

Reviewer's report

Title: Is motivation enough? Responsiveness, patient-centredness, medicalisation and cost in self-styled Family Practice and conventional care in Thailand

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Reviewer: Paul Bossyns

Reviewer's report:

General

The subject of the script is highly relevant. In the industrialised West, comprehensive and patient-centred care is considered of high value. Family practice is meant to deal with psycho-social and somatic disease, to keep the patient if possible out of the hospital and to protect him from medicalisation.

Experiences in (relatively) low-income countries like Thailand are scarce. The concept is culture specific and therefore often understood in different ways in different cultures.

Nevertheless, a quality health care system cannot ignore the necessity to deal with a patient in a global way, taking into account all disease dimensions.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

The main author is clearly not a native English speaker. Phrasing can be much improved upon and is compulsory for smooth reading. Some words are missing, sometimes there is a word too much (example: second paragraph responsiveness) Something went wrong with the computer editing of the title and the references at the end that became unreadable.

In the abstract the word self-styled practitioners is used. It was for me not evident to know what the authors meant with that. It only became clear when reading the rest. I would suggest to explain the term there or to avoid it in the abstract.

Still in the abstract, significance-testing results should not be exposed there. It makes the reading very difficult. (M-WU ?)

Conclusion in abstract: see also comments further on the general conclusions. But it is not so clear for me whether the authors want to say that "self-styled practice can go a long way..." or rather "S-S practice still has a long way to go..." which would be in my opinion more close to the findings.

The way results are presented leads to confusion. The results should in the first place present the data of the 4 dimensions under investigation. The most important graphs would be 'responsiveness', 'patient-centeredness', 'medicalisation' and 'cost'. But figure 1 concerns waiting times followed by median consultation time, then patient-centeredness, then additional investigations, doctors' reactions and average cost. Out of the 6 graphs, only 2 are dealing with 2 out of the 4 dimensions of family practice. The others are subdivisions (of course it could be interesting to look into).

Under the minor revisions it is suggested to present also a summary table of the 4 dimensions and its sub-components in the methods part.

Either under the discussion or methods a word should be said about possible weaknesses in the study: we have no proof that the measured parameters are a good indicator for the concepts they should describe. The study design does not allow to take a process into consideration: patients are unknown to the practitioners who might very well react differently when it would be a known patient or when the patient would come back with a repeat visit. Many scores are nominal (ex patient-centeredness). Why anxiety relief contributes double to patient-centeredness than empathy or information.

In the same sense, differences in waiting times are maybe statistically different, but from the point of view of acceptability for the patients maybe waiting time zero is not an objective as such.

The conclusion should more clearly state that the typical characteristics of family practice are not met spontaneously: even if convinced, self-styled doctors do not automatically arrive at a significantly better performance. In other words: there is a clear need for professional training. That costs are going down for patient and state is a good lever to convince the government to promote family practice training.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

Introduction: it might be interesting to note in the second paragraph that "Largely an initiative of public sector....." is a negative or opportunistic motivation: quality care is the right for all patients

In the last paragraph of the introduction: the gate-keeping role of family practice is not the same and not always compatible with the typical quality-care characteristics of family practice. It was something which was added afterwards by health care managers.

In the background and methods:

The text might become much more digestible when a table would be introduced with an overview of the 4 dimensions investigated and their respective sub-components. It might make the discussion more easily as well.

In the conclusion it might be interesting to say something more about the perfunctory physical examinations: physical touch is an important quality of any relation and a good medical examination shapes the human relation between client and practitioner. Poor examination usually indicates that the relation is poor.

Discretionary Revisions (which the author can choose to ignore)
none

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article of importance in its field

Quality of written English: Needs some language corrections before being published

Statistical review: No, the manuscript does not need to be seen by a statistician.