Sport and diabetes

People with diabetes are not disabled and should not be sheltered from the normal activities of mankind. The person with well controlled diabetes, free from the complications of the disease, should be able to undertake a full range of sporting activities. We have leading professional footballers, rugby players, and cricketers who have diabetes and play to the highest level; given modern technology it should be possible to check one's diabetic status on the touchline and if necessary eat a Mars bar! Some of the finest people with diabetes run marathons, undertake long distance cross-country walks, or even ski-race. A British athlete with diabetes recently competed in the Scottish Coast-to-Coast, a major three day endurance test involving cycling, running, and canoeing, and came 61st out of over 100 international competitors. Next year he plans to enter Iron Man events.

It is therefore regrettable that some sports bodies attempt to treat people with diabetes as disabled. When the Channel Tunnel was opened with a charity walk, although people in wheelchairs were allowed to take part, people with diabetes were banned. The recent case of the suspension of a jockey's licence when he developed diabetes highlighted the lack of understanding that exists within the governing bodies of some sporting organisations of the modern management of diabetes. Current discussions with the medical advisers to sports associations are aimed at dispelling anxieties about diabetes and sports.

Careful monitoring and proper adjustments of insulin and calorie intake can allow the athlete with diabetes to participate safely and successfully in almost any activity. Good control for safe participation requires close cooperation between the athlete and the professional diabetic team.1 A really clue'd up person with diabetes, with good understanding of their condition, and using quick electronic glucose meters and pen devices, can ensure excellent control so that most physical activities are well within their capability.

The formation of a UK branch of the International Diabetic Athletes Association,2 which might have links with the British Diabetic Association, is to be welcomed and would do much to promote better professional understanding of how diabetes can be managed and the idea that people with diabetes can participate at international and professional levels in most sports.

MICHAEI HALL
Chairman, Board of Trustees
British Diabetic Association
10 Queen Anne St
London W1M 0BD

2 International Diabetic Athletes Association, c/o Neil McQuoid, Flat 1F, 3 Henderson Row, Edinburgh EH3 5DH.

Distance learning in sport and exercise medicine

The need for continuing medical education has been recognised since the 19th century and became more formalised with the establishment of postgraduate medical centres in the 1950s. Postgraduate training allowances have led to an explosion of training programmes similar in presentational style to undergraduate teaching. However, this is not always an effective way of teaching or learning,1 nor may these formalised courses, based on lectures or papers, suit many of those who attend.2

There is little in undergraduate training that prepares the doctor for the study of the body in action—the physiological and biomechanical changes that occur in response to vigorous exercise. A sports and exercise education programme has therefore to accommodate both theory and practice.

Adults learn best when they recognise the need to learn and perceive the relevance of what is learnt to their work. A menu of educational opportunities allows the individual to take up options that fit learning styles, which might include distance learning, in addition to the more traditional lectures, courses, and seminars.2

Distance learning is a relatively new teaching method first developed in the 1950s and now epitomised by the Open University. Initially dismissed as merely “correspondence courses” or a “cheap and trashy” form of education, distance learning is now accepted by academics.1

It is a specialised teaching medium. The workbooks, audiotape, and videotape material are produced to a design that allows for formative assessment (how am I doing?) as well as the traditional summative assessment in the form of an examination or test followed by constructive feedback from the module tutor.

Formative assessment helps students, through frequent self-assessment exercises and interaction with other texts, to evaluate their knowledge and understanding, practise their skills, and consolidate their learning in a non-stressful, non-judgmental way.3 Short residential courses concentrate on practical skills and also allow the peer contact and discussion that is an important part of self development.

The advantage for students is that they can fit the course to their own pattern of learning. The modular nature allows flexibility to mix and match with other educational opportunities. By the interactive nature of the material it encourages the wider aim of self development rather than just training. Students can, however, feel very isolated and it is vital to have good tutor support and systems to identify those students who may be falling behind or having difficulty. The practical aspects of sport and exercise medicine are not easily addressed. Residential sessions are of prime importance and audiotape and videotape material is useful. Students are encouraged to apply their learning to their everyday practice and to attend clinics informally in their area. British, university based courses, are still much admired abroad and distance learning makes these much more accessible.

Distance learning is effective. A package related to eye disease for general practitioners, distributed to 270 doctors, showed a marked increase in knowledge and a significant increase in patient management decisions.4

Public demand and government inspired initiatives, such as the Academy of Sport, are placing an increasing demand on doctors to be aware and informed of the needs of all those who enjoy vigorous exercise. Distance