A Special Interview with Dr. William “Bill” Glaros

By Dr. Joseph Mercola

DM: Dr. Joseph Mercola

BG: Dr. William Glaros

Introduction

DM: Welcome, everyone. This is Dr. Mercola, and today we’re going to talk about a really important topic: biological dentistry. I’m joined today by Dr. Bill Glaros, who is a practicing biological dentist and based in Houston, Texas. He’s the past president of the International Academy of Biological Dentistry and Medicine, and he’s also an accredited member of the International Academy of Oral Medicine and Toxicology, (commonly known as IAOT) and the American Naturopathic Medical Association. He’s also testified before the FDA about the health risk in dental nutrition and dental amalgam.

So, welcome and thank you for coming all the way from Texas and joining us today.

BG: Thank you. It’s a pleasure to be here.

DM: I have been aware of biological dentistry now for just about two decades – 20 years. I was first introduced to it by one of my physician mentors, and I saw Dr. Doug Cook up in Northern Wisconsin.

BG: Yes.

DM: Who you’re familiar with, because the biological dentistry is a small community. But I’m wondering if you could tell us a little bit about how long you’ve been practicing, and how you sort of had your epiphany and became interested in this niche of dentistry and this important aspect of total healthcare.

BG: As I look back, it started in dental school. The issue then and now was how could a material – a neurotoxic material – like mercury that has warnings accompanying it – about “Don’t touch it with your bare hands, breathe it in, and keep it in a sealed container” – how can that same material be safe to put into people’s mouths? I was sure that before I got out of dental school I could get all that worked out. They would explain all that to me, the magic of that. That didn’t happen, and it still hadn’t happened. But it got me confused, which was good, because it got me stimulated.

When the first composite materials that were suitable for posterior teeth came out in the 80s, I jumped on board with those guys. I remember the last day of October of 1984, because my receptionist said, “Bill, you didn’t place any mercury fillings this month.” I said, “Great. I quit.”

DM: One of the first mercury-free dentists.

BG: Yeah, maybe so.
DM: But back then, those were the days when it was actually against most local dental societies to actually tell patients truth that there was mercury in this material.

BG: Right.

DM: In amalgam.

BG: All of us have some scars, you know, from that strict position that they took. I’m pleased that they have taken a less strict position, even though they haven’t taken the place. They’re not where I want them to be yet.

DM: It’s interesting, because about 50 percent of dentists now are what we consider mercury-free. We actually have alerts from the search engines that tell us when there are new articles that come out on mercury. We see a lot of press releases for many new dentists now, advertising their practices as mercury-free dentists. I’m not sure if that is from an intrinsically aware – not intrinsically, but a position of understanding that really allows them to incorporate some of the principles that we’ll talk about, which is in biological dentistry.

But, you know, right at the beginning... I think almost anyone watching this understands the dangers of mercury, that it’s not something they want in their mouth. And that really, ideally, like I did in the mid-90s after seeing a “60 Minutes” exposé of Mike Wallace on the dangers of mercury.

BG: Uh-huh.

DM: I went immediately to my dentist who was not a biological dentist, removed all the mercury, and did in a way that caused me personal harm, which I’m still suffering from until now, 20 years later. I have some kidney challenges.

There’s this understanding that it’s dangerous, and that it should be removed. But what I’d like you to address is this really important topic, which is to not jump from the frying pan into the fire and just repeat the mistake that I did, which is just to pick your dentist who’s probably a wonderful individual…

BG: Yeah.

DM: Incredibly competent, but when it comes to understanding the hazards of this severely neurological poison, not trained in any way, shape, or form to take it out without causing damage to the individual. I’m wondering if you can address that, help people understand the importance of doing it, what some of the precautions are, and how to find a dentist who has that specific training.

BG: Yeah, knowing your audience, I’m part of your audience. It’s a percentage of the people that have interest in finding a match for them. Some people are looking for the closest dentist or someone who’ll take their insurance only. The people that come to our office or that call us are looking for a match. They’re asking questions.

My wife, who works in my office sometimes, says, “You need to ask open-ended questions here.” We have questions on our website that people can use as they’re looking to find that match. It’s not – to me – about right or wrong, because that could never be settled.
DM: Uh-huh.

BG: It’s a matter of people being able to find the dentist that matches with them. What kind of precautions does the dentist use? These are things that can be done before a dental appointment, not at the time of the dental appointment.

DM: Sure. Waste your time and the dentist’s time.

BG: Sure. People will call up our office, and my wife would spend hours with them for over weeks if she has to.

DM: Is she the practice manager?

BG: Yes, in my office. Well, she’s the alligator in the moat. We want people to really… Then I want to spend two hours for an exam if their goal is to get a filling fixed.

DM: Uh-huh.

BG: We want to make sure that their time is honored and also that our time is honored. Interviewing them all. You can look at the website that the dentist has. If everything is about cosmetics and Snore Guards®, which is very important… Cosmetics are important, too. I’m not making less of that.

DM: Sure.

BG: But if you don’t see anything about biological dentistry in there and his office says, “Oh yeah, we do that,” then you need to ask some specific questions, you know, what kind of…

DM: Maybe you can review some of those questions now…

BG: Sure.

DM: …so our audience would have an understanding and be aware of what really is an individual who’s qualified and has the ability to remove those mercury fillings safely and not harm them.

BG: Yeah.

DM: And cause almost potentially worse damage.

BG: Yeah. Qualified and experienced is one thing. It’s a belief system.

DM: Uh-huh.

BG: It makes me anxious to think that people – and neither can I say, “Oh yeah, I’m mercury-free.” Then there’s mercury-safe, which is an added issue.

First of all the questions that patients can ask can be: what kind of protection do you offer the patient, and what kind of protection does the staff have? The offices that I believe in, and what we do in our office, is we protect the patient when they’re physically there, covering their nose with a guard and with a mask. They’ve got an eye protection. The room has got an ionizing filter
plus a mercury filter for the room. We’re going to do a sequential removal of the mercury fillings rather than just pick one then, you know, just starting anywhere.

DM: Do you have any other precautions like high-vacuum suctions and mercury…

BG: Sure.

DM: …and rubber dams?

BG: We in our office believe that the rubber dam is the best way to do it. There are some people that don’t like the rubber dam, the dental dam. It’s non-latex, so we call it dental dam now.

DM: Okay, sorry.

BG: But if I didn’t have that so… But the dental dam covers both. I believe in using it. We put a saliva ejector underneath. I use it since I have my own mercury vapor sniffer. We were checking where the mercury vapors are in. Underneath, it goes through the dental dam.

DM: Really, so this is during the draining?

BG: During the removal of the mercury fillings.

DM: Okay. Where is the vapor going again now?

BG: It goes through the dental dam. We isolate the tooth.

DM: Oh, wow. How thick is that dam? Is it just like a thin piece of?

BG: Yeah, just like a paper bag, you know.

DM: Okay, that’s what I was thinking.

BG: Yeah.

DM: So, it’s not that thick at all? And that the mercury vapor is penetrating the bag?

BG: It can penetrate there. That was the highest concentration.

DM: Behind the bag!

BG: Behind the dental dam.

DM: Dental dam. Wow.

BG: We start putting a saliva ejector underneath there to pick up that pressure.

DM: Do you pick up to reduce the level?

BG: Oh yeah.

DM: And the saliva ejector is actually a suction.

BG: It’s a suction.
DM: Yeah.

BG: It’s just low-volume suction. Then we have two high-volume suctions on the outside. We’ve got water coming from the hand piece, and we got [inaudible 9:38] spraying water on it. We’re using what we learned from Doug Cook. We’re using low RPMs – 20,000 RPMs is the most that we’ll use touching your tooth.

DM: Yeah, maybe, Dr. Cook is the dentist who I saw 20 years ago.

BG: Right.

DM: He’s about four hours from Chicago, somewhere between four hours. It’s a little bit distant to get to him.

[---- 10:00 -----]

But he has developed this process with low-speed drilling. Maybe you can discuss some of the benefits of that, his belief system around it, and why it might be beneficial to use that.

BG: Yeah. When we use the high-speed drills that can be used at 40,000 RPMs, there’s an effect on the dental tubules. As it cuts the tooth, it actually sucks the fluid and sucks the moisture out of the tooth. It causes microfractures in the tooth. Those might not ever show up clinically, but they often do. All the tooth just broke, you don’t know why. Well, teeth get old. They get dry and they break.

Maybe because the first time they were touched, they were touched with a high-speed driller at 40,000 RPMs cutting through the enamel, creates microfractures, creates the suction effect on the dental tubules.

That’s why I say knowing the rules is one thing; being committed to honor them is another.

DM: There are some downsides of doing it, because it takes longer.

BG: It takes longer?

DM: Is it more painful to do that drill?

BG: No, it doesn’t.

DM: It just takes longer, and you go through more bits, because you’re not...

BG: I haven’t noticed that part.

DM: Okay, but it just takes longer.

BG: It’s just a little bit longer. Dentists and business people want to do the same job.

DM: Sure.

BG: Braces are going to take longer than they have to.

DM: Right.
BG: But I wouldn’t even worry about an answer, “Do you want me to do this as fast as I can or as good as I can?”

DM: Uh-huh.

BG: They’ll say, “Well, I think I’ll take good as well as you can.” Okay, good.

DM: Yeah, if you want it as fast as you can, you should probably see another dentist.

BG: Yeah. We’ve determined all that in advance of the restorative appointments. There are some other issues that can happen before you start the dental part, and that would be nutritional support and making sure that people’s exit routes are open – their bladder and bowels are functioning – because it’s easier to get it out of the mouth than it is to get out of the body. Getting it out of the body is the main goal. It doesn’t do it by itself easily for some people.

DM: For most people, I think might be…

BG: That’s true. Everybody needs supporting.

DM: I know.

BG: And it’s interesting looking at the urine mercury.

DM: Because normally we’re not exposed to mercury in the environment. I mean, our ancestors…

BG: No.

DM: They’re very rarely were ever exposed to high-levels of mercury. This is a relatively recent occurrence.

BG: Well, the last hundred years, though.

DM: Well, last hundred years.

BG: Yeah.

DM: But the reason I meant with respect to the effect to our entire ancestral period…

BG: Yes.

DM: However long you want to debate that is…

BG: Yeah, sort of.

DM: But it’s certainly longer than a hundred years.

BG: Yes.

DM: Much longer.

BG: Yes.
**DM:** The point of that is that we just haven’t had this exposure. There’s no specific detoxification mechanism that’s targeted towards mercury.

**BG:** Right.

**DM:** You have to rely to the sort of generic ones. That’s why we need all the help that we can get. But the best help is to not have it to begin with.

**BG:** In the first place.

**DM:** Yeah, this is a type of mercury exposure that really is what we call inorganic. Because the organic one is really more from the food we eat, like the fish or the seafoods.

**BG:** Right.

**DM:** But this is inorganic, and – I believe – is more toxic than the organic.

**BG:** The methyl mercury is the most toxic. That’s from the fish.

**DM:** Okay, the methyl mercury. Sorry, I got it mixed up. Thank you for correcting.

**BG:** Yes. The methyl mercury is the most toxic.

**DM:** Okay.

**BG:** In our bodies, the bacteria in our gut try to methylate mercury.

**DM:** This is the inorganic one?

**BG:** Yes.

**DM:** So the…

**BG:** They try to methylate it.

**DM:** Okay.

**BG:** They do. The Candida in our body, in our stomach, in our intestine, and all demethylates it. People that are trying to get rid of Candida issues, very often, their body is being way smarter than they are. They can’t get rid of it – the Candida issues. They’re all upset about it. It’s doing a bigger job for them. Whatever other symptoms they might be having, it’s doing a big job for them, as it’s demethylating the mercury for them and decreasing the toxicity that they’d be experiencing.

**DM:** Yeah.

**BG:** We have patients that often report, after they get the mercury fillings out, that they’re able to address the Candida issues successfully.

**DM:** You had mentioned some of the characteristics of a biological dentist would be their approach to general biological dental care, especially with respect to the aspect of mercury removal safety and then the nutritional component.
BG: Right.

DM: Are there any other elements about and measures you’d like to make the distinction?

BG: Probably, when you say the mouth connected to the rest of the body, or if you made a statement, “Do you think the mouth is connected to the rest of the body,” probably, most conventional dentists could agree with that: “Yeah”, you know, “Yeah, I think that’s right.” However, for biological dentists that is foundational. That is inseparable, innately, and intimately totally related to that. You can’t have a relationship of one without the other.

One of the things that we believe in biological dentistry is it’s important to check for the compatibility of dental materials. There are different ways to do that. In a meeting of biological dentists, you’ve got 10 people that might be four or five different ways that it’s done. I don’t care which way; I just like that it’s paid attention. That is the way to honor a patient. We all have patients that can take anything. You’d give it to them, and they can just – they just go through it all without an issue. Then we all have patients for whom everything becomes an issue.

DM: Uh-huh.

BG: They’re sensitive to new paint in the hallway of the building that they’re in or all those issues.

DM: They’re real canaries.

BG: Yeah, I call them my little yellow canaries.

DM: Right.

BG: They don’t mind being called that. It’s not an insult; it’s just a description.

Testing for compatibility of materials is crucial. Part of the protection of the patient besides the physical things that they do and the nutritional support, we want to protect the environment. Having mercury separators in dental offices is a unique unfortunate thing. It’s unfortunate that it’s unique. But dentists don’t see that as an issue. It’s not particularly expensive, you know, 500 bucks maybe to put a separator in your office, so that the effluent is coming out of the office. The mercury fillings that you’re grinding out and cleaning out aren’t ending up in our water supply.

The companies that sell these units will also accept the mailing of them, and they will send a receipt to you how this is being cared for in the proper manner. But it’s not done.

DM: We work with Charlie Brown with the Consumer for Dental Choice, and I know he’s making great progress on this World Health Organization treaty, which is moving towards actually making the requirement for dental mercury separators in all dental offices. Hopefully, that will be passed in the not-too-distant future, because that is becoming perhaps the leading source of mercury in the environment, right after industrial. It’s number two now, but industrial use is going down. The dental use is continuing to climb.

BG: In tons – 30 tons a year or something are put in people’s mouths every year in the United States.
DM: Is that amalgam or the mercury enamel?

BG: The mercury.

DM: Okay, just pure mercury? Thirty tons, that’s a lot of mercury.

BG: San Francisco Bay had a big problem with mercury in it. They try to get the dentists to volunteer to put the traps on, the separators. They didn’t do it, so they mandated it. Within four or five years, the problem has cleared up in San Francisco Bay.

DM: Simple basis.

BG: It’s real.

DM: Yeah.

BG: Dentists are so commendable in so many areas. It’s a little embarrassing maybe that we don’t pay attention, that we’re not doing everything that we can do.

DM: Well, some are. I mean 50 percent of dentists who are mercury-free, although I imagine a good percentage of those… What would your guess be? Of those 50 percent who aren’t currently using mercury in their practice, how many of them really understand the extent of the full issue of using a separators and taking it out?

BG: I think 10 percent of that 50 might be honoring the things that we know are possible to do.

DM: Only five percent, even though 50 percent?

BG: I don’t know that for sure, but that’s my guess.

DM: Yeah.

BG: If you’re going to ask…

DM: But you’re right. I mean you’re a dentist; you’re in the community. Your guess is as good as anyone else’s. I mean better than almost anyone else, because you’re in the community. That’s an extraordinary percentage. The vast majority up to 90 percent of those people who are advertising themselves as mercury-free, it’s a step in the right direction, but you really need to do your due diligence, and go to the next step.

BG: Yes.

DM: They may perhaps go to your website and look at some of the questions that you encourage people to ask. That would be good.

BG: Right. That is to find the right match. Because I don’t place it as great in what protocols do you use – open-ended questions.

[----- 20:00 -----]
DM: Now you served as past president of the International Academy of Biological Dentistry and Medicine or IABDM.

BG: Right.

DM: A group of which I’m speaking to in Washington D.C.

BG: Yes, you are.

DM: In two months, at least, at the time of this filming.

BG: Yes.

DM: I’m excited about that, because I’ve never spoken to them before. They’re a good group. I’ve known them for quite some time. They’ve had a whole history, especially since their founder passed away. Maybe you could tell us a little about that group, what it’s all about, and educate our viewers about it.

BG: The International Academy of Biological Dentistry and Medicine is our current name. It was the American Academy of Biological Dentistry. Ed Arana, a dentist in California, and another dentist in California, Gary Verigin, kept meeting each other at different meetings. They kept encountering one another. They started talking. They realized that they were having similar views about lots of issues, and that there were endless numbers of issues that needed to be studied and needed to be worked out. They decided to form an organization, and they did.

They were first using the Germans, because the Germans then and now were more focused on energy. We’re more focused on chemistry. We’re more focused on the pharmaceutical aspect, and they tend to be more focused on the energetic elements of it. Kramer, Voll, and these guys came over. They invited them. They spoke at the early meetings.

DM: Wait, Voll was a dentist?

BG: Yes, he was a physician-dentist, I think.

DM: Oh, okay, that’s right.

BG: Yes.

DM: But then he was a dentist. He was typically considered the founder of what we call EAV or Electroacupuncture according to Voll, which is really the foundation of energy medicine, at least as practiced by professional clinicians.

BG: Yes. I’m blessed to have a lady to be in my office, Dawn Ewing, who practices that. Doug Cook was the one that stimulated us to get into that. It is a fascinating tool. You want to get the belief that the body and teeth are connected and related to one another, going both ways, teeth affecting body and body affecting teeth. EAV is a fascinating tool.

DM: Maybe you can…

BG: Okay.
DM: I could imagine the majority of people watching this aren’t familiar with that, because it is a relatively unusual approach and certainly viewed very skeptically by most conventionally trained physicians.

BG: Sure.

DM: Maybe you can briefly describe that.

BG: Sure.

DM: You perform this service in your office, right?

BG: Right. Voll was a physician-dentist, very skilled in acupuncture. In the late 50s, I think he started figuring out that he could put a little bit of energy current—electrical current—on the meridian that have the same effect, which today, you know, acupressure is commonly used, understood, and accepted. He got very sophisticated with his work. He had something like two volts of current, three volts of current in the ground. He would measure how long it took and the energy that it took to pass through the body. There’s a proper speed.

He set it up with the computers. He calibrated it. That healthy tissue would get there, and it would be a reading of 50 on the computer. If something was being blocked along the way, if there were some chronic ischemic diseases or some burden there, a root-canal treated tooth or something, then that would block the energy. The reading on his meter would be less than 50—48 or 12, you know. We have readings that low. If something is excited and there’s an inflammatory response going on, then the readings would be higher, because the energy was getting there faster.

It can be used as a way to check teeth and teeth signs to see what their energy is. Then there’s ways to balance that. If a tooth had a high energetic reading, then these units that have been created to do electronic acupuncture will supplement. What would be a balance for that? Well, it could be a full-body inflammation in the pulp or occlusal stress. We can get it. Then it will balance that. You put those things online with that and it balances it energetically.

DM: One of the things that impressed me about that, too. I believe Voll was the clinician who made the correlation with tooth number or the position of the tooth and clinical diseases, so that large numbers of people have root canals. I’ve done a video on that that goes into more details. I’m not in favor of those. I believe IBDM is not either.

BG: We are not in favor.

DM: But rather than wholesaley recommending to everyone to have them removed—because it’s a big commitment and can be quite expensive.

BG: Absolutely.

DM: Is to look individually as to what the person’s problem is. If the person has breast cancer and it’s on the tooth that’s connected to the breast, well, then you might want to be a little more aggressive—or heart disease or things like that.

BG: Sure.
DM: Maybe you can address that connection.

BG: Well, part of what you’re talking about is the dentist – I, as a dentist, do not tell people, “You should do this,” or when they ask, “What should I do?” I say, “I can’t answer that.” I can’t answer, because that would be inappropriate for me. I’d be making the decision for you and because it’s practicing medicine, and I don’t have a license for that. I can tell you what I would do. I can tell you what I’d do if this was my daughter. Often, I’ll have somebody in the chair who’s wondering about what they should do, and they’re wondering if I’m judging them.

I say, “If you were my daughter, I would tell you what I do, and then I would honor whatever you said.” If you said, “I just can see losing my left front tooth. I just can’t see you doing that.” I’d say, “Great. I hear you, and I respect that. Would you consider seeing Dr. Ewing for evaluation of that tooth every year just to see if it looks like it’s becoming an increasing burden for your system?” And they’d go, most of the time, “Yeah, that’s not a problem. That’s an easy choice.” That is one of the ways that we help people get through that issue.

But it's all these decisions, you know, we have to be so careful. Even though it’s a friendlier climate to what we do in biological dentistry, we have to be so careful that we’re clearly not practicing medicine, and we’re not telling people, “Do this and this will change.” We have a mission statement that people will understand after they've been through and had appointments with us. This is: we’re together to support health and well-being through relationships based on understanding, trust, and excellence in care, skill, and judgment.

DM: Uh-huh.

BG: First, we have to listen to them. We have to understand where they are. Then they trust us more, and then we can talk about what dentistry we’re going to do in that due.

DM: Sure.

BG: It’s a good process.

DM: Now, would you say most of the members of IBDM follow these principles? Then maybe if you could discuss a little bit more about IBDM…

BG: Right.

DM: With respect to its continued education and if they include members other than dentists in their organizations.

BG: Sure.

DM: Because a lot of professional organizations don’t. Especially, physician ones, they just restrict them to physicians. They don’t include chiropractors or alike health therapists.

BG: Well, we can’t do it by ourselves. Nutritionally, there are so many issues – craniosacral, chiropractic adjustments, body manipulations, and things like that. There are so many things that are critical to people’s health that we think is critical. The founders did. They called it the American Academy of Biological Dentistry, but when the early…When we’ve had our change over, after Ed passed away, during the time that I was the president, we said, “Let’s broaden
We called it the “International Academy” rather than American, because we have international members.

And we knew that we depended on, critically, having support from whether it’s naturopathic doctors. Once again, if the patient comes to us with their belief systems, and our goal is not to fix them or fix their belief systems. But our goal is to honor their belief systems and see if we’re a match for them. If we are, then they’re going to continue to see their physician, naturopathic doctor, kinesiologist, or chiropractor for that nutritional support. We want to have as many of those people as we can in our fold. We want to have as broad a base as we can.

We want to have, you know, 50 percent of the dentists that aren’t placing mercury fillings. They’ve taken one step that we think is wonderful. We’d love for them to learn some procedures that they can maybe increase their effectiveness for the health of their patients. It’s not tic-tac games lot kind of event. It’s open. There are other groups. You’ve already talked about the National Academy of Oral Medicine and Toxicology and the Holistic Dental Association. There’s another group.

DM: Do either of those groups allow other alike healthcare professionals come in?

BG: Yes.

DM: Oh, they do. They both do.

BG: They all do. There are three of them. We encourage it aggressively. I don’t know if what percentage of the IOMT… I don’t how many member’s that.

[----- 30:00 -----]

We don’t have as many as we would like. We have people come for a couple of years. They we’re trying to get better sticking power. We’re trying to broaden our horizons there, broaden our membership.

DM: Oh, it’s good. Part of the reason this is so important – what we touched on earlier – is to effectively address the mercury issue, which is pervasive.

BG: Yes.

DM: Well, large numbers of the population. I think it’s three out of four American adults still have mercury filling in them.

BG: I don’t know about that.

DM: It’s a high number. It’s a very large number. You know, for the person who hasn’t been exposed to this before, I made an assumption earlier that most people would.

BG: Right.

DM: But just to review the basics, if you could help us understand some of the side effects of having this chronic low-level mercury exposure, even higher levels or acute levels.

BG: Right.
DM: Because you’ve made reference to the meter that you have.

BG: The vapor sniffer.

DM: The vapor sniffer that would – actually I think we’ve shown the video that, I think – was done by IOMT a number of years ago.

BG: Yes.

DM: That actually shows or visualizes the mercury coming off every time you’re chewing. What are the consequences of having this chronic exposure, specifically neurological, because it’s pretty widely accepted as a potent neurological toxin?

BG: Sure. Well, it’s a difficult issue from the standpoint that it causes… Dr. Hal Huggins, one of the founders and leaders of this whole movement, would say it picks on people’s genetic weak link. If mercury was like asbestos and it causes mesothelioma, every time you get mesothelioma, you’re looking for the exposure to asbestos.

Mercury tends to pick on people’s genetic weak link. It might be irritation of the skin or itching of the skin. It might be memory loss or brain fog. It’s something that people who’ve been through it identify with frequently. They say, “Gosh, the fog cleared up.” It went away.

There are issues. It will affect neurological issues and their immune systems. The fact that it crosses the blood brain barrier that causes the neurological issues. It crosses the placental barriers, and you have this embryo with no immune system, but the mercury is starting to affect him immediately. Hair loss, I don’t have any interest in that.

DM: I don’t either.

BG: We have the same barber maybe.

DM: Yeah.

BG: But still, different issues like that. There’s testing that could be done and give us an idea about what’s going on. Some people will use urine mercury as one way to check what their levels are. I like it when they do that and find what the urine mercury level is before they’re challenged with a chelating agent. That’s what it’s like for them every day.

They collect urine for three to six hours or 24 with two different techniques, similar results, and find what the urine mercury level is. Then the next 24 hours, they will take a chelating agent – whether it’s DMPS or DMSO. Not DMPS, not DMSO, but a different chelate, penicillamine, and different chelating agents. You collect urine for another six hours or 24 hours, the same that you did on the first day.

Sometimes urine mercury levels will go from below four micrograms per liter, which is considered a healthier rate, to way above that, which indicates that those people are retainers of the mercury toxicity. They have a retention problem. They don’t get rid of it well. Those people aren’t going to respond as quickly to removal as people whose urine mercury levels before it was challenged might have been eight or 10, and it was 12 when they had it challenged.
There you have this body that has a good sense about how to get rid of mercury. Those are the people that tend to not have the symptoms. People that tend to have the symptoms are the people that have retention of the mercury. If mercury gets into all the cells of the body, and it’s like the water dripping in the kitchen sink. You go on vacation and the water’s dripping. It’s okay as long as the plugs are not in there. But if the plug settles in and that same dripping builds up, then you have the retention toxicity issue, it spills over, and starts to create the symptoms that cause the problems.

**DM:** Yeah, it’s a complex issue, though. We’re actually in the process of evaluating mercury testing. But as I understand, there are basically two different types: organic and inorganic mercury. Even the urinary chelation challenge that you mentioned, it only measures one specific type. I think it’s the inorganic?

**BG:** Yes.

**DM:** The organic levels and, I think, in the blood. If you could measure the blood, inorganic, and even saliva and you can combine all these things, you can get a better idea exactly of the bigger picture. I think that type of testing process is an evolution, and in my understanding, is probably the state-of-the-art this point – combining all of them, not just doing hair analysis.

**BG:** Yes.

**DM:** Blood or urine. Actually, it wasn’t saliva; it was hair that I was referring to. Hopefully, you have enough to do the testing.

**BG:** Right.

**DM:** We’ve established that mercury fillings are something that you would best avoid. We’ve been using this since the Civil War. There’s no reason at all to use them. Charlie Brown is working aggressively to have them banned from the world.

**BG:** Yes.

**DM:** The president – I think – of the European Union just recently announced that Europe is moving towards banning them within the next five years, which is a major announcement.

**BG:** Oh, cute.

**DM:** It’s huge. The world is moving in that direction. Eventually, we won’t have it. The practical question was, “Well, if I’m not going to use that” – and 50 percent of dentists don’t do them any – what is the next step? What are the alternative options?

**BG:** Lots of choices started in the 80s, with the first composite that was suitable for posterior teeth that I talked about earlier. We now have five generations. But I used to have to apologize, “Oh, this might not last as long, but I’m more interested in how long you last than how long the filling last.”

**DM:** Some of my first ones were Dicor or the glass material, which lasts for about five years.
BG: Well even P10 was a composite. That was a ceramic material. I started this 30 years ago, so I've been through…

DM: Many generations.

BG: All the generations. Really, to replace the mercury fillings, we have composite resins fifth or so generation from where I started out. Our binding techniques, the materials themselves, are much stronger. No apologies are required anymore for me because of how long they might not last. We have wonderful materials. Using glass and ominous cements, using air abrasion techniques, things about ozone and tools that we have to measure how aggressive the chaos in teeth are all things that are way beyond mercury fillings.

Then the ceramic materials. Now we have crowns that can be made in the office even and that are three times stronger than the ceramic bond to whether it was nickel… It used to be gold, then we changed it to nickel, because it was cheaper and it had a better bond. The biological dentists were, “Oh, my gosh, we can’t use that stuff.”

DM: Nickels may be worse than mercury.

BG: No, I don’t think worse.

DM: Or close.

BG: But it’s…

DM: It’s bad news.

BG: Yeah, it’s bad. It’s harder to get exposed to it. Mercury is very easy to get exposed to. But still, truth of the thing: we don’t need to be exposing ourselves to that. I haven’t used metal in a decade.

DM: Yeah.

BG: We have materials. The ceramics are so good now. They look good. They’re strong. They’re less abrasive than the harshest ceramics that we used years ago.

DM: Now, you’ve mentioned doing the crowns. The problem with having mercury amalgams and using the high-speed drilling…

BG: Right.

DM: …is that eventually it wears out. They don’t last forever. Then you have to put another one. You’ve taken so much of this tooth out that there’s hardly any tooth left. You have to put a crown on it. Now the technology is advanced where they have these CAD/CAM machines, which is a machine that will essentially allow you to quickly have your tooth repaired. You don’t have to have it temporary placed and come back having send out to the lab and come back three weeks later. It’s done in the office while you’re sitting in a chair.

BG: Exactly.

DM: What percentage of dentists has these CAD/CAM crown replacement tools?
BG: I think in Houston, which is the only place that I have any numbers on, it’s about seven or eight percent of the dentists will have it. I was surprised with how high that was.

DM: Yeah. It’s a significant capital investment. These machines are, at least, six figures.

BG: Yeah.

DM: It goes up than that.

BG: You can spend a couple of hundred thousand dollars, but for dentists or for anybody that’s a big number. But what I love about that technique is that it replaces another expense.

[----- 40:00 -----]

DM: Uh-huh.

BG: You have a lab fee of 200 dollars, or you can send it to [inaudible 40:08] and get a better deal.

DM: At least financially, but maybe not biologically.

BG: Yeah, exactly. But if you got to turn it on a lab fee and it only costs you 50 dollars to make it in your office… People have been to my office. They wouldn’t say “Speedy.”

DM: Right.

BG: They would say “One visit.”

DM: Well, it’s convenience for the person.

BG: Oh, it’s …

DM: Because it’s time, effort, and resources…

BG: Less anesthetic, another visit, it’s just tons of stuff. If they need other things while we’re waiting for it to mill and we’re waiting to glaze it, once it’s in the oven for that, then we can be doing other procedures. That guy who was in last week, I said, “You doing okay?” He said, “Doc, with this chair, this nitrous oxide, take your time.” We’re trying to make it as pleasant for folks as we can.

DM: It could be very fun. You’ve mentioned also mercury-free dentistry, which I’m also a big believer in. And actually one of the reasons I’m opposed to having the traditional approach… The alternative to root canal would be an implant. Almost all of the conventional implants have a titanium rod, but there are newer materials now.

BG: Right, zirconium.

DM: Zirconium, which are not metal but can actually be more safely used as an effective alternative.

BG: Yes.
DM: Because the other one is a bridge.

BG: Yes, a bridge is now being more and more considered a three-tooth solution to a one-tooth problem.

DM: Yeah, I have two of those.

BG: I read about it. I saw that. We don’t like – I don’t like tying the teeth together.

DM: Yeah.

BG: Especially across the midline. That’s where there are so many elements. One of the elements of biological dentistry that is different from conventional dentistry is that a biological dentist is much more likely to be interested in electronic acupuncture, general acupuncture, Ayurvedic medicine, and homeopathy. There are a lot of dentists. I use some homeopathic remedies, but there’s a whole lot of interest in that in biological dentistry, not so much in conventional.

DM: Frequently, it’s important to hear stories of individuals, and many people can relate to those stories. I’m wondering if you have any relatively dramatic examples of people who’ve had silver (mercury amalgam) fillings removed, and if they had notable improvements in their life.

BG: I have. I have to preface this with we’re very, very careful to not promise people results. We promise to do our very best and to provide the best care that we can. Some people haven’t responded yet. We’re ready. We’re waiting for them, too, but they haven’t yet. But then again, it’s really exciting when you’re working on a patient, they look at their watch, and I’d look at my watch when they do that. When I pull their silver filling, I say, “What happened at four o’clock?” They say, “At four o’clock, my ear opened up, and I could hear out of that ear again.”

DM: Wow.

BG: In preparation for our meeting, I was thinking about particular patients, and we had a lady that came in. She was a wife of a physician. She had mercury fillings. She had non-precious crowns. She had a root canal. She had two titanium implants. She had her symptoms that she described were low energy to no energy. Her memory was not what she wanted it to be. Her face was swollen. She got pain in her shoulder, pain in her breasts. She just didn’t have the energy to get along and to do anything. The first visit, she had facial pain that she couldn’t explain and couldn’t understand.

That first visit, we did diagnostic blocks. We placed local anesthetics, just a leap of local anesthetics around her root canal, tooth, and her two implants. Then people say, “Well, what’s supposed to happen?” I say, “Well, what are you noticing?” because I don’t want to feed them. I want them to tell me what they’re noticing on their own. She said, “I don’t notice that much. My pain is gone, but I don’t…”

When she came back two weeks later, she said, “When you put that block there, it became clear to me that my pain was localized in those three areas.” When the anesthetic was gone, she said “I was able to focus the pain from those areas.”
We didn’t start there. We started with removing her mercury fillings and non-precious metal crowns. Every time she came back, she said “I feel better.” She had more energy. She had a different look. She was not from Houston. She came with her sister, and her sister said, “This is a different person.” I brought part of her notes, and she told us what she’d noticed. She said, “I get up once a night to go to the bathroom rather than multiple times,” which is the effect on the kidney of the toxins. Her shoulder pain was gone. Her breast pain was gone. Her energy level, she said that she felt like lifting weights now.

The morning she gets up, she wants to start the day. She’s read the newspaper. Before, she just wanted to go back to sleep. Her sister said, “This is not the same person.” She had those symptoms increasingly, but she’d had them her whole life.

**DM:** It’s pretty dramatic.

**BG:** It can be very dramatic.

**DM:** Now the FDA recently issued warnings about skin care products, some with the size of 130,000 times the acceptable level of mercury, yet there are no warnings on dental amalgams.

**BG:** I’ve read your article. Great.

**DM:** Yeah, it’s kind of shocking actually. It’s even worse than that, because they have agreed to require dentists to inform patients. Because 75 percent of people who get silver fillings don’t know there’s mercury in there. They require them to actually inform them that there is mercury, but that never happened. What do you think is going on with this?

**BG:** I’m very naïve about it, and I’m getting less naïve. But in 2006, they had a meeting. They got their experts together. The FDA got their experts together – 20 scientists, doctors. No dentists, which is fine, because we need people looking at the systemic effects of all this. Their conclusion: 13 of the 20 said, “We need to put some warnings on this.”

The FDA had on their website: mercury can be a hazard for the unborn child and for children. I thought “Oh my gosh, it’s starting to turn. We got it.” For reasons that nobody understands and nobody will explain or answer, by the end of the year, they’ve taken those warnings away, that somehow mercury became safe again.

**DM:** Weren’t you actually involved with testifying before the FDA, too?

**BG:** Well, we did that. Before that happened in 2010, they had a second meeting of experts. Charlie Brown was there with his team, and they were writing down what the comments were and what the results were being stated by the group. After the meeting was over, the release by the FDA of what was said did not match well with what Charlie’s stenographers had picked up and the notes they’ve taken. It was counter to that.

There was a meeting in December of 2011 in Irving, Texas. I was asked to be a presenter at that meeting about the dental concerns. I brought them the notes. Dr. Shirr, an M.D. who heads up this part of the FDA, was at the meeting. He was very courteous and very head-nodding about everything. I was so naïve. I thought they just needed more information. I thought they just needed a plan.
I said, “We need to educate people. We need to have informed consent. We need to protect the most vulnerable, and we need to start the phase out now.” Well, they really didn’t want that. They nodded their head, but nothing happened.

When I read your article about the precautions, I was just, again, dumbfounded. I don’t like to think that there’s a conspiracy of the ADA. I know that – well, I don’t know. I’ve read public information that they have more money in their lobbyists than the medical association has.

[----- 50:00 -----] It’s interesting when they formed and how they formed. In the 1830s, mercury came to United States – the people who practiced dentistry then were barbers and physicians. Anybody could do it. The physicians said, “Don’t use that mercury filling. You can’t be a member of our organization if you use that mercury filling material, because mercury is toxic.” Well, the barber-dentists, they didn’t care. They used it anyway. It was easy to use, it was effective, and it was relatively inexpensive – not the same reasons that it’s continued to be used today.

A group of physicians saw how successful these barber-dentists were being. They said, “Look, we’ll form our own group.” They formed their own organization. It was the American Dental Association, founded on the principles that mercury is a safe thing. That has been a 150 years since that time. I would forgive them for having new information.

That’s one of the things that I respect so much about you. And for the years that I’ve been following you, you get new information. You go, “Oh, this isn’t what I exactly thought. Twice a week isn’t enough for these Peak performances or once a week. I need to build up to three.”

**DM:** Or a converse.

**BG:** Or whatever, yeah.

**DM:** Yeah.

**BG:** When you get new information, many people feel compelled to change their behavior. I cannot understand how the same Food and Drug Administration can take that position in one area and choose to be so, from my perspective, blind about another.

**DM:** Yeah, I think it’s probably likely related to the massive conflict of interest and revolving door between the industry. We’ve documented some of that there. But I’m wondering if there’s, you know, as our interview comes to a close, are there any other items that you’d like to bring to our attention to emphasize to our viewers that’s really crucial and important about their understanding of biological dentistry.

**BG:** I think it’s just a couple of things: one thing, it’s crucial that people find a match for them. Once again, it’s not about right or wrong, who’s doing it right, who’s doing it wrong. It’s about an individual being able to give themselves up with the information, questions, or the techniques to find somebody that’s going to match their belief systems. We know that when you’re doing stuff that you believe in, it works better. That would be one element.

The other element is I’ve been in this field for 30 years or so. Charlie’s been in it that long or longer. Some have been longer than I have. I think that the role that you’re playing and that
you’re taking in this is going to be the tipping point. I think it started last year when you had Mercury-Free Week attention to that. I didn’t know if it was going to be a one-time thing, and then I heard you were doing it again. I think that because of how hard you’ve worked in medicine and in nutrition areas that your influence is going to be the tipping point that’s going to get it going.

I know it supports Charlie. He’s so fired up, and he’s so energetic anyway about this cause. He’s dedicated his life to it. To have you supporting that just gets more fires in him, which is for me very exciting.

DM: Yeah.

BG: I thank you for that.

DM: Well, it’s a good combination, you know. Fortunately, we’ve acquired resources to help support really dedicated people who are committed to what we believe are important causes that will help extend our lives and protect us from really reversible, foolish, and needless dangers. That is just absolutely unnecessary, and really, for the most part, only there because of massive conflict of interest, human greed, and total disrespect for the impact that it has on human health. There’s really no need for that. We’re committed to fighting those types of causes and addressing that.

We’re just happy to connect with Charlie and the academy and really work with people who are committed to seeing those changes happen.

I thank you for all that you’ve done, for all that you’ll continue to do, and for being really a great resource out there. Certainly, if you’re in Houston, Texas, it would be kind of foolish not to at least explore your office as a possible resource locally to help improve this important aspect of your health. Because it really is crucial to have – as you mentioned earlier, your mouth is connected to the rest of your body. If your oral health isn’t optimized, it’s real easy for the rest of your health to be compromised in a very serious way. So, thank you.

BG: It’s my pleasure. Thank you.

DM: All right.

[END]