

The views and experiences of Malaysian primary care doctors in managing patients with chronic low back pain: a qualitative study

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Abstract

Background: Chronic low back pain (CLBP) is a common and often difficult to treat condition in the primary care setting. Research involving in-depth exploration on the views and experiences faced by primary care doctors in managing patients with CLBP in Malaysia is limited.

Objective: To explore the primary care practitioners' views and experiences in managing patients with CLBP.

Study design: A qualitative approach was employed using focus group discussions (FGD) at an academic primary care clinic in Kuala Lumpur, Malaysia. Twenty-three primary care doctors were purposively selected. Data were collected through audio-recorded interviews, which were transcribed verbatim and checked for accuracy. Data saturation was reached by the third FGD. An additional FGD was included to ensure completeness. A thematic approach using the one sheet of paper (OSOP) method was used to analyse the data.

Results: Participants view managing patients with CLBP as challenging. This is mainly due to the difficulty in balancing the doctors' expectations with the patients' perceived expectations during consultation. Barriers identified include lack of awareness and conflicting views regarding the usefulness of the local clinical practice guideline (CPG) in clinical practice. Other barriers include time constraints and perceived lack of support from multidisciplinary teams in managing these patients.

Conclusion: Managing patients with CLBP is still a challenge for Malaysian primary care doctors. Any intervention should target identified barriers to improve the management of patients with CLBP.

Introduction:

Chronic low back pain (CLBP) is a major cause of morbidity worldwide. Back pain accounted for 1.3% of the estimated 214 million visits to primary care physicians in the United States in 2010.¹ The prevalence of low back pain in developed countries is estimated to range from 10 to 31%.^{2,3} In Malaysia, the prevalence of back pain was found to be 12%, and it was rated as the ninth and fifth most common complaint in public and private primary healthcare clinics, respectively, between August to November 2012.⁴ In terms of cost, closer to home, Japan spent approximately 2.7 billion yen in direct costs and another 3.3 billion yen in indirect costs managing low back pain, between 1991 to 1995.⁵ To date, there is limited data on cost analysis for low back pain in Malaysia.

Chronic back pain is defined as back pain persisting for more than 12 weeks.⁶ Compared to acute back pain, the management of chronic low back pain may take years with significant morbidity. It causes pain, diminished mobility, work absenteeism, and is a burden on the healthcare system.^{3,5,6}

Despite the abundance of guidance available, CLBP still poses considerable challenges and frustrations for both patients and health care practitioners.^{6,7} In Malaysia, the local clinical practice guideline (CPG) on management of low back pain was first introduced in 2010 by the Malaysian Association for the Study of Pain.⁶ As this guideline was constructed by experts in the area of pain management, it targets pain management, rather than holistic care, for patients with CLBP.

In Malaysia, studies conducted on low back pain were mainly examining its prevalence, causes, and risk factors.⁸ There is limited evidence on CLBP management using a holistic approach at the primary care level. In actuality, the majority of CLBP patients are treated in primary care clinics.⁷ Thus, exploring the primary care practitioners' perspectives on and understanding of the management of CLBP is important in terms of initiating future efforts to improve delivery of care to patients with CLBP. Hence, we aimed to explore primary care practitioners' views and experiences in managing patients with CLBP in Malaysia.

Study design:

A qualitative study design was employed. This study used face-to-face focus group discussion (FGD) among primary care doctors in a hospital-based primary care clinic.

Setting and population:

This study was carried out in a hospital-based primary care clinic in central Kuala Lumpur, Malaysia. This primary care setting provides comprehensive services to an ethnically-diverse population from different socio-economic backgrounds in Kuala Lumpur.

The setting and participants were purposely selected as this is an academic centre that trains primary care physicians who will subsequently be posted throughout the country. They will go on to be guideline developers, and leaders and trainers of future primary care physicians.

Sampling:

We used purposive sampling to recruit primary care doctors. A total of 23 primary care doctors were interviewed who had from 6 to more than 20 years of working experience (**Table I**).

The participants were primarily post-graduate trainee physicians, and a few were non-trainee physicians. Each focus group comprised 5-7 participants selected based on similarity of working experiences and years in the master program. This was done to facilitate group interactions. All participation was voluntary.

Data collection:

All FGDs were carried out and moderated by the researcher (HS). A semi-structured

interview guide was developed containing a list of open-ended questions covering broad themes designed to address study objectives. More specifically, we formulated the questions for this guide based on the construct of the Theory of Planned Behaviour (TPB).⁹ The Theory of Planned Behaviour explores the relationship between attitudes, normative beliefs, and perceived behaviour control and how these aspects affect the intentions and later mould the behaviours of primary care doctors in managing CLBP.⁹ Questions to uncover attitudes, subjective norms and perceived behaviour control were formulated to gain understanding on how these factors affect the intentions and behaviours of primary care doctors in a consultation.⁹

The FGDs were not restricted to the questions in the semi-structured interview guide, and the participants were allowed to bring up topics that they felt were important. The guide was tested for clarity and refined after a pilot interview, which was carried out before the actual data collection.

The interviews were done in English and lasted for between 45 minutes and an hour. Informed consent for participation and audio-recording was obtained from the outset. The interviews were then transcribed verbatim by two transcribers, and all identifiers were anonymised.

A note taker was present during the interviews to document non-verbal cues and capture participants' identities for transcribing. These observations served as field notes and were also used to note participants' behaviours during the interviews and the overall impressions of the interviewer.

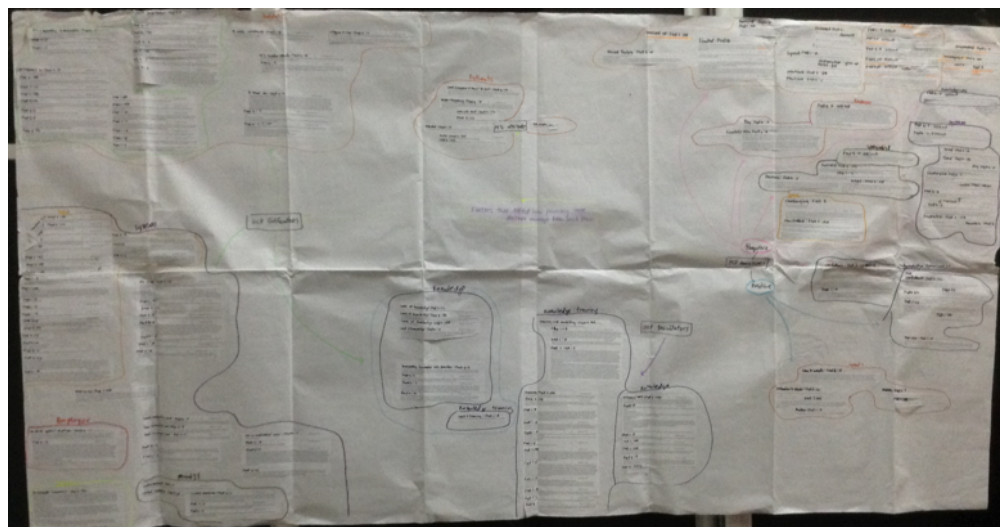
Data analysis:

Data analysis was an ongoing process which started during data collection and proceeded iteratively. A thematic analysis technique was employed, and themes were derived from the construct of the TPB and responses.⁹ As mentioned, interviews were transcribed by two persons and read repeatedly to gain overall understanding. The text from the transcripts was then coded independently by two coders, HS and LSM, using the derived themes. Coding was a data reduction process and aimed to classify all the data so that it could be compared with other sets of interviews.¹⁰ Discussions between HS and LSM were used

to resolve any discrepancies with the open coding. They also discussed and checked the labelling of the coding framework. Following the open coding, codes were examined using OSOP (one sheet of paper) analysis.¹¹ This was accomplished by grouping specific quotations according to relationships or linkages within a code. A NVivo report was created using the

software package NVivo 10 which consisted of all the different issues brought up by the participants. This was then noted on a single sheet of paper, along with the relevant respondent coded identities. The transcript was then rechecked for any data which was not included in the NVivo report, and any relevant data was added into the OSOP (**Figure I**).

Figure I: One-sheet of paper (OSOP) analysis



When the OSOP was completed, a summary of all the relevant issues was created and relationships examined. The next step was to group the issues into broader themes and, finally, main themes. The main themes were then compared with the Theory of Planned Behaviour framework and other existing data in the literature.⁹ NVivo 10 allows the organization of quotations into different codes to identify co-occurring codes, and the OSOP approach allows the researcher to make theoretical links within the data set and axial coding. Axial coding is a process of grouping the open codes together into different themes and sub-themes after a process of interpretation of and reflection on the meaning the codes carry. The additional themes and subthemes were re-analysed, and similar subthemes were merged. The whole research process was repeated again and again in an iterative process. Data analysis took place during data collection to ensure data saturation was reached. Primary care physicians continued to be recruited until

this occurred. Saturation is a point at which no new or relevant themes emerge during the data collection process.¹² Data saturation was reached by the interview of FGD 3, and the interview of FGD 4 did not yield any new themes.

Ethical consideration:

Ethical appraisal was obtained from the Ethics Committee of the University of Malaya (MECID NO: 20143-63). Written informed consent to participate in the focus group interviews and have non-identifiable information appear in journal publications was obtained from participants prior to the interviews.

Results:

Of the 23 participants, there were six men and 17 women aged between 30 to 64 years of age (**Table I**).

Table I: Participants' Profile

FGD	Participants	Age	Gender	Ethnicity	Nationality	Years of working experience
FGD 1	P1	36	Male	Indian	Malaysian	11 years
	P2	30	Female	Malay	Malaysian	7 years
	P3	35	Female	Indian	Malaysian	7 years
	P4	33	Female	Malay	Malaysian	9 years
	P5	35	Male	Chinese	Malaysian	9 years
	P6	32	Female	Malay	Malaysian	7 years
	P7	32	Female	Malay	Malaysian	7 years
FGD 2	P8	32	Female	Malay	Malaysian	7 years
	P9	34	Male	Malay	Malaysian	9 years
	P10	34	Female	Malay	Malaysian	10 years
	P11	32	Female	Malay	Malaysian	8 years
	P12	31	Female	Chinese	Malaysian	6 years
FGD 3	P13	35	Female	Malay	Malaysian	9 years
	P14	32	Female	Chinese	Malaysian	6 years
	P15	33	Female	Indian	Malaysian	7 years
	P16	31	Male	Chinese	Malaysian	6 years
	P17	30	Female	Chinese	Malaysian	5 years
	P18	32	Female	Malay	Malaysian	7 years
FGD 4	P19	57	Female	Indian	Other	35 years
	P20	64	Male	Other	Other	37 years
	P21	61	Male	Other	Other	30 years
	P22	50	Female	Other	Other	28 years
	P23	58	Female	Indian	Malaysian	30 years

Four main themes emerged from the analysis of the barriers in managing patients with CLBP. They are as follows.

Theme 1: Mismatched expectations between doctors and patients

Subtheme 1: Matched expectations leads to satisfaction

Participants had expectations of outcomes to be achieved in a consultation for low back pain. If these expectations were met, this created satisfaction. One of the expectations that a number of participants expressed was the ability to explore the patients' expectations.

"Firstly, we should ask; what are the concerns of the patients? Why did the patients come? What has been done before? And what are his expectations from us [doctors]? Then you address it" (P22, FGD 4)

Other expectations included being able to alleviate patients' chronic pain, and to

categorize patients into those needing urgent and non-urgent treatment.

"We need to see whether there is any alarming symptom in patients who present with chronic low back pain. If there is none, that's ok, non-urgent. If there is an alarming symptom, we need to refer urgently for treatment. So, that is the main expectation. I think most of us clinicians want to find out whether this case needs urgent treatment or not." (P5, FGD 1)

Subtheme 2: Unmatched expectations lead to frustration

However, when some of these expectations were not aligned with the perceived patients' expectations, it created frustrations among the participants. These frustrations were seen as obstacles to managing these patients. Frustrations were also expressed with the use of different words such as difficult, limited, heart sunk, and giving up. Other emotions expressed, such as feeling powerless, irritated, stressed, and annoyed, were also used to describe how these participants felt in a

situation where they were struggling to find common ground in terms of management plans with the patients.

"I always find it frustrating when dealing with the patients' expectations. It's an obstacle to manage these patients. It's like trying to hit a brick wall if someone already wants something, and they will not move from the chair to get it done." (P13, FGD 2)

The participants expressed difficulty in managing perceived patients' expectations, such as requests for medical certificates, hidden agendas, or investigations, including imaging. Some physicians stated that patients came to the clinic with preconceived beliefs that an investigation such as imaging was the only way to discover the root of their problems.

"The sole purpose of the patients coming to the clinic is to get the X-ray done. They will request investigation straight-away. They [patients] say that the x-ray or MRI can visualise the spine and any spinal pathology. With our [doctors] assessments alone, we may miss the problems." (P7, FGD 1)

Sometimes patient behaviour that was seen as rude or threatening contributed to frustrations among the participants.

"I'm stressed out when patients start to act rudely in a consultation." (P10, FGD 2)

Primary care doctors in this study will give in to patients' demands due to several reasons. These include perceived difficulty in changing patients' mind-sets, feeling obligated to fulfil these demands in order to maintain a good doctor-patient relationship, and to prevent patients' complaints to higher authorities.

"Some patients, they insisted for something to be done to the extent that they will threaten us. They want to make complaints to the higher management if you refuse to do it. At this point, you have to oblige." (P6, FGD 1)

Although numerous negative emotions surfaced in the management of patients with CLBP, some also felt happy if the patients that they managed felt better, were easy to deal with, or behaved nicely towards them in the decision-making process. Some participants felt frustrated when confronted

with demanding patients who controlled the consultation, while others felt that this was a motivation for them to learn and seek evidence-based knowledge regarding management of back pain. Some participants pointed out that they felt more confident and clinically competent when their clinical findings tallied with the radiological findings.

"Sometimes, you feel good when what you suspected from your examination tallies with the radiological findings. Not good for the patients, but at least it proved that you are clinically competent, and it increased my confidence." (P1, FGD 1)

Theme 2: Time as a challenge in managing patients with chronic low back pain

Subtheme 1: Time constraints can be frustrating

Most participants verbalized their frustrations when it came to time spent managing patients who present with CLBP. They felt that history-taking was a long process as CLBP is a long-standing condition needing a thorough physical examination. Some participants resorted to not performing even a basic physical examination. However, other doctors, even though their time is limited, felt that it was their responsibility to take a proper history and conduct a careful examination in order to help the patients.

"It's not that we [doctors] have a lot of time. But I feel obliged as it's my responsibility to take a proper history and examine the patients. The patients come to me to seek help and they trust me to treat them. So, I will usually take the history and examine them." (P10, FGD 2)

Theme 3: Doctors' perceptions on the local clinical practice guideline (CPG) on low back pain

Subtheme 1: Lack of awareness about a CPG on low back pain

Most participants were unaware of the existence of a local clinical practice guideline (CPG) on managing low back pain. One participant possessed a copy of the guidelines but had never read it.

"Seriously? We have a CPG?" (P8, FGD 2)

Subtheme 2: Lack of practicality for use in clinical practice

There were participants who felt that the clinical practice guidelines were impractical to use in daily clinical practice. They believed that the guidelines only provided them with an algorithm to manage the patients, but that nothing was mentioned on how to deal with patients' concerns and expectations.

"In the low backache guideline, they have the algorithm on how to approach acute and chronic low back pain. I think the algorithm can be followed, but whether it helps the patients, I don't think so. I don't think this guideline talked about patients' expectations and patients' concerns." (P20, FGD 4)

There were those who decided not to follow the guideline recommendations, while others followed them, but felt that, by doing so, they were not able to fulfil the patients' expectations, and thus created dissatisfaction.

"We may be satisfied as we followed the recommended guidelines and we are not missing anything. But the recommended guidelines don't cater for the patients' expectations. They [patients] may not be satisfied." (P15, FGD 3)

However, there were some primary care doctors who felt that the clinical practice guideline helped in terms of improving knowledge regarding diagnosis, providing a structured approach for the consultation, and defending their clinical management when questioned.

"In a way, guideline's recommendations are quite useful because it made me more structured when I see my patients." (P10, FGD 2)

Subtheme 3: Lack of a target to be achieved in a consultation

A participant stated that guidelines for other conditions, such as diabetes and hypertension, provided them with targets to achieve, but this was missing in the local guidelines for CLBP management. Most felt that managing patients with CLBP is about managing the patients' expectations. Some felt that the guidelines were created by highly specialized personnel and that the recommendations were very hard to follow.

"The guideline's recommendations give you

the recommendations on how to approach for chronic low back pain, but you can't practice that. Because the guideline was done by super-specialized heroes [specialists and consultants]. It is difficult for us in primary care practice to follow it [the guideline's recommendations]." (P19, FGD 4)

Subtheme 4: Lack of emphasis on complementary and alternative medicine

As not much emphasis is made in the guidelines regarding complementary and alternative medicine (CAM) in the country, some participants in this study refrained from discussing massages and chiropractic therapies in managing CLBP due to their lack of knowledge regarding these therapies. Some discouraged the use of alternative medications and herbs as they worried that these medications might contain an unknown dose of steroid. A participant mentioned that she had to admit to her patients that she lacked knowledge regarding acupuncture when she was asked about the efficacy of the treatment.

"I have patients who asked me about acupuncture. I just told them that I don't have good knowledge about alternative therapies. So, I cannot tell them whether it can help them with their chronic back pain or not. Maybe they [the patient] can just try." (P15, FGD 3)

Theme 4: Doctors' perceptions of the management of patients with chronic low back pain

Subtheme 1: Lack of a multidisciplinary approach

The participants perceived that a multidisciplinary approach is lacking in the management of patients with CLBP despite this being emphasised in the local CPG. At the primary care level, some felt that the services they could offer were limited and thus felt powerless when patients presented to them with CLBP. The participants felt they were not well-supported in the management of CLBP. In their opinion, the lack of multidisciplinary care made it difficult for them to properly care for patients with chronic back pain.

"It's a dilemma. The system and the lack of multidisciplinary approach are making it difficult to manage chronic back pain in our

practice. We are not giving proper care to the patients.” (P19, FGD 4)

Subtheme 2: The disciplines that are involved in the care of patients with chronic low back pain

The participants viewed that the multidisciplinary team should include disciplines such as orthopaedic, radiology, rehabilitation medicine, physiotherapy, and occupational therapy despite the constraints on personnel and finances in these specialities. Some also mentioned the involvement of social workers, policy makers and non-government organizations (NGOs) in retraining workers. The participants felt that having a multidisciplinary approach would allow patients with CLBP to be managed in a holistic manner.

“We [primary care doctors] need other teams. Orthopaedics [speciality], occupational [therapy], rehabilitation unit, you know. All these [multidisciplinary team]. Together we can help the patients holistically.” (P5, FGD 1)

Furthermore, the participants felt accessibility to commonly referred disciplines, such as physiotherapy, needs to be improved as waiting times can be a challenge to patients.

“Commonly, we refer to physiotherapy. But appointments to the physiotherapist are not like before. Before this, you can walk in on the same day [that] you are referred. Nowadays, let's say you go [to the physiotherapy unit] today with the [referral] form. It's not going to be today. No way. They give an appointment after 2 to 3 weeks. This is difficult for the patient. Why do they need to wait that long?” (P13, FGD 3)

When discussion centred on whether or not primary care doctors should be trained in these areas to cater to the needs of patients, they felt they should not.

“There are occupational therapists and rehabilitation services. They are the ones who received the training. And they do their training in rehabilitation or occupational therapy, so they are the best people to be in the team. Maybe we can help in the initial treatment, initial clerking, initial diagnosis, and channelling them. I don't think any specialist training in occupational therapy or rehabilitation will help us in any way. We are going to be a master of none.” (P23, FGD 4)

Discussion:

In this study, it was found that the doctors' expectations in a consultation were predominantly doctor-centred as opposed to patients-centred, in opposition to current training in family medicine. This conforms to a study done in a similar setting whereby general practitioners were found to be less likely to be patient-centred as compared to other specialists.¹³ A few studies have suggested that patient-centredness is related to satisfaction and use of health resources.¹⁴⁻¹⁶ One study has observed that, if doctors fail to use a patient-centred and positive approach, patients will be less satisfied, less enabled, and may suffer greater symptom burdens.¹⁵ Thus, in the care of patients with CLBP, patient-centredness and a positive approach can improve the care of patients by reducing symptoms burden, enhancing patients' empowerment, and reducing the use of healthcare resources.¹⁵

Ideally, outcomes to be achieved in a consultation should be negotiated between the doctors and patients. This shared decision-making process can improve the patients and doctors' satisfaction in a consultation. The literature related to doctors' expectations in a consultation for back pain is scarce, and there is presently no valid tool with which to measure this.¹⁷

The doctors in this study tend to adhere to patients' demands rather than the evidence-based practice recommended by the CPGs. This contributes to frustrations among doctors. Literature similarly reported that frustration and a sense of powerlessness dominated the consultations on CLBP.^{18,19} Adherence to patients' wishes, such as request for imaging by doctors, is mostly done to prevent unnecessary conflict. This may negatively impact the doctor-patient relationship.^{7,20} However, one study suggested that doctors were overestimating the importance of sustaining the relationship with patients by abiding to their requests without any informed discussion and that doing this may diminish the decision-making powers and professional standings of doctors.²¹

Patients' attitudes, such as being rude and threatening, were also found to cause frustrations among participants in this study. Similarly, the literature indicates that a substantial number of health care workers

experience some form of aggression from patients.²²⁻²³ Careful assessment and logical management of an aggressive situation using a systematic risk assessment and well thought-through protocols can prevent serious harm to the patient, other patients, and members of staff.²⁴

This study showed a spectrum of opinions regarding the local CPG. The unpopularity of the local CPG might be due to lack of promotion regarding its existence and a perception of its lack of usefulness in daily practice, such as containing recommendations which did not suit patients' preferences, and a lack of emphasis on the management of patients' expectations and discussion on the use of complementary and alternative medicines. These findings were similar to other studies which examined the lack of compliance in terms of the implementation of guidelines.²⁵ Other factors mentioned in the literature for ignoring CPGs included perception of the recommendations as not being cost-effective, lack of motivation, and lack of reimbursement for using the guidelines.²⁵ We need to bear in mind that the Malaysian guideline was constructed by experts mainly in the field of pain management.⁶ Future guidelines that focus on holistic care of patients with CLBP should involve other stakeholders, i.e., family physicians, physiotherapists, and representatives from agencies such as the social security organization (SOCSSO).

There is a dire need for holistic treatments options, such as physiotherapy, occupational therapy, psychological services, rehabilitation medicine, and social workers, in the setting under study. Although the services were available in this setting, there is a lack of continuity of care, co-ordination, and communication between these specialties and the primary care unit, which leads to under-utilization of these services. However, funding and manpower may be an issue in an attempt to materialize this. It was viewed that unless back pain were part of the government's targets, it would not receive the attention and funding needed.²⁶

The strength of this research is the study design and study participants. A qualitative study design allows the researcher to conduct an in-depth exploration of the questions under study. However, as the interviewer for this study is a novice researcher, construction

of the interview guide had more targeted questions rather than open questions with which to facilitate the interview. The study participants were the most appropriate key informants for the topic under study as all the participants had been and are managing patients with CLBP in their clinic. In Malaysia, previous studies conducted on low back pain were mainly quantitative. There is still a lack of research in this region regarding the topic under study. One of the limitations of this research was that this study only recruited primary care doctors in a single primary care setting. More perspectives regarding management issues may be generated if other primary care settings within the Ministry of Health and private general practitioners are included. The study also did not take into account patients' expectations, but merely perceived patients' expectations by their doctors. Future studies should include direct exploration of patients' expectations.

Conclusion:

This study highlights the management of CLBP, which is viewed as inadequate. Managing patients with CLBP is still a challenge among Malaysian primary care doctors. These challenges include a lack of even rudimentary interdisciplinary care among core healthcare members, i.e., primary care physicians and physiotherapists. Training on managing frustrations at work and the establishment of an effective multidisciplinary approach is fundamental in providing effective and holistic care to patients with. Future follow-up study can be done to look at the impact of an interdisciplinary and cost-effective approach involving all the core members of the healthcare system. This program should be innovative, structured and include patient education on self-management of their chronic problems.

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How does this paper make a difference to general practice?

- This study shows that primary care doctors' expectations in this study are mainly doctors-centred despite being in a training program that emphasise on patient-centredness and holistic patients' care.
- The study promotes awareness regarding frustrations at work faced by primary care trainees in managing patients with chronic conditions.
- The findings highlight that future strategies to improve the care of patients with chronic low back pain must include a multidisciplinary approach and improvement of the guideline recommendations to suit primary care practitioners.

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