**Changing the Narrative on Osteoarthritis: A Call for Global Action**

**Authors:**

Jinks C, Botto-van Bemden A, Bowden J, Bunzli S, Eyles J, Egerton T, Foster NE, Healey EL, Maddison J, O’Brien D, Parry E, Quicke JG, Schiphof D, Thomas MJ, Holden MA; and the Change OA Narrative (COAN) Initiative

Professor Clare Jinks. Professor of Health Research, Primary Care Centre Versus Arthritis, School of Medicine, Keele University, Staffordshire, ST5 5BG UK c.jinks@keele.ac.uk

Dr Angie Botto-van Bemden, Musculoskeletal Research International USA. drvanbemden@gmail.com

Dr Samantha Bunzli, Senior Research Fellow, Griffith University, School of Health Sciences and Social Work, Australia, Physiotherapy Department, Royal Brisbane and Women's Hospital, Australia s.bunzli@griffith.edu.au

Dr Jocelyn Bowden. Research Fellow, Sydney Musculoskeletal Health, Kolling Institute, Faculty of Medicine and Health, The University of Sydney and the Rheumatology Department, Royal North Shore Hospital, Northern Sydney Local Health District, Sydney, NSW, Australia jocelyn.bowden@sydney.edu.au

Dr Jillian Eyles. Research Fellow, Sydney Musculoskeletal Health, Kolling Institute, Faculty of Medicine and Health, The University of Sydney and the Rheumatology Department, Royal North Shore Hospital, Northern Sydney Local Health District, Sydney, NSW, Australia jillian.eyles@sydney.edu.au

Dr Thorlene Egerton. Senior Lecturer, Physiotherapy Department, Melbourne School of Health Sciences, The University of Melbourne, Melbourne, Australia thorlene.egerton@unimelb.edu.au

Professor Nadine Foster, STARS Education and Research Alliance, Surgical Treatment and Rehabilitation Service, The University of Queensland and Metro North Health, Brisbane, Queensland, Australia and School of Medicine, Keele University, Staffordshire, UK

n.foster@uq.edu.au

Dr Emma L Healey. Reader in Long Term Conditions, Primary Care Centre Versus Arthritis, School of Medicine, Keele University, Staffordshire, ST5 5BG UK e.healey@keele.ac.uk

Mr John Maddison. Research Users’ Group. Primary Care Centre Versus Arthritis, School of Medicine, Keele University, Staffordshire, ST5 5BG UK jamaddisonuk@gmail.com

Dr Daniel O’Brien. Senior Lecturer, School of Clinical Science, Auckland University of Technology, Auckland, New Zealand. daniel.obrien@aut.ac.nz

Dr Jonathan G Quicke. Postdoctoral Research Fellow, STARS Education and Research Alliance, University of Queensland, Australia and Honorary Senior Research Fellow School of Medicine, Keele University, Keele, UK j.quicke@uq.edu.au

Dr Dieuwke Schiphof. Assistant Professor, Department of General Practice, Erasmus MC, Rotterdam, Netherlands d.schiphof@erasmusmc.nl

Dr Emma Parry. NIHR Clinical Lecturer in Primary Care, Primary Care Centre Versus Arthritis, School of Medicine, Keele University, Staffordshire, ST5 5BG UK e.parry@keele.ac.uk

Dr Martin J Thomas. Senior Research Fellow in Clinical Epidemiology, Primary Care Centre Versus Arthritis, School of Medicine, Keele University, Staffordshire, ST5 5BG UK & Haywood Academic Rheumatology Centre, Midlands Partnership University NHS Foundation Trust, Haywood Hospital, Staffordshire, ST6 7AG, UK m.thomas@keele.ac.uk

Professor Melanie A Holden. Professor of Musculoskeletal Rehabilitation, Primary Care Centre Versus Arthritis, School of Medicine, Keele University, Staffordshire, ST5 5BG UK m.holden@keele.ac.uk

Change OA Narrative Initiative members

Allen KD, Babatunde OO, Bennell KL, Berry A, Bierma-Zeinstra S, Callahan LF, Campbell L, Dziedzic KS, Finney A, French HP, Haber T, Hadley-Barrows T, Hall M, Hawker G, Henriksen M, Hinman RS, Ho-Pham L, Hunter DJ, Lawford BJ, Mallen C, McHugh GA**,** Kopkow C, Neogi T, Nicholls E, Nicolson PJA, Østerås N, Paskins Z, Protheroe J, Roos EM, Runhaar J, Skou ST, Simkins J, Swaithes L, Thomas G, van der Esch M, Whittaker JL, Zhang W.

COAN initiative members

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| --- | --- | --- |
| **First and middle name(s) or initials**  | **Surname(s)** | **Affiliations** |
| Kelli | Allen  |  Department of Medicine & Thurston Arthritis Research Center, University of North Carolina at Chapel Hill; Health Services Research & Development, Durham VA Healthcare SystemKdallen@email.unc.edu |
| Opeyemi O | Babatunde | School of Medicine, Primary Care Centre Versus Arthritis | Keele University, Keele, o.babatunde@keele.ac.uk |
| Kim L | Bennell  | Centre for Health, Exercise & Sports Medicine, Department of Physiotherapy, University of Melbourne, AustraliaProfessor BAppSci(physio), PhDk.bennell@unimelb.edu.au |
| Alice | Berry | School of Health and Social Wellbeing, University of the West of England, Bristol, UK. alice.berry@uwe.ac.uk |
| Sita | Bierma-Zeinstra  | Department of General Practice, Erasmus MC, Rotterdam, Netherlands alice.berry@uwe.ac.uk |
| Leigh | Callahan | Department of Medicine & Thurston Arthritis Research Center, University of North Carolina at Chapel Hill: Osteoarthritis Action AllianceLeigh\_Callahan@med.unc.edu |
| Laura | Campbell  | Impact Accelerator Unit, School of Medicine, Keele University, Staffordshire, UK. Knowledge Broker. BA (Hons). MPhil l.campbell@keele.ac.uk |
| Krysia S | Dziedzic  | Impact Accelerator Unit, School of Medicine, Keele University, Staffordshire, UK. k.s.dziedzic@keele.ac.uk |
| Andrew | Finney  | School of Nursing, Impact Accelerator Unit, School of Medicine, Keele University, Staffordshire, UK. a.finney@keele.ac.uk |
| Helen P | French | School of Physiotherapy, Royal College of Surgeons in Ireland (RCSI) University of Medicine and Health Sciences, Dublin, Ireland hfrench@rcsi.ie |
| Travis | Haber  | Centre for Health, Exercise & Sports Medicine, Department of Physiotherapy, University of Melbourne, Australiathaber@student.unimelb.edu.au |
| Tina | Hadley-Barrows  | Impact Accelerator Unit, School of Medicine, Keele University, Staffordshire, UK, Royal Wolverhampton NHS Trust, Wolverhampton, UK tina.hadley-barrows1@nhs.net |
| Michelle | Hall  | Centre for Health Exercise and Sports MedicineSchool of Health Sciences, University of Melbourne, halm@unimelb.edu.au |
| Gillian | Hawker | Professor of Rheumatology, Temerty Faculty of Medicine, and the Institute for Health Policy Management and Evaluation, Dalla Lana School of Public Health, at the University of Toronto, Canada g.hawker@utoronto.ca |
| Marius  | Henriksen | The Parker Institute, Copenhagen University Hospital Bispebjerg Frederiksberg, Copenhagen, Denmark.Marius.henriksen@regionh.dk |
| Rana S | Hinman  | Centre for Health, Exercise & Sports Medicine, Department of Physiotherapy, University of Melbourne, Australia ranash@unimelb.edu.au |
| Lan | Ho-Pham  | Bone and Muscle Research Group, Saigon Precision Medicine Research Center, Ho Chi Minh City, Vietnam, lan.hopham@saigonmec.org |
| David J | Hunter  | Sydney Musculoskeletal Health, The University of Sydney, Kolling Institute, St Leonards, NSW, Australia. david.hunter@sydney.edu.au |
| Belinda J | Lawford | Centre for Health, Exercise & Sports Medicine, Department of Physiotherapy, University of Melbourne, AustraliaBelinda.lawford@unimelb.edu.au |
| Christian D | Mallen  | Dean, School of Medicine, Keele University, Keele, Staffordshire, ST5 5BG, c.d.mallen@keele.ac.uk |
| Gretl A | McHugh | School of Healthcare, University of Leeds, LeedsEmail: G.A.McHugh@leeds.ac.uk |
| Christian | Kopkow  | Department of Therapy Science I, Brandenburg University of Technology Cottbus-Senftenberg, GermanyEmail: christian.kopkow@b-tu.de |
| Tuhina | Neogi | Section of Rheumatology, Boston University Chobanian & Avedisian School of Medicine, Boston, USAEmail: tneogi@bu.edu |
| Elaine | Nicholls  | School of Medicine, Keele University, UK. Keele Clinical Trials Unit. Keele University, UK. e.nicholls@keele.ac.uk |
| Philippa JA. | Nicolson  | Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, University of Oxford.philippa.nicolson@ndorms.ox.ac.uk |
| Nina | Østerås  | Center for treatment of Rheumatic and Musculoskeletal Diseases (REMEDY), Diakonhjemmet Hospital, Oslo, Norway nina.osteras@medisin.uio.no |
| Zoe | Paskins  | School of Medicine, Keele University, UK and Haywood Academic Rheumatology Centre, Midlands Partnership University NHS Foundation Trust, Stoke-on-Trent, UK z.paskins@keele.ac.uk |
| Joanne | Protheroe | School of Medicine, Keele University, Staffordshire, ST5 5BG UK j.protheroe@keele.ac.uk |
| Ewa M. | Roos | Center for Muscle and Joint Health, Department of Sports and Clinical Biomechanics, University of Southern Denmark, Odense, Denmark. eroos@health.sdu.dk |
| Jos | Runhaar  | Erasmus MC University Medical Center Rotterdam, Department of General Practice, Rotterdam, the Netherlands. j.runhaar@erasmusmc.nl |
| Soren T | Skou  | The Research and Implementation Unit PROgrez, Department of Physiotherapy and Occupational Therapy, Næstved-Slagelse-Ringsted Hospitals, Region Zealand, Denmark, Center for Muscle and Joint Health, Department of Sports Science and Clinical Biomechanics, Faculty of Health, University of Southern DenmarkStskou@health.sdu.dk  |
| Joanna | Simkins  | Primary Care Centre Versus Arthritis, School of Medicine, Keele University, Keele, Staffordshire, ST5 5BG, UK, Musculoskeletal Outpatient Physiotherapy, Princess Royal Hospital, Apley Castle, Telford, TF1 6TF, UKj.m.simkins1@keele.ac.uk  |
| Laura | Swaithes | Impact Accelerator Unit, School of Medicine, Keele University, Staffordshire, UK. l.swaithes@keele.ac.uk |
| Geraint | Thomas | Robert Jones & Agnes Hunt Orthopaedic Hospital, OswestryShropshire, SY10 7AGPrimary Care Centre Versus Arthritis, School of Medicine, Keele University, Staffordshire, ST5 5BG UKgeraint.thomas1@nhs.net  |
| Martin | van der Esch  | Amsterdam University of Applied Sciences, Reade center for Rehabilitation and Rheumatology. Amsterdam the Netherlands. m.vd.esch@reade.nl |
| Jackie | Whittaker | Department of Physical Therapy, Faculty of Medicine, University of British Columbia, Vancouver CanadaArthritis Research Canada, Vancouver Canadajackie.whittaker@ubc.ca |
| Weiya | Zhang | School of Medicine, University of Nottingham, Nottingham, weiya.zhang@nottingham.ac.uk |

**Corresponding author:** Professor Clare Jinks, School of Medicine, Keele University, Keele, Staffordshire, UK ST5 5BG, Email: c.jinks@keele.ac.uk

Osteoarthritis in 1944: *“It should be emphasized that degenerative arthritis (osteoarthritis) … is perhaps nothing more than generalized traumatic arthritis concomitant with advancing age and overuse.”1*

Osteoarthritis in 2023:

*"Osteoarthritis (OA) is a condition that affects the whole joint including bone, cartilage, ligaments and muscles. Although often described as ‘wear and tear’, OA is now thought to be the result of a joint working extra hard to repair itself….The most common symptoms are pain and stiffness of the joints….These symptoms may affect your ability to do normal daily activities.”2*

Osteoarthritis (OA) descriptions highlight that over the last 80 years, understanding of this condition has evolved. However, societal perceptions remain largely unchanged. Antiquated beliefs that OA is a normal part of ageing, loading the joint through weight-bearing or exercise makes OA worse, ‘nothing can be done’ for OA, and joint replacement is inevitable, are common day-to-day conversations. These beliefs are unhelpful as they can lead people to think they are unable to improve their situation and, even worse, that activity harms joints. Demonstrated links between illness perceptions and self-management means there is an urgent need for global, targeted, and collaborative action to changing the narrative on OA and how society thinks and talks about OA. This change is a required prerequisite to reduce the burden of OA over coming decades, and tackle pressing OA and healthcare challenges worldwide (OA prevention, expanding access to, and uptake of, supported OA self-management programs and evidence-based care in low resource settings and across diverse communities).

*Contemporary understanding of OA and its management*.

Long-term observations have helped reframe the traditional view of slow, inevitable decline where ‘nothing can be done’, to a variable clinical course, where ‘acute-on-chronic’ episodic flares can also feature. Recognition of variable trajectories now enables a more positive outlook on long-term OA management focused on individuals’ presenting symptoms, feelings, and the impacts of living with OA, rather than on structural changes. This requires a biopsychosocial approach including optimizing healthy lifestyle behaviours, sleep, mood, and social support as well as improving muscle strength and restoring joint function and taking a person-centered approach considering other health conditions and individual needs, goals, and preferences (including for social participation).

International clinical guidelines provide consistent core recommendations for supported self-management prioritizing exercise, weight management (where appropriate) and education. Education should include information (individualised and understandable) to reduce fear and build confidence to help people understand that weight management and regular exercise and physical activity can reduce pain over the long-term and improve physical functioning and quality-of-life.

*Problems with current views of OA.*

Despite evolution in understanding, OA has an identity crisis and a deeply engrained disease and impairment discourse. 3,4 This discourse frames OA as a disease of cartilage worsened by physical activities that ‘wear down’ the joint, and that can only be “cured” by joint replacement. This outdated discourse perpetuates how OA is discussed by the public, and in conversations in healthcare settings, continues to negatively impact beliefs about the condition, potential benefits of self-management approaches, and uptake of recommended treatments3-6 leading to missed opportunities for optimizing health outcomes.

The way OA is understood and acted upon is subject to influences outside of healthcare settings. The impact of social determinants (e.g., social and community networks, socioeconomic, cultural, and environmental factors) is now widely recognized yet not routinely considered as part of OA service design.7 Undertaking a particular course of action (e.g., exercise) might not be achievable due to lack of funds, social support, or access to appropriate opportunities. How OA is portrayed in the media is also influential. OA is most represented as an ‘ailment’ or ‘disease’ as opposed to a ‘condition’ which more closely mirrors treatment guidelines (understanding of risk factors, weight management, exercise and multidisciplinary care).8 Because OA as a condition is not represented by the media, people living with OA may be less likely to engage in effective self-management behaviours or seek help from the most appropriate health services.

*What needs to change?*

The antiquated impairment-based understanding of OA exists across populations, in people with and without pain, across cultures and socioeconomic backgrounds and among healthcare professionals (HCPs).4 For this to change, urgent, global, targeted, and collaborative action by individuals, HCPs and governments is needed. Examples of where change is needed are outlined below.

Firstly, patient information in general is too complex. The impact of health literacy on OA care has been clearly identified.9 Many people with OA may be unable to *use* the information given to them to make good decisions about their health. The narrative about OA therefore needs to go hand in hand with strengthening health literacy. HCPs have a key role by using strategies in consultations to take health literacy into account (e.g., teach back, chunk and check, use of simple language).

Secondly, OA information is often not developed or presented with relevance to different cultures or communities. Information needs to be acceptable, accessible, and understood.10

Thirdly, educational resources for the public and people with OA and HCPs need to include biopsychosocial aspects of living well with OA and avoid unhelpful words and images. Educational resources, that use empowering language and promote self-efficacy for being physically active, have been developed11 and shown to better promote effective self-management than patho-anatomical information.12

Fourth, the OA narrative needs to be cognizant of other factors like work, education, socioeconomic level and the local built environment (e.g., buildings, parks, transport systems) as these can be both barriers and enablers to people fully participating in recommended OA care.7

Finally, the burden of OA within low-resourced settings needs to be recognized and addressed. OA is rising in these settings, yet it remains a low priority, and there are many barriers to best evidence OA care.13

*What is needed now?*

The OA impairment discourse needs to be replaced with an empowerment and participatory discourse that promotes understanding of OA within the biopsychosocial framework, facilitates active participation in lifestyle behavioural changes and effective supported self-management, using language promoting joint health through healthy lifestyles (e.g., physical activity and weight management). Strengths based language can be used to focus on what people can do (rather than can’t do), including terms like “healthy”, “strong” and “active”, and that emphasizes the modifiable aspects of the pain experience that people can be supported to gain control over. This new narrative needs to be disseminated in acceptable, accessible, and understandable ways, strengthening health literacy. The narrative needs to be pervasive across all settings and geographical locations and integrate social determinants of good health.

*Candidacy* can be a useful construct to organize actions related to achieving change. Candidacy is defined as the ways in which people's eligibility for healthcare is determined and continually negotiated between themselves and HCPs14. Candidacy has seven domains including: Identification (recognition of symptoms as needing attention); Navigation (awareness of services or resources); Permeability (ease of use of services); Appearance at Services (attending services); Adjudications (judgements made by healthcare professionals about care); Offers and Resistance (offers and uptake of care); and, Operating Conditions (the local or context specific influences or initiatives). Using candidacy allows recognition that change requires action at many levels, by different organizations, groups of health care professionals, communities, and individuals. Offers and Resistance, Adjudications and Navigation are particularly relevant to HCPs. Our call-to-action framework in Figure 1 includes examples of actions across candidacy domains to help achieve widespread narrative change.

(Figure 1 here)

Largescale dissemination and implementation of educational resources (that can be easily updated) incorporating the new narrative, and development of a healthcare workforce that knows and understands the condition and recommended care (and have highly developed health communication skills), are key to changing the OA narrative. A growing number of free evidence-based resources are already available to support this call to action (Table 1) and target knowledge and understanding of OA (both healthcare professionals and public). Resources include videos addressing what people want and need to know,11 and training courses and materials for healthcare professionals to update the workforce about current management recommendations and develop their skills and confidence to communicate effectively with people with OA.15 This new narrative must also penetrate policy and health systems design in order to address variability, prioritise and reduce barriers to recommended OA care, and support implementation of OA self-management programs in under-resourced settings.

(Table 1 here)

*Summary*

Widespread global action is needed to change the narrative on OA to give hope and empower people living both with and without OA. Education resources need appropriate design to be fit-for-purpose and use language carefully. Better conversations between healthcare professionals and people with OA need to be pervasive, start earlier, go beyond just information-giving, connect to individuals' health beliefs, socio-economic context, cultural expectations and experiences, and health and digital literacy. Action at a population level (e.g., through public health measures) and policy level. (e.g., refocus of healthcare provision, allocation of resources) are also required. We hope this call for global action can help drive changes that increase provision of high-value care, reduce the impact of secondary multiple long-term conditions, address health inequalities, and improve the quality-of-life of many people with OA.

**Author Contributions**

CJ and MAH originally conceived the idea for the commentary. Lead authors contributions were from CJ, SB, ABB, JB, JE, TE, NEF, ELH, JM, JQ, DOB, DS, EP, MJT and MAH. All authors and COAN initiative group members were involved in writing, editing, and reviewing the manuscript critically for important intellectual content. All authors approve the published version and agree to be accountable for its content. CJ takes responsibility for the integrity of the work as a whole.

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1. **Other Contributions**

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**Conflicts of interest**

M Henriksen is advisory board member of the Thuasne group and is an editor of Osteoarthritis and Cartilage. M. van der Esch is board member of the OARSI. ST Skou is associate editor of the Journal of Orthopaedic and Sports Physical Therapy, has received personal fees from Munksgaard, TrustMe-Ed, and Nestlé Health Science, outside the submitted work, and is co-founder of GLA:D®, a not-for profit initiative hosted at University of Southern Denmark aimed at implementing clinical guidelines for osteoarthritis in clinical practice. EMR is the copyright holder of Knee injury and Osteoarthritis Outcome Score (KOOS) and several other patient-reported outcome measures, and co-founder of the Good Life with Osteoarthritis in Denmark (GLA:D), a not-for profit initiative to implement clinical guidelines in primary care hosted by University of Southern Denmark. She or her institution have received payments for online lectures from TrustMe-ED and Learn.Physio. JLW is a senior editor of the Journal of Orthopaedic and Sports Physical Therapy, associate editor of the British Journal of Sports Medicine and is supported by a Michael Smith Foundation for Health Research Scholar Award. ZP has received personal fees from UCB-Pharma and receives remuneration from Versus Arthritis for a committee role. DJH is employed by the University of Sydney and Royal North Shore Hospital. His salary support for the University of Sydney is supported by Arthritis Australia and an NHMRC Investigator Grant Leadership 2 (#1194737). DJH is the co-director of the Sydney Musculoskeletal Health Flagship. In addition, DJH is the editor of the osteoarthritis section for UpToDate and co-Editor in Chief of Osteoarthritis and Cartilage. DJH provides consulting advice on scientific advisory boards for Pfizer, Lilly, TLCBio, Novartis, Tissuegene, and Biobone. CK is editor of physioscience, head of research of GLA:D® Germany and is involved in several national clinical guidelines on or related to osteoarthritis. SB-Z is Deputy Editor of Osteoarthritis and Cartilage and received consultancy fees off Pfizer and off Infirst Healthcare.

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