Reviewer’s report

Title: Discordance between physician-rated health and an objective health measure among institutionalized older people

Version: 4  Date: 25 February 2015

Reviewer: Erik Giltay

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This study by Damián and colleagues showed that physicians tended to overrate the overall health of 643 older persons from Spain. The study is well written, but the introduction and discussion do not seem to place the study and its findings well in perspective of previous findings. Moreover, some limitations were not mentioned in the discussion, which I would like to point out hereunder.

Major Compulsory Revisions:

- There may also be a high level of subjectivity to the so-called objective health measure that was used in this study. For example, self-report skin cancer is in a different league than breast or prostate cancer, and self-reports of stroke (opposed to TIAs) or dementia are prone to misclassification. Why was objective data from hospital discharge letters and codes not used instead?
- The classification into three groups of objective health is not well validated: ADL, no. of chronic diseases, and cognition were chosen, and if rating poor on any of these three, their health was already classified as poor. This is a very questionable choice, and not backed up by their data or literature. The finding that only 4.2% displaying good health may be an artifact of this classification scheme. I would be much more interested in the relationship between the physician rating health and each of the 3 components, and I would assume that the strongest relationship would be found with the self-report no. of chronic diseases. A similar argument (as their conclusion of physician overrating health) could be made that objective health grossly underestimates the actual health status.
- The number of references used is too sparse. Only 4 references were used in the introduction. For example, the statement “Self-rated health has been shown to be of great value by innumerable papers” has not been backed up by any reference. The findings from the few previous studies in this field have not been thoroughly described in the introduction or in the discussion.
- A major limitation is that the difference physicians were not instructed in any way on how to fill in the item on Physician rated health. Some form of training sessions and calibration would have been preferred. Were there large (statistically significant) differences among the physicians for the rating? When adjusted the Cox regression models for the different raters (using dummy variables), how did this affect the findings?
- I would be interested in how the 3 different health estimates predicted for
mortality in one model. Which one was the strongest predictor for mortality?

Minor Essential Revisions:
- Please also explain which “extreme categories” (page 5) were present.
- In the abstract 643 instead of 674 residents should be mentioned as some data were missing from the 31 subjects.
- How were the subjects with missing age handled in the (multivariable) analyses? I would prefer that these subjects would be excluded from the study.

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: Yes, and I have assessed the statistics in my report.

Declaration of competing interests:

I have not conflicts of interest to declare.