Arthritis Educational Materials: An Exploratory Study to Investigate How Best to Reach People with Arthritis Through their Family Physicians

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EXECUTIVE SUMMARY

- An exploratory study was done in July/August, 1995, to examine methods of providing educational material to people with arthritis through their family physicians. The specific objectives of this study were to ascertain from family physicians the potential usefulness of selected Arthritis Society (TAS) educational materials and to determine how best to distribute TAS educational materials to them, and through them, to their patients.

- There were two separate phases of the study; waiting room visits to determine the type of educational materials physicians had in their waiting rooms, and physician interviews to gather information regarding their opinions about educational material.

- Waiting room visits were done of 34 separate practises. Only two waiting rooms had any materials about arthritis, and in both cases the material was related to The Arthritis Society's Arthritis Self-Management Program (ASMP). Most offices had pamphlet displays in their waiting rooms (71%); fewer displayed posters (44%).

- Thirty-four physicians were interviewed using a semi-structured format. Approximately 60% of physicians were female and most had graduated from the University of Toronto. The median year of graduation was 1984. Sixty percent of physicians surveyed were in group practices and the remainder were in solo practices.

- The most common types of educational materials received by physician offices were information pamphlets and posters. Physicians generally received these materials via drug companies and direct mail.

- Of the educational material received in the office, many physicians reported using pamphlets. Many physicians did not like displaying posters as they take up too much space.

- Most physicians reported that they had someone sort through the mail to determine which educational materials were useful. Physicians kept materials that were relevant to their patient populations, and that were practical/beneficial/useful.

- Generally, patients most frequently asked for information on exercise, nutrition/diet and menopause.
• Just over half (56%) of physicians reported that they displayed arthritis information in their offices. Of these, 58% displayed information in examining rooms only, 10.5% in waiting rooms only, and 26% in both examining and waiting rooms.

• Most physicians had heard of TAS and knew that TAS has educational material about arthritis. Very few physicians had heard of the Consultation and Therapy Service (CTS) and only two physicians had ever referred patients to the CTS.

• Over 80% of physicians reported that they would find specific TAS pamphlets useful. Approximately 70% reported they would find the ASMP poster useful. Physicians reported that the best methods of receiving these materials would be through the mail and drug representatives.

• Sixty-five percent of the physicians reported that continuing medical education (CME) conferences about arthritis would be a good method for TAS to reach them. At least half of physicians also reported direct mail, drug company representatives and booths at conferences would also be good methods for TAS to reach physicians.

• Although physicians generally stated that they would give patients pamphlets sent with a consultation letter from a rheumatologist, many commented that they would have expected the specialist to give the pamphlet to the patient.

• Recommendations based on the results of this survey included: continuing distributing educational material through the mail and drug representatives; distribute educational materials via booths at CME conferences (especially family practise meetings), and through TAS volunteers, offering CME accredited courses on arthritis, focusing on upgrading and distributing pamphlets, investigating possibilities of collaborating with other health organizations to promote nutrition and exercise, possibly targeting distribution of brochures to older physicians who tend to have older patients in their practices who would have more frequent arthritis diagnoses and increasing the profile of TAS services in Ontario.

• By implementing some of the guidelines provided in this report regarding arthritis educational materials, it is hoped to increase the public's awareness of arthritis as an important health problem in the population.
I. INTRODUCTION

Arthritis affects an estimated 18.5% of those over the age of 16 in Ontario and has been found to be the most frequently reported cause of physical disability in the population.\(^\text{1,2,3,4,5,6}\) Canadian population surveys have indicated that the prevalence of arthritis-associated disability is approximately 2.5% (ages 16+),\(^\text{1,6}\) which is almost twice that of circulatory disorders; the next most frequently reported group of conditions causing disability.\(^\text{1}\) As arthritis is more prevalent in the older population, it is anticipated that the number of people with arthritis related disability will almost double by the year 2020 due to the aging of the population.\(^\text{7}\)

Despite the high prevalence of arthritis in Canada and its great impact due to related disability, it has been found that the general population's knowledge of arthritis is limited. A tracking study commissioned by The Arthritis Society (TAS) done in 1991\(^\text{8}\) and followed up in 1994\(^\text{9}\) by Informa Inc., found that 41% of people who reported having arthritis did not know what type they had. Results of the study appeared to indicate that many people who said they had arthritis were either self-diagnosing or had been misdiagnosed. Similarly half of people with relatives with arthritis did not know what type of arthritis they had. More than a quarter of people without arthritis were unaware of the symptoms associated with arthritis. As a result of the general population's limited knowledge about the disease, it is likely that many people do not receive an accurate diagnosis of their condition and subsequently do not receive appropriate medical treatment.\(^\text{9}\)

In order to increase the public's awareness of arthritis, TAS has produced a variety of patient educational materials for distribution. These materials include brochures, posters, special edition magazines and videos. In 1990, TAS, Ontario Division, commissioned Freedman & Associates (marketing consultants), to provide consultation regarding their communications and planning strategies.\(^\text{10}\) Part of this consultation included a review of existing TAS educational materials. The consultants found several weaknesses associated with the materials. These weaknesses included:

1. The size and colour of the type on pamphlets were weak and difficult to read especially for older people
2. Although arthritis affects people, there were no people in any of the pamphlets
3. All pamphlets looked alike, and they were visually uninteresting.
4. TAS had no consistent method or approach to packaging or distributing the materials to help staff and volunteers direct the information to the right audience.

Results of both the 1991/1994 Informa Tracking study,\(^\text{9,9}\) and the report by Freedman and Associates\(^\text{10}\) found that family physicians function as the key source of information for patients about arthritis.\(^\text{9,10}\) Despite these findings, Freeman and Associates reported that in 1990, TAS, Ontario Division had little formal, ongoing communication with family physicians and there was no strategy for distributing its educational
materials to the medical community. With the support of the Trillium Grant, TAS has been undertaking a range of initiatives to develop a communications plan and educational materials that will inform and educate the public and medical professional community about arthritis. As part of these initiatives, TAS and the Arthritis Community Research and Evaluation Unit (ACREU), conducted an exploratory study in July/August, 1995, to examine methods of providing TAS information to people with arthritis through their family physicians. The specific objects of this study were to:

1. Ascertain from family physicians the potential usefulness of selected TAS educational materials
2. Ascertain from family physicians how to best provide TAS educational materials to them and through them, to their patients

II. METHODS

This study involved 2 separate phases which are described below.

1. Phase 1: Waiting room visits

Visits were made to the waiting rooms of primary care physicians in Metropolitan Toronto to provide insight as to the types of educational materials that are available to patients in physicians' waiting rooms. A data form was completed during each visit. Several waiting room visits were done as walk-ins off the street with the receptionist's permission. Other waiting room visits were done of offices of family physicians who were interviewed in

Phase 2 of the study.

2. Phase 2: Interviews with family physicians

A randomized selection of physician participants from the Canadian Medical Directory proved to be unrealistic due to low participation rates. A convenience sample was therefore used instead. Inclusion criteria included:

a. being a licensed Ontario family physician for at least one year
b. practise located in the Metropolitan Toronto area.
c. had some patients with arthritis in their practise.

Physician participants were recruited using the following methods:

a. Primary care physicians who had referred patients to two rheumatologists associated with the Arthritis Community Research and Evaluation Unit (ACREU).
b. Primary care physicians who worked at the Wellesley hospital.
c. Primary care physicians who were randomly selected from the Canadian Medical Directory and who agreed to participate in the study.
d. Personal contacts of ACREU staff not involved specifically in arthritis research.
e. Recommendations from physicians interviewed.
f. Interviewer walked in to the office off the street.

Attempts were made to recruit physicians from a wide geographic distribution in the
Metropolitan Toronto area. Telephone contact was made with each of the physicians and/or their receptionists at which time the objectives of the study were described. Eligibility criteria (as described above) were reviewed. The physician was informed that the study was being carried out on behalf of the Arthritis Society and was being funded by a grant from the Trillium foundation. It was explained that a copy of the *Primer for Rheumatic Diseases* (10th edition)\(^\text{11}\) would be provided to the physician for participation in the study. When it was determined that the physician was eligible, a verbal consent was received for participation in the study, and an interview date and time was set.

A representative of TAS conducted a semi-structured interview in the physicians' offices (Appendix A). During the interview, three specific examples of Arthritis Society educational materials were presented to physicians to assess their responses to the materials. Two pamphlets were presented; one entitled "Living with Osteoarthritis" (Appendix B) and the other "Rheumatoid Arthritis" (Appendix C). There was also one poster presented advertising the Arthritis Self-Management Program (Appendix D).

The osteoarthritis brochure was produced and distributed by Tylenol. It was selected as it had colourful pictures of people and diagrams. It was easy to read and provided useful information about a condition that is highly prevalent in the population. The rheumatoid arthritis pamphlet was selected as it presented information about a condition that is quite debilitating, and occurs relatively frequently compared to other types of arthritis (excluding osteoarthritis). This pamphlet had no pictures, and the layout was not particularly eye-catching. The pamphlet did contain useful information. Finally, the poster on the ASMP was selected as it was the only poster available from TAS.

The data obtained during the interview were entered and analyzed in SPSS 4+.\(^{12}\)

Ethics approval for the study was received from The Wellesley Hospital Research Ethics Committee (see Appendix E).
III. RESULTS

1. Phase 1: Waiting room visits

Waiting room visits were completed of 34 separate practices. Only two waiting rooms had any materials about arthritis, and in both cases the material was related to the Arthritis Society's Arthritis Self-Management Program (ASMP).

Only 44% of offices had posters displayed in their waiting rooms. Many of the posters that were displayed were related to O.H.I.P. billing and the implications of social contract legislation for physicians.

Most offices had pamphlet displays in their waiting rooms (71%). In the larger group practice settings, there was usually a large rack containing many pamphlets covering a large variety of topics. In the smaller practices there were generally fewer pamphlets displayed, and they tended not to be organized on a rack. The most common pamphlets displayed were related to parenting/baby care, bike helmets, menopause and smoking.

2. Phase 2: Physician Interviews

Thirty four physicians were interviewed. Their characteristics are described in Table 1. The physicians surveyed were located throughout the Metropolitan Toronto area, with the majority in the downtown/midtown core (Appendix F).

<table>
<thead>
<tr>
<th>Table 1: Characteristics of Physicians and their Practices (n = 34)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td><strong>Medical School:</strong></td>
</tr>
<tr>
<td>University of Toronto</td>
</tr>
<tr>
<td>McMaster</td>
</tr>
<tr>
<td>Other Canadian</td>
</tr>
<tr>
<td>Outside of Canada</td>
</tr>
<tr>
<td><strong>Year of Graduation:</strong> (median)</td>
</tr>
<tr>
<td><strong>Type of Practice:</strong></td>
</tr>
<tr>
<td>Group</td>
</tr>
<tr>
<td>Solo</td>
</tr>
</tbody>
</table>

Approximately 60% of physicians were female and had graduated from the University of Toronto (see Table 1). The year of graduation ranged from 1959-1991, with the median year of graduation being 1984. Sixty percent of physicians surveyed were in group practises and the remainder were in solo practices.

The results of the physician interviews are presented in the following figures according to interview question.
a. Which of the following educational materials do you receive at your office?

FIGURE 1.1

Educational materials received in physician offices

<table>
<thead>
<tr>
<th>Material</th>
<th>Percent of Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information pamphlets</td>
<td>100</td>
</tr>
<tr>
<td>Posters</td>
<td>100</td>
</tr>
<tr>
<td>Magazines</td>
<td>88</td>
</tr>
<tr>
<td>Videos</td>
<td>79</td>
</tr>
<tr>
<td>Other</td>
<td>62</td>
</tr>
</tbody>
</table>

Physicians received a variety of educational materials in their offices. The most common types of materials received were information pamphlets and posters. Most physicians also received magazines and videos. Other types of materials included models (e.g. of joints/bones), audio cassettes, books and diagrams/pictures.
b. **How do you receive most of these educational materials?**

**FIGURE 1.2**

Methods by which physicians receive educational materials

- **Drug companies**: 71%
- **Mail**: 59%
- **Physician requested**: 18%
- **Societies**: 9%
- **Other methods**: 9%

Physicians generally received educational materials via drug companies and direct mail.

c. **Of the educational materials you receive at your office, which ones do you use?**

Of the educational material received in the office, many physicians reported using pamphlets. Reasons for using pamphlets were that they didn't take much space, they augmented consultation, they saved time in explanation and patients could take them home to review. Several physicians reported liking tear-off pads, which were easy to use, and the patients could take them away with them. Several physicians also reported using magazines, as they found them to have a wide scope of information, and that they were good for waiting rooms.

The usefulness of posters was more debatable. Physicians who did not use posters stated that they took up too much space and that physicians in group practises could not put posters up on the walls. Physicians who used posters stated that posters were beneficial as they were educational and easy for patients to read.
d.  *Due to the volume of materials you receive, you must be selective in what you keep. What general criteria do you use regarding what to keep and what to throw out?*

**FIGURE 1.3**

Criteria used to keep material

![Criteria used to keep material chart]

When physicians were asked what criteria determined how they decided which educational materials to keep, the results were varied. Generally, most physicians reported that they had someone sort through the mail to determine which materials were useful (e.g. office manager or receptionist). Physicians generally reported that they kept materials that were relevant to their patient populations, and that were practical/beneficial/useful.

e.  *What type of educational materials, do your patients frequently request?*

Physicians responded that patients most frequently asked for information on exercise, nutrition/diet and menopause.
f. Do you display any information regarding arthritis in your waiting room or examining room (e.g. pamphlets, posters, videos, magazines)?

**FIGURE 1.4**

**Office display of arthritis information**

<table>
<thead>
<tr>
<th>Display Arthritis Information in Office</th>
<th>19 (55.9%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting room only</td>
<td>2 (10.5%)</td>
</tr>
<tr>
<td>Examing rooms only</td>
<td>11 (57.9%)</td>
</tr>
<tr>
<td>Both waiting and examining rooms</td>
<td>5 (26.3%)</td>
</tr>
<tr>
<td>Not Specified</td>
<td>1 (5.3%)</td>
</tr>
</tbody>
</table>

Fifty-six percent of physicians reported that they did display arthritis information in their office. Most of these physicians (58%) reported displaying the information in examining rooms, and 26% reported displaying the information in both examining and waiting rooms. Only 10.5% of physicians reported displaying arthritis information in waiting rooms only.

g. How did you receive the arthritis information you have in your waiting room or examining room?

Only 8 of the 19 physicians displaying arthritis information responded to this question. Of those 8 physicians, 5 (63%) responded that they received their arthritis materials from drug representatives.
h. a) Have you ever heard of the Arthritis Society?
b) Do you know that the Arthritis Society provides educational materials regarding arthritis in the form of pamphlets, posters, magazines and videos?
c) Have you ever heard of or referred to the Arthritis Society Consultation and Therapy Service (CTS)?

FIGURE 1.5
Familiarity with The Arthritis Society (TAS)

Most physicians had heard of The Arthritis Society (TAS) and knew that TAS has educational material about arthritis. Very few physicians had heard of the Consultation and Therapy Service (CTS) and only two physicians had ever referred patients to CTS.
i. Would you find this pamphlet/poster useful?

FIGURE 1.6
Perceived usefulness of educational materials

Physicians were shown the national TAS brochure *Living Well with Osteoarthritis*, the national TAS brochure *Rheumatoid Arthritis*, and the provincial *Arthritis Self Management Program (ASMP)* poster. Over 80% of physicians reported that they would find the pamphlets useful. Approximately 70% reported they would find the ASMP poster useful. Reasons for not finding the poster useful were related to space restrictions in the office.
Physicians who reported finding TAS educational materials useful, were asked to comment on the best methods of distributing the pamphlets and the posters to them. Generally, they responded that the best methods were through the mail and drug representatives. Some physicians responded that they would also like to receive materials through TAS volunteers (21-34%). Other methods of distribution were extremely varied and included faxes, internet, medical meetings (including TAS sponsored speakers at medical rounds in hospitals), nurses, family practice updates etc.
k. *What would be some of the best ways for the Arthritis Society to reach you?*

**FIGURE 1.8**

Recommended methods for TAS to reach physicians (n = 34)

![Bar chart showing the percent of physicians reached by different methods.]

Physicians were asked to comment on the best ways for TAS to reach them. Sixty-five percent of physicians reported that continuing medical educational conferences about arthritis would be a good method. At least half of physicians reported direct mail, drug company representatives and booths at conferences would also be good methods for TAS to reach physicians. Other recommended methods of reaching physicians included: hospital rounds, drug seminars, through patients, office meetings/lunch time education hours, and through already existing family practice networks.
I. If a rheumatologist sent you a letter regarding a patient that you referred to them and enclosed with the letter an Arthritis Society pamphlet specific to the patient's condition, would you give the pamphlet to the patient?

If other pamphlets were enclosed with a note like "you may see other patients with arthritis who may find this information useful...", would you distribute these pamphlets to your patients?

Only 24% of physicians stated that a recommended method for TAS to reach family physicians would be through consultants (see Figure 1.8). Seventy-four percent of physicians responded that they would give a pamphlet sent to them with a consultation letter to the patient. Seventy-seven percent responded that they would give additional pamphlets regarding arthritis to other patients who might find the information useful. Although physicians generally stated that they would give the patient the pamphlet, many commented that they would have expected the specialist to give the pamphlet to the patient. Several physicians also stated that they would assume the pamphlet was for themselves, and that they might be insulted by receiving it.

m. Do you have any suggestions as to how the Arthritis Society can market its educational materials to family physicians?

Suggestions generally came under the following three categories:

1. Marketing
   • more advertising on the television (e.g. cable t.v.), radio and in newspapers
   • more advertising in drugstores
   • advertise to other types of professionals e.g. chiropractors, physiotherapists

2. Direct Mailing
   • send small numbers of samples in mail, with a check list/reply card to order more if the physician wanted. Several physicians stated that it was not necessary to send large amounts of materials in the mail

3. Continuing Medical Education
   • plan conferences in conjunction with rheumatologists
   • link up other organizations promoting health issues that may be related to arthritis (e.g. menopause, aging etc.)
   • information booths at conferences and meetings. Several physicians stated it is important to design booths so they don't look like advertisements for drug companies.
   • hook-up to already existing family practise agenda for CME
   • coordinate with drug representatives
Do you have any suggestions as to how the Arthritis Society can improve its educational materials to make them more useful to family physicians?

- ensure that address and phone numbers are clearly visible
- pictures of joints and anatomy diagrams are helpful
- make it concise, easy to read
- spend money to get it out
- point form format, question and answer format is good
- availability in other languages
- provide brochure stands
IV SUMMARY AND RECOMMENDATIONS

The major findings of this study together with recommendations will be discussed under 4 subheadings; methods of distribution, types of educational material, content of educational materials and physician awareness of The Arthritis Society (TAS).

1. Methods of distribution

Results of this study indicated that family physicians generally received educational materials from drug companies and through the mail. They reported in the study that these continue to be the preferred methods of receiving the materials. Physicians reported that someone in their office went through the mail they received to select what they wanted to keep. Several physicians stated that it was important that materials from drug companies do not look like advertisements for pharmaceuticals, as they might not be so ready to take the materials. Physicians reported that they would also like to receive TAS information via a TAS volunteer, at continuing medical education conferences (CME) about arthritis, and at booths at conferences in general.

Of the 34 waiting rooms visited in phase one of the study, only 2 had materials about arthritis. In the physician interview however, a total of 37% of physicians reported displaying arthritis information in waiting rooms. It is unclear why there was a discrepancy in these findings. It may be that physicians do not know specifically what type of information is in their waiting rooms, or that they may have had arthritis materials in the waiting rooms that have run out. It would be important to note that physicians may not be aware of the types of materials they have in their waiting rooms when planning future studies of educational materials in physician offices.

An unexpected finding of the study was that physicians were generally not positive about receiving brochures from consultants. A question exploring this method of information dissemination was based on the results of a small pilot study done at ACREU in 1994.13 In the 1994 pilot study, physicians responded that specialists (ie. rheumatologists), were an important source of information to help them maintain their knowledge about arthritis. An explanation for these conflicting findings may be that the family physician feels that their education about arthritis is enhanced by the consultant through the consultation letter concerning a particular patient. Family physicians may consider brochures to be at a basic level designed specifically for patients and would be offended by receiving brochures from the specialist, as he/she may assume that the specialist intended the brochure for the physicians themselves.

**Recommendation:**

- To continue distributing educational material through the mail and drug representatives. Caution should be taken to ensure that materials sponsored by drug companies do not look like advertisements for pharmaceuticals.

- To distribute educational materials via booths at CME conferences (especially
family practise meetings), and through TAS volunteers.

• To offer CME accredited courses on arthritis with materials available

2. Types of educational materials

Physicians reported they received a variety of materials but seemed to prefer pamphlets. Pamphlets were identified as being useful as they did not take up much space, they augmented consultation and the patient’s could take them home to review the information. In a study by Silvers et. al.,\textsuperscript{14} it was found that the majority of physicians rated printed material such as pamphlets, to be extremely or very important as channels for delivering educational regarding rheumatoid arthritis in rheumatology clinics.

Although the present study did not investigate patient preferences for educational materials, there are several studies reported in the literature that have addressed this question. Silvers et. al.\textsuperscript{14} reported that 73% of 185 patients with rheumatoid arthritis reported that printed materials such as pamphlets were the preferred method for receiving general information related to their arthritis. In a family practice setting, Shank et. al.\textsuperscript{15} found that of 360 patients with all diagnoses, 90% reported wanting a pamphlet, and that generally more patients desired pamphlets in this setting than actually received them. It was also found in this study that 67% of patients reported reading/looking through and saving pamphlets received, 30% reporting reading/looking through the pamphlets and then throwing them away, and only 2% throwing them away without reviewing them.

Several other studies also report on the effectiveness of pamphlets for patient education. Moll et. al.\textsuperscript{16} found that patients with osteoarthritis in a rheumatic disease centre who were exposed to booklets about their condition, scored higher on knowledge questionnaires than those who were not exposed. Kessler also found that the most effective means of transmitting drug information to patients was through pamphlets.\textsuperscript{17} An important finding of several studies was however, that pamphlets were more effective when given and explained by a health professional rather than simply handing the patient a pamphlet without some one-to-one interaction.\textsuperscript{18,19,20}

Recommendation:

• There is a need to for TAS to focus on upgrading and distributing pamphlets.

3. Content of educational materials

This study found that the most important determining factor affecting whether physicians kept educational materials they received, was that the materials needed to be relevant to their patient population. They also stated that the materials must be practical/beneficial/useful and easily understood/readable/simple. Similar results were found in a study done of general practitioners in a cross-sectional nation-wide survey in Denmark (n = 998).\textsuperscript{21} In this survey, practitioners also reported that good health education...
pamphlets should be easy to read and understand. This is particularly important when considering educational pamphlets about arthritis, as it has been documented in the literature that the reporting of these disorders is more frequent in individuals with low education levels (i.e. less than 12 years).²²

There was less consensus regarding the actual visual presentation of pamphlets in the present study. Some physicians reported a brochure does not have to be "fancy" or "glossy" as long as the information was good. Others felt that visual presentation was very important, and that diagrams and pictures were extremely useful in brochures. A study by Moll,¹⁶ found that illustrated books were more effective than unillustrated booklets for patients with osteoarthritis in educating them about their disease. This finding has also been supported in other studies.²³,²⁴ In Moll's study, photographs were generally found to be the most favoured style of illustration by patients, and that recall of booklet material was significantly correlated with a variety of psychological (e.g. intelligence, memory, reading skill) and personal factors (e.g. age, sex, educational level, socioeconomic status, disease duration).¹⁶

A more general finding of the present study related to the content of educational brochures. Physicians reported that the most frequently requested brochures from patients of all diagnoses were those concerned with nutrition/diet and exercise. The Danish Health Study Group, also found that health educational materials most used by general practitioners were also related to diet.²¹

**Recommendations:**

- As physicians tend to keep educational materials that are relevant to their patient populations, it would be beneficial for TAS to target distribution of brochures to physicians with large numbers of arthritis patients. Information regarding patient diagnosis by individual practice is however, extremely difficult to obtain. It might be beneficial therefore, to target distribution of brochures to older physicians who tend to have older patients in their practices who would have more frequent arthritis diagnoses.

- Many of The Arthritis Society's pamphlets have been found to be lacking in terms of content, visual appeal and readability (see introduction). TAS needs to upgrade brochures so that they are more visually appealing, with pictures/illustrations. Brochures also need to be simple and readable and in a variety of languages to reach a wide audience.

- As patients tend to like information on nutrition/diet and exercise, it might be beneficial to focus on producing/upgrading pamphlets related to these topics and arthritis. Options for collaborations with other organizations that promote nutrition and exercise (e.g. heart and stroke) might be explored regarding the development of a series of health promotion brochures outlining the many health benefits of nutrition and exercise.
4. Physician awareness of The Arthritis Society

Results of this study indicated that physicians have heard of The Arthritis Society, but generally do not know of the patient services the organization offers. Only two physicians reported ever referring patients to the Consultation and Therapy Service (CTS) (6%). An ACREU province-wide study surveying family physicians in Ontario found that only 34% of physicians had ever referred to the CTS.25 The results of the provincial survey may actually be overly optimistic. Physicians may tend to overestimate referral frequency on a written survey as opposed to when they are engaged in a personal interview with a TAS representative when the services would be more fully described.

Related to this is the general public's lack of awareness regarding TAS services.9 If public awareness could be increased of TAS services, perhaps this information would be passed along to physicians via patients' requests for services. This information might also reach physicians directly as members of the general public.

Recommendations:

• Need to increase the profile of The Arthritis Society's services in Ontario

The goal of this study was to explore means of providing TAS information to people with arthritis through their family doctors. Although the generalizability of the study results may be somewhat limited due to the small sample size of the study and the method of participant recruitment (ie. convenience sample rather than randomization), it is felt that the results highlighted some important issues relevant to dissemination of information by The Arthritis Society. The study also introduced some ideas for opportunities for further exploration regarding the use of arthritis educational materials in family practise.

It is important to note that at least some of the physicians surveyed in this study had previously referred to rheumatologists, as part of the sample was directly obtained via rheumatologists (see methods section). It is possible that the group sampled may be more aware of arthritis as a health issue than family practitioners in general. Thus, the results presented in this study may actually be overly optimistic in terms of existence of arthritis information in physician's offices, the physicians' desire for more arthritis-related information and their knowledge of TAS and its services.

In the present study, only the family physicians' opinions were surveyed. It must be recognized that in order to obtain a complete picture of the types of educational materials that might be most useful in a family practice setting, patient preferences must also surveyed. The study also did not look at the actual effectiveness of the materials. More specifically, when determining the best type of educational materials to use in a family practise setting it would be important to ascertain whether the educational materials were actually ever received by the patient, and whether they affected patient knowledge and/or behaviour. Although some studies have been conducted of patient preference and
effectiveness regarding the use of educational brochures, none included people with arthritis in a family practice setting. As this is the patient population that has been targeted by The Arthritis Society towards which to direct educational materials, it would be useful to focus future research specifically on this population.

This report provides some guidelines regarding options for reaching patients with arthritis through their family physicians. The results stress the importance of designing appropriate educational materials and implementing a specific strategy for their distribution. By implementing some of these guidelines regarding arthritis educational materials, it is hoped to increase the public's awareness of arthritis as an important health problem in the population.

REFERENCES


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APPENDIX A

- Physician Interview
THE ARTHRITIS SOCIETY COMMUNICATION PROJECT

1a. Which of the following education materials do you receive at your office? (Please check all that apply):

☐ Information pamphlets  ☐ Posters  ☐ Magazines  ☐ Videos (for patient loan/in waiting room)  ☐ Other (specify)

1b. Of the education materials you receive at your office, which ones do you use? Explain why?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

2. How do you receive most of these education materials?
   Probe: Do you get this information mostly from drug companies, from other physicians, from other specialists, from various Societies (e.g. The Cancer Society)?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

3. Due to the volume of materials you receive, you must be selective in what you keep. What general criteria do you use regarding what to keep and what to throw out?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
4. What education materials, if any, do your patients frequently request?


5. Do you display any information regarding arthritis in your waiting room or examining room (e.g. pamphlets, posters, videos, magazines)?

☐ YES...☐ waiting room  ☐ examining room
How did you receive it and why did you decide to use it?


☐ NO
Why?


6. Have you ever heard of the Arthritis Society?

☐ YES  ☐ NO

[If NO to question 6, then briefly explain who the Arthritis Society are and some of their major goals. Tell the physician that the Arthritis Society provides educational information to patients with arthritis (e.g. pamphlets, posters, magazines, videos). The interviewer will hand the physician a copy of the provincial pamphlet “Arthritis and its Treatment”. The interviewer will now proceed to question 8a.]

7. Do you know that the Arthritis Society provides educational materials regarding arthritis in the form of pamphlets, posters, magazines, and videos?

☐ YES  ☐ NO

[If NO to question 7, then tell the physician that the Arthritis Society has education pamphlets that can be given to patients at their consultation or placed in the waiting room; they have a poster advertising an arthritis self-management program; they have videos about arthritis. The interviewer will hand the physician a copy of the provincial pamphlet “Arthritis and its Treatment”. The interviewer will now proceed to question 8a.]
[The interviewer will now show the physician a copy of the ASMP poster and ask the questions below]

8a. Would you find this poster useful? and why or why not?

8b. How is it best to get this poster to you and get it put up? [This question will be presented on an answer card. It will be explained to the physician that this question applies to all the education materials they will be presented]

1. have it sent to you (your secretary) through the mail
2. have it sent to you by a rheumatologist
3. have it sent to you by another physician
4. have it delivered to you by an Arthritis Society volunteer
5. have it delivered to you by a drug representative
6. have it delivered to you by a consultant
7. Other (specify)

[The interviewer will hand a complimentary copy of the Arthritis Society national OA pamphlet to the physician, describe briefly that OA is the most common form of arthritis in Canada, having its greatest effects (leading to dependency) in many adults over the age of 50, and ask the questions below]

9a. Would you find this pamphlet useful? Why or why not?

9b. How is it best to get this pamphlet to you and get it put to use?

1. have it sent to you (your secretary) through the mail
2. have it sent to you by a rheumatologist
3. have it sent to you by another physician
4. have it delivered to you by an Arthritis Society volunteer
5. have it delivered to you by a drug representative
6. have it delivered to you by a consultant
7. Other (specify)

In Partnership with The Arthritis Society - Ontario Division
The interviewer will hand the physician a copy the Arthritis Society national RA pamphlet. A pamphlet that the physicians would probably need less frequently, and ask the questions below.

10a. Would you find this pamphlet useful? Why or why not?

10b. How is it best to get this pamphlet to you and get it put to use?
   1. have it sent to you (your secretary) through the mail
   2. have it sent to you by a rheumatologist
   3. have it sent to you by another physician
   4. have it delivered to you by an Arthritis Society volunteer
   5. have it delivered to you by a drug representative
   6. have it delivered to you by a consultant
   7. Other (specify)

11. Have you ever heard of or referred to the Arthritis Society Consultation and Therapy Service (CTS)? (The interviewer will hand a copy of the CTS brochure to the physician)

Heard of CTS... YES□ NO□
Referred to CTS... YES□ NO□

(The interviewer will explain to the physician that they will now describe a couple of scenarios to them and then ask for their response)

12a. If a rheumatologist sent you a letter regarding a patient that you referred to them and enclosed with the letter an Arthritis Society pamphlet, specific to the patient's condition, would you give the pamphlet to the patient?

□ YES □ NO

Explain why?

12b. If other pamphlets were enclosed (refer to 2g) with a note like "you may see other patients with arthritis who may find this information useful...", would you distribute these pamphlets to your patients?

□ YES □ NO
Explain why?

13. What would be some of the best ways for the Arthritis Society to reach you? (please check all that apply) [The choices in this question will placed on an answer card]:

1. Announcements in journals
2. Information through direct mail
3. CME Conferences on arthritis
4. Information booths at conferences
5. Arthritis Society volunteers visiting offices
6. Drug Company Representatives
7. Consultants
8. Other (specify)

14. Do you have any suggestions as to how the Arthritis Society can market its education materials to family physicians? and have these materials put to use?

15. Do you have any suggestions as to how the Arthritis Society can improve its education materials to make them more useful to family physicians?

16. What Medical school did you graduate from?

17. Year of graduation from medical school 19

18. Is your clinical practice:  □ Group  □ Solo

18. Is the Physician (Please check the appropriate box):  □ Male  □ Female
APPENDIX B

• Pamphlet
  "Living with Osteoarthritis"
Living Well With Osteoarthritis

An estimated 1.5 million Canadians suffer from arthritis, of which there are many different forms. The most common form, osteoarthritis, affects an estimated 2.7 million people (one person in six). It is the single most common cause of lost time from work and hospitalization.

Osteoarthritis (OA) is usually described as joint or "wear-out". People of all ages can get OA, but it more often affects older people. OA is the most common form of arthritis and is not contagious. Although there is no cure or prevention for OA, there are ways to help reduce the pain and keep people active and productive.

Diagnosis

Establishing the correct diagnosis is very important, because something can be done to manage most forms of arthritis, and most diseases work best when started early in the disease.

Your doctor may be able to diagnose OA based on your medical history and a physical examination. Sometimes, your doctor may order certain tests to help confirm the diagnosis, to determine how much joint damage exists, or to distinguish OA from other types of arthritis. These tests may include X-rays, blood tests, or joint fluid tests.

Symptoms of OA usually come on slowly and gradually involve the areas around the joints. If you have joint pain, stiffness, or swelling, you may want to see your doctor.

Symptoms of OA may include:
- Swelling and tenderness
- Stiffness or problems moving a joint
- Gelling (locking) of a joint
- Warmth around a joint
- Pain that increases with activity

OA May Affect Any Joint

OA may affect any joint. It commonly affects weight-bearing joints such as the knees, hips, and feet. However, non-weight-bearing joints such as the fingers and thumb joints may also be affected. It can affect either joints, especially as a result of injury or unusual stress.

Prevention

No one knows how or why OA occurs, although Canadian scientists are working to understand the events that lead to the breakdown of cartilage. Researchers now think that there are several factors that may increase your risk for getting OA.

Key Risk Factors
- Inactivity
- Safety weight
- Infection
- Complications of other types of arthritis

Some factors may increase the tendency for joint damage, others may protect against it. Joint damage often progresses slowly, and defects in the joint may change over time. The natural cure for OA is to make it go away completely, which cannot happen.

Although joint damage caused by another type of arthritis, such as degenerative arthritis, can eventually lead to OA.

Knee joint pain extra stress on weight-bearing joints, especially the knees. The good news is that regular exercise such as a little as 11 pounds in middle age can help prevent OA in the knees. Even if you already have OA in the knees, being weight bearing can help reduce stress on your joints.

Certain injuries to the joints from academic or from repetitive use, such as in some jobs, can increase your risk of developing OA. It is very important to let joint injuries heal completely, and to exercise within medical advice.

Osteoarthritis is a progressive disease. It may start slowly and then progress more rapidly over time. The pain may become more severe as the joints lose their ability to move smoothly and glide across each other.
WHAT TO DO ABOUT THE PAIN OF OSTEOPOROSIS

Although there is no cure for OA today, a lot can be done to help people who develop the condition. Benefits of treatment include less pain, lost stiffness, and fewer symptoms. Active involvement in your prescribed treatment plan is essential.

TREATMENTS FOR OSTEOPOROSIS

1. Medication
   - During non-inflammatory phases of OA, some medications act as anti-inflammatory agents (ibuprofen, naproxen, etc.) and help with pain and swelling. For optimal results, it is important to take these medications as directed.
   - Anti-inflammatory drugs (NSAIDs) may reduce the risk of unwanted effects. Before combining medication for your relief, however, you should discuss it with your doctor.
   - For inflammatory phases of OA — when inflammation is significant — medication should be used. Medications such as aspirin or ibuprofen can provide temporary pain relief. It's worth noting that systemic inflammation can be used safely for additional pain relief with other prescription medications, particularly non-steroidal anti-inflammatory drugs (NSAIDs), whereas use of aspirin and ibuprofen with prescription-strength NSAIDs may increase the risk of unwanted effects. Before combining medication for your relief, however, you should discuss it with your doctor.

2. Fractures
   - Bone density is often lost, particularly in elderly women. Antiresorptive agents, such as bisphosphonates, can help maintain bone density.

3. Joint Protection
   - Fruits and vegetables are often recommended for joint protection.
   - A healthy diet can help reduce the risk of OA of the knees.

4. Physical Therapy
   - Physical therapy can help reduce the risk of OA of the knees.

5. Joint Replacement
   - Joint replacement surgery can help reduce the risk of OA of the knees.

6. Lifestyle Changes
   - Weight loss can help reduce the risk of OA of the knees.

7. Surgery
   - Surgery may be necessary for severe cases of OA.

WHAT DO YOU THINK ABOUT YOUR PAIN?

1. What is the name of the medication (brand name and drug name)?
2. How are you feeling today?
3. Do you have any pain or discomfort?
4. Have you been taking your medications as directed?
5. Are you following any special diets or exercise routines?

LIVING WITH ARTHRITIS

Living with the physical symptoms of OA, many people experience feelings of helplessness and depression. Learning daily living strategies to manage your arthritis can help you feel more in control of your pain and more positive about your life.

The Arthritis Society offers the Arthritis Self-Management Program (ASMP) to help you control and manage your arthritis.

Arthritis News, published quarterly by the Arthritis Society, provides a current perspective on the many issues of living with arthritis.

Several communities have self-help groups, such as the Arthritis Blues Club, which you can locate by contacting the Arthritis Society office in your area.

Additional resources or schemes are coming up with arthritis such as the Arthritis HelpLine, Kate Long, M.D., or the Arthritis Self-Management Program (ASMP) to help you control and manage your arthritis.

Arthritis: A Comprehensive Guide to Understanding Your Arthritis, Dr. James Fries, M.D.
• Pamphlet
"Rheumatoid Arthritis"
What Is Rheumatoid Arthritis?
Rheumatoid arthritis is one type of inflammatory joint disorder that shows itself by pain, swelling and inflammation in and about the joints, stiffness in joints and muscles (most noticeable in the morning), general weakness and fatigue. Pain, stiffness and fatigue are rather commonplace and widespread complaints that do not in themselves mean the presence of rheumatoid arthritis. Joint swelling, objectively documented by a physician, is characteristic of this disease. The small joints of the hands and feet are those most usually affected, but it may occur in any of the joints. Rheumatoid arthritis may start gradually or with a sudden, severe attack. The disease usually remains for a long time, but periods of complete freedom from symptoms may occur. The patient may feel unwell and depressed, easily tired, and frustrated by being unable to do things as easily and quickly as expected.

Does Rheumatoid Arthritis Affect The Body In Other Ways?
Yes. Lumps (nodules) in or under the skin, particularly around the elbows, are found in about 20 percent of people with rheumatoid arthritis. Some patients become slightly pale and the skin may thin and be easily bruised, usually as a consequence of severe disease, cortisone treatment and age.

Changes take place in the blood. The rate, “sed. rate,” at which the red blood cells fall to the bottom of a special test tube is a useful measurement of the disease’s activity. A substance not usually found in the blood of persons without rheumatoid arthritis is found in the blood of about 80 percent of persons with the disease. This substance is known as Rheumatoid Factor and its presence can be detected by laboratory tests.

Rheumatoid arthritis can affect other organs, such as the lungs, the eyes and small blood vessels in the skin (“vasculitis”). Fortunately, this occurs in only a small proportion of people with the condition.

Who Gets Rheumatoid Arthritis?
Anyone, at any age, can get rheumatoid arthritis. Most commonly it first appears between the ages of 25 and 50. Women are affected about three times as frequently as men. It can occur in children and older people.

What Causes Rheumatoid Arthritis?
Recent research has increased our knowledge about rheumatoid arthritis. What is now clear is that continuous inflammation of connective tissues accounts for the damage or destruction of joints. The inflammation associated with rheumatoid arthritis appears to be due to a disorder of the body’s immune defence system. This results in a phenomenon called autoimmunity—an immune reaction to the body’s own cellular constituents.

The precise cause of this disease is unknown, but there may be several important factors. Although the disease is not directly inherited, it can be seen a bit more commonly in the families of patients. A predisposition to rheumatoid arthritis may be inherited.

According to the evidence now available, rheumatoid arthritis...
• Is not directly caused by drafts, cold, dampness or changes in the weather.
• Is not caused by excesses or deficiencies of vitamins or any other dietary element, such as
oils, fats, sugars or acids.
• Is not caused by faulty absorption or elimination of substances from the bowel or by excess acid or alkali in the system.
• Is not directly due to the presence of infection in teeth, tonsils, gall bladder, appendix or other organs.

What Causes Swelling, Painful Stiffness And Fatigue?
Inflammation of the lining of the joint capsule causes an increase of fluid in the joint, and leads to thickening of the lining itself. Swelling is partly due to increased fluid in the joint cavity, and partly due to thickening. Inflammation of the ligaments (structures which bind us together) and lining of the joint make the nerve endings sensitive. Thus, there is pain when we move or touch an inflamed joint.

If the pain is very severe, the body attempts to defend itself by contracting the muscles surrounding the affected joints. This is called muscle spasm. Muscle spasm itself may cause more pain, which leads to still more spasm. In addition, there is a generalized stiffening of muscles after a period of inactivity. This is particularly troublesome on waking in the morning, but gradually lessens with activity taking perhaps one or two hours to disappear. General tiredness and fatigue also seem to be related to the amount of inflammation present. They are occasionally the first symptoms of a flare-up of the disease.

Fatigue is as much a part of rheumatoid arthritis as pain, swelling and stiffness. Pain, limitations to joint movement and muscle weakness all combine to require more than ordinary energy to do any particular task. All this leads to fatigue — fatigue which may be difficult for family and friends to understand as the patient may not appear to be outwardly different from anyone else.

What Is The Outlook For Patients?
Most disabilities due to rheumatoid arthritis can be prevented. Most patients with rheumatoid arthritis can, once their treatment program has started, look to the future with confidence. Even when some disability has occurred, it can usually be lessened or eliminated.

It is important to remember that rheumatoid arthritis, like other diseases, can be mild, moderate or severe. You may know some badly crippled patients and wonder if you are going to be like them. These are the minority who have done badly because of unusually severe disease or neglect in the early stages. With appropriate treatment, the majority of people with rheumatoid arthritis improve. The fact that your doctor may suggest a period in hospital for you does not mean that he thinks the outlook in your case is poor. At some stage, most people with rheumatoid arthritis will benefit from a period in hospital.

Is There A Cure For Rheumatoid Arthritis?
No. But continuing appropriate treatment, usually involving some form of medication, can usually keep the disease under control. This means only that there is still no drug or remedy which will wipe out all signs of the disease completely and in all cases. Throughout the years countless quack remedies have been advocated as "cures" for arthritis. The powerful faith of those who believe in these so-called "cures" usually arises from an experience known as spontaneous remission, which is likely to be temporary.

The disease often improves on its own accord. If this remission occurs while a sufferer is using a quack remedy, he naturally attributes the remission to the remedy.

Is There Any Effective Treatment For Rheumatoid Arthritis?
Yes. Despite the absence of a cure, there is effective treatment. Its main elements are rest, therapeutic exercises and medication. The treatment program will vary from patient to patient and must be followed precisely to obtain full benefits. The combined program usually has to be continued for many years. The main purposes of treatment are the reduction of disability. These are goals worth achieving.

The following are elements of a complete treatment program.

Therapeutic Exercise
Once inflammation is satisfactorily controlled, muscles that have become weak can be strengthened by appropriate exercises. Stiff joints can regain their range of movement.

A daily exercise program will help maintain muscle strength and tone, aid nourishment of joint cartilage, prevent muscle stiffness and structural change, and improve range of movement in the joints.

Therapeutic exercises differ from the kind of exercise associated with ordinary work and recreation, and should be monitored by a professional, most often a physiotherapist.

These exercises are specifically designed to preserve or regain movement and strength in areas that are specially threatened.

There is no set pattern of therapeutic exercises applying equally to all persons with rheumatoid
arthritis. Exercises are designed to meet the needs of each patient, and will be varied from time to time.

**Heat and Cold**
Heat increases the circulation of blood and lessens pain. Most patients find it helpful to apply heat to the affected joints for 10 or 15 minutes before their exercises. A hot water bottle or electric heating pad (wrapped in a cloth to prevent burning the sensitive skin around the arthritic joint) are simple, effective ways of applying heat. Note: Heat lamps or sun lamps may be dangerous because of skin burns.

Ice is often used in the treatment of a joint to relieve pain and allow more effective exercise. Cracked ice is usually applied to the joint, using a rough towel wraparound.

**Self-Help Devices**
Some patients find difficulty in performing ordinary activities of daily living. There are many devices that make it easier to perform such tasks. Problems commonly arise in four areas: **Grooming** — Long-handled combs, brushes and lipsticks are often very helpful, particularly to those with limited elbow movement. **Dressing** — Elastic shoe laces and long-handled shoe horns are often very helpful for those with limited hip movement, as are devices for putting on stockings. **Eating and Housekeeping** — Special handles which make it easier to grasp cutlery are helpful, as are can openers that can be used with one hand. Cooking utensils specially suited to persons with hand and arm disabilities are available. Special handles make it easier to open and close doors and cupboards. Long-handled devices, such as long-handled dustpans, reduce the amount of backbending associated with housework. Long-handled tongs make it easier to pick items from the floor or shelves.

Many of these devices are available commercially — others can be simply devised. The number and kind of such devices is limited only by your imagination. Assistance is available from professionals called occupational therapists, who are trained in the development and use of these self-help devices.

**Adequate Rest**
Rest helps the body mobilize its defences to fight rheumatoid arthritis. Rest decreases the swelling and pain around inflamed joints and reduces fatigue. The number of hours that patients should rest every day, and the way they should rest, should be reviewed with their doctors. In some cases, splints may be prescribed to help and protect affected joints. Examples of such splints include modified footwear and special wrist supports.

A few basic rules will usually be: plan the things you have to do and how to do them; break up activities with frequent rest periods. Life is for living, so concentrate your energies on those activities that give life its fullest meaning. Don’t drop out in despair, but don’t foolishly strain joints that should be protected, or waste energy needed for other things.

Beneficial results will not be obtained from rest alone, nor from therapeutic exercise alone, but only when these elements are combined in a proper balance, and when inflammation is satisfactorily controlled by appropriate medication.

If an unpleasant sensation of discomfort and pain persists after any particular activity, then that activity should be discussed with your doctor or physiotherapist.

**Medication**
This consists of anti-inflammatory drugs, designed to reduce the swelling, heat, redness, stiffness and pain resulting from the inflammatory process. A patient’s response to a particular medication, as well as the degree of disease activity, dictate the type and potency of anti-inflammatory drugs prescribed. Some patients require drugs called “remittive” agents, such as gold salts or Penicillamine, which have been shown to alter the course of the disease. The main purposes of treatment are the reduction of disability resulting from the long-term effects of joint destruction, which may occur if the inflammatory process is not curbed early. (For more information about these drugs, consult your doctor or pharmacist, or write the office of The Arthritis Society nearest you.)

**Surgery**
Surgical operations on one or more joints may be recommended in certain cases. Surgery is generally of a reconstructive nature, designed to restore function to joints damaged by the inflammatory process. While surgery is not curative, significant advances in surgical correction of these deformities and reconstruction of the joints are being made — and more can be expected.

**Diet**
No special form of food or diet causes or cures rheumatoid arthritis. Nevertheless, an ordinary well-balanced and nutritious diet is beneficial, because it is beneficial to good health generally. If you are overweight, a diet to decrease weight will reduce stress on affected joints. Discuss such a diet with your doctor.
If You Have Rheumatoid Arthritis:

- Seek your doctor’s advice early when he or she can help most. Follow the advice faithfully.
- Avoid unnecessary strains or pressures on affected joints. If your physician recommends therapeutic exercises, follow his instructions carefully and faithfully.
- Don’t rely on unprescribed drugs, special cures or folk remedies.
- Get adequate rest and sleep.
- Don’t be afraid of arthritis. Handled by a physician, many of the disabling and painful aspects of arthritis can be controlled.
- Learn as much as you can about your disease. You can obtain a recommended reading list from your local office of The Arthritis Society.

The Future is Bright – Will Be Brighter

The inflammation of rheumatoid arthritis can be controlled by a suitable treatment program in almost every case. Research has not yet produced an ultimate cure for rheumatoid arthritis, nor has it produced a means of preventing the disease itself. It, however, produced understanding of this disease beyond the most optimistic forecasts of 10 or 20 years ago. Further research — which depends almost entirely upon public support — holds promise for still further improvement and a bright prospect for the conquest of arthritis in our time.

ARTHritis Society offices

National Office
250 Bloor Street East, Suite 401, Toronto, Ontario M4W 3P2

Newfoundland
Box 522, Station C, St. John’s, Newfoundland A1C 5K4

Prince Edward Island
P.O. Box 1537, Charlottetown, P.E.I. C1A 7N3

Nova Scotia
5316 Spring Garden Road, Halifax, Nova Scotia B3J 1G6

New Brunswick
65 Brunswick Street, Fredericton, New Brunswick E3B 1G5

Quebec
2075 University Street, Suite 1206, Montreal, Quebec H3A 2L1

Ontario
250 Bloor Street East, Suite 401, Toronto, Ontario M4W 3P2

Manitoba
Suite 103, 386 Broadway Ave., Winnipeg, Manitoba R3C 3R6

Saskatchewan
864 Victoria Avenue East, Regina, Saskatchewan S4N 0P2

Alberta
301, 1301-8th Street S.W., Calgary, Alberta T2R 1B7

British Columbia and Yukon
895 West 10th Avenue, Vancouver, British Columbia V5Z 1L7
APPENDIX D

- Poster
  Arthritis Self-Management Program (ASMP)

(photocopy, actual size = 11X17)
LEARN HOW TO COPE WITH ARTHRITIS

Enrol in the Arthritis Self-Management Program (ASMP)

A six-week course that will help you to:

- understand your arthritis
- learn ways to cope with chronic pain
- take a more active role in your arthritis care

For more information, please call
The Arthritis Society.

BARRIE
(705) 721-4155

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(519) 659-3014

OTTAWA
(613) 723-1083

SARNIA
(519) 344-3469

TORONTO
(416) 967-5679

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RICHMOND HILL
(905) 508-5177

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ASMP is sponsored by SEARLE
APPENDIX E

- Ethics Approval
THE WELLESLEY HOSPITAL
RESEARCH ETHICS COMMITTEE
APPROVAL FOR PROTOCOLS

TO PRINCIPAL INVESTIGATOR: Patricia Pitcher

PROTOCOL #295

TITLE: Arthritis Society Educational Materials: An Exploratory Study to Investigate How to Reach Patients Through Their Family Physicians

Ms. Pitcher, your research proposal and consent form have been reviewed by the Research Ethics Committee and are approved from an ethical standpoint.

The approval of this committee is valid for a period of three years from this date provided there are no substantial changes to the approved protocol nor any new information or developments which must be considered with respect to the study. If, during the course of the research, any unanticipated developments should occur, these should be brought to the attention of the Research Ethics Committee.

Your protocol will now be forwarded to the Medical Advisory Committee and Research Advisory Committee for their approval.

Ron Heslgrave, Ph.D.
Chair, Research Ethics Committee

Date: July 26, 1995
• Map of Distribution of Physicians' Offices