

Research

Clinician experiences in providing reassurance for patients with low back pain in primary care: a qualitative study

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KEY WORDS

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ABSTRACT

Questions: What reassurance is being delivered by physiotherapists and chiropractors to people with non-specific low back pain? How is it being delivered? What are the barriers and enablers to delivering reassurance to people with non-specific low back pain? **Design:** A qualitative study. **Participants:** Thirty-two musculoskeletal clinicians (16 physiotherapists and 16 chiropractors) who manage low back pain in primary care. **Method:** Semi-structured interviews were conducted about their experiences delivering reassurance. The interview schedule was developed using the Theoretical Domains Framework and analysed using framework thematic analysis. **Results:** Four themes were identified: giving reassurance is a core clinical skill for delivering high-quality care; it takes practice and experience to confidently deliver reassurance; despite feeling capable and motivated, clinicians identified situations that challenge the delivery of reassurance; and reassurance needs to be contextualised to the individual. **Conclusion:** Clinicians possess a strong understanding of reassurance but require clinical experience to confidently deliver it. This study provides insights into how reassurance is individualised in clinical practice, including suggestions for clinicians about how to implement reassurance effectively for people with low back pain. [Young A, French SD, Traeger AC, Ayre J, Hancock M, Jenkins HJ (2025) Clinician experiences in providing reassurance for patients with low back pain in primary care: a qualitative study. *Journal of Physiotherapy* 71:48–56]

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Introduction

Low back pain (LBP) is common and is associated with substantial disability. Worldwide, 619 million people experienced back pain in 2020,¹ and there are significant personal and societal costs related to LBP.^{2,3} In Australia, back pain continues to be the second leading cause of disability⁴ and back pain management cost AU\$3.36 billion in 2020.⁴ The prevalence of LBP has been projected to increase over the next 25 years, with associated increases in disability with healthcare costs.¹ Most LBP is non-specific low back pain (NSLBP), referring to LBP that does not have a known pathoanatomical cause.⁵ LBP is a complex condition that is multifactorial in nature, where a person's pain experience is influenced by biological, psychological and social factors.⁶ Recovery from an episode of LBP is also complex; approximately 25% of people with LBP experience recurrence within 12 months⁷ and 44% of people can still experience pain at 12 months.⁸

Clinical practice guidelines consistently recommend that people with NSLBP of any duration (acute, sub-acute and chronic) receive reassurance as a component of their care and not in isolation.^{9,10} Reassurance is the act of reducing fear, worry or concern.¹¹ In a clinical context, reassurance may include a combination of clinician behaviours. The term 'affective reassurance' refers to creating rapport and

showing empathy. The term 'cognitive reassurance' refers to the provision of reassuring information. A systematic review of observational studies found that cognitive reassurance was associated with better outcomes but the impact of affective reassurance was uncertain.¹² Reassuring information recommended in clinical practice guidelines for NSLBP relates, where appropriate, to the absence of serious pathology, the likelihood of a favourable prognosis and the safety of movement.^{10,13} A systematic review found that providing patient reassurance is important because it decreases healthcare utilisation and costs, and leads to improved patient outcomes.¹² Despite identified benefits, there is a disparity between guideline recommendations and use in clinical practice. In primary care settings, such as general practice, physiotherapy and chiropractic, clinicians have reported not offering reassurance in the form of information about prognosis in approximately 25% of first-time consultations for LBP.¹⁴

Considering that not all people with LBP receive reassuring information, there appear to be complexities when implementing this recommendation into clinical practice. These complexities may be due to guidelines providing limited detail about how best to deliver reassurance,¹⁴ or that there are circumstances that make it more challenging for clinicians to engage in this behaviour. To gain a deeper understanding of the factors that influence clinicians in delivering

reassurance, this study sought insights from clinicians to assist in implementing guideline-recommended reassurance for people with NSLBP. A qualitative study allows for the gathering of in-depth and context-rich information on reassurance use. The only available qualitative study exploring reassurance for managing LBP is from a patient perspective in UK general practice.¹⁵ That study highlighted the importance of providing information and advice, but the role of affective reassurance (eg, empathy and relationship building) was less clear.

It is believed that this study is the first qualitative investigation of the use of reassurance in two other primary contact professional groups, physiotherapists and chiropractors, who commonly manage people with NSLBP.¹⁶ This study aimed to explore the experiences of physiotherapists and chiropractors in delivering reassurance to people with NSLBP in clinical practice.

Therefore, the research questions for this qualitative study were:

1. What reassurance is being delivered by physiotherapists and chiropractors to patients with NSLBP?
2. How is it being delivered?
3. What are the barriers to and enablers of delivering reassurance to people with NSLBP?

Method

Design

This study employed a qualitative research design using the framework method of thematic analysis. The reporting of this study followed recommendations outlined in the COREQ criteria for reporting qualitative research.¹⁷

Participants

The study recruited clinicians who deliver care to people with NSLBP of any duration (acute, sub-acute or chronic). Physiotherapists and chiropractors were considered eligible if they regularly treated people with LBP of any duration (self-reported, minimum two to three patients with LBP per week), and were registered to practise with the Australian Health Practitioner Regulation Agency (AHPRA).

Clinicians were approached using: sampling of clinicians via the research team's professional networks; snowball sampling based on recommendations from other clinicians participating in the study; and electronically via email, professional associations and social media advertisements. The electronic data capture system REDCap¹ was used to screen clinicians for eligibility and collect consent and baseline data. Baseline data included: demographic information (age, gender, years in clinical practice, type of practice and LBP caseload estimate); beliefs about the importance of reassurance for LBP; and frequency of reassurance use.

Purposive sampling of eligible participants ensured that a diverse range of perspectives were captured (eg, profession, years in practice and gender). Participants were invited to participate in a single 30-minute, semi-structured, one-to-one online interview with a researcher (AY), which was conducted using commercial videoconferencing software². Interviews were audio recorded and automatically transcribed using the software, and then checked for accuracy by a researcher (AY). Transcripts were not returned to participants for review or further comments. The study aimed to continue to recruit participants until an acceptable breadth and depth of themes had been achieved.¹⁸ For most participants (28 of 32) there was no existing relationship with the researcher prior to study commencement. Four of the participants were colleagues of the interviewer. No details about the study were discussed between the participants and AY prior to or after the interview. No participants withdrew from the study after providing consent.

The interview guide was designed using the Theoretical Domains Framework (TDF), which is a theory-informed tool to identify key determinants of behaviour.^{19,20} A copy of the interview guide is

available in Appendix 1 on the eAddenda. The TDF describes 14 domains that may impact behaviour: knowledge; skills; social or professional role/identity; beliefs about capabilities; optimism; beliefs about consequences; reinforcement; intentions; goals; memory, attention and decision processes; environmental context and resources; social influences; emotion; and behavioural regulation. In this study, the TDF domains were used to describe barriers and enablers impacting a specific behaviour, which in this case was the provision of reassurance. Interview questions mapped to each of the TDF domains, to ensure that all potential barriers to and enablers of provision of reassurance were identified.²⁰ The baseline survey and interview guide were piloted with two clinicians (one physiotherapist and one chiropractor) who did not participate in the study. Feedback from these pilot interviews was used to refine the interview guide.

Data analysis

A data-driven (inductive) approach was used and a thematic framework approach was applied to data analysis²¹ through a critical realism lens.²² The framework approach to thematic analysis was advantageous in this context, as the study was able to look at patterns across participants while allowing for the integration of perspectives from a multidisciplinary team. We did not deductively code to the TDF explicitly as there are limitations to using this method that can lead to a superficial analysis.²³ The inductive approach allowed for greater depth in the analysis.²¹ We followed the six-stage procedure to analyse the data described by Gale et al²¹ in 2013: transcription, familiarisation, coding, developing a working analytical framework, applying the analytical framework, and charting data into the framework matrix. Three researchers analysed the data (AY, HJ and JA). The lead analyst and interviewer (AY) is a female PhD candidate and chiropractor with 6 years of experience in clinical practice and previous experience conducting qualitative interviews with health professionals and people experiencing LBP.^{24,25} HJ is a female researcher and chiropractor with experience in clinical practice and qualitative research. JA is a female public health and behavioural science researcher with experience in qualitative methods. The researchers familiarised themselves with the data prior to coding. The initial transcript coding of four interviews using NVivo 14^{c,26} was performed independently by two researchers (AY and either HJ or JA). One researcher (AY) coded an additional two interviews. Investigators met to discuss coding and reflect on differences in perspectives. After this initial coding, the researchers developed and agreed upon the preliminary analytical framework. The coding framework was applied to the remaining interviews by one researcher (AY). The data were then charted into the framework and discussed with the wider research team to develop the preliminary themes. After subsequent iteration, the research team decided on the final themes. The coding tree can be found in Appendix 2 on the eAddenda.

Results

Flow of participants

Thirty-seven clinicians expressed interest in the study, with 32 (16 physiotherapists and 16 chiropractors) invited and consenting to participate in the interviews. Interviews were conducted between September and December 2022.

Participant characteristics

The population was diverse in age (range 23 to 68 years; median 36 years; IQR 30.5 to 50 years) and years of clinical experience (range 0.5 to 47 years; median 10.5 years; IQR 6 to 24.5 years). Males represented 63% of the sample. Most participants (88%) rated reassurance as being extremely important with people with NSLBP, and all reported using reassurance frequently (Table 1).

Table 1
Participant characteristics.

Characteristic	(n = 32)
Profession, n (%)	
physiotherapist	16 (50)
chiropractor	16 (50)
Gender, n (%)	
female	12 (38)
male	20 (63)
Age (y), median (IQR)	36 (30.5 to 50)
Clinical experience (y), median (IQR)	10.5 (6 to 24.5)
Location of practice, n (%)	
metropolitan	23 (72)
regional	7 (22)
rural	2 (6)
Current workplace, n (%) ^a	
private practice	31 (97)
hospital or outpatient	2 (6)
How do you value providing reassurance during a clinical encounter for low back pain?, n (%)	
extremely important	28 (88)
important	4 (13)
neutral	0 (0)
unimportant	0 (0)
extremely unimportant	0 (0)
How often do provide reassurance for low back pain?, n (%)	
frequently	32 (100)
sometimes	0 (0)
rarely	0 (0)
never	0 (0)

Percentages may not sum to 100% due to rounding.

^a Respondents could select more than one response.

Main themes

Four main themes were developed: giving reassurance is a core clinical skill for delivering high-quality care; it takes practice and experience to confidently deliver reassurance; despite feeling capable and motivated, clinicians identified situations that challenge the delivery of reassurance; and reassurance needs to be contextualised to the individual.

Theme 1: Giving reassurance is a core clinical skill for delivering high-quality care

Clinicians described providing reassurance that aligned with current guideline recommendations for NSLBP. Clinicians also felt strongly motivated to deliver reassurance, as they believed that reassurance is associated with improved patient outcomes and they viewed it as their professional responsibility to provide it.

Clinicians described that delivering reassurance for people with NSLBP mainly comprises providing educational messages about NSLBP (cognitive reassurance), creating a realistic path forward for the patient, while also engaging in relationship-building components of care (affective reassurance) that enhance the delivery of reassurance. The educational messages aimed to reduce low back-related fears, including: reassurance about the absence of underlying serious pathology as a cause of their pain; providing advice about a favourable prognosis (where appropriate); and the use of messaging that encourages the safety of movement. Table 2 details specific examples given by clinicians.

Clinicians described that the delivery of educational messages alone is not enough. They emphasised the importance of how the messages were delivered; this included the framing of messages to facilitate a positive outlook, where appropriate, and to outline a realistic and measurable pathway forward.

Reassure them that whatever they're experiencing is real, reassure them... about what the pathway forward looks like and giving them a very like, a very realistic picture of what the journey looks like with me (P103, physiotherapist, male, 15 years of clinical experience).

How these messages are delivered depends on what the individual needs, with one clinician stating:

That's happened a few times where maybe people when I thought they're looking for more of that factual base stuff and you can sort of see the eyes glaze over... You know you pivot and come back to that more empathetic reassurance. Reassurance is never hard. You have to pick that right mix and fact and empathy for that individual there in front of you... (C87, chiropractor, male, 11 years of clinical experience).

Clinicians described being motivated to deliver reassurance to help address patients' fears related to their back pain. Clinicians described that the de-escalation of patients' fears was a professional responsibility.

...it's largely part of our role. I think people come to see us because they want your opinion on the severity of their issue and also they come in worried and they're looking for either some sort of reassurance or... escalation of urgency around their case (P16, physiotherapist, male, 6 years of clinical experience).

In addition, clinicians believed 'that reassurance is a key factor for good outcomes' (P109, physiotherapist, male, 5 years of clinical experience).

Through reassurance, clinicians aimed to validate patients' concerns, build trust and, by reducing concerns, avoid unnecessary use of further healthcare (imaging, medicines and surgeries).

I think when you reassure patients, it validates their feelings, it makes them feel more trust in you as a practitioner (C07, chiropractor, female, 2 years of clinical experience).

...the goal of reassurance is to reduce the likelihood of care escalating to more invasive or non-conservative treatment options that may be unwarranted. So, if it stops someone from getting an MRI when it might not be needed and having surgery when it might not be needed or having injections or lots of painkillers when it's not necessarily going to be beneficial (C13, chiropractor, male, 2 years of clinical experience).

Conversely, if reassurance was not delivered in an appropriate way, clinicians felt that this may negatively impact the patient by making them feel dismissed.

If you haven't [validated the patient], you'll just sound dismissive, so you actually won't be reassuring... A lot of physios, chiro or doctors can think they're being reassuring, but in fact, they're not reassuring the patient at all (P100, physiotherapist, male, 28 years of clinical experience).

Theme 2: It takes practice and experience to confidently deliver reassurance

Theme 2 explored the additional learning curve required to translate knowledge into the capabilities needed to confidently deliver reassurance in clinical practice. While many clinicians spoke with high levels of confidence about delivering reassurance, that confidence was developed through the clinicians' experiences with managing NSLBP and practice delivering it to a range of different people.

Most clinicians felt that they had the interpersonal skills needed to deliver reassurance to people with NSLBP, but these skills had developed over time through clinical experience. Clinicians felt that they possessed knowledge pertaining to LBP diagnosis, prognosis and management needed to deliver cognitive messages of reassurance upon entering the workforce; however, they did not feel confident to immediately implement that knowledge in practice due to a lack of interpersonal skills (eg, communication skills, establishing rapport) on how to confidently deliver the information:

I think you kind of get a kick start at university but certainly not to the extent... Look, I certainly had the knowledge, but I didn't have the

Table 2
Examples of reassurance messages used by clinicians.

Categories of reassurance for NSLBP	Examples from clinicians
Absence of pathology	...there's unlikely to be anything broken, any muscle tears or anything that is unstable... in up to 95% of cases there isn't anything specific or structural going on and it's a non-specific type of pain. It is unlikely anything is seriously wrong (C13, chiropractor, male, 2 years of clinical experience).
Prognostic reassurance	...their outcomes are more than likely going to be pretty good. And that things regress to the mean relatively well and that even though they're uncomfortable immediately, good outcomes are common and quite possible (P06, physiotherapist, male, 7 years of clinical experience).
Activity reassurance	...getting moving again and getting active again. You know, reassurance that movement is OK. Reassurance that they're sore, but they're safe (P113, physiotherapist, female, 15 years of clinical experience).

NSLBP = non-specific low back pain.

skills of being able to do it (P105, physiotherapist, female, 7 years of clinical experience).

One clinician spoke about a course in motivational interviewing, equipping them with communication skills, which assisted with delivering reassurance:

We had a 10-day [motivational interview] training and, wow, that made me much more confident in talking because all we did was practise how to talk. So motivational interviewing was really helpful and also having seniors watching me deliver some of this stuff gave me more confidence (P102, physiotherapist, male, 15 years of clinical experience).

Confidence levels in delivering reassurance are shaped by clinicians' experiences and knowledge of the evidence base for NSLBP. Although all clinicians reported high levels of confidence in delivering reassurance at the time of the interview, they reflected that on-the-job practice and frequently managing people with NSLBP were responsible for building that confidence.

I'm pretty confident in delivering reassurance... that I think reflects my knowledge level on some conditions. With typical non-specific low back pain, that's relatively acute on chronic, I'm pretty confident in explaining that because you get a lot better at it because you see it consistently and then you're more confident in delivering to the patient... So the more you actively try to reassure and because that's the thing I typically do like to do, I think you get better at it. So I'm pretty confident in it (C07, chiropractor, female, 2 years of clinical experience).

One chiropractor with 11 years of clinical experience identified their current confidence level by reflecting on the way they had delivered reassurance previously, and that further gains in confidence levels are likely to continue to occur into the future:

...I feel very confident. I probably felt very confident two years ago and probably felt very confident five years ago. But I'm a lot better at it now than I used to be, so I'll probably say I was not very good at it in five years' time, but I feel confident now I'm a lot more confident than I used to be (C87, chiropractor, male, 11 years of clinical experience).

Theme 3: Despite feeling capable and motivated, clinicians identified situations that challenge the delivery of reassurance

Despite reporting having the knowledge, skills and confidence to deliver reassurance, in general, clinicians described specific situations when they were in fact not very confident delivering reassurance to individual patients. These situations included the presence of clinical features associated with poorer recovery and patient factors impacting the reception of reassurance, including previous patient experiences that reduce their trust in clinician recommendations.

Clinicians often felt conflicted when deciding how to offer prognostic reassurance in clinical settings. This conflict primarily arose when there was uncertainty about the patient's prognosis due to

clinical features (such as psychological distress, pain duration > 12 weeks and previous episodes of LBP) that indicated a higher risk of poor outcomes.

I feel uncomfortable if I'm reassuring someone, but I don't know if you're actually going to get better... because you should get better, but there's going to be other factors, maybe that delay your recovery. I don't want to break someone's trust by reassuring them. But I also don't want to then flag you might have a delayed recovery because that's the opposite of reassurance (P106, physiotherapist, female, 9 years of clinical experience).

In addition, these challenges with delivering reassuring prognostic messages were amplified if patients did not demonstrate expected improvements in subsequent treatment sessions, or recovery took longer than anticipated. This created uncertainty, introducing doubt about the appropriateness of the prognostic reassurance provided in the first instance:

But once it passes a certain time frame and if the pain is still quite severe, it definitely becomes a lot harder, because people start to doubt whether it is ever going to go away or if this is going to be a... rest of their life type thing (C13, chiropractor, male, 2 years of clinical experience).

Patients who felt that the diagnosis implied a poor prognosis were seen by clinicians to be less receptive to reassurance:

...cases that have their pre-existing thoughts on low back pain are the challenging patients... if a patient has a pre-existing idea on that diagnosis. They'll have a tendency to maybe be less receptive to your advice and your reassurance as a clinician (C94, chiropractor, male, 8 years of clinical experience).

Clinicians described circumstances where it was difficult to establish rapport and highlighted the importance of developing rapport with an individual before providing reassurance. Clinicians described that where rapport was easily established or pre-existing, their ability to deliver reassurance was enhanced.

Building rapport allows the patient to feel safe enough that they can be heard and understood and showed some empathy. To show that the practitioner has some understanding of the issue. When you have the rapport with the patient... they will trust your opinion and what you're saying when it comes to reassurance (P16, physiotherapist, male, 6 years of clinical experience).

Clinicians reported that rapport was more difficult to establish with certain individuals. This phenomenon related to a mismatch in either personality or communication style between the patient and the clinician.

I think sometimes, you know, we're always going to come across a patient that it is a little bit harder for us to build rapport with. So if you haven't done a great job of building that rapport early on, that's going to be harder for them to buy into what you're talking about with reassurance (P113, physiotherapist, female, 15 years of clinical experience).

Table 3
Suggestions for clinicians for implementing guideline recommendations for reassurance for non-specific low back pain.

Guideline-based reassurance recommendations ^{10,33}	Purpose	Components to address/deliver	Suggested questions or messages
Data gathering			
Address understanding of back pain	Assess individual understanding of NSLBP (beliefs and previous experiences)	Identify beliefs/experiences that may be a barrier to providing reassurance or be a target for education.	<p>'Tell me what you know about your back pain?'</p> <p>'What do you think might be contributing to your back pain?'</p> <p>'What have you been previously told, if anything, about your back pain?'</p> <p>'You've had this kind of back pain before. What was it like then?'</p> <p>'What have others (doctors/physiotherapists/chiropractors) said about your pain?'</p> <p>'What have you been told about the images of your back?'</p> <p>'Do you think your back pain will get better or worse?'</p>
Understand person-specific concern	Assess individual NSLBP-related concerns (current and future)	Identify specific targets for reassurance while simultaneously enhancing/building rapport.	<p>'What concerns you the most about this pain?'</p> <p>'What are your worries about the future with respect to your back pain?'</p> <p>'How much is your back pain impacting the things you enjoy doing?'</p>
Providing individualised reassurance			
Address concerns about pathology	To de-escalate the threat of pathology as a cause of their LBP	<ul style="list-style-type: none"> • Provide education on the likelihood of serious pathology • Provide evidence for exclusion of serious pathology as a possible cause 	<p>'Serious causes of back pain are very uncommon and present in less than 1% of people with back pain'</p> <p>'You told me you have concerns about having [insert pathology here]. Based on my examination, I can assure you that [pathology] is very unlikely and that your back is healthy and strong despite being very sore at the moment'</p>
Explain prognosis	To de-escalate concerns that back pain may persist indefinitely	<ul style="list-style-type: none"> • Provide accurate prognostic advice, including the expectation that pain will reduce where appropriate • Use objective measures to inform prognostic advice (eg, OMPQ) • Address concerns related to delayed recovery or previous history of long-lasting LBP • Address fears and worries related to personal relationships with people who have experienced poor recovery 	<p>Acute LBP</p> <p>'Most people experience a rapid reduction in pain and resolution in symptoms in 6 to 8 weeks. Based on my assessment, you should recover from this episode within that timeframe.'</p> <p>Fluctuating/episodic LBP</p> <p>'As you have seen from your previous experiences, your pain tends to come and go. Even though you're uncomfortable now, I expect this episode to recover quickly similar to your previous episodes.'</p> <p>Persistent LBP or high-risk of poor outcome</p> <p>'We have identified some factors such as [insert factors here] that are contributing to your pain and I am confident that if we can address those factors together then I am confident you will start to improve.'</p> <p>Personal relationship to someone with a poor recovery</p> <p>'I understand you have fears that your back pain is going to follow a similar course to your friend who had [insert pathology here]. Here are the reasons why your LBP is different: Y, and Z' [Provide targeted information about lack of the feared pathology that their friend/family member has, or de-threaten that pathology]</p>
Encourage activity	To de-escalate concerns that movement/activity will make the problem worse and to encourage activity To build confidence in returning to normal activities	<ul style="list-style-type: none"> • Provide education on the benefits of activity/movement • Identify specific movements or activities that are of concern for the individual and reasons for concern • Provide individualised activity advice considering current activity level and preferred activities • Demonstrate the safety of movement through experiential reassurance^a 	<p>'Movement is safe, and beneficial for recovery.'</p> <p>'You have said that you are hesitant to bend your back, as you have fears about these structures being damaged. I understand that when you bend this sometimes triggers your pain. However, these tissues are very sensitive now and your spine is actually very strong. The good thing is that sensitivity can be improved by starting with easy movements that are similar to bending and gradually doing more as you get used to it.'</p> <p>[Already physically active]</p> <p>'You have said that you enjoy [X activity], and you usually do X amount of this activity. I would encourage you to still do X activity as it will assist your recovery, let's just do a little less to begin with and we can then build up to your previous activity levels over the next X weeks.'</p> <p>[Less physically active]</p> <p>'We know that movement can help recovery, I suggest finding a form of movement that you like doing and that should help your recovery.'</p> <p>'Are you open to starting to do a little bit of [X activity] even though you get some pain and have concerns? I am expecting that your pain will start to reduce as you gradually do more, and this will then build your confidence and enjoyment of doing X'</p> <p>Reassurance during in-session active care</p> <p>'You are sore, but you are safe.'</p> <p>'You're OK, this isn't going to physically hurt you.'</p>

LBP = low back pain, NSLBP = non-specific low back pain, OMPQ = Örebro Musculoskeletal Pain Questionnaire.

^a Experiential reassurance is reassurance that is achieved through doing.

Some clinicians described that difficulty in establishing rapport usually meant that reassurance would not be as effectively delivered. A strategy detailed by two clinicians, both with ≤ 2 years in clinical practice, in this situation was to refer the patient to another health-care provider.

If I don't feel the patient is clicking with me as a practitioner, I always provide them with the opportunity to see another practitioner... they already have a rapport with, or I could refer them to someone that they might be more comfortable seeing... If they don't feel reassured by you, then there's only so much you can do and you should make

sure that the patient gets care whether that's with another practitioner or through you (C07, chiropractor, female, 2 years of clinical experience).

Patients' previous experiences were thought to influence their ability to trust the reassurance being delivered by clinicians, primarily when the patients' previous experiences were negative or conflicted with current clinician advice. The patients' trust of clinician advice was impacted by previous non-reassuring encounters within the healthcare system. Non-reassuring encounters included experiences (consultations or imaging) that may have had the opposite effect of

reassurance by enhancing concerns. In addition, clinicians reported that patients who felt that their concerns had previously been dismissed might have less trust when they sought a subsequent opinion.

I think there's sort of no secret in this field that you know will often come across patients that are distressed or concerned by imaging findings that they may have had that don't necessarily correlate well with symptoms that they might present with (P98, physiotherapist, male, 7 years of clinical experience).

A lot of clients have reported feeling a bit dismissed by the GP and not having time with the initial practitioner to go through things really thoroughly (P109, physiotherapist, male, 5 years of clinical experience).

Conversely, clinicians reported that it was easier for patients to trust their recommendations when they had previously experienced reassuring consultations and there was consistency in the information provided between consultations.

I think it's easier when the client has a good understanding of... pain and how pain works and if they've had education from someone previously and they've been reassured previously (P06, physiotherapist, male, 7 years of clinical experience).

Patients who had past experiences with NSLBP that did not resolve well or were managed inappropriately could also be more challenging to reassure and establish trust with, as guideline-recommended reassurance might be incongruent with their own or others' lived experiences. Poor previous experiences encompassed either personal experience or the experience of other important people in their lives.

I would say the longer that they've had the lower back pain or the more... severe the back pain episodes have been [more challenging to reassure] (P106, physiotherapist, female, 9 years of clinical experience).

their personal experiences... one client who's in her early 40s has a disc bulge at sort of L1/L2... has dermatomal pattern of symptoms that match that. One of the things that she reported was her sister has had disc bulges and herniations and she can't sit down on a plane for an hour. I think in terms of trying to reassure her, it's kind of again difficult. Because I haven't necessarily got the history of the other family member, but she also will have this preconception that that's what she's going to end up like (P109, physiotherapist, male, 5 years of clinical experience).

Conversely, clinicians reported that it was easier to reassure and build trust with patients who have had a more favourable experience with NSLBP, such as low pain intensity and quick resolution of previous episodes.

I think it's definitely easier to provide reassurance to someone who has had an episode similar to it before, and they normally know their body quite well and they know that if something like this happens, it will go away over a certain period of time (C13, chiropractor, male, 2 years of clinical experience).

Theme 4: Reassurance needs to be contextualised to the individual

Clinicians felt that a one-size-fits-all model was not appropriate for clinical practice. Clinicians emphasised the importance of considering the individual and adapting reassurance accordingly, as 'without it [individualisation] you are taking a stab in the dark and you may or may not be reassuring' (P100, physiotherapist, male, 28 years of clinical experience). This theme addresses the way that clinicians have identified targets to individualise reassurance, and how reassurance is individualised and delivered.

Clinicians detailed strategies used to identify individual targets for reassurance. These relate to data gathering by specifically asking about patients' concerns and their understanding of their pain. Simultaneously, this is also a strategy employed to help establish rapport and build trust with the patient.

You've got to keep asking the probing questions to really get to the rub of what their main concern is. Otherwise it just becomes a throwaway line that they've heard 50 million times before and still not addressing their main concern. So, it's not reassuring at all (P112, physiotherapist, female, 28 years of clinical experience).

In addition to the identification of specific patient concerns, clinicians must understand a patient's context and how their concerns may be shaped by personal experiences. Subsequent reassurance must be delivered with consideration of the patient context in mind.

They might have a family member who hasn't gotten better or has had surgery or a family or a friend of the family who hasn't done well with back pain. So those we do provide that just a bit more guidance and reassurance... (C92, chiropractor, male, 29 years of clinical experience).

After specific patient concerns have been identified, clinicians detailed the strategies they used to provide reassurance around those specific concerns. Strategies included providing educational messages (cognitive reassurance) and a safe environment for them to experience movement (experiential reassurance).

Clinicians detailed how they contextualised cognitive reassurance to the individual. Clinicians described providing reassurance on the exclusion of serious pathology by providing evidence after a thorough history and physical examination, using individual examples pertinent to their case.

...this is what I got from the assessment, and this is how I know that there's no serious pathology in your case... So, I didn't just say that this person didn't have it. I told them why I knew they didn't have it or why I thought that they didn't have it and then explained what I thought was going on with the reasons why as well... It is a lot of education, not just 'this is what's happening' (P104, physiotherapist, female, 0.5 years of clinical experience).

Clinicians also described contextualising imaging findings to their clinical history and their physical examination findings, for example: de-escalation of disc bulge as a concern when there is no radiculopathy present.

If I've got someone who has already shown me that they're really caught up on what the scan says. So you tell me your pain is in the L4/5 disc. OK, I'm going to have to look at the scan and actually look at that L4/5 disc, and then I'm going have to do something in my physical examination to demonstrate that in fact, the L4/5 disc is actually OK, et cetera. You don't need surgery... (P100, physiotherapist, male, 28 years of clinical experience).

Rather than purely relying on didactic means, clinicians may ask patients to actively perform or be exposed to an exercise as a tool to allow patients to experience the safety of movement. Clinicians reported gradually exposing patients to elements of feared movements, thus building the patient's tolerance and de-escalating the threat and fear associated with the movement.

You can give them as much education and advice and reassurance as you as you like, but sometimes, you just have to show the patient that they can do it... As a physical therapist that you physically get the patient to do something or move towards doing something that they didn't think they might be able to do... You know a particular functional goal that they have that you're exposing them to it (P98, physiotherapist, male, 7 years of clinical experience).

Discussion

This study developed four themes about clinicians' use of reassurance for NSLBP. Clinicians in this study possessed comprehensive knowledge about delivering reassurance and believed that it was an important part of the high-quality care they delivered. They believed that reassurance helped them to: foster a positive outlook in patients; dispel fears related to underlying pathology; dispel fears related to a poor prognosis of the NSLBP; and encourage safe activity. While clinicians expressed confidence in their ability to provide reassurance, they acknowledged that this confidence was developed gradually through clinical experience. They reported that delivering reassurance was more challenging in situations where: patients were less likely to experience a favourable prognosis; there were difficulties in establishing rapport between the clinician and patient; factors were present that impacted the patient's ability to trust in the reassurance provided by the clinician, such as the patient's previous experiences with NSLBP and the healthcare system. Participants also stressed the importance of establishing rapport and trust and tailoring reassurance by addressing individual concerns.

Consistent with recommendations in clinical practice guidelines, clinicians in this study believed that the provision of reassurance was important for people with LBP. However, quantitative investigations of the effect of reassurance on patient outcomes have yielded mixed results. A systematic review that investigated the effects of reassurance on patient outcomes found that affective reassurance demonstrated inconsistent results for patient enablement and satisfaction, whereas cognitive reassurance was associated with increased satisfaction, patient enablement, and reduced concerns and healthcare utilisation.¹² A subsequent systematic review found that patient education reassures patients with acute LBP, as well as reducing subsequent healthcare use.²⁷ In contrast, a mediation analysis of the PREVENT trial²⁸ found that reassurance does not reduce disability or healthcare utilisation.²⁹ The PREVENT trial²⁸ explored the effectiveness of patient education on low back pain outcomes. These mixed results may reflect the complexity of the delivery of reassurance and the need for appropriate individualisation, also highlighted in this study.

These results support and extend existing evidence that relationship building and individualised data gathering (understanding a person's pain) are essential precursors to delivering effective reassurance. A qualitative study of patients consulting with general medical practitioners found that patients value affective reassurance (including relationship building, being taken seriously, feeling that the doctor listened and understood their story, and when they felt that the doctor was doing everything they could to help).¹⁵ Although these behaviours are viewed positively, there is some evidence to suggest that affective reassurance is associated with reduced recovery and higher symptom burden.¹² They concluded that the role of relationship building and empathy remains unclear.¹⁵ The current study provides insights from a clinician's perspective that relationship building and empathy might be necessary for patients to engage with cognitive reassurance. These elements of a patient encounter (relationship building and data gathering) are also part of a validated patient-reported outcome measure, the consultation-based reassurance questionnaire, used to ascertain a patient's level of reassurance and includes subscales on relationship building and data gathering, further emphasising the known importance of clinicians engaging in these behaviours.^{30,31} This study is the first to explore whether and how clinicians are actually performing these reassuring behaviours during consultations and the barriers and enablers that they face with delivering reassurance. The findings demonstrate strategies that were employed by the clinicians when delivering reassurance to enhance relationship building and individualise data gathering.

Clinicians detailed the importance of an individualised approach to reassurance, which includes tailored data gathering to identify a patient's concerns and their understanding of LBP, and tailored delivery to reduce their specific concerns and worries. This approach is supported by available qualitative evidence, which found that to be

reassured, a patient needs to feel that their practitioner understands their history, has carried out thorough examinations and understands how the pain has impacted their lives.^{15,32} In addition, the Australian Clinical Care Standard recommendations for LBP support this approach and recommend to 'assess their [the patients'] understanding of, and concerns about, diagnosis and pain' and provide 'targeted advice to increase their [the patients'] understanding and address their concerns'.¹⁰ This study builds upon this knowledge by offering insight into the strategies used to deliver interventions tailored to patient-specific concerns and worries. These strategies included providing tailored educational messages (cognitive reassurance) and a safe environment for them to experience movement (experiential reassurance). Based on the findings from this research, the expertise of the author team and available evidence,^{10,33} a table was created that outlines some suggestions for clinicians to use to assist them in implementing guideline recommendations for reassurance for NSLBP (Table 3).

Clinicians face challenges with delivering prognostic reassurance when they are uncertain as to whether the patient will experience a favourable prognosis or not. Where clinicians faced uncertainty or identified clinical features making a favourable prognosis less likely, they tended to de-emphasise prognostic discussions in the consultation. This finding is consistent with existing literature that reported 22% of patients who presented with increased distress did not receive prognostic information.¹⁴ In addition, a population of people experiencing LBP generally had beliefs that a poor prognosis was common.³⁴ From a patient's perspective, there is frustration when they seek advice about the expected course of their pain and they receive either vague or no information related to this.¹⁵ While this can be frustrating for patients, prognosis for LBP can be challenging to predict.³⁵ An alternative approach in circumstances where complete recovery is unlikely could be to provide reassurance that their LBP will not get progressively worse. This messaging may be reassuring, particularly in a population who believes that their prognosis is poor. It is proposed that the presentation of information alone is insufficient and that clinicians should also approach consultations as a partnership to help patients to navigate this uncertainty.³⁶ These findings highlight the need for strategies to improve the delivery of prognostic information in these challenging populations.

This qualitative study with rich data explored the perspectives of both physiotherapists and chiropractors about the delivery of reassurance for NSLBP in primary care. This study included clinicians who varied in age, gender, geographical location and years in clinical practice. However, most clinician participants practised in metropolitan areas, meaning that the study may not be representative of clinicians' experiences in regional and rural settings. Most clinician participants rated reassurance as being important and reported frequent use. The findings in this study reflect the perspectives of clinicians who think that reassurance is important; however, this is likely to be a common attitude amongst clinicians. This is evidenced by two qualitative studies that explored general medical practitioners' management of LBP and found that reassurance was important³⁷ and discussed reassurance being included in some form in the first consultation.³⁸ The interview schedule was developed using the TDF, which is a framework that was developed systematically and widely used to explore the implementation behaviours of clinicians. Using this framework helped to ensure that this study included a more comprehensive set of questions. Data were coded by more than one analyst and our team included multidisciplinary perspectives. Employing a qualitative research design provided deep insights into strategies used by clinicians to implement reassurance into practice. Details about clinicians' experiences in delivering reassurance have not been explored in previous research.

Although clinicians reported having the confidence and skills to deliver reassurance, it is unclear to what extent they are delivering reassurance within a consultation for NSLBP, and to what extent the patient is reassured. The delivery of reassurance is important and the reception of this reassurance by patients can be varied. If reassurance is not delivered in the right way, these messages can be perceived as dismissive, as evidenced by '...How am I supposed to feel reassured if

I feel there is something wrong with me, and they keep telling me that everything's fine?³² To gain a deeper understanding of reassurance practices, it is necessary to undertake observation of reassurance practices via ethnographic studies. Furthermore, self-reported patient data should also be collected during these consultations to determine the reception of reassurance by patients. Further investigation of the relationship between clinicians' self-reported reassurance delivery, observed reassurance during a consultation and patient-reported measures of reassurance should be explored.

Clinicians felt that there was scant detail available to them about how to apply guideline recommendations regarding reassurance or to manage more challenging clinical situations and that they relied on clinical experience to develop the necessary skills. While this study highlighted patient-specific factors challenging the delivery of reassurance, clinician and systemic factors may also be important and may need further investigation to inform strategies to improve the delivery of reassurance.³⁹ To further support clinicians with limited clinical experience, entry-level clinical training programs for health-care professionals involved in the management of NSLBP should incorporate competencies related to the delivery of reassurance, as recommended in recently developed curriculum content standards for NSLBP.⁴⁰ Suggestions to begin this process are provided in Table 3.

Clinical experience is one mechanism that clinicians have used to gain the skills to deliver reassurance; however, there is evidence to support alternative strategies such as the use of implementation interventions to assist clinicians in bridging the evidence-to-practice gap.^{41,42} Some examples of these strategies could be observational methods of audit and feedback, and interventions designed to train clinicians to subsequently improve an aspect of patient care. To accelerate skill gain, implementation interventions should be developed to target improving reassurance delivery skills. Implementation interventions may assist with increasing the use or adoption of reassurance delivery.⁴³ Examples from existing research have shown that implementation interventions not only enhance the uptake of clinical practice guidelines into clinical practice, but also increase clinicians' knowledge and confidence in delivering guideline-based care.⁴¹

To conclude, the clinicians had a strong understanding and motivation to deliver reassurance for NSLBP in clinical practice; however, they recognised that they required clinical experience to effectively translate knowledge into reassurance skills. Individualised delivery of reassurance is required in clinical practice to address patient-specific factors that challenge rapport building and the successful delivery of reassurance. This study provides insights into how reassurance is individualised in clinical practice to address patient concerns and reduce fear.

What was already known on this topic: Clinical practice guidelines consistently recommend that people with NSLBP of any duration (acute, sub-acute and chronic) receive reassurance as part of their care. Reassuring messages recommended in clinical practice guidelines for NSLBP relate, where appropriate, to the absence of serious pathology, the likelihood of a favourable prognosis and the safety of movement. Clinical practice guidelines typically provide limited detail about how best to deliver these reassuring messages.

What this study adds: Clinicians possess a strong understanding of reassurance but require clinical experience to confidently deliver it. This study provides insights into how reassurance is delivered and individualised in clinical practice, including suggestions for clinicians about how to implement reassurance effectively for people with low back pain. Suggestions to help clinicians overcome these barriers were developed as a result.

Footnotes: ^a REDCap, REDCap Consortium, Nashville, USA. ^b Microsoft Teams (version 4.2.4.0), Microsoft Redmond Campus, Redmond, USA. ^c NVivo software (version 14), Lumivero. 2023. Available from <https://www.lumivero.com>

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