Dear Editor,

Wang *et al* ("Trends in Prevalence of Diabetes") in your August 24/31 issue report a new high in diabetes prevalence, and Gregg and Moin ("New USPSTF Recommendations for Screening for Prediabetes and Type 2 Diabetes") sensibly call for "new ideas." Here's mine.

I have advanced training in several scientific disciplines, my youngest daughter is a doctor, I read every issue of *JAMA*, and I write to declare profound disapproval of the thrust of the issue (in regard to T2D), namely medicalization of a nutritional and behavioral process. This letter is founded on my research and my own personal experience, recounted (as part of a larger narrative) in a presentation I was asked to give to a Harvard 55th Reunion event, accessible at <http://www.jeffreyrace.com/nugget/feather.pdf>.

In four years at a famous medical school, my daughter received three hours of nutritional training, some of it wrong. She was warned not to make her patients anxious. Metformin was the answer.

My endocrinologist at a famous Boston hospital prescribed Metformin when I became an induced diabetic due to an auto-immune disorder, just as my daughter had been taught at famous medical school. The result was dramatic but as a scientist I judged it bad science and bad policy, so I ceased medicating and developed the get-well plan described in the linked URL. On my return visit my numbers were now good so my endocrinologist began to prepare a new prescription. She was surprised to learn I had ceased medicating. Apparently she never had met a patient who recovered without pills.

That's what needs to be fixed. The substantial effort overviewed in your August 24/31 issue is substantially wasted because it does not deal with the etiology of T2D which the USPSTF Recommendations plainly state as you yourself report.

Here's a get-well plan that works, leading in unexceptional cases to complete avoidance of T2D if you start early enough. *And at negligible cost.*

*** Every at-risk patient must leave his doctor's office with a scale, a firm monthly schedule of A1c tests and of clinical followup visits a week later, and the following instructions.**

*** Completely eliminate sugar and sugar-supplemented processed foods from your diet, and abstain from wheat, corn, rice and potatoes, substituting lentils, beans, and chickpeas. Your numbers will improve and you'll never be hungry as you would on a "diet."**

*** Weigh yourself daily. If your weight is not decreasing on a weekly basis, reduce (possibly to zero) residual consumption of wheat, corn, rice, and potatoes and if that doesn't suffice, increasingly cut portion sizes until weight begins to drop toward a healthy level.**

*** For the clinician (doctor, nurse, nutritionist), if the patient's weight is not dropping weekly, and A1c not dropping monthly, the laws of physics and biochemistry declare he is not compliant. If so**

at any encounter, inform the patient--caringly and compassionately--he's going to live a foreshortened and unhealthy life and possibly die a horrible death. Patients can exercise moral agency only if they have full knowledge and are told the truth--repeatedly if necessary. Stop infantilizing patients.

Some patients will feel anxiety. My daughter's medical school training was innocent of any behavioral awareness that anxiety is a beneficial physiologic response to danger with which evolution has blessed us. Those at risk for diabetes *face danger* and *should* be anxious. The scientifically informed response is to coach the patient to a constructive redirection of his anxiety, which many doctors could do were they trained, specialized anxiety counsellors supplementing as necessary. Telling the patient he'll do fine with a pill (as my endo did) leads *directly* to the failure Wang and colleagues clearly document.

Some overeat from anxiety over other issues, resulting in weight gain, then pre-diabetes, then T2D. The clinician must identify the generative factors and create a responsive plan including, as necessary, external counselling and the resources necessary to mitigate anxiety.

If society allocates insufficient resources to enable this, the medical profession's duty is to say that to society's leaders--honestly, loudly, insistently and unendingly--just as it must tell an at-risk patient he's committing suicide. Shrugging one's shoulders and saying (as in the subject issue) "we must do more research on a failed medicalization strategy" is not a plan, just as a pill is not a plan.

Your oath commits you to do no harm. The failed medicalization strategy does great harm by wasting enormously valuable human and material medical resources and by perpetuating fantasies and false hopes which enable our leaders to evade their responsibility. Were the medicalization strategy successful, obesity and T2D would be decreasing. They are not. It's past time for the profession to recognize this screaming fact and to develop a get-well plan for itself.

Very respectfully,

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archived as http://www.jeffreyrace.com/document/0920jama.pdf