

Listen to the two different conversations with the same patient, and choose the correct answers. Mrs. Skinner's Hand

1. Mrs. Skinner has **hurt** / **broken** her hand.
2. She's had the problem since **the week before last** / **last week**.
3. The pain is located on the **heel** / **back** of her hand.
4. It affects **both** / **one** hand.
5. She has **tried** / **avoided** taking painkillers.
6. The pain **returns** / **disappears** when the tablets wear off.
7. The doctor says arthritis is something they have to **confirm** / **rule out**.
8. The pain may be related to her **work** / **family life**.
9. The pain is worst when she's **at the gym** / **resting**.
10. The doctor jokes that the **boss** / **gym instructor** probably makes it worse.

Read and reflect...

What is the difference in the questions that the doctor uses in each conversation?

Which technique is better for the patient? Which approach do you find easier to use?

Types of questions

We use different types of questions according to the kind of information we want.

Yes / no questions

These are closed questions. They don't begin with a question word, and generally require a 'yes' or 'no' answer. With yes/no questions, we invert the subject and verb.

Have you got the medication with you?

Is your knee painful?

Do you take your medication every day?

Can you bend your arm?

Wh- questions

When we need to have more information, we ask open questions, often beginning with a question word such as *where*, *what*, *when*, *how*, *why*. The word order is the same as for yes/no questions.

What's the problem?

Where does it hurt?

How long has your leg been infected?

However, we can modify these questions to make them even more open. We can invite someone to talk about or describe something by using *Can you tell me ...?* or *What do you think ...?*

Can you tell me how it happened?

What do you think the problem is?

Note that in the sentences above, the question form is indirect.

NOT *Can you tell me what is the problem?*

We can use a word such as *else* in yes/no or *wh-* questions to elicit a longer reply from a patient. Note the position of *else*.

Does it hurt anywhere else?

Where else does it hurt?

Is there anything else you'd like to talk about?

Open or Closed?

How long have you had the pain in your hand?

Does it hurt when you move your wrist?

Can you describe what the pain feels like?

Have you noticed if anything makes it worse?

Now, read the text and complete the activities below:

Physical fitness and health

A series of research findings illustrates the positive relationships between physical activity and bone mineral density (BMD) in a variety of sub-populations. In longitudinal studies using various sample sizes, Kemper et al and Puntilla et al illustrate that regular (weight-bearing) physical activity is significantly related to BMD at the lumbar spine and femoral neck. In relation to total body and lumbar spine BMD, van Langendonck et al illustrate that the type of sports participation is a significant factor, with high impact sports (ground forces higher than four times body weight) most effective and remaining beneficial for the skeletal health of males aged 40. Ryan et al report on the effects of six months' whole body resistive training in both young and older men and women. They report that the programme increased

muscle mass and improved BMD in the femoral region for all and suggest that if BMD is increased at skeletal maturity, reductions might be achieved in fracture risk in later years. Supporting this conclusion Neville et al demonstrate the importance of sports involving high peak strain for determining peak bone status, especially in young men and possibly for young women (who are less likely to take part in such sports). Greendale et al, in a study of 42- to 52-year-old women, explore four domains of physical activity (sport, home, work, active living). They illustrate that both sport and weight-bearing work in the home were the best, and equal, predictors of greater BMD at lumbar spine and femoral neck sites. The work of Cheng et al raises the one negative note in this literature, finding that high levels of physical activity (running twenty or more miles per week) were associated with osteoarthritis (knee and hip joints) among men less than 50 years of age (although no relationship was suggested among women or older men).

A number of papers address the more general issue of the relationship between sports participation and health behaviours in young people. Miller et al (2000) use data from a large-scale survey of school pupils to illustrate that athletic participation has both positive and negative implications for adolescent health and recommend ways to use sport for health promotion. Pastor et al use survey data on fifteen- to eighteen-year-olds to conclude that the higher the levels of sports participation, the higher the perceived fitness and consequently enhanced perceived health, with lower levels of smoking and alcohol use also enhancing health perceptions. However, the relationships are only weak to moderate. Pyle et al's survey data on high school students illustrate that, for males and females, competitive sports participation was associated with a lower frequency of mental ill-health, eating and dietary problems, and total risks (although there was a higher frequency of sports-related injuries).

1. Regular weight-bearing / non-weight-bearing exercise is linked to higher bone mineral density (BMD).
2. High-impact sports (more than four times body weight) were found to be most / least effective for skeletal health in men aged 40.
3. Six months of resistive training increased / reduced muscle mass and femoral BMD in both young and older adults.
4. Increasing BMD at skeletal maturity may reduce / increase fracture risk later in life.
5. Neville et al highlight that high peak strain sports are especially / rarely important for young men's bone status.
6. Greendale et al found that both sport and weight-bearing housework / passive work and rest predicted greater BMD.
7. Cheng et al found high levels of physical activity were linked to osteoarthritis / osteoporosis in men under 50.
8. Among young people, higher sports participation is associated with better perceived health / poorer perceived health and lower substance use.

Researcher Focus – Who Did What?

1. Who studied women aged 42–52? → Greendale et al / Cheng et al
2. Who found that running long distances was linked to joint problems in younger men? → Cheng et al / Ryan et al
3. Who studied both genders over a wide age range in a resistive training program? → Ryan et al / Pastor et al
4. Who examined adolescent health behaviours linked to sports participation? → Miller et al / Neville et al