury with pathways in medicine, physiotherapy and science</td>
</tr>
<tr>
<td>Manchester Metropolitan University</td>
<td>MSc/Dip in science of sports injury</td>
</tr>
<tr>
<td>University of Wales</td>
<td>MSc/Dip in sports and exercise medicine</td>
</tr>
<tr>
<td>Queen Mary University of London</td>
<td>MSc/Dip in sports physiotherapy</td>
</tr>
<tr>
<td>University of Ulster</td>
<td>MSc/Dip in sport and exercise medicine</td>
</tr>
<tr>
<td>University College London</td>
<td>MSc/Dip in sports physiotherapy</td>
</tr>
<tr>
<td>University of Bath</td>
<td>MSc/Dip in sports and exercise medicine</td>
</tr>
<tr>
<td>Leeds Metropolitan University</td>
<td>Dip/MSc sports and exercise injury management</td>
</tr>
<tr>
<td>University of Nottingham</td>
<td>MSc/Dip in sports medicine</td>
</tr>
<tr>
<td>South Bank University</td>
<td>MSc/Dip in sports physiotherapy</td>
</tr>
<tr>
<td>University of Salford</td>
<td>MSc/Dip in sports rehabilitation</td>
</tr>
</tbody>
</table>

### Analysis

The data were treated as ordinal data. Each subject’s total score, the sum of the scale scores of all items, was used to show the degree of agreement with the listed learning outcomes. Both “strongly agree” and “agree” were used as indicators of agreement. As a result, the sum of the percentages of “strongly agree” and “agree” was used to show agreement with each learning outcome and to perform a general ranking of them. Cronbach’s coefficient α was used to evaluate the reliability of our questionnaire and interitem correlation of learning outcomes.

### Table 3  Listed learning outcomes in the questionnaire

On completing the course, students will be able to show and demonstrate knowledge and understanding, qualities, skills, and other attributes in the following areas.

**Knowledge and understanding and skills in specific subjects**

1. Prevention, diagnosis, and treatment of injuries related to exercise and sports.
2. Prevention, diagnosis, and treatment of diseases related to exercise and sports.
3. Rehabilitation of sports injuries and the role of physical activity in rehabilitation.
4. The principles of human nutrition and its application to exercise and sports.
5. Sports medicine issues of special groups (children, adolescents, older and handicapped people).
7. The principles of sports psychology.
8. The use and abuse of drugs in sports and doping.
9. How to deal with most medical emergencies likely to be encountered during sports events and advise on the organisation of medical cover for sports events.
10. The science of exercise and training.
11. The principles of biomechanics applied to different sporting and exercise activities and the injury context.
14. Effects of environmental conditions and travelling on athletes and sports activities.
15. To understand the particular needs in athletes suffering from a medical condition.
16. Advice on exercise and sport for patients with chronic conditions such as cardiovascular diseases and diabetes.
17. The role of exercise and sports on public and individual health.
18. To define guidelines for the scientific monitoring and training of athletes.
19. Theory and practice of different sports.
20. The role of the main organisations of sport, sports medicine, and health promotion at national and international levels.
21. Ethics and the law in sports medicine.
22. Research methodology skills and the ability to perform research.

**Knowledge and understanding following areas**

1. Prevention, diagnosis, and treatment of injuries related to exercise and sports.
2. Prevention, diagnosis, and treatment of diseases related to exercise and sports.
3. Rehabilitation of sports injuries and the role of physical activity in rehabilitation.
4. The principles of human nutrition and its application to exercise and sports.
5. Sports medicine issues of special groups (children, adolescents, older and handicapped people).
7. The principles of sports psychology.
8. The use and abuse of drugs in sports and doping.
9. How to deal with most medical emergencies likely to be encountered during sports events and advise on the organisation of medical cover for sports events.
10. The science of exercise and training.
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14. Effects of environmental conditions and travelling on athletes and sports activities.
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19. Theory and practice of different sports.
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21. Ethics and the law in sports medicine.
22. Research methodology skills and the ability to perform research.

**Key and cognitive skills**

1. Communication.
2. Using information technology.
3. Problem solving.
4. Ability in critical analysis.
5. Lifetime learning.
7. Team working.
RESULTS

Description of subjects and response rate

Graduates
There were 61 graduates (34 medical doctors, 21 physiotherapists, two osteopaths, two exercise therapists, and two chiropractors) who studied MSc/Dip in sports medicine at the University of Nottingham and graduated from 1999 to 2002. The response rate of graduates was 54%.

Teachers
There were 56 teachers on the course. There were 11 sports medicine specialists, 14 orthopaedic surgeons, nine physiotherapists, and 22 specialists in the other fields such as public health, anatomy, nutrition, physiology and metabolism, radiologist, ophthalmic surgery, rheumatology, and cardiovascular medicine. The response rate of teachers was 79%.

Students
There were 32 students studying the course, 20 doctors and 12 other professionals, mainly physiotherapists. The total response rate was 78%.

Course directors
The response rate of 20 course directors was 75%.

Results

Table 4 shows Cronbach’s coefficient \( \alpha \) for different groups of subjects.

There are 29 items (learning outcomes) in the questionnaire, and the scores were given weights as follows: strongly disagree, 1; disagree, 2; neutral, 3; agree, 4; strongly agree, 5. Therefore the maximum possible score was 145, the minimum 29, and the central score 87. Attitudes between “agree” and “strongly agree” scored more than 116. All of the total scores of the subjects, except one teacher, were more than the midpoint of 87, and 93%, 66%, 64%, and 48% of total scores of course directors, teachers, graduates, and students respectively were more than 116.

Learning outcomes are ranked on the basis of the sum of the percentage of the “strongly agree” and “agree” (table 5). Median scores of different groups of subjects for different learning outcomes were 4 and 5, except the learning outcomes 19, which was 3 for all groups, and 20, which was 3 for teachers.

DISCUSSION

Correlations among learning outcomes

The values of Cronbach’s coefficient \( \alpha \) for all groups shows good reliability (>0.8), which is based on high interitem correlations.14 It suggests that the learning outcomes are reasonably consistent and have good interitem correlations. It also shows the good reliability of the questionnaire.

Opinion of the subjects on the whole list of learning outcomes

The total scores of all the subjects, except one teacher, are above the midway point. It shows a positive attitude toward the idea that “the listed learning outcomes should be the learning outcomes of an ideal MSc in sports and exercise medicine”. It indicates that all subjects generally agree with

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### Table 4

<table>
<thead>
<tr>
<th>Subjects</th>
<th>( \alpha )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course directors</td>
<td>0.8893</td>
</tr>
<tr>
<td>Teachers</td>
<td>0.9427</td>
</tr>
<tr>
<td>Graduates</td>
<td>0.9233</td>
</tr>
<tr>
<td>Students</td>
<td>0.9233</td>
</tr>
</tbody>
</table>
all of the listed learning outcomes and there is a consensus among all groups of subjects.

A total score of 93% of course directors, 66% of teachers, 64% of graduates, and 48% of students of more than 116 shows a strong positive attitude or agreement towards the specified learning outcomes.

**Final list of learning outcomes**

As shown in table 5, except for learning outcomes 18 and 19, most course directors (>80%) agreed or strongly agreed with each of the other learning outcomes. Most of the other subjects also agreed or strongly agreed with nearly all of the learning outcomes. Subjects had a less positive attitude about the learning outcomes that are at the bottom of table 5. It seems that there is no recommended cut off point that could be used to decrease the number of learning outcomes based on the percentage of agreement (sum of “agree” and “strongly agree”). However, if agreement of two out of three (66.66%) subjects is used as a cut off point, the following learning outcomes have less agreement for different groups of responders:

- course directors: learning outcomes numbers 18 and 19.
- teachers: learning outcomes numbers 18, 19, and 20.
- graduates: learning outcomes numbers 19 and 20.
- students: learning outcomes numbers 11, 19, 20, and 21.

All groups agreed less with learning outcome number 19. With learning outcomes numbers 18 and 20, at least two groups of responders agreed less. Therefore, in this study, learning outcomes numbers 18, 19, and 20 could be omitted from the list. Also the medians of the scores support the assertion that the subjects agreed less with learning outcome number 19.

It seems that, on the basis of the opinion of the course directors, all of the listed learning outcomes, except numbers 18 and 19, should be included in an ideal MSc in sports and exercise medicine. On the basis of the opinion of all subject groups, all of the listed learning outcomes, except number 19 should be included in the course. If one widens the cut off, then it is suggested that learning outcomes 18, 19, and 20 could also be omitted.

It has been suggested that the optimal number of learning outcomes for a course is between 8 and 12, and the final list of learning outcomes identified here could be summarised to achieve that number.

Some other data are important in developing the learning outcomes for an ideal MSc course in sports and exercise medicine, such as the needs of athletes and society and the opinion of other experts such as teachers and graduates of other MSc courses, which was not addressed in this study. Also other factors can be important, such as the duration and entrance requirements of the course. The duration of MSc courses in the United Kingdom are one year and in Australia generally more than one year. The courses are restricted to doctors in some universities, commonly in Australia, but are not in others.

Despite this, all the course directors and nearly all of the other subjects are agreed that the listed learning outcomes should be included in an ideal MSc in sports and exercise medicine. We suggest that they could be useful to universities in designing new MSc courses in the future.

**ACKNOWLEDGEMENTS**

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**REFERENCES**

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SAGITTAL MOVEMENT OF THE MEDIAL LONGITUDINAL ARCH IS UNCHANGED IN PLANTAR FASCIITIS


Background:
It has been suggested that a lowered medial longitudinal arch is a causal factor in the development of plantar fasciitis, but there is little evidence to support this hypothesis.

Research question/s:
Does sagittal movement of the arch during gait differ in subjects with and without plantar fasciitis?

Methodology:
Subjects: 20 subjects: 10 subjects with unilateral plantar fasciitis (PF) and 10 matched controls (CON).
Experimental procedure: All of the subjects underwent walking at a self-selected speed during which digital fluoroscopy was used to acquire dynamic lateral radiographs from each subject by digitising and then recoding the respective maxima of (1) arch angle; and (2) first metatarsophalangeal joint (MTPJ) angle. Sagittal movement of the arch was defined as the angular change between heel strike and the maximum arch angle observed during the stance phase of gait. The thickness of the proximal plantar fascia was determined from sagittal sonograms of both feet.

Main finding/s:
- Arch angle: there was no significant difference in either the movement or maximum arch angle between limbs
- MTPJ angle: subjects in the PF group had larger MTPJ angle compared with CON subjects (p < 0.05)
- There was a significant correlation (p < 0.05) between fascial thickness and peak arch and metatarsophalangeal joint angles (p < 0.05) in the symptomatic limb

Conclusion/s:
- Patients with chronic plantar fasciitis do not have an abnormal shape or greater movement of the medial longitudinal arch during walking
- Arch mechanics may influence the severity of plantar fasciitis, once the condition is present
- Digital flexion, in contrast, has a protective role in what might be a bilateral disease process

EFFECTS OF TAPING ON PAIN AND FUNCTION IN PATELLOFEMORAL PAIN SYNDROME: A RANDOMISED CONTROLLED TRIAL


Background:
Two common treatments for patellofemoral pain syndrome are patella taping and muscle strengthening exercises.

Research question/s:
Does daily patella taping and exercise reduce pain and improve function in individuals with patellofemoral pain syndrome?

Methodology:
Subjects: Thirty subjects (24 male, six female) (mean age 18.7 years) with patellofemoral pain syndrome.
Experimental procedure: All of the subjects were randomly allocated to one of three treatment groups: Patella taping combined with a standardised exercise programme (PLEX), placebo patella taping and exercise programme (PLEX), or exercise programme alone (EX) (10 in each group). Taping was applied and exercises were performed on a daily basis for 4 weeks. Pain (VAS) and functional index questionnaires were recorded at weekly intervals by a therapist who was blinded to group allocation.

Main finding/s:
There were better pain and function scores following treatment in the PLEX group, compared with the PLEX and the EX group, but no significant differences between the PLEX and the EX groups at any time point.

Conclusion/s:
- A combination of daily patella taping and exercises over 4 weeks successfully improved pain and function in individuals with patellofemoral pain syndrome
- The combination of patella taping and exercise was superior to the use of exercise alone

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WALKING AND DEMENTIA IN PHYSICALLY CAPABLE ELDERLY MEN

Background:
Increased physical activity is associated with reduced clinical expression of dementia, but whether this includes low intensity activity such as walking is not known.

Research question/s:
Does regular walking reduce the risk of dementia in older men?

Methodology:
Subjects: 2257 physically capable men (ages 71–93 years) (part of the Honolulu-Asia Aging Study)
Experimental procedure: The daily walking distance walked was assessed in the subjects over 2 years (1991–1993). Subjects were then followed up for the development of dementia (overall dementia, Alzheimer disease, and vascular dementia) (based on neurological assessment at two repeat examinations in 1994–1996 and in 1997–1999). In this period 158 cases of dementia were identified (15.6/1000 person-years).
Measures of outcome: Walking distance (miles/day) was related to the development of dementia.

Main finding/s:
- Men who walked the least (<0.25 miles/day) experienced a 1.8-fold increased risk of dementia compared with those who walked >2 miles/day (17.8 vs 10.3/1000 person-years)
- An excess risk of dementia was also observed in those who walked 0.25–1 miles/day (17.6 vs 10.3/1000 person-years; RH, 1.71; 95% CI 1.02 to 2.86) compared to those who walked the most (>2 miles/day)
- These associations persisted after accounting for other factors, including the possibility that limited amounts of walking could be the result of a decline in physical function due to preclinical dementia

Conclusion/s:
- Regular walking in elderly men (>2 miles/day) is associated with a reduced risk of dementia
- Promoting active lifestyles in physically capable men could help late-life cognitive function

Evidence based rating: 7.5/10  Clinical interest rating: 7.5/10
Type of study: Prospective cohort study
Methodological considerations: Observational study, no females included
Keywords: dementia, elderly, men, physical activity, risk, walking

PREDICTORS OF EXERCISE BEHAVIOUR IN PATIENTS WITH RHEUMATOID ARTHRITIS 6 MONTHS FOLLOWING A VISIT WITH THEIR RHEUMATOLOGIST

Background:
If factors that influence exercise behaviour are known, health care professionals can more likely design and modify patient education materials targeted to promote exercise behaviour.

Research question/s:
Which factors predict exercise behaviour in patients with rheumatoid arthritis 6 months after a visit with their rheumatologist?

Methodology:
Subjects: 113 patients (mean age 54.8 years, 79% female) with rheumatoid arthritis (mean duration 9.8 years) who completed the 6-month follow up (85.6% of the original group).
Experimental procedure: Rheumatologists and patients completed baseline questionnaires and were audiotaped during a subsequent visit. Physical function and exercise behaviour were ascertained via questionnaire 6 months following the visit.
Measures of outcome: Multivariate logistic regression identified predictors of exercise behaviour at 6 months.

Main finding/s:
Thirty-four patients (27%) were exercising 6 months after visiting their rheumatologist. More than 50% of the rheumatologists had five or more years of clinical experience, 18 (72%) were male, and 10 (42%) reported they exercised regularly.

Conclusion/s:
- Patients with rheumatoid arthritis were nearly seven times more likely to exercise 6 months after visiting their rheumatologist if they participated in exercise in the past, and if the patient’s rheumatologist was currently performing aerobic exercise, the patient was 26% more likely to be engaged in exercise at follow up
- These data may be useful in understanding patient motivation to participate in exercise

Evidence based rating: 7.5/10  Clinical interest rating: 7.5/10
Type of study: Prospective cohort study
Methodological considerations: Small sample size, lack of generalisability to all patients with RA, confounding variables influencing exercise behaviour not examined
Keywords: exercise behaviour, rheumatoid arthritis