(introductory music)

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MARYN: Welcome to Indie Birth's Taking Birth Back series of podcasts. Today we are going to be talking about gestational diabetes. This has been a long awaited podcast as far as I can tell based on popular opinion and inquiry into what pregnant women want to know about, and this has been one of those topics that people keep asking about. So we are finally here, and I myself am about 24 weeks pregnant right now. And I thought this would be a great time to talk about this. Typically gestational diabetes testing is done anywhere between the 24 and 28 week mark. So I thought this would give some people some head's up if they're following my pregnancy and depending on where you're at in yours, give you a heads up and plenty of time to digest this information, do your own research, and come to an understanding, conclusion, and decision for yourself by the time most testing is going to be done, which would be in about another month or so.

So again this testing is generally done around the 24-28 week mark because that's really the best timing for it, and we'll go into why that is. But if it's done earlier, it's not as accurate. So if this is something you're considering, timing is important. So I'm hoping to sort of condense the information that I have come across and that I work with on a regular basis to be able to explain this to you today and again giving you time to understand, digest, do your own research and information so you can truly make an informed choice.

Diabetes or gestational diabetes testing is mostly routine in the U.S. So that means that pretty much every pregnant woman is subject to this testing, and it's an issue that I said already people are curious about because it seems really mysterious. And I think many women are scared into the testing without knowing really what it's for or what it's about and then having to deal with the repercussions of that which could be being diagnosed as a gestational diabetic which we'll talk about. And we'll talk about why that is so dangerous.

So my short personal, anecdotal story would be that with my second pregnancy when I was still under the medical model of care, I experienced sort of the panic that comes with testing, consenting to testing for gestational diabetes without understanding what I was doing or what gestational diabetes even was. So that led me to taking many tests,

and all in all, of course, I didn't have any kind of diabetes—gestational or not—but it was a very stressful experience. And the testing itself was stressful on my body and for my baby, and I wouldn't recommend that three hour testing which we'll get into for anybody really unless there's something else going on. It's really hard on your body, and just emotionally really hard to feel like, "Oh my gosh, is there something wrong? Is there something wrong with me or my baby or the way my body is behaving in this pregnancy?"

And again this was awhile ago, so I wasn't very in tune or in touch or informed, but I didn't think so. I didn't think there was anything going on so that made it even more confusing. So that's partly my goal I guess having been through this myself is whether you're under sort of the typical medical model of care or if you're seeing a midwife—there are many midwives that are either obligated to the state to test for this and/or aren't really up on the latest. So that may mean you get tested routinely, and it may mean that it's not even mentioned. So I don't think either is a good situation. I think we should all be informed about what the options are even if we decide we don't want to do them.

So first what is gestational diabetes? What is it? If three out of four women—pregnant women today—are being "diagnosed," then we should have a good understanding about what it is. We should be able to explain it to people. So you'll hear that that's slightly hard to do. So there's lots of names for gestational diabetes in a sense, and gestational diabetes that phrase is probably the least helpful way of describing this transient condition that may occur during pregnancy only.

So other words would be a carbohydrate intolerance, impaired glucose intolerance, abnormal carbohydrate metabolism. There's all kinds of fancy ways of saying, "You know what? When a normal pregnant woman is pregnant, she's going to metabolize sugar differently." So that in and of itself is not a problem. However, the term gestational diabetes is a lot more serious than that. We're not calling this carbohydrate intolerance of pregnancy in mainstream circles or really anywhere at all. We're calling this gestational diabetes. Diabetes, which is a very real and serious disease, and we're attaching the word gestational to it.

So if I'm confusing you, just relax. I'll get there. Hopefully it will be clear. So in other words, the word diabetes was decided that that was going to be used instead of something sort of less serious like glucose intolerance so that insurance companies would cover costs. Because as we're going to go into, gestational diabetes is very

different from what we know as true diabetes. So Type 1 diabetes is an illness. It's serious and can be serious in pregnancy.

So the clinical entity, the thing, the morphing body of I don't know what—this thing somebody invented, gestational diabetes—officially began in 1979. So the National Diabetes Data Group was kind of updating their classifications of diabetes types, and they decided to include one that fit the pregnancy time. So a workshop got together on this gestational diabetes, and this little group of people in the workshop declared gestational diabetes to be a disease. They considered calling it glucose intolerance of pregnancy but decided on gestational diabetes because they thought this would promote women and doctors into taking it more seriously and would again also allow for insurance reimbursement.

So there you have it. Those are some facts, and again we're not into the nitty gritty yet. So that's not to say that nobody has a problem in pregnancy with sugar, not at all. We're simply discussing what this term means and where it came from, and again if three out of four women are going to be diagnosed with this mysterious disease called gestational diabetes then we had better be clear on what we're talking about.

So again this is sort of a made up term for lack of better description, and again not because there isn't sort of a transient condition in pregnancy where most women will have more difficulty with sugars, but is it a disease process? I would say no based on my research and the information that I have. I would say it is a completely different animal than Type 1 diabetes. So we'll get into why that is, but to kind of give you a hint right now, the diagnosis of gestational diabetes or GD is based largely on lab values that have sort of been changing over the years whereas real diabetes—Types 1 and 2—have pretty severe symptoms, signs and symptoms, and potentially create damage in the mom's body and/or the baby's body. This damage is not seen with gestational diabetes.

So Henci Goer who is one of my favorite authors—I'm trying to think of the name of the book that this is from. Well, you can get me if you would like to know which of her books this is from, but she also believes that gestational diabetes doesn't fit the definition of a disease, right? It's like we could call it anything and there are probably a million other names we could have called it to sort of call it what it is, but calling it a disease doesn't fit because it's based on faulty logic that because someone might have a higher glucose level in pregnancy that that's somehow the same as the high glucose levels in true diabetes that harm moms and babies.

So hopefully that makes sense. So right now at the very least, high sugar levels or higher than normal because there's slightly high and there's severely high, we're saying that a mom that has slightly higher blood sugar levels in pregnancy is somehow at the same—has the same risks of someone that has super high blood sugar levels because they're truly diabetic. So those are two completely different things, but somehow they've gotten the same name, and people think that the risks are the same.

So it is a fact as I've said already that having slightly higher blood sugar during pregnancy is normal. That's not everybody necessarily. A lot of women in pregnancy struggle with lower blood sugars, especially in the morning, especially when they don't eat often enough. Morning sickness is a great example of fluctuating blood sugars in many cases. So I think most people could agree on that. It is also true—so here's another truth thing—that a woman could have diabetes and not know it—true diabetes, true diabetes, the illness, the disease—or she could sort of be pushed over into developing true diabetes during pregnancy and that this could be dangerous.

So those two things are true, and as someone that cares for pregnant women, I would agree that you don't want to miss someone that is truly diabetic and doesn't know it and is therefore unaware of the risks and the treatment options to them. So I think that's really important to point out that you could potentially do some of this gestational diabetes testing simply because you might have diabetes. Maybe you have symptoms of this disease so it's not ridiculous that some women would have diabetes and that we would want to know who they are. We would want to make sure that they knew and that they could be cared for and make the choices right for them. So those two things are true, and again, may influence why someone would do this test, but again, this is getting all the information, right? This isn't about just doing the test because it's there or because you've been told to but understanding if you are somebody that perhaps should.

So a woman with true diabetes—let's just say she's undiagnosed, she doesn't know she has diabetes, and she's had it already before pregnancy—chances are she would have had a lot of trouble getting pregnant or wouldn't be pregnant truly. Infertility is one of the—well, sort of effects I suppose you should say—of true diabetes. So honestly women that are truly diabetic and it's severe and left untreated will have infertility problems.

Okay, so that aside say there's still a woman that is pregnant and may be an undiagnosed diabetic, she should really have such high blood sugar levels—so if you were to test her blood—that along with the extremely high lab values and signs and

symptoms that you may have to sort of ask her or investigate if they somehow seem normal to her—those two things together should be really good clues that something else is going on and that this woman isn't just a normal, pregnant woman who has normal glucose metabolism issues. She's got something real going on. It might be diabetes, and she should be assessed and she should understand what's going on if that is indeed what's going on.

So again all to say that it should be pretty clear with a little investigation so I guess I say that for people that all of a sudden get fearful that, "Oh no, what if I have undiagnosed diabetes?" Well, we'll talk more about signs and symptoms, but again it should be pretty clear between lab values and signs and symptoms, this should not be confusing. And this person really should not be confused with a normal pregnant woman who does not have this going on.

So the woman that is truly diabetic, truly has real diabetes, is probably more at risk for a legitimately larger baby for one and some other complications such as stillbirth. And that doesn't mean all women with diabetes because if it's under control and she's on insulin, then obviously that's different. We're talking about an undiagnosed diabetic with no treatment.

So there are risks to these women, and again that's to say that we do want to find women where it's a problem. That would be one potential benefit of the so-called gestational diabetes testing. But again in the bigger picture and for the focus of this podcast, we're not really talking about women with diabetes. That's not what we're talking about. We're talking about the routine testing of all women and then the label that comes from that.

Okay, so we need to balance this sort of reality of life that there are people that do need things and do have health concerns. We need to balance that with this development of essentially a nonexistent disease, which is gestational diabetes. For normal, healthy, pregnant women, this label of gestational diabetes is misleading and if all they have going is a higher lab value than normal, then that's simply not enough to diagnose them with something like this. So it's very, very interesting.

The one thing that seems to come up is that if someone is diagnosed as a gestational diabetic—again, because her lab value is higher than normal—is that she may have a risk of a bigger baby. And I say risk kind of in quotes because to me—I don't know. I guess that is a risk sort of in the medical model, but she may have a bigger baby. Okay, well, plenty of women do, plenty of women do and have totally normal blood

sugar levels. So to me, I don't know that those things really go together. I don't know. I mean maybe, maybe that's why, and what would the size of her baby be if her blood sugar wasn't above what we think is normal, right? We can't really compare those two things.

So that's something people seem to agree on, but again, I would question that even myself. I think that's definitely debatable for sure. The other thing is that the lab values being used are being set often lower than non-pregnant people. So you have a lab value for a non-pregnant person as to what their blood sugar should be and then you're saying that the pregnant woman should have a level lower than that? That makes no sense, right, because we've already said that women tend to have higher blood sugar levels in pregnancy. So again I think it's another case of the medical world over compensating and saying that if low is good then lower must be better. And there's no proof of that at all. We have no proof that a lower level than normal is more beneficial, and in fact, I think that's definitely debatable. I'm not a researcher at all, but I would just be curious why anybody thinks that's true and if they really think that outcomes are improved somehow with lower than normal blood sugar levels.

If any of you have ever had low blood sugar especially in pregnancy, it is not a fun experience, and when I've experienced it, it's something I want to remedy right away by eating because it doesn't feel good. And I can't imagine it feels good for a baby. So I don't know who came up with this, but we need to consider that the information out there and the lab values being used don't often make sense. So it only confuses the situation.

So the testing. The testing is all over the place. If any of you have had it, I don't even need to tell you how awful the testing can be. But of those of you that haven't or are coming up on this decision, the most common way to test is called the GTT, which stands for glucose tolerance test. And this is what's recommended by the American Diabetes Association for every pregnant woman. Now even ACOG has selection criteria. So even ACOG says, "No, not everybody. If you're over 25," which of course is a huge percentage of pregnant women, "if you're obese, if you have a family history, then yes, but not everybody." But nope, American Diabetes Association says everybody because they're pretty convinced this is a disease process.

So the GTT is a test where you fast overnight or for at least six, eight hours and when you go in in the morning, they take your fasting glucose. So they take blood, and then you drink a 50 gram load they call it of sugar. It's really disgusting. It's like syrup. You basically drink syrup. It's like a concentrate to a soda or something. That's what it

tasted like to me years ago. It's really disgusting, and so imagine you're pregnant. You're already starving. It's the morning. You've gotten your blood taken already. Now you have to drink this disgusting glass of sugar and then wait an hour for them to take your blood again. Of course, you can't eat or anything in between.

So honestly that's a pretty rough test I think. We'll talk about some other options. But then they want the one hour value to basically not exceed 140. So that's sort of the marker for if you pass or fail this test. There's other options that we'll talk about as far as testing, and then there are options—I shouldn't say options—there are other tests that would come after this one should one fail. So this is sort of known as the one hour. And then there's the three hour GTT where it's similar but blood is drawn every hour on the hour for three hours instead of one. That one is really brutal, and then if a woman is to fail sort of two out of three of those hours, then she's labeled gestational diabetic.

So that's sort of the continuum of how the testing works to diagnose someone in this country at least, in the U.S., as a gestational diabetic. But we've already talked about sort of all the problems that comes with this manner of thinking. So if a woman fails—fails the one hour or the three hour—and she has no symptoms of diabetes, then she is at no higher risk of being harmed by diabetes and neither is her baby. Because guess what? She does not have diabetes. She has what could be a total normal glucose metabolism of pregnancy, and let's just consider the obvious here, anybody that has been through it. Again a pregnant woman fasting, hungry, given sugar to drink. I remember feeling like I was going to pass out. It was an absolutely terrible feeling, and because that sugar load was so foreign to my body because I wasn't and am not a big sugar eater, my body sort of freaked out. Lots of women's bodies react the same way. So it's not a one size fits all thing that fluctuating blood sugars during this test really mean anything and really mean anything serious other than the woman's body was severely stressed during this testing. I think we can agree on that.

So again this woman that fails and has no symptoms just got put through a really rough test, and nine times out of ten doesn't have diabetes. We did say before that she may have an increased "risk"—whatever—of having a bigger baby. But guess what? Nothing according to studies will change that. So in other words, her baby is growing more according to genetics than anything and not diet, not insulin is really going to change the weight of this baby. A fetal weight is largely predetermined and limiting calories at this point—well, may cause problems for sure, but if it were to make a baby smaller, we're talking like a quarter of a pound.

So that's not to say diet isn't important, and if you don't have true diabetes and you're pregnant, that you should just go eating candy bars and eat crap all day and not pay attention to the balance of protein and calories and good food that make a healthy pregnancy diet. That's not to say that diet isn't important. Of course, it is, but we're looking at studies here that are just saying that, "You know what? We can't change what is," and because she doesn't have diabetes, we can't change the size of this baby really.

So as you've guessed, this is a problem. The testing is a problem especially when it's being done routinely, to every woman. Not only is this expensive and really hard on her body, and I wonder what kind of effects this has on her and the baby, but the worst part perhaps is a label that comes from this. So again because I was that woman, I can almost tell you what it's like to have that label, and as a result of not having done my homework, not having understood any of this years and years ago, I put myself at risk for being labeled high risk. This can change a woman's life, right? This can change who she's seeing for her pregnancy. This might mean a midwife has to drop her or transfer care to an obstetrician. She's considered high risk. So not only does her care during the pregnancy change potentially, but her birth plans will most definitely change unless she's being cared for by somebody that truly understands all of this.

So this matters. This isn't just a tiny little thing. I think a lot of women in the face of testing just kind of think, "Well, whatever, this is normal. This is routine. I'm just going to do it. I just want to make sure everything is okay." Well, these are the risks when we don't understand what we're testing for. And suddenly we're lumped into this category that we don't belong in, and our life is altered. Our birth and our birth stories are altered. So yeah, there's many unsuspecting women out there who just do this test, and they are healthy people. They are not true diabetics. They wind up being labeled high risk, and then not only do their plans change, but it's sort of like what they've been labeled kind of comes to be. So they've been labeled high risk when of course they are not. But then they're put on low calorie diets which again have been proven to have no effect on fetal weight because a baby for the most part is going to be what the baby is going to be.

A low cal diet, a reduced or no carb diet and no, no, no, no, no. Again someone that's eating candy bars all day, do they need to look at their diet and change things? Yes gestational diabetic or not. But a woman that's been labeled gestational diabetic and is put on a restricted diet will be more at risk for everything—preeclampsia, preterm birth. She will be at a higher risk of elective C-section because most likely they will tell her her baby is too big, and will this fear be based in reality? No. This will be based on fear

that—this myth that gestational diabetes is a disease process and that her baby is diabetic. And again that is not true.

So the fear that can come from being diagnosed with this is plentiful, and it comes from the care provider. So the doctor is afraid of her even having a vaginal birth. What is he going to suggest? Repeated ultrasounds. How big is this baby getting? Every week, measure the baby, and we know that ultrasound isn't that great at measuring babies. So repeated ultrasounds. May suggest an induction. And if the vaginal birth actually comes to pass, then it's possible the care provider still has lots of fear about this alleged big baby. So are they going to be afraid of shoulder dystocia? Are they going to be afraid of CPD, of this baby not fitting? I mean the fears are many when these things get out of control.

So fear, never good in birth. Never connect yourself with someone in fear if you can avoid it because you'll take it on. So if you've got a care provider that's afraid of all these things, all it takes is planting that seed for some women. And that's a very real thing. Planting that seed of, "Oh, you're high risk," and then at every prenatal afterwards, "Oh, this baby is getting big. Stop eating," which of course is terribly dangerous, incredibly dangerous. You're going to wind up with a preterm birth at 35 weeks. That's frightening.

So I don't think that I'm making too big a deal out of this to be honest. I don't think so because this is a very real issue. It's sort of become an epidemic again at least in the U.S. where this sort of seen as benign testing is not, and we're labeling something normal a disease process which calls for medical intervention, right? Because I believe birth is normal, and birth is not a medical event. But suddenly someone is labeled with a disease process so even the most dedicated people to natural birth may be fooled if they don't understand this. Suddenly they're labeled with a medical condition, and birth is medical or could be for them.

So let's talk about some real symptoms if you really had diabetes because I think it is important to always have in the back of your mind if you're weighing an option like this and you're taking it really seriously, you've got to look out for yourself. You've got to know what's what, and you have to be the first to know if you do have something going on. Because why look at a lab test only? We can get this information from ourselves. Our bodies are usually pretty good at telling us when things are not right.

So for women that really have diabetes—again undiagnosed or diagnosed—there's symptoms. So excessive weight loss or gain is one. Excessive thirst is another, and I

think that's one that is interesting, right, because the excessive thirst kind of goes along with the increased urination. Because a lot of women say, "Well, I always have to pee when I'm pregnant." Well, of course you do. Pressure on your bladder, etc. But this diabetic signs and symptoms are different. So having excessive thirst, being really, really, really thirsty all the time, and you can never, ever quench your thirst. And that goes along with peeing a lot.

So think about that. That is not normal. If you're really, really, really thirsty because you're out in the desert all day and you're working in your garden and you just haven't drunk all day, then when you drink all of that liquid, you're most likely going to retain it because your body really needs it. So in other words in a normal situation, excessive thirst does not lead to increased urination. It leads to decreased urination or just normal. So this which is a disease process of course is not normal. So excessive thirst somehow leads to increased urination just because the kidneys are struggling and the system is off. So that is something to keep in mind because I think that's easy to remember. If you're really, really thirsty, you shouldn't be peeing it right out. That doesn't make any more sense.

And the amount of urine that comes out—someone with real diabetes—is allegedly more volume. So again women that are pregnant say, "Oh, I have to pee all the time. Maybe I have diabetes." Well, probably not if every time you pee you're just getting a little, tiny bit out, which is pretty normal for pregnant women. So someone with diabetes is just volume—lots and lots of pee. That kind of doesn't make sense with what they're drinking.

So sugar in the urine if you do urine sticks or have urinalysis done. Sugar can be really normal in pregnancy, not to say we shouldn't look at diet and see where we can improve, but it can be considered normal in trace amounts in pregnancy on a urine stick for a variety of reasons. One of which is just a high sugar diet, which again should be corrected, but a woman that's eaten a whole bag of candy before she pees on a stick probably will spill some sugar.

So ketones in the urine. We've talked about ketones I think in other podcasts. Ketones is essentially a sign of your body not getting enough calories. Ketosis is when your body starts to kind of eat its own fat. It's pretty nasty to imagine. But ketones in the urine in pregnancy along with sugar can indicate true diabetes. So both of those things together.

And then usually the woman has a history of insulin dependent diabetes in her family. She may have other cardiovascular symptoms. High blood pressure, things like that, and then pregnancy-wise her fundal height may be large for dates, right? So a centimeter per week after about 20 weeks equal weeks of pregnancy, but she's 23 weeks, and she's measuring 28. Maybe, maybe she has twins, who knows? But that's one of the things. A baby large for dates because again a true diabetic that's left untreated will have a baby that's large in sort of a strange way. So we're not talking just a chubby, fat baby. We're talking a baby that is filled with fluid for lack of a better way of describing it., and this can make a baby bigger.

It also will often increase the amniotic fluid in the mom's uterus. So again it's not one symptom that you would say, "Oh, she has diabetes," but it's a combination of these things and looking at lab values. So a fasting glucose—and we'll talk maybe more in a minute about that—a fasting glucose so that would be drawing blood sugar the minute you get up when you've not eaten in six to eight hours, a true diabetic will massively fail that along with the one hour, the three hour test. All of them will be really out of range. So again signs and symptoms, lab tests. Those are some ways to identify if there is something going on.

Let's see research wise here thanks to Gail Hart who knows so much Vitamin C may help with glucose intolerance. So those are sort of some preliminary studies. The truth is it's not an area where there's tons of knowledge and research at this point. All we know at this point is that this disease entity isn't and that we must distinguish between women that are truly in a disease process and those that are normal, and let's quit labeling them when they're normal. That's what this comes down to.

So if you were going to make this choice for yourself soon, in our online class—we have an online five week series that you can do at your own pace—and that's called How to Have an Indie Birth. In the first class, we spend a lot of time talking about the prenatal time and not this disease or this disease entity in particular because we just don't have time to go into everything there, but we talk about informed choice making and what goes into that. So I'm going to review that just really briefly for the people in our class that get to listen to this podcast as well as everybody else. And we use something called the BRAIN method, which we did not invent. I think it's Childbirth International has a worksheet on it that is really cool.

So BRAIN, and it's an acronym. It stands for B-Benefits, R-Risks, A-Alternatives, I-Intuition, and N-Nothing. So this mostly applied to making informed choices during birth. This is a way of encouraging women to look at all their options before they make

a choice, but I think using it prenatally is really cool as well. And if we're talking about something like gestational diabetes, you can look at this or use this and kind of have it help guide you into your own choice.

So B for benefits. Benefits of this testing. I mean it's really kind of personal what you would come up with as the benefits of this testing. Perhaps you have symptoms of possible diabetes, and you'd like to investigate that. That may be a benefit.

Risks, obviously we've talked about many risks since I think the risks outweigh the benefits for sure for normal, healthy women in routine testing. So plenty of risks as we've talked about today. Again the most of which is just this label that can really alter someone's experience and ability to make any further choices.

Alternatives. We talked a little about that. So we talked about the GTT, the one hour, and then somehow some woman are lucky enough—ha, ha—to take the three hour, but then there are some other options. And so I think alternatives are always something that we need to know about. So whether you hear all this information from me or someone else, you always take it with a grain of salt. And you hear what someone has to say, and then you go off on your own and say, "Okay, but what else? What else is there?" So alternatives, I think that's my favorite part of this BRAIN acronym.

So for this not only is there the testing we mentioned, but there's doing a fasting level. So again with a true diabetic a fasting level could be anywhere from 145-300 and probably higher honestly. So if you sort of wanted the quickest testing with the least injury to your body, mind, and spirit, a fasting level might be the way to go. Just do a fasting. If you're 105 or below, 99% chance you do not have true diabetes, which again is what we're really looking for here. We're not really looking to diagnose any old woman with some mythological disease. We're looking to actually see if she's one of the few that have a true disease process.

So fasting, that's a great alternative. Get a fasting level, and you can do that yourself. You know a finger prick may not be as accurate as an actual blood draw, but hey, there's glucometers you can go buy. And you may know someone that has one, and it takes just a teeny, tiny drop of blood. You can do it at your own convenience, in your own home. So you do not need anybody for that at all. Another lab value which would come from a blood draw would be a hemoglobin 1AC, and that's another way of pretty definitively looking at true diabetes or not because that's all we care about.

Other alternatives to the one hour would be—there's all kinds of variations—eating jelly beans as opposed to drinking that disgusting sugar soda or eating a real meal. I know many midwives that recommend that, and it would be getting a fasting number and then a breakfast, like a full breakfast, like eggs, and a protein, and some syrup on some pancakes. So a well-balanced meal and then testing the blood sugar an hour after. But again if you're getting the fasting from that, some would say that's all you need. You don't need this whole other thing although eating a meal and taking a blood sugar an hour after is common practice as well to see how your body is metabolizing the meal. Now of course it depends what you've eaten. If you sat and ate a donut and a cup of juice, yeah, that would be a scary one hour blood sugar. So you do have to put some balance into it.

So those are some other alternatives, and then the rest of the acronym—the BRAIN acronym—would be intuition and nothing. And I think those are really valid ways of putting together a decision for yourself. So all this information I've just given you, making your head hurt with numbers and talking about diseases and things like that, many of us come back to intuition, which is I'm fine. There's nothing wrong with me. I do not have diabetes. Therefore I'm going to opt out of this craziness. And another woman might say, "There might be something going on. That sort of rings a bell, some of those symptoms. I think I'll just do it," or, "I'm going to do an alternative. I'm going to see what my fasting is and go from there."

And then nothing. I think that's always a good option in a sense. We're doing nothing. We're not entertaining any of this for whatever reason. So those can all be used in combination. Hopefully that little acronym helps. I know it kind of helps me sometimes, and hopefully this podcast really helped you just grapple with what people are talking about. And I really, really hope it's helped, and I hope that those of you that work with pregnant women and those of you that just—I mean who doesn't know somebody, right? You have a sister. You have a friend, cousin that you're able to digest this information enough to kind of give them the highlights and suggest possible testing for them really. Testing is not something that just is in the realm of doctors and the medical community. We can do a lot of testing on our own and at home, and I think that's good acknowledgement that we are looking at the whole picture for those of us that would like to.

So take this information with a grain of salt and digest it. Come up with the highlights and be able to share them with people. Resources I am always happy to share. Gail Hart is a huge influence on what I know and work with every day. She is amazingly brilliant. And a lot of this information comes from her research, updates for midwives,

and man, I don't know where we would all be without her. But I have many other sources here that would take me forever to talk about. So if you'd like to know specifics about where I got this information, please let me know. I'm happy to share with you. I'm always happy to share this information and make it as sort of factual as possible so that I'm not just here spouting my opinion on things like gestational diabetes. I'm offering you some real information so that you can go forward and make a truly informed choice which of course is the point. So thanks again for listening. Catch you here soon.

(closing music)