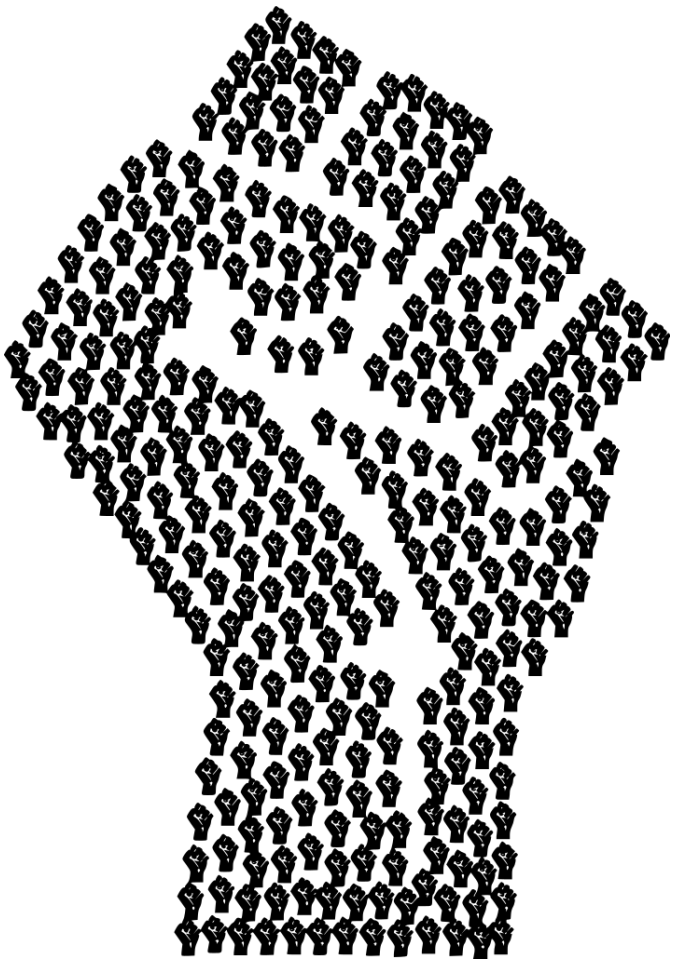
THE TYPE A DIABETIC



MANIFESTO

(currently in beta)

Welcome!

Welcome to the Type A Diabetic Manifesto.

Yes, I recognize the term manifesto has been kind of scarred by the unabomber and his manifesto. But that's not going to stop me from describing this for what it is: a document designed to "...promote a new idea with prescriptive notions for carrying out changes the author believes should be made." [source]

So why did I draft this manifesto? After being diagnosed as diabetic in 2019, two things happened simultaneously:

- I found it all too easy to follow doctor's orders (follow the American Diabetes Association Diet, take Metformin, test glucose levels 2x/day, etc.). I'm sure the majority of people diagnosed with type 2 diabetes follow a similar path. After all, diabetes is a mainstream condition, and the medical community has a pretty straight-forward approach and process to diagnosis and treatment.
- For a number of reasons, I didn't completely agree with my diagnosis. Which changed my trajectory from accepting the conventional wisdom to digging into research to figure out what was happening to me, why it was happening, and ultimately, to figure out what was *really* going on.

Long story short, it does seem like I have what people would consider to be diabetes *[spoiler alert: a significant portion of this manifesto is dedicated to making the case that I, and many others, do not in fact have diabetes]*. However, it's not entirely clear yet what type of diabetic I am. More importantly, this investigative process led me to a ton of data, research, and insights that completely changed my perspective on not just diabetes as a condition, but *how* we think about diabetes, and *why* we think about this condition so differently from other conditions.

My objectives for this manifesto are three-fold:

1. Share what I've learned so that I can perhaps help others on this journey
2. Improve the state-of-the-art of conventional wisdom that is currently, in my estimation, not serving those with insulin disorders as well as it could
3. Challenge the medical community in how it thinks about, talks about, and treats insulin disorders

What is a *Type A* Diabetic?

While diabetes is a poly-phenotypic condition consisting of a wide assortment of types (the most common being type 1 and type 2), a Type A Diabetic is not a biological phenotype. Rather, it is a psychological phenotype. The Type A Diabetic is someone who:

- is diagnosed with diabetes who decides to take control of the situation instead of letting the situation take control over them
- is open to challenging conventional wisdom on the topic
- is interested in fully understanding the underlying dynamics that occur due to this condition
- views the medical community, like most other professional communities, as an industry consisting of advisors and practitioners ranging from mediocre to excellent
- most importantly, is not willing to accept that this condition will negatively impact their health

The term Type A Diabetic has some value in that it pulls from the common “type” nomenclature of diabetes. However, it is far from an ideal label: I started writing this manifesto as a Type A Diabetic, but by the time I finished, I am, according to this very manifesto, no longer technically diabetic.

Despite this somewhat confusing conundrum, the Type A Diabetic label will suffice until the entire diabetic community aligns arounds the ideas and notions outlined in this document.

What Is Diabetes?

What better way to start than relaying how the National Institute of Diabetes and Digestive and Kidney Diseases, a part of the U.S. National Institute of Health defines diabetes:

> *Diabetes is a disease that occurs when your blood glucose, also called blood sugar, is too high.* (source)

How fun that the highly-regarded NIH not only incorrectly defines diabetes, but basically gets it *backwards*. Sorry, NIH, high blood glucose does not create diabetes. In fact, diabetes isn’t something that “occurs.” Diabetes is the term we currently use to describe one or more very different situations where your body no longer can maintain healthy glucose homeostasis.

How about another U.S. Government entity, the Center for Disease Control (CDC):

> *Diabetes is the condition in which the body does not properly process food for use as energy.* (source)

Here we have another highly-regarded U.S. health institution, whiffing on defining diabetes. To be fair, it's better than the NIH's definition (which isn't saying much), but this attempt at a definition tries to describe the underlying condition by describing how the condition impacts the metabolic process. It's an *impact-centric* definition, which is a theme I see in parts of the medical community, which concerns me (more on that later).

What about the World Health Organization - surely they get it right?

> *Diabetes is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar), which leads over time to serious damage to the heart, blood vessels, eyes, kidneys, and nerves. (source)*

Compared to the NIH and the CDC, this is light years better. Yet, it's still wrong. It's pretty good with regards to type 2 diabetes, but it is flatly incorrect for every other type of diabetes, including type 1, LADA, MODY, etc.

Let's try the Diabetes Research Institute Foundation:

> *Diabetes is a serious condition that causes higher than normal blood sugar levels. Diabetes occurs when your body cannot make or effectively use its own insulin, a hormone made by special cells in the pancreas called islets (eye-lets). Insulin serves as a "key" to open your cells, to allow the sugar (glucose) from the food you eat to enter. Then, your body uses that glucose for energy. (source)*

Now that we get to the non-government, non-profit world, the definition suddenly gets far better. To be clear, I'm not anti-government. I think government deserves more credit than it gets considering what it's up against. But when it comes to defining diabetes, the U.S. Government and its agencies fail miserably. And if they can't define it right, does that impact how they perceive it, research it, and try to cure it? Let's hope not.

But back to the Diabetes Research Institute Foundation's definition. They get a key thing right: diabetes is the label we (currently) give to a *condition* that *causes* things to happen. This is a super important point to keep in mind, and in fact is a crucial component to the Type A Diabetic Manifesto. Yet, this definition is *still* not right because diabetes as we currently define it is not a single condition. It's a variety of different conditions.

Clearly, either medical and governmental experts can't define things well, or, *perhaps*, we've gone about describing these conditions so fundamentally ineffectively that it is far too easy to misidentify, misdescribe, and even misdiagnose these conditions we currently call "diabetes."

Should We Call the Condition Diabetes?

No. For a number of reasons. For starters, let's level-set on where the term diabetes came from:

> *The term **diabetes** is the shortened version of the full name **diabetes mellitus**. **Diabetes mellitus** is derived from the Greek word **diabetes** meaning **siphon** - to pass through [ed: pee] and the Latin word **mellitus** meaning **honeyed** or **sweet**. This is because in diabetes excess sugar is found in blood as well as the urine.* (source)

On the face of it, the medical community has assigned a "brand name" to a condition based on a common pre-treated symptom: untreated diabetics pee a lot. And, I suppose to confirm diagnosis in the good ol' days, people would taste it to boot to confirm if it was honeyed or sweet. Good times.

Overstaying the Terminology Welcome?

So we started calling it diabetes because, untreated, it makes you pee a lot (I get it. You gotta start somewhere, right?). Yet, here we are, thousands of years later, and we've evolved the term diabetes to describe a *chronic* condition, meaning that as we define diabetes today, even after you're treated...you still got diabetes for the rest of your life.

To drive this point home, people who are managing their diabetes are called *diabetics* (i.e., "those who pee a lot"). Yet, if they are effective in treating and managing their condition, they *no longer pee a lot.*

Doesn't something seem off here? We've initially labeled a condition based on initial outward symptoms (back when those symptoms almost always led to a rapid death). We've since permanently affixed this symptomatic label to afflicted people well after those "diabetic" symptoms subside.

The most troubling aspect of the current labeling system is that we have no common language to discern between people who have the underlying conditions that create glucose toxicity and people who are experiencing glucose toxicity.

If I'm diagnosed with diabetes, it's because I have some problem in my physiology that's leading to dangerous glucose levels. But if I am able to resolve the glucose level problem (through diet, exercize, medication, insulin), I'm currently still considered to have diabetes, even though, when measured, my body would report back that there is no diabetic state. This has huge consequences in the type and cost of care, and (as you'll read later) in how the healthcare system rations care.

As a very small example of this in action, I've been instructed to now have eye exams every year because I was diagnosed with diabetes. Yet, my glucose levels are at normal levels due to my *Type A Diabetic management techniques*. As a result, I have no distinguishing physiological features that would mandate spending more healthcare dollars on additional eye exams. Yet, it is now an expected behavior because "diabetics tend to experience retinopathy as a diabetic complication." Take this example and extrapolate it to every extra doctor visit, quarterly blood test, and all the other "expected" additional interactions with the healthcare system for perhaps millions of people who simply do not require this level of treatment due to the *real world evidence* that they are no longer in a diabetic state.

Classification Confusion

If sticking too long with a two-thousand-year-old symptom-based label isn't a good enough reason to rethink how we talk about this condition, let's explore another avenue that creates unnecessary problems: *types.* The different types of diabetes are so unrelated in terms of cause and therapies that it likely does *more harm than good* to lump people together based on a label that was designed to describe how much they pee before diagnosis, instead of focusing on what's actually *causing the problem.*

I'm just going to say it as plain as I can: It's patently ridiculous that type 1 diabetes (an autoimmune condition that has more in common with rheumatoid arthritis and multiple sclerosis) shares the same disease label as type 2 diabetes (which is a metabolic condition that has more in common with high cholesterol).

By linking type 1 and type 2 (and other types!) together under the term diabetes (which was only created to explain the early symptoms), the medical community has created unnecessary confusion -- and conflation -- around quite distinctive physiological situations.

The upshot: Because of inadequate naming/branding, the medical community and the public think of type 1 and type 2 diabetes as related only because they both share the same initial symptoms of peeing too much. Meanwhile, if you look at the pathology, type 1 and type 2 are *completely different disease states*. Meaning, they probably deserve *different labels.*

Branding 101

What does branding have to do with diabetes, you ask? You'd be surprised how much branding and labels impact thinking. It's a well-known dynamic that people, in general, stop thinking about something once they label it. It's also well-known that a brand attracts certain emotional attributes that convey meaning around a brand.

In the naming aspect of branding, there are two primary types of names: descriptive and coined. Descriptive labels aim to describe what the object *does*, whereas *coined* labels that are new

terms added to the lexicon to describe something in a new way that's not a word in the dictionary. An example of a descriptive label is "speaker" - the name of the object actually attempts to describe (albeit in a very old-fashioned way) what the object actually does - it "speaks" to you. Perhaps a better example is the "toothbrush" - so descriptive that I don't even have to explain what it is!

Coined labels are more associated with branding, because coined labels indicate something new or novel, which tends to lead to more sales because a coined name insinuates something special and different. Examples of coined labels: frisbees, kleenexes, podcasts, and xerox machines.

Which brings us to diabetes. Diabetes is a coined name. It's a brand. It's such a brand, in fact, that people who suffer from this condition readily call themselves "diabetics" -- like it's some kind of cult. The idea that people are diabetics indicates just how strong the brand is - people readily identify with it - not so different from people who define themselves as Christians, Jews, or Muslisms.

Recalling the etymology of diabetes, isn't it ridiculous that people willingly label themselves diabetics, which is to say that they are the "people who pee far too much sweet, sweet urine"?

Yes, of course it's ridiculous.

Type 1 diabetics who are peeing far too much sweet, sweet urine won't be around to talk about it unless they get immediate treatment and manage their condition. In other words, if you're a type 1 diabetic, and you're still alive and around to talk about it, you're actually not peeing much at all anymore. So, you're actually...not diabetic in the strict sense of the term. What you are is someone who has an autoimmune condition that boots you out of glucose homeostasis unless you supplement your system with insulin.

Type 2 diabetics who are peering far too much sweet, sweet urine will develop life-threatening complications unless they get treatment and manage their condition. In other words, if you're a type 2 diabetic and you're managing your condition and bringing your glucose levels in line, you're actually not peeing much at all either. So, you, too, are actually...not diabetic. What you are is someone who has a glucose metabolic disorder that kicks you out of glucose homeostasis unless you manage the situation through diet, exercise, and/or therapies.

In summary, diabetes is a coined label, which is a *brand*. As such, it acts as a cognitive shortcut to the point where it does everyone a disservice.

It would be *far better* if we used *descriptive labels* to describe the different physiological conditions that lead to the imbalance of glucose in the blood of untreated diabetics.

Is it Type 1 or Type 2, or is it *From* Type 1 *to* Type 2?

There's another issue that should be explored before we apply descriptive labels. We seem to be right in the midst of learning that there are more gradations of insulin issues (both in production and in resistance) than previously recognized. Studies are revealing that some type 1 diabetics also experience insulin resistance and that many type 2 diabetics can increasingly over time develop insulin production problems.

Given this overlap of dynamics between type 1 and type 2 diabetes, perhaps it's now time to move away from describing types based on arbitrary numbers and start describing types based on the underlying causes for the insulin issues: production and resistance.

From Numbers to Descriptors

Type 1s don't produce insulin (and some type 2s don't produce enough insulin). This is a production problem. In type 1s, it's an auto-immune based reason for the halting of production. For type 2s, it may be just exhausted beta cells in the pancreas that just can't keep up with the carb loads.

Type 2s (and some type 1s as well) cells are no longer able to efficiently store glucose, because these cells are "insulin resistant."

Notice how there is not a clean, 1:1 connection between insulin production and resistance and the different primary types of diabetes? Given this situation where "type 1" and "type 2" definitions are no longer accurate, they are increasingly less helpful - and perhaps even harmful. To this end, I suggest we blow up all the nomenclature and look at it as a single, unified system.

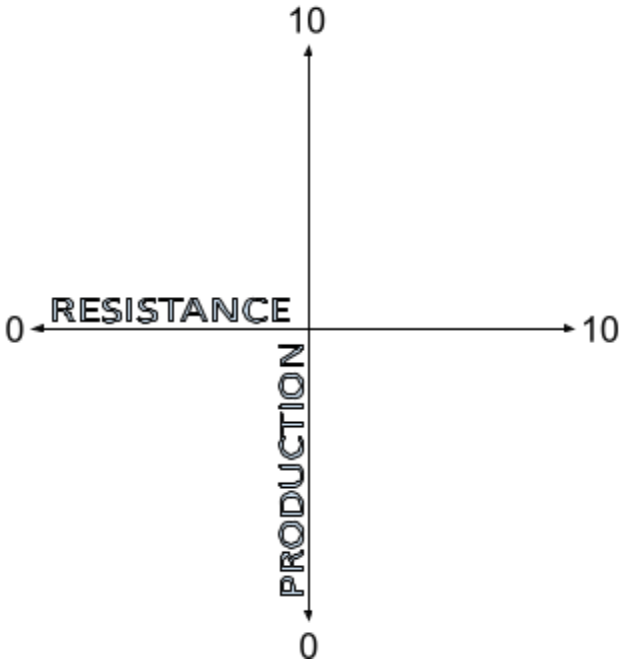
An Appeal for a New Paradigm

The diabetic community, including medical professionals, patients, and manufacturers of therapies and devices, would benefit from a *reboot of thought* around what we currently consider diabetes. This reboot spans the entire spectrum of the condition, including symptoms, diagnosis, labels, culture, and most importantly, treatment paths.

Let's start with symptoms and diagnosis:

- Diabetes describes the symptoms that indicate glucose *dys*homeostasis
- Investigative medicine can (often) determine the cause of said dyshomeostasis: determining if it's issues of production or resistance, or some combination of both.
- Given that any individual is somewhere on the continuum of insulin production and resistance issues, we should diagnose as such, in a descriptive fashion.

- To start, I suggest we describe all people with glucose dyshomeostasis as an *insulin disorder.* This comes directly from hematology which considers all blood conditions as blood disorders. Since glucose toxicity is very much a blood-centric disorder (yet, the hematological medical community does not include glucose in its library of conditions?), it makes sense to leverage common language from related fields to drive descriptive name continuity.
- Given that insulin disorder is the higher-order description, we now need to develop a system to describe the continuum of nature of the disorder. I suggest a sliding scale to indicate how close your condition is to production and resistance.
- P0 = no insulin production, which is what most type 1 diabetics experience, and P10, which represents a system where healthy beta cells produce the naturally correct amounts of insulin to create homeostasis. This value is determined by C-Peptide levels.
- R0 = all insulin is safely and securely received by cells for energy storage, and R10 which represents the most extreme type 2 diabetic where literally no glucose was able to be naturally stored in their cells.



In this new diagnostic paradigm, we've determined that what is currently called *diabetes* is actually an *insulin disorder*. This new descriptive name unifies all the former type 1s, type 2s, LADA, MODY, gestational diabetics, and the rest of them. But treatment is dependent on the nature of the disorder. So, we must be able to explain, clearly and accurately, the nature of the disorder. Doing so will not only help patients help describe their condition, but allow them to find others with a similar condition if they so choose to, in order to create relevant communities of education and support, etc.

I suggest that we code the continuum such that it's accurate and useful, but not to the extent that it creates a tribal affinities:

P[x] / R[y] Insulin Disorder (where x is determined by beta cell function and y is determined by the insulin resistance factor from the HOMA model)

Here's how this can be used to clinically describe various diabetic disease states:

- Type 1 diabetic with no insulin resistance: P0/R0 Insulin Disorder
- Type 1 diabetic with some insulin resistance: P0/R5 Insulin Disorder
- Moderate type 2 diabetic with full-functioning beta cells: P10/R5 Insulin Disorder
- Severe type 2 diabetic with full-functioning beta cells: P10/R8 Insulin Disorder
- Severe type 2 diabetic with exhausted beta cells: P5/R8 Insulin Disorder

Using this scheme, someone with an insulin disorder would be able to track the evolution of their condition as the P and R values went up or down. There would be trends for clinicians to track over time, and patients would get a sense of condition trajectory.

While helpful for medical conversations, this labeling system is not easy enough for normal conversations. We would need some shorthand:

- Typical type 1 diabetics have a *insulin production disorder* (alternatively, although slightly less accurately, an *auto-immune insulin disorder)*
- Typical type 2 diabetics have a *insulin resistance disorder* (alternatively, a *metabolic insulin disorder*)
- Those with gestational diabetes have a *gestational insulin disorder*
- Those with Maturity Onset Diabetes of the Young (MODY) have a *genealogical insulin disorder*
- Those with secondary diabetes have a *pancreatogenic insulin disorder* (alternatively, simply an *insulin disorder*)

Does Diabetes Even Exist?

Technically, diabetes exists only when an insulin disorder is untreated. If diabetes is defined based on its etymology, then you only have diabetes if you're peeing a lot of sweet, sweet urine. If diabetes is defined based on the best definition shared earlier (from the Diabetes Research Institute Foundation), then you only have diabetes when your blood glucose levels are in an unhealthy range. Either of these definitions fit the bill: You are diabetic when your insulin disorder is not *effectively being treated or managed*.

And this makes sense. This about it: You only have high cholesterol when your cholesterol is in an unhealthy range. You're not a "hypercholestoralholic" just because at one point in your life your cholesterol levels were dangerously high. What if you have high blood pressure? Are you

forever labeled a “hypertensionatic”? Of course not. You say “I suffer from high blood pressure” or “I suffer from hypertension” *when* you are exerting the unhealthy physiological symptoms of the condition. **If you figure out how to manage these conditions through exercise, diet, and/or therapies, you don’t continue to identify as someone with a chronic disease. You identify as someone who has taken control of the situation.**

Why, prey tell, must diabetes be so different from every other medical condition?

I’m here to tell you *it doesn’t*. If you are managing your glucose levels to the point where you’re at glucose homeostasis, then the **Type A Diabetic credo dictates that you do *not have diabetes.*** What you have is a condition that, if unmanaged, will lead to peeing too much and having unhealthy levels of glucose in your blood, which is diabetes.

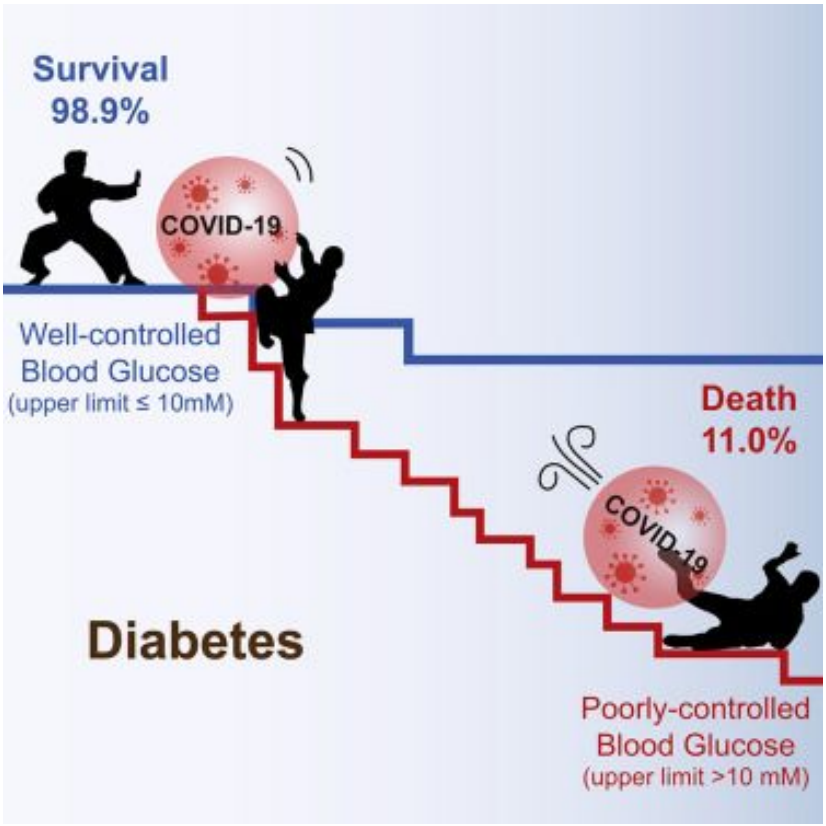
Note: I see metabolic diabetes (i.e., untreated type 2, gestational, and pre-diabetes) as particularly insidious as it’s basically pain-free, and therefore easy to ignore, and then far-too-easy to be unexpectedly stricken with painful, permanent, and costly complications. For this reason, it’s arguable that the term diabetes does add some level of seriousness to the metabolic condition commensurate with the potential long-term problems and costs. However, this only applies to the metabolic (type 2 and related) condition, and, as you’ll read below, the medical community blows it big-time when it comes to pre-diabetes. The thing is, even with the diabetes brand name, we’re still seeing far too many glucose toxicity complications. What we have in place now is still not working well enough. Further, complications from hypertension and high cholesterol are equally pain-free and easy to ignore until it’s too late. Yet these conditions don’t seem to merit their own brand names, or similar tribal affiliations.

Comorbidity Confusion

This manifesto is being authored during the COVID-19 outbreak. It has been tragic to read the thousands of confused and worried posts on diabetic forums when they hear that “diabetes is a comorbidity” for COVID-19 and that those with diabetes have a 9.2% fatality rate.

This is a *perfect example* of the mistake in calling a chronic insulin disorder “diabetes.” Are the high death rates due to compounding complications from glucose toxicity? Are the high death rates because insulin dependent type 1’s were too sick to take their insulin? Or because they were type 2 diabetics who hadn’t been managing their diet and exercise and contracted COVID-19 with unhealthy blood glucose levels?

Well, after a few months of panic spreading through the diabetes community about this broad-brush, unhelpful 9.2% fatality rate metric for diabetics, what do you know? More specifics were released that, of course, **validate the Type A Diabetic credo**: it’s glucose toxicity, after all, that’s the comorbidity to COVID-19, not “diabetes” writ large:



Source: Cell Metabolism: Association of Blood Glucose Control and Outcomes in Patients with COVID-19 and Pre-existing Type 2 Diabetes

There are far too many variables and situations to help anyone by saying “diabetes is a comorbidity.” It would be *far more helpful* if glucose toxicity, insulin production disorder, or insulin resistance disorder information was shared. I can’t tell you how many people around the world were scared by the 9.2% diabetes comorbidity rate, and posted on social media their worries and concerns. This is unnecessary stress. We can do better.

Should We Call Elevated Glucose Toxicity Pre-Diabetes?

No.

This might be the *worst* use of branding in medicine to-date. The *pre-diabetes* label is very likely creating significantly more problems than it is solving. By calling an elevated level of glucose toxicity “pre-diabetes”, the medical community is attempting to scare people into behaviors that stop them from advancing to full-on diabetes. But, I fear, the *exact opposite* is happening (*bear in mind, this is anecdotal, as I have myself and my friends and colleagues who are pre-diabetic to base this on).*

The diagnosis of pre-diabetes telegraphs that you are still *OK,* but that you need to control your sugar intake so that you do not progress to the “magic threshold” of A1c of 6.5. Embedded in

this message is that you're *not* diabetic, and therefore, still technically healthy. Just adjust your lifestyle a bit and you'll probably stay *OK*.

But here's the *actual* impact of this branding: "Whew! I'm not diabetic. That's good. So, I'll do my best to skip that soda and that pasta when I can. That should do the trick!"

Sadly, this does not do the trick. Any possible adherence to a more strict diet doesn't stick, because there is no data or true awareness of the damage being done even in the so-called pre-diabetic state. And, frankly, with no overt pain or discomfort as a result of glucose toxicity at moderate levels, there's nothing holding you any more accountable to carb management as what holds you to any diet over the long-term. People generally stink at sticking to diets.

So, the whole idea of being diagnosed as pre-diabetic is directly related to the "therapy" of going on a diet. What a fool's errand to rely on such an unreliable tactic (a diet) to address something so much more harmful than being overweight. What is actually happening is that "pre-diabetics" are lulled into a feeling of "I'm actually OK for now" yet are, in fact, inflicting damage on their internals over the long-term (especially for those "pre-diabetics" who have A1c's over 6!) because the message is "You're OK right now. Watch what you eat." when the message ought to be "Your glucose levels are elevated, which means that even in small ways, you're doing long-term damage to your internals. If you don't watch what you eat, you will most likely suffer from permanent, painful complications if you're lucky enough to live to a ripe old age."

The reality is that any A1c over 5.0 is inviting increasing risk of complications due to glucose toxicity. To be fair, the *real* elevated risks that lead to permanent damage start occurring at 6.0 A1c, but there are plenty of studies that show substantial increase in probability in health problems starting at 5.1 A1c *(don't get me started on endocrinologists who have some secret handshake to all agree that anything "under 7 A1c is good control for a diabetic" - infuriating, patronizing, and wrong. OK, you got me started - more on this below in The Healthcare Industry Predicament below).*

Yet, pre-diabetes is defined in the medical community as an A1c of 5.7 - 6.4. Which means that through this entire range, people are already doing some potential damage to their system that cannot be undone. Worse, those on the higher end of pre-diabetes are doing far more potential damage to their systems that most likely *will* impact their livelihood if they are lucky enough to live a long life.

The upshot: The medical community must stop using the term pre-diabetes, which is just another unhelpful coined name that allows us to not think about what it means or worry about what's behind the label.

What should we call pre-diabetes, then? The recommendation is to call it what it is: an *insulin resistance disorder.* However, because this is the low-end/entrypoint of the disorder, we can leverage a term from other medical diagnoses - a term that people already understand because

it is clear and descriptive - to help clarify the type of insulin resistance disorder this is: **it's a *stage one insulin resistance disorder.*** Makes sense, right? It's clear, descriptive, and harmonizes with how we use "stages" in other diagnoses.

Diabetes: A Culture of Victimization?

"We diabetics don't heal as quickly as normal people."
"Diabetics need to check their eyes more frequently."
"Diabetes is a disease."
"Diabetics is an obesity disease"
"Diabetes is a life-long struggle that is full of frustration."
"Diabetics don't live as long as normal people."

These are all quotes and sentiments I've heard numerous times across message boards, spoken by physicians, and shared by friends and family.

The Type A Diabetic perspective on this is that **they are all bogus claims** designed to reinforce the bizarre tribal nature of the "diabetes community." Look, as someone recently diagnosed with diabetes, I am all for community. It's been a godsend as I look to learn, share, and feel connected with others who are diagnosed with the same or similar condition.

In the community, there seem to be two basic camps: The first camp sees diabetes as a challenge that they work hard to overcome by managing it, and integrate it into their lives, like any other challenge. The second camp sees diabetes as a chronic disease state that dominates their lives and, mostly, defines their lives.

In other words, the first camp is Sophie, and the second camp is Scott.

As the writers of South Park so clearly articulate it, every person has a choice to be Scott or Sophie. Sophie has the clear makings of a Type A Diabetic!

Diabetes as Identity

I'm not going to dance around this one. From the Type A Diabetic perspective, ***"I am a diabetic"* is an insidious statement.** It's one thing to say "I have diabetes" - at least this lays out that you have contracted some sort of illness, disease, or disorder. Fair enough. But it's an entirely different concept to transform what you *have* into what you *are.*

Once you connect a disease state to your identity, the disease is now more a part of you than simply your insulin disorder. The disease is now in your mind as well. That's right, **if you have thought or said "I'm a diabetic," you've let an insulin disorder metastasize to your mind.**

If you have diabetes and wonder how you would find “your people” in a world where we don’t use the term diabetes or identify as diabetics, it’s actually quite straightforward:

1. Remember that sharing a medical condition with others doesn’t necessarily make them any more “your people” than if you found people your same height and weight. There are many more dimensions to communities than physiological attributes.
2. In a future world where we truly rid ourselves of the diabetes cognitive anchor, we can search for *insulin disorders*. And if we add adjectives like *resistance* or *production* to the search, we can fine-tune the people and communities we’re looking for with precision.

The Type A Diabetic position on diabetes-as-identity is contempt and disapproval.
Diabetics, disband!

The Healthcare Industry Predicament

Let me start by stating that I’m generally a fan of the healthcare industry *[full disclosure: I work for a company in the healthcare industry]*. This industry is full of people who dedicate their careers - and some beyond their careers - to finding, creating, and, yes, selling, therapies and devices that improve the lives of millions of people who would otherwise have little-to-no hope managing or treating a medical condition. Like many industries, it’s not all roses. We all know about the challenges (especially in the United States) around insulin prices and, the gaming of the patent system, and the sometimes-ruthless pricing that is patient-unfriendly.

Now that *that’s* out of the way, I’m going to focus on a significant problem that I’ve not only experienced myself, but have seen evidence of broadly, across many countries: providers (doctors, specialists, the American Diabetes Association) doing a *super sub-optimal job* of communicating with people with diabetes. And, boy, is there a good reason for this: 1.5 million new cases of diabetes are diagnosed every year in America alone.

In other words, to healthcare providers, diabetics are a never-ending freight train of glucose dyshomeostasis, which means we’re all treated about as importantly as just one of the anonymous cars you see on a train as it rolls by a train crossing.

Due to the scale of the problem, physicians see us as cookie-cutter cases. So much so that it wasn’t until the 1990s that doctors realized that adults could even contract type 1 diabetes (formally medically referred to juvenile-onset diabetes). Talk about cookie-cutter diagnosis - adults who had an autoimmune disease were being treated for a metabolic condition! But doctors don’t have much choice - their job is to see and treat as many people as they can without burning out. So of course they rely on some templates when they can to drive efficiency into the system. Any decent operational strategist would advise the same - spend as little time on repeatable tasks and spend the most time on the valuable tasks that improve outcomes.

Because diabetes of all types is seen as defined, quantifiable diseases, the healthcare industry has templates: Got type 1? Here's insulin (if you can afford it). Got type 2? Lay off the beer, pasta and bread, and here's your prescription for Metformin. *Wham, bam, thank you, ma'am!*

This certainly improves efficiency, but like every efficiency-driven system, quality tends to suffer. Worse, the autopilot nature of template-based prescriptions leaves many diabetics with an incomplete understanding of what exactly is going on, why it's happening, and how patients can best mitigate this insulin disorder's long-term effects on health.

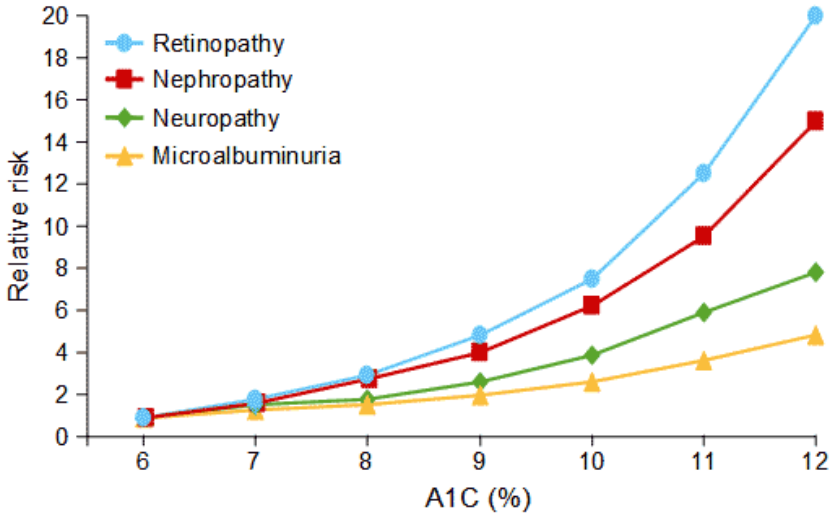
Reasons Not to Entirely Trust Your Physician

In talking to relatives and colleagues at work about their diabetes (including pre-diabetes) and reading hundreds of threads on online diabetic forums, there appears to be a preponderance of substandard health advice being given by well-meaning physicians, world-wide. Of course there are exceptions, but the rule is that you are probably getting suboptimal advice from the medical establishment *(for more on this, see the "Taking Control of Your Glucose Homeostasis" section below, and the "The American Diabetes Association Diet" entry in my companion site, DiabetesLifeHacker.com)*.

It pains me to learn just how many people put all of their faith in physicians, when the vast majority of those physicians aren't diabetic. And because they're not diabetic, they look at diabetes through the diagnostic and therapy lens vs. the *actions-and-consequences* lens. The difference being diagnosis and therapy is the job of a physician, but it is not the job of a physician to ensure that the patient fully understands precisely what is behind the diagnosis and the therapy. They don't feel accountable for ensuring that their patients understand the fundamentals behind both the diagnosis and therapy, and most patients are fine with this. They just want to know what to do.

In the case of diabetes (and likely many other disorders), this leads millions of people to "follow doctor's orders" without understanding why, which unfortunately leads to horrific outcomes, including 60%-70% of diabetics experiencing nervous system complications.

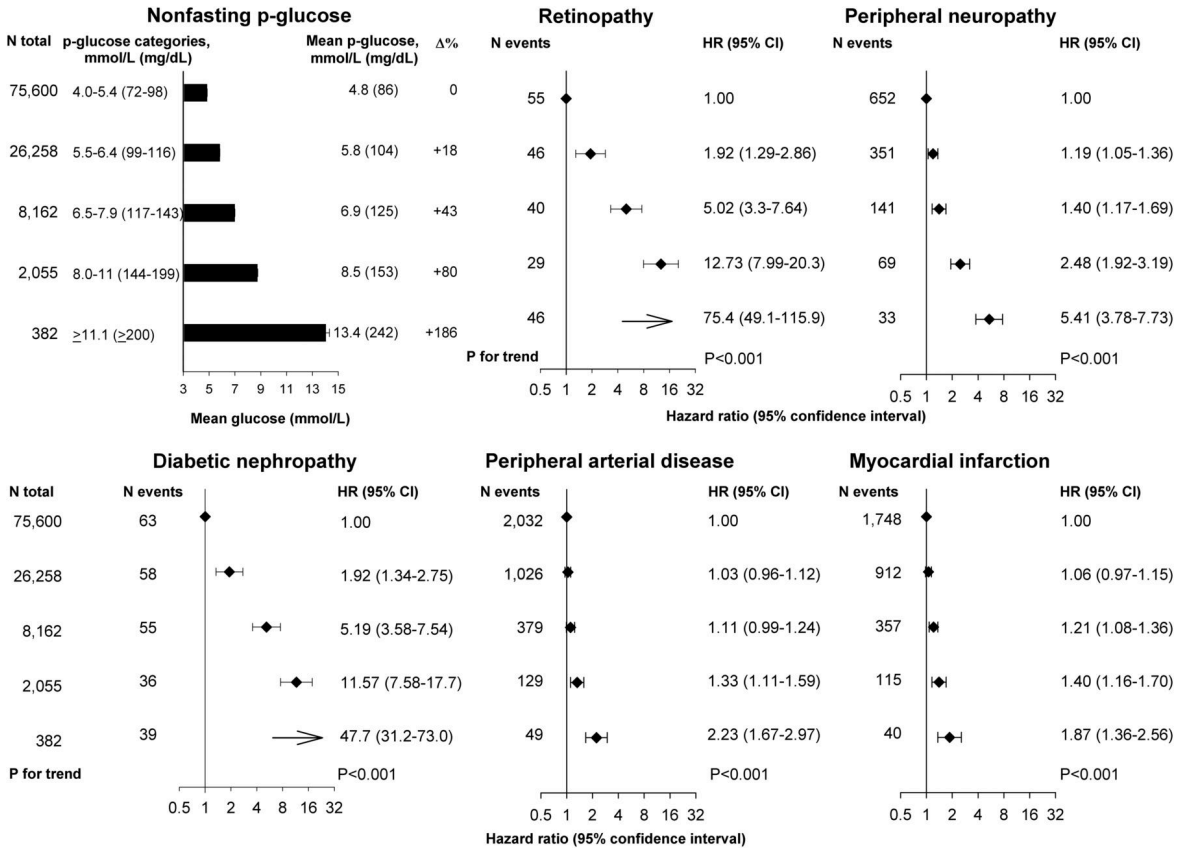
One of the most concerning trends I've seen is that while an A1c of 6.5 or higher designates you a diabetic, once you are a diagnosed diabetic, the healthcare industry recommends A1c's "under 7" or even "under 8", depending on the source.



Adapted from DCCT. Diabetes 1995;44:968-43.

Yet if we look at the evidence, notice in the chart how 7 nearly doubles the chances of diabetic complications? And some doctors tell their patients that they're "successful" if below 8!

A study released in 2020 not only re-enforces this issue, but takes it a step further:



Diabetes Care 2020 Apr; 43(4): 894-902.
https://doi.org/10.2337/dc19-1850

In this study, what we see confirms the Type A Diabetic Manifesto hypothesis: so-called diabetic complications aren't based on diabetes -- *they are based purely on the severity of glucose dyshomeostasis.* This study really drives this point home by showcasing that so-called *gluconormal* people (with an A1c of ~5.3) have a 2x hazard ratio for developing retinopathy and diabetic nephropathy (kidney disease). Think about that: we have a condition called "diabetic nephropathy" yet it can impact people who have elevated glucose levels but are not considered diabetic, or even pre-diabetic.

Further, the so-called *pre-diabetic* cohort (with an A1c of ~6.0) in this study demonstrates severe hazard ratios for so-called diabetic complications: retinopathy (5x), peripheral neuropathy (1.3x), and diabetic nephropathy (6x). The only complications reserved exclusively for people who remain in the diabetic range are peripheral arterial disease and myocardial infarction.

Actual scientific research, now spanning three decades, paints a clear picture: **many complications from elevated blood glucose levels are linearly correlated, and begin *below* an A1c of 6.0.**

I understand the psychology behind the strategy of managing reasonable expectations across millions of patients. Many diabetics are initially diagnosed with 10-15 A1c levels, so reaching 7 or 8 A1c levels is a tremendous accomplishment. And doctors want to keep patients engaged and not give them targets that they cannot easily meet. However, because the patient doesn't understand what the A1c really is, how it relates to glucose levels, and how that links to future complications, they go on their merry way, happy that they're meeting their doctor's expectations.

But if every diabetic patient knew *what* was going on, *why* it was happening, what the risk factors truly look like, and *how* the therapy was addressing the issue, each patient would have a *better understanding* of how to ensure they could maintain a healthy glucose homeostasis, which would all but eliminate painful, costly, and even deadly glucose-related complications.

Unfortunately, in my travels, what I hear overwhelmingly from diabetics and pre-diabetics alike is "my doctor thinks I'm doing great!" *Case closed.* They are not interested in understanding why their doctor may be leading them down an unhealthy path, and leading them to unnecessary and potentially debilitating pain, discomfort, and future disabilities.

The result? Healthcare systems are being unnecessarily taxed by a diabetes pandemic. In America, you hear countless stories of people who cannot afford to buy insulin, and even die as a result. Has anyone thought about completely changing how we deal with insulin disorders so that there would be *less* medical care needed, and *less* insulin needed? Read on to see how this is absolutely achievable.

Taking Control of Your Glucose Homeostasis

The Type A Diabetic believes in being in control of the situation, instead of allowing the situation to take control of you. For this reason, the Type A Diabetic invests in a CGM (continuous glucose monitor). Without a CGM, you're literally flying blind, and you'll never truly understand how to take control of your situation. This applies to every type of insulin disorder.

Every person with an insulin disorder should monitor their glucose for at least one month every year using a CGM. Here's why:

When you have an insulin disorder, your body, annoyingly, will naturally wander into glucose dyshomeostasis. And glucose dyshomeostasis, as discussed above, eventually leads to painful, costly, and even deadly complications. So what do people do?

- If they are insulin resistance challenged (type 2), they (sometimes) follow a modified diet, take metformin and perhaps a series of other pharmacologics. If they're on top of things,

they will finger prick twice a day to understand morning and evening glucose levels. And once every 3 months, they'll get an A1c test to see how they did that quarter.

- If they are insulin production challenged (type 1), they give themselves insulin by estimating the number of carbohydrates they'll be ingesting. If they're on top of things, they will finger prick 5-8 times/day to check their glucose levels. And once every 3 months, they'll get an A1c test to see how they did that quarter.

Type 2 Diabetics: You Essentially Have a Carbohydrate Allergy

Let me just get this out of the way from the get-go: the American Diabetes Association's Diabetes Plate Method is akin to ***prescribing poison*** to a diabetic. Their recommendation is to fill up ¼ of your plate with carbohydrates. To make things worse, in their example of what a diabetes plate would look like, they recommend sticking to *"just 1 or 2 slices [of pizza] and serve with a side salad so that half your meal is nonstarchy vegetables."*

The actual photo, containing pizza, from the American Diabetes Association website.

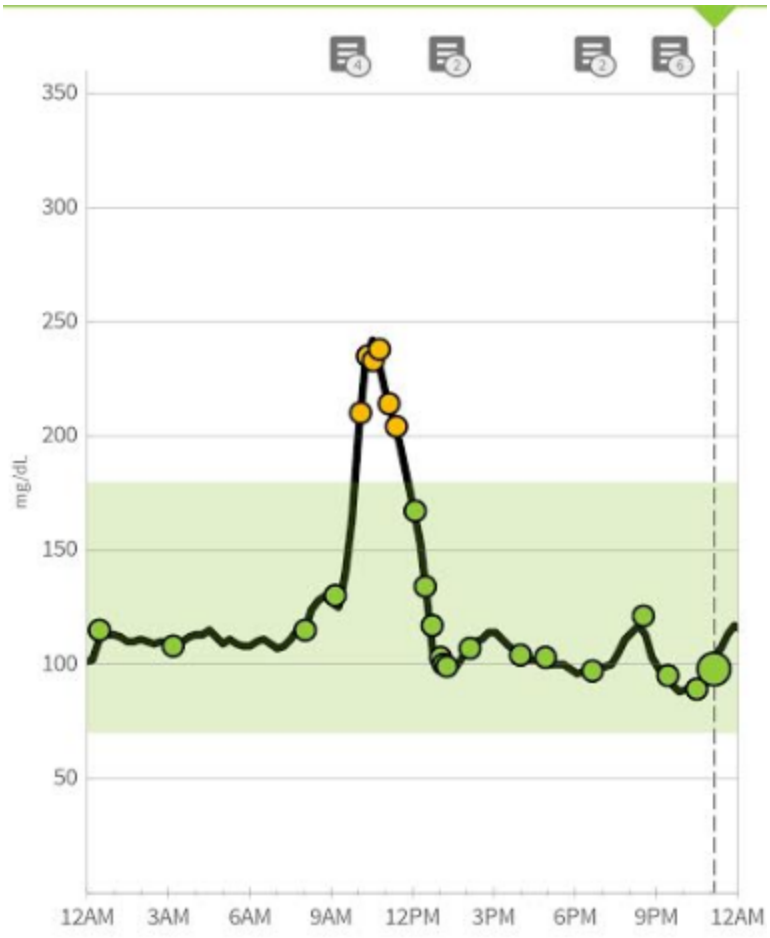
If there's one thing I've learned in my journey to-date (thanks mostly to my Freestyle Libre CGM), it's that for someone with an insulin resistance disorder (type 2 diabetic), **it's comparable to having a *carbohydrate allergy.***

When someone has a food allergy, such as strawberries, they tend to have a physiological response that is clearly dangerous. Hives. Rash. Throat closes up. Violent gastronomical response. There are a number of ways a food allergy expresses itself. But with most food allergies, the cause-and-effect is pretty straightforward. People figure it out. And when they do...they stop consuming that food type. Because, y'know, most people want to continue living.

The Type A Diabetes Manifesto states that people with insulin resistance disorders (type 2 diabetics) should rethink their condition as being allergic to carbohydrates. This was the biggest *ah ha!* moment for me to-date, and is at the core of what drove me to want to write this manifesto.

As soon as I was diagnosed, I went on the American Diabetes Association diet, and (very un)happily pricking my finger in the mornings and evenings. Everything seemed fine. But then I got my first continuous glucose monitor. And it changed *everything.*

Suddenly, that “healthy” apple (or mango or whole-wheat slice of bread or whole-grain salad, etc.) that caused no rash, no pain, no swelling of the throat - no typical allergic reactions that would scare me out of eating them again - would send my glucose skyrocketing, live and in real-time on my monitor. Here’s an example when I tried to eat a cup of “healthy” oatmeal for breakfast:



At 9am, had 30g of carbs in the form of oatmeal + 1 tsp brown sugar
By 10:30am, my glucose had spiked over 100 mg/dl’s
A fingerstick at 8AM and 10PM would have told me I had a *great glucose day!*

When I saw how my body was screaming bloody murder (inside, quietly) when I ate high carb food, it became quite obvious, super quickly, just how dangerous those types of foods were for me.

This is what I describe as a painless-yet-insidious *allergic reaction* to carbohydrates that is literally hurting my internals every time this happens - perhaps even *more damaging* than most other, more obvious allergic reactions. And only due to continual monitoring did I become aware of just how much damage the *recommended ADA diet* was doing to millions of clueless diabetics everywhere.

The *real-time nature* of the feedback via a CGM is a game-changer. When you have a CGM, the quarterly A1c feels like a test whereas the CGM is a meter that measures how your body is reacting to ingredients you're ingesting.

Once you see, in real-time, the damage you're doing to your system, you start to see this for what it functionally is - a carbohydrate allergy. Clearly, allergists would not agree as it's not medically considered an allergy, but when I look at my CGM results, it's the closest mental model for what is actually happening. For those with insulin resistance disorders, the CGM basically becomes an *allergy translator*.

BOOM: We've just downgraded millions of "type 2 diabetics" who have been convinced that they have a disease into millions of otherwise-normal people who simply developed an allergic reaction to carbohydrates.

This is an important recharacterization of metabolic insulin disorders. As you'll read in more detail below, thinking about insulin resistance in this new, novel way does two things:

1. It shifts the mental model from having a disease to having an allergy, which may reduce stress and pain for many,
2. More importantly, it can *align behaviors* with what the condition requires more effectively. After all, it's far easier to understand how to not die of an allergic reaction (i.e., stop consuming what causes the reaction) than it is to understand the complex dynamics surrounding glucose management.

Studies should be conducted to test this hypothesis.

Type 1 Diabetics: Eat As if You Have a Carbohydrate Allergy

One of the most frustrating things I've learned on this brief journey is that those with an *insulin production disorder* (i.e., IPD, or what are typically considered type 1's) are only taught about carbohydrates as something to compensate for with insulin. As a result, they continue to eat a normal diet, and simply add insulin to mitigate the carbs being ingested. This would seem to be the right move - instead of the pancreas creating insulin, someone with an insulin production disorder simply calculates how much insulin a pancreas would release and injects that amount manually.

But, no. Turns out, needle-injected insulin is not the same as a pancreas releasing insulin. In fact, injected insulin is quite inefficient compared to how well-integrated the pancreas beta cells

are with the bloodstream. In fact, we've learned from several studies that inhaled insulin is far more responsive than injected insulin. It makes sense - your lungs, being organs and all, are passing the insulin to your system far more broad-based than a single injection site can.

Why am I deep-diving into the efficiency of injected insulin? Because that inefficiency means you can't simply give yourself a shot to compensate for carbs being ingested. Due to delays between injection and impact, a person with an IPD (insulin production disorder) needs to inject well before ingesting said carbohydrates. Because of this, they need to guess how many carbs, and when, they will be eating. This is a messy guessing game, rife with calculation and timing errors. The result? People with an IPD typically have glucose spikes that are now thought to be more dangerous to homeostasis than a higher A1c glucose average. This is articulated by the A1c vs. Time-in-range debate in the diabetic community today. Time-in-range focuses on glucose levels staying within a healthy range (approx 70-180mg/dl) whereas an average is not the mode, and as such, is easily skewed by very low and/or very high glucose levels. The result? A "great" A1c of 5.5 could actually be due to a patient going hypoglycemic every evening (which is unhealthy), and having an elevated glucose during the day, which is *also* unhealthy. Yet, the average would seem fine.

If you've got an IPD, and you're eating a normal high-carb meal like pizza or pasta, you are likely spiking to 250-350mg/dl until the insulin kicks in and brings it back down to a healthy range. This "spikey" glucose management leads directly to *glucose toxicity complications* over time. Yet this is what so many (the vast majority?) of people with an IPD do *all the time.*

I know many people with decades-old insulin production disorders (IPDs, aka type 1's), and all of them suffer from glucose toxicity complications. I also know that their endocrinologists guided them down the path toward these complications by being satisfied with A1c's under 8. This is unacceptable. While there's not telling how compliant each patient is, the patients I know would have followed doctor's orders if they were geared toward an A1c under 6, even if that meant a more regimented lifestyle. At the end of the day, patients may not be compliant as doctors with low expectations predict, but it's a disserve to not give patients the option to live a life *free of glucose toxicity complications*. Every diabetic patient deserves to understand what's happening, why it's happening, and provided the tools required to monitor and manage the condition.

Specifically, the Type A Diabetes credo suggests that someone with an insulin production disorder (type 1's) should be given the same diet and lifestyle training as many with an insulin resistance disorder (type 2's) - training that demonstrates the value of a low-carbohydrate diet for managing glucose level spikes and reducing the possibility of glucose toxicity-driven complications.

Another Type A Strategy for Type 1s: Sugar Surfing

There is, however, another “Type A” tribe that has emerged for people with insulin production disorders (IPDs) - the “sugar surfers.” The emergence of the CGM allows for constant (if slightly delayed) glucose level feedback, which, in turn, empowers people who require insulin injections (or inhalation) to tightly link their ability to predict glucose outcomes via pattern-detection with their ability to tightly control insulin support. The result? A different kind of *closed-loop system* that enables people with IPDs who love to control life (vs. being controlled/victimized) to dynamically adjust insulin supplementation against any kind of carbohydrate ingestion.

This strategy is almost diametrically opposed to the above call for those with IPDs to manage carbs like an allergy. This strategy essentially uses *data and trends* to overcome the *virtual allergy*. The Type A Diabetic credo supports this strategy as it fits the manifesto criteria. However, just be aware that there are raging debates over the overall health benefits/problems with a high-carb/high-sugar diet. The great part about sugar surfing is that it’s simply an empowering technique; not a mandatory lifestyle choice. If you control your own insulin intake, you have the opportunity to *completely control* your glucose homeostasis by *understanding your diet* instead of *managing your diet.*

While most say that people who can’t create insulin due to an auto-immune disorder have the “worse” version of diabetes because it requires far more management and maintenance, the Type A credo *prefers* to have control over things: having *complete control* of your glucose thanks to manual/automated infusion allows for more sophisticated and highly-managed approaches to maintaining glucose homeostasis. Applying the Type A Diabetic philosophy to “type 1” creates a path towards tightly managing insulin levels in exchange for tightly managing dietary requirements.

Diabetic Complications Don’t Exist

As a Type A Diabetic, I am always armed with a CGM/carbohydrate translator device. Unfortunately, I am also part of the ~10% that has developed an allergy to the adhesive Abbott Labs uses to keep my CGM firmly attached to my skin. So I went to my primary doctor to get a remedy to clear up the chemical burn that I had developed. During this appointment, he said to me “you know, as a diabetic, these things will take longer to heal.”

Boy, did I give him the *Type A Diabetic* treatment.

“Help me understand what you mean by that,” I said. “What part of my 105 mg/dl average glucose levels over the past 3 months would create the physiological dynamics that would impair my body’s healing abilities?”

Now, before I share his response, I want to provide some quick context: He’s a good doctor. He’s been my “primary” for close to 20 years. He’s an intelligent systems thinker who doesn’t just dole out drugs to solve problems. He is conservative in all the right ways. Yet his response

was disheartening: “Diabetes is a disease, Jon, and you need to come to grips that this will impact your health.”

He (correctly) identified my resistance to being labeled and categorized as someone in a disease state. As a *Type A Diabetic*, my conviction is that while I certainly have the underlying conditions that can create a diabetic state, I am able to mitigate these fundamental conditions using a variety of techniques to bring my body into glucose homeostasis, which lifts my body out of a diabetic state and into a healthy, balanced state (at least when it comes to glucose levels!).

Armed with my Type A Diabetic conviction, I retorted that he would have to do better than to throw labels at me as a way to escape the raw facts that my body had similar glucose levels as any other gluco-normal human being, and challenged him to explain to me precisely what physiological dynamic that included normal glucose levels would lead to slow healing of wounds.

He nodded (and probably rolled his eyes) and moved on.

This is just one story of many that I’ve experienced in the same vein. When I post questions similar to this on diabetes forums online, I am inundated with similar (tribal-laden) responses like “we diabetics don’t heal as fast as normal people.” I am having a difficult time putting into words just how unfortunate I find this very common way of thinking is. Suffice it to say, it’s not just inaccurate, but it’s deflating… and dehumanizing.

If my doctor would have not been “programmed” to think of diabetes as a label/shortcut for someone in glucose dyshomeostasis, he may not have mistakenly conflated my underlying insulin disorder with my current lack of diabetic state.

It’s true - you can have an insulin disorder while also being in perfect physiological health.

So, let’s put an end to brands and unhelpful labels in medical conditions. Let’s remove “diabetic” from “diabetic complications” and refer to them in a more accurate, helpful, and descriptive fashion. We need to be more accurate and use less marketing: **Anything considered a diabetic complication should be referred to as a *glucose toxicity* complication.**

Living the Type A Diabetic Lifestyle

As someone who is currently ambiguously diagnosed as diabetic (presenting symptoms of insulin resistance problems, but could be leading to insulin production problems), I have been forced to rewire my approach to living toward making glucose management a full-time background process in my life. Wearing my CGM, I am constantly checking where my glucose

is, and responding to these levels with a variety of tactics that guide my levels into safe zones for as long as possible.

As a Type A Diabetic with both insulin resistance and insulin production issues, I am currently committed to keeping an average glucose level between 105-115 mg/dl's (which is an "equivalent" of a 5.3-5.6 A1c - below pre-diabetes levels) without any prescription medications or insulin supplements.

Note: I will likely need to add medications and perhaps insulin as my condition evolves, but I am holding back for as long as possible so that I can add these when I need them and escalate treatments as slowly as possible.

Some may be asking "how do you keep non-diabetic levels of glucose without medication or insulin?" This is where being a Type A Diabetic really shows its metal.

How I Maintain Glucose Homeostasis Without Medication

- To combat my dawn phenomenon, which used to have me waking up to glucose levels of 130+ mg/dl, I discovered a supplement called Restful Sleep that seems to keep my liver sleeping along with the rest of my body at night. I now wake up between 95-115 instead (but that 115 occurs just as I wake up, so I'm hanging out at around 100 all night)
- To mitigate my "morning highs" (which is the combination of a "shower spike" and a "caffeine spike" each morning) where I surge up to 130-150 mg/dl, I jump on a treadmill for a brisk walk for 1 mile (8.5 degree incline; 3.5 mph rate). This will *usually* bring me right back down to 100. When it doesn't, going a little faster or for 1.5 miles will usually do the trick.
- I consume a low-carb diet (soon you'll be able to visit LowCarbLifeHacker.com where I outline my fun and fulfilling diet!): Usually no more than 10 net carbs per meal, and snacks that are 4 or less net carbs. Low-carb snacks and meals will only raise my glucose between 5-25 mg/dl.
    - *NOTE: As you'll learn in the future sister-site LowCarbLifeHacker.com, this low-carb diet is barely a compromise. Thanks much to the super-popular keto movement, low-carb innovation is at an all-time high. Would you believe that I can eat low-carb versions of pizza, pad thai, ice cream and candy bars without impacting my glucose levels?*
- If/when my glucose levels are hanging out around 110-129 during the day or evening, I'll sip on an ounce of scotch, have a glass of wine, or drink a can of spiked seltzer. Any one of these will take me down about 20-40 mg/dl.
- By the time I go to bed, I'm usually in the 80s-90s, balancing out my temporary morning highs.

The key to my Type A Diabetic strategy, however, is to *immediately mitigate glucose levels above 130 at all times.* I've gotten on the treadmill at midnight when I've accidentally overcarbed late at night, and I've briefly left parties to do a brisk walk around the block for 20 minutes if I happened to have eaten too many carby things at said party.

To many, this way of living might sound *exhausting*. Nearly every pre-diabetic and type 2 diabetic that I know seems to want to keep their insulin resistance disorder as distant from their daily lives as possible. Sure, they will prick their fingers once in a while and "keep tabs" on carb intake, but they mostly want to live a life that is not impacted by an insulin disorder. They want to be "normal." I get it. I was in this mode as well when I was first diagnosed. I was appalled by the idea that I was a victim of a disease that was going to force me to change my life for *it.* This seemed *wrong* to me. And, in all honesty, *depressing*.

[Note: Those with insulin production disorders (type 1s), of course, have no choice and must make insulin supplementation and glucose monitoring a core aspect of their lives. This section of the Type A Diabetic Manifesto is essentially a ***call to arms*** *for all other types of diabetics to manage their condition just as tightly as those who have to.]*

How I Shifted from Victimization to Empowerment

So how did I get from being depressed and victimized to being a *Type A Diabetic*? By realizing a few things in my pursuit of understanding what it meant to have my first "chronic" disease:

1. Virtually everyone has to deal with something. For me, it's now glucose management. For others, it might be depression, or cancer, or a debilitating auto-immune disease, Alzheimers, or simply chronic anxiety that makes people miserable no matter how many carbs they're "allowed" to eat. So, I'm definitely not alone. I just have "my" thing to deal with.

2. With a CGM like the Freestyle Libre, the entire food/drink management situation changes from "being told" what I could no longer eat to self-actualization. With a CGM, I get to see real-time results of how my body responds to what I consume. As a result, I now understand that if I eat a bunch of carbs, my glucose spikes to dangerous levels (as if I have a carbohydrate allergy). This is not my doctor telling me what I ate was "wrong" or "bad" or that "I cheated"...this is *my body* telling me that it is not responding well to what I just consumed, which honestly is so much different. My body isn't scolding me, or making me feel guilty...my body is just like "Here's what's up, bud. Do what you wish with the information I'm providing you." My CGM results are *not judging me*...my CGM is just telling me what's up. And *I* get to decide how I want to deal with the information I'm being provided. I'm in *complete control*. When your body is telling you what's up, you tend to empathize with it because, y'know, you're kind of in this thing together. You realize that that piece of cake just set you back a bit and, if you keep up that kind of thing,

indulgences like that will likely convert into glucose toxicity complications sooner rather than *never*. The result: that piece of cake might just be worth the risk, or it may not be worth the risk. It's my choice. I'm in control based on my own personal risk profile.

3. With a CGM, you will quickly learn (within a week!) that you can put a ton of stuff in your mouth that is not a death sentence (well, at least not one caused by glucose toxicity!). With my new low-carb diet, I'm eating far more meats and cheeses than I ever could on my regular calorie/fat-counting diet that I had been on for decades. And on this new low-carb diet, I'm like never hungry, and snacks are now whatever cheese or meat I like. Not too shabby.

4. When friends and I went out to dinner in the past, I'd usually order a salad or something "light" (because when on my normal diet, I'd only be looking at calories and fat). Now when we go out, I am now more inclined to order a nice juicy steak with a side of broccoli (with cheese sauce - and even a blue-cheese wedge salad if I want!). Meals like this are like the opposite of dieting for me. Eating meat, cheese, and fatty foods is like an indulgence. And while it might be a *cholesterol death-trap*, it certainly is good for my glucose homeostasis! Point being - I was able to convert my prior calorie/fat-limited diet into a carb-limiting diet, and found out that the new diet is actually, on the whole, more fun *[learn more about how to hack your diet at my sister site: DiabetesLifeHacker.com]*.

5. Thanks to the CGM, I've learned an important lesson - this is not about what I can't *consume*. This is about how things *impact* my body. It's just a completely different frame. If everyone in the world were required to install a sensor that reported blood health on a regular basis, I bet a lot of people without any disease would change their eating habits because they'd see real-time data about how it's negatively impacting their health and body.

6. As I engaged deeply in my learning journey about "diabetes" and how to mitigate long-term complications, I was suddenly in a world of medicine and diseases that I had never been immersed in before. Having just turned 50 years old, I have been fortunate enough to not be forced to think much about my own mortality. Suddenly, everything I was researching was about how to ensure diabetes wasn't the cause of my mortality. And, as this sunk in, I came to the realization that what everyone (my doctors, researchers, me) was doing was trying hard to let *something else* lead to my death! In other words, this was basically an exercise in *finding the longest path to death*. Grim? Perhaps, but analytically, this is precisely what is happening. This, perhaps ironically, made diabetes more of a possible accessory to the crime than the criminal itself. The crime I'm speaking of is the end of ourselves (at least as we know it, on earth). Diseases, accidents, over-oxidation (age)... one of these will likely be the prime or at least co-conspirator to each one of our deaths. Even if I completely mitigate my insulin disorder, something else will eventually get me. This shifted my thinking from "managing my diabetes" to "living the best *and* longest life I can" - which included taking my other

issues like cholesterol levels and blood pressure levels just as seriously as my glucose levels. After all, there are complications for *each one* of these blood anomalies - it's not *just diabetes.*

7. Finally, all of this led me to a philosophy of life reconing: Given my belief that we all get one shot at life, on my deathbed, do I want to see my life as being more of a *consumer* or more of a *contributor*? I ask this because, like many, I really enjoy consuming! I used to be a craft beer aficionado. I love sampling local cuisine when traveling the country and the world. Many of my most enjoyable vacations included surfing craft breweries with my fiance. Now, I am questioning this approach to life (yes, because I'm forced to, but....). Perhaps if I shift my focus from "I am what I consume" to "I am what I produce", I'll live a more fulfilling and purposeful life as a result. Trust me, I'm not fully there yet (but I am making progress - have you seen my Type A Diabetic manifesto? :)). In theory, this philosophy could be a situation where diabetes "saves" me from a life of consumption to a life where I produce things that are durable, help others, and are things to be proud of when eventually staring death in the eye.

In Summary

Whew! That was a lot of stuff that I needed to get off my chest. I hope you found the information informative and perhaps even enjoyable at times. Let me try to summarize the key components of the Type A Diabetic Manifesto.

Type A Diabetics:

- are not willing to be told what's happening; they are determined to *understand* what's happening
- respect the medical community, but are not afraid to challenge conventional wisdom
- see diabetes as a disease state that is only chronic for as long as it's untreated
- view diabetes is a branded name that not only tries to describe too many disease states
- understand that the underlying conditions for diabetes are chronic, but feel empowered to mitigate these suboptimal conditions to gain healthy physiological homeostasis
- believe type 2 diabetes should be thought of as a *carbohydrate allergy*
- believe type 1 diabetics should follow type 2 diabetic diet strategies (or go nuts sugar surfing if you can manage it and feel a high-carb diet works for you)
- understand that complications from poor glucose management are not inevitable, and are far more avoidable than currently practiced of in the medical and patient community

Being a digital manifesto, this document has the ability to be dynamically updated and improved. To this end, I invite feedback, additional insights, and even strong disagreements. I look forward to improving this document based on the wisdom of and perspectives of you, the interested reader.

Thank you,
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