Reviewer’s report

Title: ‘Motivational work’: a qualitative study of preventive health dialogues in general practice

Version: 2 Date: 06 Jul 2020

Reviewer's report:

I was happy to read the revised version and really believe that the authors have worked well with the review comments. The paper presents as much clearer now, much more consistent and coherent, with an argument that is central to the text all the time, not going in different directions, and well documented empirically.

So I have a few comments now only, these are minor comments:

Line 132: "MI was followed in order to uncover patients' motivation, wishes, understandings and priorities in terms of their own health in a patient-centered dialogue" - here I am not sure what is meant. Is MI followed or supposed/attempted to be followed? The sentence is part of a paragraph that explains the intervention and whether 'MI was followed' seems to be a finding but should perhaps be just a statement of what the intention wanted? If it is a finding, then the whole analysis should reflect this more and, how it was followed - as it is now the analysis finds that MI is not used/followed as it is supposed to be, right? See e.g. page 13. Perhaps you see this as an example of how MI is followed, being followed inconsistently? To me this was not clear but rephrasing the sentence above might help.

Line 196: I suggest you take out 'and discussion' of the headline. You have a discussion section later. Or is it BMC guidelines wanting you to have that title of the section?

Line 315-317: You mention issues that are appropriate to share with the GP, such as everyday life issues. But I guess you wish to say that 'everyday life issues' are NOT seen as appropriate because they are at the margin of what the general practice setting contains? See also what you write in line 319. Or do you wish to discuss with Mjølstad et al?? If you do, then this is not clear.

Line 432: Could you title this section: Concluding discussion

During the discussion you might include/discuss that whatever risk profile the patients had, this seemed to be 'insignificant' to the health dialogues. I think that this is an important finding and should not be left out, just because it does not play a central role….it is exactly interesting that it has no role, I believe. If you find a space for it, you could include it, but this is just a suggestion for my part.

My main point:
Throughout the paper, the authors continuously use the concept 'biomedical' to designate the GPs' knowledge, reasoning and rationale, and to characterize whatever strategies, comments, solutions, suggestions, approaches etc that the GP may have during motivational work of the health
dialogues. I am not saying that I fundamentally disagree with this, but I encourage you to rethink this somewhat. This is because you risk subsuming all medical knowledge and rationale, everything the GP does, into biomedicine and I think you tend to present to the reader a picture of medicine as a very homogeneous phenomenon, leaving out variations and complexity. I am well aware that we may speak of a dominant biomedical 'medicine' but this is also something that contains numerous variations of different kinds and to leave this out by using a language that reifies and leads to dichotomous thinking is somewhat too simplified. Consequently, what this results in and what you happen to be doing, I think, is that you contrast the biomedical knowledge with the patients' experiences, values, everyday life etc, (e.g. page 14) which eventually reproduces a sharp distinction between 'knowledge and experience' = science and belief = nature and culture/the exotic. This is something Byron Good warned strongly of long ago and I recommend reading his first two chapters in Good: Medicine, rationality, and experience, Cambridge University Press 1994.

I admit it is often difficult to avoid distinguishing in ways that do not fall into this trap, I also struggle with this often, but I felt it important to bring on this critique since it pervades your paper - even though you actually present the patients as also adhering to the biomedical rationale, just not to the topic of the actual consultation! So you do have the option to talk about complexity, on half of the patient and I would say also on behalf of the GP - they do try something which is not entirely biomedically anchored, but also embedded in ways of approaching everyday life that is more public health perhaps, more social medicine/social knowledge? Latour talks about the social basis of medical knowledge, medicine not being based on natural science but social science. For example page 13 - the examples you bring there, first paragraph, are they necessarily biomedical? Or only biomedical?

It might be difficult to fully integrate this perspective into the paper, I think, but I recommend that you go through all the sentences/arguments where you make the distinction as above mentioned and try to soften it a bit. My main message here is that the paper should not reproduce too sharply that doctors think only biomedicine and patients think only everyday life (whatever that is), because you also show that the latter actually do not.

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If not, please specify what is required in your comments to the authors.

Yes

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