Reviewer's report

Title: Low and high attendance at general practice reveals family influence

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Reviewer: Kevin Bennett

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This is an interesting article, but with somewhat limited appeal or application. With modifications, however, it would be suitable for publication.

It seems the point of the manuscript is to encourage providers to view their patients within their social context. It is unclear how they are to do this based upon the results. It would be helpful to identify those factors that result in a lowering or raising effect family, such as education etc. These are factors that a provider can identify and utilize to identify the patient as being in one of these families.

Significant re-wording throughout would be helpful—it is clear it was written by a non-native English speaker. While still well written, it does need editing to be more clearly understood, and for the authors' message to be delivered more completely.

Background, Page 3: Reiterating the comments above, it would be helpful to re-set the paper as a discussion of social factors that providers can learn of and utilize in their practice. The background discussion should be revamped to emphasize this.

Page 3: “In larger families parents may have less time to monitor closely the health of all members.” I am not sure this is necessarily true. Citations from the literature to support this assertion would be helpful, otherwise it should be removed.

Data, Page 4: I am unsure of what the population of this study actually is. The 96 practices represent what percent of all clinics? What percent of the total population is represented? What is the total N, for both families and individuals? The random sample (n = 12,699)—what percentage is that? Is this family level or individual level? Did those who did not respond differ from those who did? What was the final sample size? How was the additional survey conducted? Were these in-person interviews, over the phone, or some other method? A table or description of the variable collected, at what unit, and form how many folks, would be very helpful here.

Definition of Families, Page 4: How many were excluded? What potential biases did this introduce?

Multilevel Analysis, Page 4: This description is confusing and less than adequate. It is also partly discussed on page 6, if I am not mistaken. To describe how the raising and lowering effect families were identified, I need to know who the population was (and how many), what the unit of analysis was (family or individual), what variables were used, what were the levels used, and how the graphs were plotted (using confidence intervals?). Much of this was either not stated, or stated in such a way that I did not follow it. Some variables listed in this section need description as well—generation, practice context for example. The analysis plan should be defined more sequential, and not interrupted by a description of the independent variables.

Independent Variables, Page 5: Health needs or health status? Use consistent terminology. I am also not convinced that these two terms are interchangeable. Self-reported health status is very different than health care utilization seeking behavior (although, they are related). I do not think it appropriate to ascribe seeking care as a proxy for health need.

Family Circumstance, page 5: Insurance type, then, has two levels? Thus your income proxy is 2/3 lower income, 1/3 higher income? This seems like a poor proxy for income. Need a citation linking family education and knowledge of health behaviors, as well as the mother’s employment as a proxy for time constraints. Expand further, and add a cite for, the number of children relating to time constraints and experience.
Socialization, Page 5: citation for cultural background (western vs. non-western) as a proxy for health beliefs?

Page 5: “….were used as proxies for the outcome of socialization.” I do not understand what is being said here.

Page 6: “A higher score denotes fewer beliefs…” what does fewer beliefs mean? Is this positive or negative?

Analyses, Page 6: I am not comfortable with omitting variables from the first analysis from the second analysis simply because they were not significant. I understand the need to restrict due to sample size. Variables should be included or omitted based upon theoretical relevance, not significance in a different model. Perhaps restrictions can be made based upon correlation matrices, collinearity, or by creating summary indices. Also, what are the sample sizes for each analysis?

Results, Page 7: Why were analyses performed in these three steps? Why not perform the full model?

Discussion, Page 7: How much are families listed in the same practice? Are there statistics to assess how much this occurs? You also stated earlier children go to other clinics as well—what is that impact on the results?

Discussion, Page 7-8: Overall, the discussion should focus on how these results would inform providers. As it currently reads, this message would not get across.

Discussion, Page 8: Expand the limitations—it is limited by more than just a small survey return percentage. Discuss the extensive use of proxy measures—education for health knowledge, western background for health beliefs, etc.

Discussion, Page 9: This last paragraph does not fit within the context of the paper—it seems to be a vignette totally unrelated to the content or purpose of the paper.

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

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 declare that I have no competing interests...