Reviewer's report

Title: Doctor-patient interaction in Finnish primary health care as observed by first year medical students

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Reviewer: Kirsti Lonka

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General

A review on the manuscript:
Doctor-patient interaction in Finnish primary health care as observed by first year medical students

Overall evaluation

In all, I do not recommend publishing this article in its current form.

There are serious methodological problems concerning this manuscript. The main problem is that the data merely describe the students perceptions of doctor-patient relationship. No causality can be inferred. The authors, however, claim that their findings support previous findings about the importance of role model in making good doctors and that early medical students pre-clinical health care visits positively contribute to their attitudes towards primary health care work and the doctor-patient relationship. (Abstract, page 3) Other strong arguments are also presented that are not supported by the present data (p. 10 the health care centre visit has a positive effect and seems to turn negative attitudes towards into more positive attitudes; p. 12 the reports strongly support previous findings that Finnish health centre doctors are highly committed) On the basis of the data, it is impossible to establish a causal relation between the health care visits and students attitudes. No external measures of attitudes were carried out. What kinds of attitudes did students have in the beginning? What is the evidence of changing these attitudes?

On page 5, it is said that the intention was to explore students observations and attitudes. If this had the research question, it would have been acceptable to only draw tentative conclusions. The conclusions on page 13, however, are not tentative or exploratory. Instead, they suppose cause and effect: our findings conflict with previous reports from the U.S. claiming that early exposure to family practice does not influence primary care specialty choice. In order to dismiss these previous studies, follow-up data or pre-post measurements would have been called for.

Qualitative research is valuable per se, but it cannot establish causality. The problem is that in the present manuscript only raw data are being presented. Students descriptions about what they witnessed provide only raw data and these data should be conceptualized and interpreted by the researchers. The perceptions of the participants should not be interpreted literally. They are not evidence about whether the health care professionals were good or bad. For instance, a phenomenographic analysis, grounded theory or some other analysis could have been applied. I would strongly recommend using a behavioral scientist in trying to abstract meaning on the basis of qualitative data.

Taking students accounts literally is a serious flaw. The reports only reflect students conceptions and perceptions, not the actual environment. One cannot evaluate health care centers or their impact on students attitudes on their basis. Actually, it remains unclear of what was the intention:
was it 1) to look at students perceptions? 2) to examine the quality of doctor-patient relationship? 3) to explore what happened in the health care centers? 5) to see whether the family doctor system outperforms the more conventional approach? Or 4) to see whether early contacts with primary health care motivate students to specialize in GP?

If interpretation of qualitative data was not the purpose of the present study, it would have been more honest to classify students answers quantitatively and to describe percentages of each category. If data had been collected for three years, why was only one year analyzed? At least it would have been possible to see how frequently certain ideas were expressed. I understand that it was too much to carry out qualitative analyses on all these materials, but at least quantitative measures would have been possible.

Minor comments:

The study took place in certain context and culture. The reader would like to learn more about the context, namely, Finnish health care system. What is typical? What are the central problems?

Previous literature on training communication skills is missing. Can doctor-patient communication be taught? If yes, how? (See Aspegren, 1999).

In the abstract (page 2), it is claimed that for testing the reliability, one of the authors read the reports of 2003 and 2004. The text does not show any reliability measures. Reliability is a technical issue and it should be reported how it was measured.

The language should be checked. As I am not a native speaker, I cannot comment on linguistic aspects more closely.

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

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

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Discretionary Revisions (which the author can choose to ignore)

What next?: Reject because scientifically unsound

Level of interest: An article whose findings are important to those with closely related research interests

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

Statistical review: No
Declaration of competing interests:

I collaborate with the Kuopio University Learning Centre and would be very happy to see their work published. I have given some lectures there and received a fee for that.