**Appendix 2.** Coding tree

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| Main theme | Code | Sub-code |
| Giving reassurance is a core clinical skill for delivering high-quality care. | Prognostic reassurance | Favourable prognosis |
| Regression to usual back pain |
| Pathology reassurance | Serious pathology is extremely rarely |
| LBP doesn't usually require imaging |
| Activity reassurance | Activity is safe |
|  | Activity assists with recovery |
| Validation | Validates the patients experience with low back pain |
| Creating a positive outlook | Highlights a path to move forward, beyond this pain experience |
| Motivators to delivering reassurance | Clinicians believe that reassurance has beneficial impacts on patient outcomes |
| Clinicians feel good providing reassuring information |
| Clinicians feel that it is their professional responsibility to reassure |
| Does not want to have the iatrogenic impacts of delivering not reassurance |
| It takes practice and experience to confidently deliver reassurance. | Clinicians feel capable and confident delivering reassurance | Knowledge is sufficient out of university, however, doesn’t have the skills to deliver reassurance |
| Clinicians are confident delivering reassurance | Clinicians are confidence in delivery |
| LBP familiarity creates confidence |
| Reassurance is a skill, and acquired with clinical experience, and observation of patients with conditions and their outcomes | Skills are gained with clinical experience |
| Skills in delivery are necessary to implement reassurance |
| Despite feeling capable and motivated, clinicians identified situations that make it more challenging to deliver reassurance. | Challenges to delivering prognostic reassurance | Knowledge of likely outcomes creates for more skilled delivery of reassurance |
| When patients have risk factors of poorer prognosis |
| Being cautious with what is relayed to patients to not elicit concern |
| When patients don't recover as anticipated |
| Worries about providing false reassurance |
| Patient factors making patients less receptive to reassurance | Patients who had negative beliefs about the cause of their LBP |
| Patients who had negative beliefs about recovery |
| Unfavourable personal experiences with LBP |
| Expectation of only passive care modalities |
| Poor back beliefs |
| Received inappropriate imaging |
| Received conflicting messaging from healthcare providers |
| Rapport | Difficulty establishing rapport (barrier) |
| Established, or easily established rapport (enabler) |
| Patient factor making patients more receptive to reassurance | Previous episode of LBP with a positive outcome |
| Previous reassuring consultations with the healthcare system |
| Positive back beliefs |
| Consistent messaging about low back pain from healthcare providers |
| Enough time present within consultations |
| Reassurance needs to be contextualised to the individual. | Asking about individual concerns | In clinicians’ experiences fears usually centre around either fear about the presence of a serious back problem, movement aggravating pain, and the pain worsening |
| Ask directly about this |
| Asking about an individual’s understanding of a condition |  |
| Individualised delivery of cognitive reassurance | Provide evidence about why serious spinal pathology is excluded |
| Fear about experiencing LBP long-term |
| Fear about not being able to do certain activities |
| Individualised messages that reinforce positive history and exam findings |
| Different levels within a consultation depending on patient presentation |
| Individualised movement-based reassurance | Reassurance through supervised exercise |
| Reassurance through regressed movement |