

Reassurance during low back pain consultations with GPs:

a qualitative study

Abstract

Background

Reassurance is commonly recommended in guidelines for the management of low back pain in primary care, although it is poorly defined, and what it means to patients remains unknown.

Aim

To explore how patients with low back pain perceive practitioners' reassuring behaviours during consultations.

Design and setting

Qualitative study undertaken with patients from nine GP surgeries in Northamptonshire, England.

Method

Twenty-three patients who had recently consulted for non-specific low back pain were recruited from general practice. Semi-structured interviews explored what they had found reassuring during their consultations and the effect of such reassurance since their consultations. Interview transcripts were analysed using the thematic framework method.

Results

Patients each brought to their consultations experiences, beliefs, expectations, and concerns that they wanted the doctor to hear and understand. They were reassured implicitly when it seemed the doctor was taking them seriously and wanted to help; this was also achieved through relationship building and feeling that the GP was readily available to them. However, it was only explicit, informational reassurance that directly addressed patients' concerns by providing them with explanations ruling out serious disease, and helped them to understand and cope with their pain.

Conclusion

The themes of implicit and explicit reassurance uncovered here correspond with ideas of affective and cognitive reassurance, respectively. Although the findings support the use of information and education to alleviate concerns, the role of implicit reassurance through relationship building and empathy remains less clear. The impact of these behaviours on outcomes should form a priority for future research.

Keywords

back pain; general practice; low back pain; physician-patient relations.

INTRODUCTION

Low back pain is common,¹ costly,² and, if it becomes chronic, can be extremely difficult to treat effectively.³ As such, preventing acute low back pain from becoming chronic is of utmost importance. Clinical guidelines commonly recommend that practitioners provide 'reassurance' to patients.⁴⁻⁶ However, what 'reassurance' means in this context, and how to deliver it effectively, is poorly defined and under-researched.

Coia and Morley⁷ posit a distinction between affective (emotional) reassurance, which reduces patients' anxiety immediately, and cognitive (informational) reassurance, which is slow, iterative, and assumed to have a longer-term effect of changing patients' beliefs and behaviours, thereby enabling them to manage their condition. They argue that because affective reassurance is easier to engage with and reduces anxiety, it may demotivate patients from engaging with the more laborious but temporally stable cognitive reassurance that would help them to cope with their problem, even in the absence of the clinician's reassuring presence. They recommend, therefore, avoiding affective reassurance entirely, although this contradicts most current thinking about patient-centred interactions and the need to build trusting relationships.⁸

A recent systematic review⁹ investigated evidence for the model from 16 prospective cohort studies of patients with non-specific disorders in primary care settings. Findings suggested that affective reassurance,

although sometimes improving patient satisfaction, was linked to poorer patient outcomes. Cognitive reassurance, in contrast, related to improvements in symptoms and decreased healthcare utilisation, providing support for the notion that cognitive and affective reassurance may not be equally beneficial to patients.

It is necessary to understand the personal meaning of reassurance from the patient's perspective. In the qualitative studies on consultation behaviour and communication, there is a broad consensus that patients want doctors to understand their personal contexts,^{10,11} that they value caring behaviours,¹² and want as much information as they can get.^{12,13} Patients appear to value both affective and cognitive reassurance as important parts of the consultation; however, the focus of previous qualitative work has been on doctor-patient communication generally, and not on reassurance specifically. This study aimed to explore how patients with low back pain perceive their consultation in reference to affective and cognitive reassurance.

METHOD

Participants

Adult patients (aged ≥ 18 years) who consulted for low back pain within the previous month (there were monthly searches between May 2013 and November 2013 to select eligible patients), at nine GP surgeries in Northamptonshire, England, were invited to participate in the study.

N Holt, BSc, postgraduate research student;
T Pincus, PhD, professor in psychology, Department of Psychology, Royal Holloway, University of London, Egham, Surrey. **S Vogel**, DO, vice principal, research, British School of Osteopathy, London.

Address for correspondence

Nicola Holt, Psychology Department, Royal Holloway, University of London, Egham, Surrey TW20 0EX, UK.

E-mail: ztjt128@live.rhul.ac.uk

Submitted: 16 January 2015; **Editor's response:** 9 March 2015; **final acceptance:** 8 May 2015.

©British Journal of General Practice

This is the full-length article (published online 28 Sep 2015) of an abridged version published in print. Cite this article as: **Br J Gen Pract 2015; DOI: 10.3399/bjgp15X686953**

How this fits in

Reassurance is commonly recommended in consultations for low back pain, but is not often explicitly defined. This study provides responses from patients with low back pain on what they consider to be reassuring when visiting their physician. This includes listening to patients' stories and making patients feel that they are being taken seriously, as well as providing reassuring information.

Patients were excluded if they:

- had 'red flag' markers for potential serious disease (cancer, severe disability, or terminal illnesses);
- had had previous spinal surgery;
- were pregnant at the time of the consultation;
- had cognitive impairment or serious mental health problems; or
- were considered by the GP to be vulnerable and unsuitable to take part.

Eligible patients were identified through searches in each practice's database. The search protocol was reviewed by an independent company that had expertise in NHS database systems; search results were checked by GPs to ensure patient suitability.

Recruitment lasted from May 2013 until November 2013. Invitation letters and information sheets were posted to eligible patients.

Materials and procedures

After participants signed a consent form, interviews were conducted at their GP surgery. A short questionnaire (completed just before the interview) collected demographic information (age and sex), as well as information about participants' back pain. Participants rated their pain intensity in the previous week on a scale of 0 (no pain) to 10 (worst possible pain) and identified how long they had been experiencing their current episode of low back pain.

Other questions focused on:

- whether patients had taken time off work due to this episode of back pain (yes/no/not applicable) and, if so, how long;
- whether this was their first episode of back pain (yes/no) and, if not, how long since their previous episode;
- how many consultations they had had with their GP for this episode of back pain;

- whether they had seen any other health professionals since their consultation;
- how long it took between contacting their surgery and seeing the GP; and
- consultation length.

Finally, the Roland-Morris Disability Questionnaire¹⁴ assessed their functional status at the time they had visited the GP. This scale has been validated for use in such populations.¹⁵

The semi-structured interview schedule was developed in collaboration with a team of experienced low back pain researchers (including two psychologists, an osteopath, and two GPs). Interviews focused on two main areas:

- what happened during participants' consultations (with a specific focus on their concerns and expectations); and
- how their pain had been since.

For the full interview schedule, please contact the authors.

Interviews were audiotaped and transcribed. Audiotapes referred to participants only by number, and identifying information was removed from transcripts.

Analysis

Transcripts were analysed using QSR International's NVivo software (version 10) utilising the framework approach.^{16,17} This approach is recommended when an existing model is being compared with interview data.¹⁸ Although a conceptual model exists for reassurance during low back pain consultations⁹ and the present researchers were involved in developing this model, analysts allowed participants' own responses to inform the development of codes and the final thematic framework.

The analysis was conducted iteratively using induction in the early stages of analysis, and deduction when considering the thematic analysis and how it fits with existing theory. As part of the analysis, the team explicitly discussed their own prior knowledge and views, along with the impact this might have on the analysis; this was to enhance the validity of the process and to control for what Ritchie and Lewis call 'bullying' the data to fit with a pre-determined theoretical model.¹⁷

After transcripts were examined to enable familiarisation, a coding framework was developed. All transcripts were then coded by one researcher according to the framework, with data arranged into separate thematic matrices for each code. Within each matrix, coded data was

summarised, retaining the participants' own words as far as possible.

Matrices were then examined by two researchers. This stage of analysis attempts to describe and explain the data by examining participants' responses across codes, labelling these in order to describe categories of thematic information, and searching for recurrent themes and associations in what is being said. Where a possible theme emerged, it was discussed between the two researchers and checked against participants' original transcripts to ensure fidelity to the data. When consensus was achieved, the themes were organised into a final theoretical framework.

RESULTS

Participants

In total, 181 eligible patients were invited to participate in the study. Twenty-eight responded, giving a response rate of 15.5%. One patient declined to participate when telephoned to arrange an interview, two failed to arrive, and one was unavailable within the study period; as a result, interviews were conducted with 24 participants. One failed to record, leaving a total of 23 transcripts for analysis.

Table 1 displays participant characteristics. Although interviewing participants after their first consultation would have been ideal, 11 had had previous

consultations with their GP for their current episode of low back pain (an average of 2.4 consultations) and some had seen different health professionals since their visit to the GP. Where applicable, this was incorporated into the interview schedule and participants were asked to discuss significant practitioner communication behaviours from any of their consultations.

Findings

Box 1 illustrates how initial coding themes and subthemes mapped onto the final thematic framework. The first two columns ('coding theme' and 'coding subtheme') represent codes that were applied to each transcript to aid data synthesis. The themes that emerged were organised under three headings:

- patient factors;
- implicit reassurance; and
- explicit reassurance (labelled 'main theme' in Box 1).

Although most of the original codes mapped directly to one of these headings, some information could be included under two of the main themes. As an example, patients' thoughts on imaging reflected their need to feel taken seriously (implicit reassurance) and their need for explanation (explicit reassurance).

Patient factors

The first main theme concerns patient factors, or what patients bring with them to the consultation, namely, their experiences and their beliefs. Their experiences include:

- experiences of pain: how the experience of low back pain has been felt by patients;
- impaired activities: impairment in daily living, for example, work, sleep, hobbies, or movement;
- mood: negative mood as a result of low back pain; and
- interactions and comorbidities: other conditions or medications that have either contributed to the pain or hindered recovery.

Patients indicated why they had been prompted to visit their GP:

'It was because I got different pain ... Because my pain was different to that which I would normally experience, I chose to see a doctor.' (PPT [participant] 013, male).

They also reported how their pain had affected them:

Table 1. Participants' characteristics (n = 23)

Average age, years (SD)	57.2 (16.0)
Sex, n (%)	
Male	13 (56.5)
Female	10 (43.5)
Average pain intensity (SD)	5.4 (2.5)
Episode length (%)	
0–1 month	1 (4.3)
1–3 months	11 (47.8)
4–6 months	1 (4.3)
7 months–3 years	5 (21.7)
>3 years	4 (17.4)
Missing data	1 (4.3)
Time off work (%)	
Yes	5 (21.7)
No	7 (30.4)
n/a	11 (47.8)
Average time off work, days (SD)	13.2 (10.9)
First episode? n (%)	
Yes	5 (21.7)
No	18 (78.2)
Average number of previous consultations for this episode of low back pain (SD)	2.4 (1.67)
Average time to appointment, days (SD)	3.92 (5.2)
Average consultation length, minutes (SD)	12.4 (5.0)
Average RMDQ score (%)	10.9 (5.3)

RMDQ = Roland–Morris Disability Questionnaire. SD = standard deviation.

Box 1. Initial coding themes mapped to final thematic framework

Coding theme	Coding subtheme	Main theme	Categories	Elements	
Data giving	Comorbidity	Patient factors	Pain experiences	Experience of pain	
	Description of problem			Mood	
	Lifestyle			Impaired activities	
	Triggers and causes			Interactions and comorbidities	
Concerns	Future disability				
	Progression of pain				
	Serious disease				
	Specific condition				
Hopes and expectations	Cessation or cure		Beliefs	Causal attributions	
	Information			Concerns	
	Pain reduction			Expectations	
	Prescriptions				
	Resignation to pain				
	Acceptance of limits of the system				
	Expectations met or not				
GP as gatekeeper	Not an expert				
	Referral point				
Examination	Examined	Implicit reassurance	Being taken seriously	Doctor listens	
	Not examined			Examination	
Reassurance	Doing everything they can			Doctor wants to help	
				Treated as a whole	Doctor-patient relationship
					Relationship building
Affective behaviours	Doctor listens			Knowing the doctor	
	Emotional responses				
	Informal discussion			Setting	
	Positive response			Availability	
	Taking patient seriously				
Dismissive behaviour					
Relationship with practitioner	Finding common ground				
	Knowing doctor				
	Seeing unfamiliar doctors				
	Trust in doctor's judgement				
Quality of care	Practice characteristics				
	Time spent with doctor				
	Waiting times				
Barriers to communication	Don't like to ask				
	Feeling like a time-waster				
	Reluctance to re-consult				
	Avoidance of further healthcare utilisation				
Addressing concerns	Concerns not addressed				
	Not given chance to discuss				
Imaging	Not offered	Implicit and explicit reassurance	Being taken seriously	Doctor wants to help	
	Requested by patient			Explanations	
	Refused			Physical explanation	
Sent for					
Diagnosis	Confirmation or disconfirmation of suspected condition	Explicit Reassurance	Ruling out serious disease	'No disease' explanations	
	Certainty from doctor			Explanations	
	Quite serious			Cause	
				Physical explanations	
				Advice	
Importance of having a diagnosis				Prognosis	
Assumptions made in absence of diagnosis					
Explanation	Ageing		Decision making	Treatment explanation	
	Physical explanation			Treatment choice	
	Discussion of scan results				
	Sharing information				
	Visual aids				
	Responsibility of patient				
	No explanation				

'The bad back is always there. It's even there now, as I'm sitting, and I think I've only got to do something extraordinary, like sneeze, or run, or do something where I turn, that it's just going to go off again.' (PPT 023, female)

'Well it affects my whole life because I can't do what I need to do, and then along with ... because I have a bladder issue, so my urgency in the morning, that's a big problem, and I'm not very old to find that that's really embarrassing, that I don't get to the toilet in the mornings.' (PPT 005, female)

'I can't walk properly or manage stairs, and I have to be careful moving the lawn and things like that, you know, and walking the dog. I have to remember which leg to leave when I go up a step.' (PPT 001, male)

Some participants reported how their pain had a negative effect on their mood:

'The pain was beyond [what] the paracetamol could deal with and I couldn't sleep at times, umm, getting irritated.' (PPT 006, male)

'It does get a bit depressing because it's sort of ... when you want to go and do something, you feel that you can't give it your full, you know, 100% because it aches too much. It just aches.' (PPT 010, female)

Participants had also found that other conditions or medications had either led to, or complicated, their experience of pain:

'I was putting it down to the fact that I was taking statins and I had tested myself going off statins for 3 months, going off for 5 days, and then going back on to them, and the back pain seemed to stop, so I put it down to the statins.' (PPT 003, male)

'I've also got another condition, polymyalgia, and I'm taking steroids for that ... And because of the lack of exercise on the steroids I've put on a lot of weight, put on 3 stone, since last October, and this was ... so it becomes a vicious circle ... umm, the more weight you put on, the worse the pain.' (PPT 002, male)

Participants wanted their GP to understand their experience of pain:

'Oh it impresses me that someone is uh ... is uh ... they must be more interested if they ask for more detail, they must be more

Box 1 continued. Initial coding themes mapped to final thematic framework

Coding theme	Coding subtheme	Main theme	Categories	Elements
Addressing Concerns	Ruling out serious disease	Explicit Reassurance [Continued]	Decision making [Continued]	Treatment choice [Continued]
Prognosis	Poor outlook Time to recovery Uncertainty over time to recovery Not much can be done			
Lifestyle advice	Changing lifestyle Fitting treatment into lifestyle How to help oneself Maintaining activity			
Reassurance	Doctor not concerned about serious disease			
Treatment	Offered a choice Doctor as expert Explanation of treatment Shared decision making Treatment preferences			
Uncertainty	Doctor not sure Guesswork Tackling uncertainty			

interested, they must be keen I think. (PPT 018, male)

In addition, patients held their own beliefs about what had caused their pain, what it might mean, and what they expected from their consultations and treatment. In terms of causal attributes, patients' comments were as follows:

'I walked in and said I think I've got sciatica, it's quite bad.' (PPT 004, male)

'I think it could be related to the job I do because, instead of bending at the knees, because I work in a shop, you tend to bend at the waist to do things, and it's a job where you have to do that quite a bit, so I don't know whether it's been over a long period of time, it's ... done something to the muscles and stuff, I don't know.' (PPT 010, female)

Many were concerned about what the pain meant:

'You wake up the next day and it's still there, and that's the only reason that I came in because ... I keep having ... that's a bit more than just nothing you know.' (PPT 019, female)

'I imagined all sort of things, you imagine cancer, you imagine something wrong with your kidneys.' (PPT 017, male)

'Well I suppose the concerns you can only say is when it's happening the pain is so

bad that you think a) it might be something worse than what you've had, or b) is this going to immobilise me for longer than I want?' (PPT 023, female)

Participants also reported on what they expected from their consultation and their treatment:

'I was hoping he would give me some soluble co-codamol and he didn't. So I get that myself now, buy that myself.' (PPT 007, male)

'As I said, I was expecting to go for an X-ray or a blood test or these sort of things what should be done to find the exact cause of the problem.' (PPT 015, male)

'I didn't know what to do, so really I was coming for advice because I thought "Shall I do this, shall I do that?" Don't really want to take any time off work, but I don't want to pay for an osteopath, because I've got private medical, the doctor will advise me.' (PPT 022, female)

Participants felt it important for their GPs to hear and understand their beliefs, especially when they worried that their pain meant serious disease. For example, if a participant thought that their job was causing their pain, they wanted this confirmed by the doctor so that they could act on it and make changes:

'If they do turn around and say, "It's your job and you've either got to put up with it, or change what you do", you can go from there, but I'm not going to do it ... not going to stop doing what I'm doing because they've not told me what it is.' (PPT 010, female)

Although almost all participants reported that they had concerns and expectations going into their consultations, some patients did not feel able to discuss these at the time, either because they were not given the chance to or because they did not want to burden the GP:

Interviewer (I): *'Have you felt able to tell the doctors about those worries [of becoming incapacitated]?'*

Participant (P): *'No.'*

I: *'Why is that?'*

P: *'Because he don't ask me for this. When he don't ask me I don't think.'* (PPT 009, male)

I: *'Were you able to address these concerns with the doctor?'*

P: *'No, not really, not really. I didn't want to burden them ... But I've just worked that out for myself as well ... So that was it really.'* (PPT 023, female)

Implicit reassurance

Implicit reassurance refers to events that patients found reassuring outside of spoken messages from the doctor, and involved:

- being taken seriously: doctor listens (patient felt the doctor listened and understood their story), examination (being examined during consultations), doctor wants to help (feeling the doctor was doing everything they could to help);
- doctor-patient relationship: relationship building (engagement in behaviours intended to form relationships between doctors and patients), knowing the doctor (having a prior relationship and feeling 'known' by the doctor); and
- setting: availability (ease of access to the GP and how much time was available for patients).

Being taken seriously was very reassuring to participants in this sample. They wanted to feel that the doctor had listened to and understood their situation and was motivated to help them. In some cases, this appeared to have been achieved:

'Only that she listened really. Umm she listened.' (PPT 020, female)

'My own doctor is a very caring doctor, very uhh ... doesn't leave it. Wants to get to the bottom of the situation and has a very good bedside manner ... So will listen to you and doesn't pre-empt or try to pre-empt.' (PPT 017, male)

'As I said, in the first one, it was a good thing that the doctor really recognised that this is a serious pain and needs resting. With the second one I'd been examined a bit better and that was a sign that, yes, this doctor wants to help me some way.' (PPT 015, male)

'So that sort of ... umm ... care that she took gave me umm ... a feeling of wellbeing if you like ... You know, understanding that she wanted to treat me properly, was willing to treat me the way I needed to be treated, and so on.' (PPT 013, male)

Examining the back or ordering further tests indicated to participants that they were being taken seriously:

'With the second one, I'd been examined a bit better and that was a sign that, yes, this doctor wants to help me some way.' (PPT 015, male)

Likewise, the opposite was also true:

'[not being examined] did bother me slightly because I wouldn't have thought you'd be having a pain that long, they would have done something a bit more than just tell me to take ibuprofen.' (PPT 010, female)

In a number of cases, these behaviours were sufficient to meet participants' expectations from the consultation, as well as indicating that the doctor wanted to help.

Building or already having a relationship with the doctor was another way in which participants were implicitly reassured. Some patients reported having a good relationship with their doctor:

'Doctor has a very good sense of humour and we always have an amusing, sensible conversation ... We could have sat there and chatted for hours but uhh ... because she's an easy person to talk to.' (PPT 003, male)

'I've got I feel it's an affinity with him ... I mean I've lost a couple of stone in the last year to help my diabetes and that, and he said he'd been on the same diet ... Yes, and also I think he goes to the same chiropractor from what he said ... So, you know, you do feel an affinity then don't you?' (PPT 001, male)

When participants felt that they had rapport, or a pre-existing bond with their GP, they felt that they could trust them to take them and their complaint seriously:

'I mean my doctor here was my doctor for 20 years ... I knew him, played golf with him on occasions, and so on, and even though he was Dutch, we actually understood one another and so on.' (PPT 013, male)

'He knows exactly inside out of my problems and he knows I don't bother him if it's only [a] small problem.' (PPT 011, female)

Finally, participants found it reassuring simply to know that their doctor was available when needed:

'That there is a doctor available when I wanted the doctor. That pain ... you can't remember pain until you get it again, but you just know it's awful. If I couldn't have got hold of any painkillers or saw a doctor

or was reassured that I was going to get better, that wouldn't have been very good.' (PPT 023, female)

Participants also felt reassured when they had easy access to appointments or were able to spend sufficient time in the consultation to say everything they wished:

P: *'... it wasn't too long, but we went through all the details that were relevant.'*

I: *'Yes. So you felt that you had enough time?'*

P: *'I had enough time.'* (PPT 024, male)

Most participants who had mentioned it felt like the allotted time was not enough:

'But it's increasingly hard for GPs because they're only given a certain slot of time for you to unburden yourself to them, and for them to sort of discern the right thing.' (PPT 025, female)

The problem with limited time for a consultation is that it limited what participants felt they were able to say. As participant 025 said, there is a finite amount of time to 'unburden' yourself with a GP, which could mean that important parts of personal histories are missed out. Participant 013 (male) even described having to plan and manage his appointments, knowing the time restrictions, in order to discuss everything he had wanted to.

Explicit reassurance

Explicit reassurance consisted of getting direct information from the GP, and its effect was closely linked to the patients' need to understand what had caused their low back pain and how to resolve it. It involved:

- ruling out serious disease: 'no disease' explanations (receiving a benign explanation for symptoms);
- explanations: cause (what may have contributed to the onset of the pain), physical explanations (physical structures that cause the pain), advice on how to manage the pain, and prognosis (what to expect in terms of recovery); and
- decision making: treatment explanation (what treatment could be offered and how it would help) and treatment choice (giving patients a choice of treatment options).

Primarily, participants wanted to hear that they did not have a serious disease.

The concerns that they had brought to the conversation were directly addressed by hearing that the cancer, kidney disease, or other illnesses they had been worrying about were not present:

'At least it was a peace of mind that my kidney is alright so it's something less to worry about.' (PPT 015, male)

'It's one of those things, when you have a back problem, you want to come in and just have that reassurance that it's nothing serious and it's, like you say, it's nothing.' (PPT 024, male)

However, although they were grateful to hear that their condition was benign, they were still in pain and needed to know why. Most explanations helped participants to understand why they had the pain, how long to expect it, and how to manage it, which gave them a sense of control:

'She said it wasn't my disc, it was the bits that hold the discs in, and all that and explained how the muscles work, so you can actually then see it in your mind's eye then, when you're doing your exercises, you can get into your mind's eye that exercise is actually doing this or doing that.' (PPT 022, female)

'He explained ... he even got wall charts out and showed me what was going on and why and he started talking about discs and I thought, OK.' (PPT 004, male)

In some cases, however, the explanation given — or a lack of one — was not particularly helpful to participants:

I: *'You said that she explained it would probably just be muscle strain.'*

P: *'Yes.'*

I: *'Did that ... help in any way to know ... to hear that?'*

P: *'Umm ... not really because, at the time, it had just kind of ... I work with a Brownie group in town and it had just kind of come on suddenly, so it wasn't like I'd just been lifting something, so I don't know exactly what caused it originally.'* (PPT 019, female)

'I think it would be nice to know if it's something which I could change briefly or ask some people to change about so that they don't get it.' (PPT 006, male, 41)

Although implicitly reassuring behaviours were appreciated, and behaviours such as ordering tests or making referrals could be

enough to meet participants' expectations, patients reported that information and explanations (explicit reassurance) were necessary to directly address their specific concerns about their backs. Participants also appreciated advice from their doctors about how to manage their back pain:

'... not saying you should do this or should do this, it was the advice of you can do this or this, but I'd suggest you do this first, so you know, all the way along, they're there and I can't argue at all, so quite happy.' (PPT 022, female)

'He just explained that umm ... watch what I do, you know what I mean, and don't over-do it, you know.' (PPT 008, male)

Participants reported what had happened with regard to their prognosis:

'I think he was expecting it to be slightly better but, again, he pointed out that umm you know it could go on for a few months or you could wake up next weekend and think "ooh" ...' (PPT 004, male)

"It can come and go." Words to that effect, you know, you can expect it and uh you can be lucky and not get it like you know, and some days, you could jump about and really get out.' (PPT 018, male)

Explanations of prognosis were generally not well reported in this sample. If participants were given an estimation of when they might recover, it was remembered as being fairly vague, such as those quoted. Participants experienced frustration with not knowing how long they might be in pain for; they had come to the doctor looking for a way to improve their situation, and they did not like to leave not knowing when, or if, such an improvement might be possible:

P: *'I've got a weak spot, that's all really.'*

I: *'OK, and did they say what that meant for you for the future or ...'*

P: *'No, it could just happen at any time really.'* (laughs)

I: *'How is that looking for you knowing that?'*

P: *'Umm it's frustrating really.'* (PPT 020, female)

Having treatments explained in terms of how they would actually make a difference also helped:

'... but again, it's thinking it's only going to ease the pain, it's not going to cure the

problem, umm, but that was explained anyway.' (PPT 004, male)

'Going back to the painkillers and explaining that it allows my muscles to rest, is one of the things and, again, the fact of saying that I need to get up and walk around to allow my back and my muscles to get back to the normal position.' (PPT 024, male)

Along with understanding their treatments, participants found it reassuring to have a choice in their treatment plan where this was offered. This increased their sense of self-control over their back problem:

P: *'He even said to me "What would you like me to do?"'*

I: *'That's what I was coming on to next. Were you pleased that he asked you?'*

P: *'Oh yes ... He could have told me what to do but he didn't. It was a two-way thing.'* (PPT 001, male)

I: *'How important is it for you, do you think, to be sort of involved in the decision making with regards to your treatment?'*

P: *'I think it's very important umm because I've got to manage it. At the end of the day I'm the one with the pain and I'm the one that's umm ... knows what does and doesn't work for me.'* (PPT 016, female)

The focus of this study was on which behaviours patients had found reassuring. If participants felt unsatisfied with their consultations, it was generally due to an absence of reassuring behaviours, rather than due to specific negative behaviours from the physician. For example, participant 005 was disappointed with the treatment she had received as she felt that the GP had not listened, had not taken her pain seriously, and had not offered the referrals she had desired. No unhelpful behaviours specifically emerged from this analysis.

DISCUSSION

Summary

The findings from patients' narratives provided a rich framework of what they perceived to be reassuring. This included the need for doctors to understand their experiences and beliefs, the perception of receiving implicit reassurance through indications of concern, being taken seriously, relationship building, and use of clinical examination procedures. In addition, and most reassuring, was explicit information and explanations that empowered patients towards self-management.

Explicit reassurance is described as most reassuring because it was the most effective method through which participants' concerns were addressed, and so reduced. Although participants appreciated the implicitly reassuring behaviours, they did not lead to a reduction in worrying thoughts about the pain. The importance participants placed on receiving explicit explanations are illustrated in the quotes below:

'... even if it's bad news, uhh, it's good to know somebody's diagnosed it ... The big worry is not knowing what it is.' (PPT 001, male)

'I think that was the biggest thing actually ... [the nurse] to say, here you go, this is the issue and this is how you resolve it.' (PPT 024, male)

Strengths and limitations

The response rate for this study was low (15.5%), which may have reflected the burden that interview studies place on participants. Additionally, though the aim was to interview only participants with new episodes of low back pain, the database search picked up patients who were not within the original search parameters. This reflects the intermittent nature of low back pain, in that it is very difficult to identify truly new cases.^{19,20} To address this, the interviewer widened the discussion with these participants to incorporate their overall experience with GPs throughout their illness, with a specific focus on early messages of reassurance they may have received. However, it is possible that their ongoing pain may have coloured their responses, meaning that the results of this study do not entirely represent the experiences of patients who have acute low back pain.

Though the aim of this analysis was to be inductive, and to let participants' responses speak for themselves, there is always a risk of researcher-related factors influencing the interpretation. The authors attempted to control for this with explicit discussion of researchers' prior knowledge, and whether this was influencing interpretations at any stage, and by checking the final thematic framework against participants' original responses to ensure that they had been accurately represented.

Comparison with existing literature

These findings support the model of reassurance comprising emotional and informational, or affective and cognitive, aspects.^{7,9} Affective reassurance can be

achieved through implicitly reassuring behaviours such as listening and credible examination, and it appears to be linked — both in the current study and in previous evidence — to increased satisfaction.⁹

There is some evidence that affective reassurance is associated with poorer patient outcomes.⁹ This study did not find evidence to support this and the findings suggest that affective reassurance is viewed positively by patients, irrespective of outcomes. Perhaps this is an example of the discrepancy between what patients want and what they need. Without sound evidence in the context of a timeline, the relationship between affective reassurance and the outcomes of patients with low back pain remains unknown.⁷

Although patients appreciated the implicit behaviours that made them feel that they were being taken seriously, they reported that it was only through explicit explanations that their specific concerns, such as those about serious disease, were addressed. Explicit reassurance also involved advice from the doctor about self-management, which allowed patients to understand and change their behaviour, activities, or movements accordingly, thereby aiding their coping and recovery. These findings support the observed association between cognitive reassurance behaviours and improved patient outcomes,⁹ as those who had received better explanations and management advice were less concerned and more enabled.

Implications for practice

The findings of this study lend support to a distinction between emotional (affective) and informational (cognitive) reassurance during consultations for low back pain. Both are valued by patients, who need to feel understood and, in turn, better understand their pain and treatment. However, the explicit giving of information appears to be a key process in addressing patients' concerns about their pain. Giving such information may help to manage patients' expectations (such as those of people who may request imaging that is not clinically indicated) and reduce re-consultations by equipping them with the knowledge to self-manage.

Further research is required to evaluate the extent to which affective reassurance is required for successful cognitive reassurance, and the relationships of both with patients' behaviours and outcomes.

Funding

Nicola Holt is supported by a studentship from the Economic and Social Research Council's Doctoral Training Centre.

Ethical approval

This study was approved by the Greater Manchester West Proportionate Review NHS Research Ethics Committee (ref: 13/nw/0107) and by the Psychology Department, Royal Holloway, University of London's ethics board.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Acknowledgements

The authors acknowledge the support of the National Institute for Health Research Clinical Research Network (NIHR CRN). The authors would also like to acknowledge the Northamptonshire Research and Development Service for their assistance in setting up this study. Thanks also go to the surgery staff involved in recruiting patients, and the patients who gave their time to be interviewed.

Discuss this article

Contribute and read comments about this article: bjgp.org/letters

REFERENCES

1. Hoy D, Bain C, Williams G, *et al.* A systematic review of the global prevalence of low back pain. *Arthritis Rheum* 2012; **64(4)**: 2028–2037.
2. Maniadakis N, Gray A. The economic burden of back pain in the UK. *Pain* 2000; **84(1)**: 95–103.
3. van Middelkoop M, Rubinstein SM, Kuijpers T, *et al.* A systematic review on the effectiveness of physical and rehabilitation interventions for chronic non-specific low back pain. *Eur Spine J* 2011; **20(1)**: 19–39.
4. van Tulder M, Becker A, Bekkering T, *et al.* Chapter 3. European guidelines for the management of acute nonspecific low back pain in primary care. *Eur Spine J* 2006; **15(Suppl 2)**: S169–191.
5. Airaksinen O, Brox JI, Cedraschi C, *et al.* Chapter 4. European guidelines for the management of chronic nonspecific low back pain. *Eur Spine J* 2006; **15(Suppl 2)**: S192–300.
6. Koes BW, van Tulder M, Lin CW, *et al.* An updated overview of clinical guidelines for the management of non-specific low back pain in primary care. *Eur Spine J* 2010; **19(12)**: 2075–2094.
7. Coia P, Morley S. Medical reassurance and patients' responses. *J Psychosom Res* 1998; **45(5)**: 377–386.
8. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med* 2000; **51(7)**: 1087–1110.
9. Pincus T, Holt N, Vogel S, *et al.* Cognitive and affective reassurance and patient outcomes in primary care: a systematic review. *Pain* 2013; **154(11)**: 2407–2416.
10. Donovan J. Patient education and the consultation: the importance of lay beliefs. *Ann Rheum Dis* 1991; **50(Suppl 3)**: 418–421.
11. Donovan JL, Blake DR. Qualitative study of interpretation of reassurance among patients attending rheumatology clinics: 'just a touch of arthritis, doctor?'. *BMJ* 2000; **320(7234)**: 541–544.
12. Laerum E, Indahl A, Skouen JS. What is 'the good back-consultation'? A combined qualitative and quantitative study of chronic low back pain patients' interaction with and perceptions of consultations with specialists. *J Rehabil Med* 2006; **38(4)**: 255–262.
13. Cooper K, Smith BH, Hancock E. Patient-centredness in physiotherapy from the perspective of the chronic low back pain patient. *Physiotherapy* 2008; **94(3)**: 244–252.
14. Roland M, Morris R. A study of the natural history of back pain. Part I: development of a reliable and sensitive measure of disability in low-back pain. *Spine (Phila Pa 1976)* 1983; **8(2)**: 141–144.
15. Pincus T, Santos R, Breen A, *et al.* A review and proposal for a core set of factors for prospective cohorts in low back pain: a consensus statement. *Arthritis Rheum* 2008; **59(1)**: 14–24.
16. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, eds. *Analyzing qualitative data*. Abingdon: Routledge, 1994: 173–194.
17. Ritchie J, Lewis J. *Qualitative research practice: a guide for social science students and researchers*. London: Sage Publications, 2003.
18. Gale NK, Heath G, Cameron E, *et al.* Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Method* 2013; **13**: 117.
19. Kent PM, Keating JL. The epidemiology of low back pain in primary care. *Chiropr Osteopat* 2005; **13**: 13.
20. Pengel LH, Herbert RD, Maher CG, Refshauge KM. Acute low back pain: systematic review of its prognosis. *BMJ* 2003; **327(7410)**: 323.