is likely that progression to type 2 diabetes will be slower with the expanded criteria compared with impaired glucose tolerance. Finally, medicalization of prediabetes may have the unintended consequence of reducing health care access to patients with type 2 diabetes and other chronic conditions. A valid method to examine for prediabetes should avoid unnecessary medicalization by labeling a disease predecessor as a medical condition and seek to concentrate on people at highest risk to allow for efficient distribution of limited health care resources.

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Editor’s Note
The Medicalization of Common Conditions

When JAMA Internal Medicine launched the Less Is More series 6 years ago, we commented that one area of concern was “medicalization” of common conditions. In this issue, Shahraz et al elegantly demonstrate how common conditions can be “medicalized.” Using NHANES data they find that a widely promoted web-based risk test would label more than 73 million Americans, including more than 80% of those older than 60 years, as being at high risk for “prediabetes,” a condition never heard of 10 years ago. We suggest a better approach to preventing the epidemic of obesity and its multiple health-related complications is emphasis on healthful diet, weight loss when appropriate, and increased physical activity at all levels—by schools, the medical profession, and public health and governmental agencies.

Rita F. Redberg, MD, MSc


Estimating 1-Year Mortality for High-Risk Primary Care Patients Using the “Surprise” Question

Palliative care improves the value of care for seriously ill patients, but resource constraints necessitate targeting palliative care interventions to patients who need them most. The “surprise” question (SQ)—“Would you be surprised if this patient died in the next 12 months?”—has emerged as an attractive, simple solution for identifying patients who might benefit from palliative care. Despite optimism about the potential of the SQ to identify primary care patients who would benefit from palliative care, there is no evidence on its performance in this setting.

Methods | We identified patients screened for a high-risk care management program at a large academic primary care practice for whom the primary care physicians answered the SQ between August 30, 2012, and February 27, 2014. We assumed a no answer represented physician prediction of high 1-year mortality risk. Our primary outcome was mortality 1 year after SQ response, determined by linkage to Social Security Administration data. We obtained demographics and comorbidities from electronic health records. We assessed SQ performance for estimating 1-year mortality using area under the receiver operating characteristic curve, sensitivity, positive predictive value, and odds ratio of a no response for 1-year mortality using univariate logistic regression. To quantify incremental benefit of the SQ for predicting 1-year mortality over and above routinely collected administrative data, we calculated the integrated discrimination improvement of adding the SQ response to multivariable logistic regression of mortality on age, sex, and comorbidity score.

The institutional review board of Partners HealthCare approved this study with a waiver of informed consent. Analysis is based on patient data from medical records and Social Security Administration data (identified records); tabulations, test characteristics, and regression analyses are deidentified data.

Results | A total of 1737 patients were included in the study. Patients were predominantly female (1041 [60.3%]). Mean age...