An Interview with Carole Baggerly

By Dr. Joseph Mercola

DM: Dr. Joseph Mercola

CB: Carole Baggerly

Introduction:

DM: Welcome, everyone. This is Dr. Mercola, and today we are fortunate to have Carole Baggerly back with us. She’s going to be enlightening us about the topic of vitamin D.

She comes to this topic with an interesting history. She was an executive in a company that served the aerospace industry (they’re actually one of the largest companies doing what they do), and has developed a lot of managerial and executive experience in that role. But while she was doing that, she developed breast cancer and went through the whole “Cut, Poison, and Burn” scenario.

And then because she’s passionate about staying healthy and doesn’t necessarily believe what she’s told, she did her independent research, found a lot of interesting information about vitamin D, and implemented what she learned. I suspect it attributes a large portion of that to her successful survival of the breast cancer challenge. Now she has really committed the rest of her lifework in this area to help educate us about the importance of vitamin D and in conducting some really important research.

So, welcome and thank you for joining us. If you could expand on your introduction to refine my understanding of your history, that would be helpful. And then we can go into some questions.

CB: That’s right. With regards to the aerospace challenge that I had, I truly love that job, too. What we had there is an opportunity within the aerospace – actually, it was an opportunity within all industries – to do business electronically as opposed to paper and pencil. Our organization, ESIS, which my son and I ran, is the [inaudible 1:46] (it’s still very, very much a part of the aerospace industry) was to enable the major aerospace companies – Lockheed, Boeing, and whatever – to serve out their major business documents like purchase orders, request for quote, etc., electronically to their thousands of suppliers through us as a service bureau.

We had the opportunity to help figure out how to make that happen with the key organizers and then implement it with thousands and thousands of people. That was a major technical challenge as well as a systems and people definition one.

To some extent, it’s very similar to what we’re doing at Grassroots Health right now. We are working with the scientists of vitamin D to return what the message is that we can then take out to thousands and thousands of people that are interested in their health. We have also bought a very expensive information technology infrastructure to go with this, to make it easier.
**DM:** Terrific. As a breast cancer survivor, what would you like to share as what you believed to be one of the most important messages about vitamin D and its relationship to cancer?

**CB:** Number one, it’s critically important. As a matter of fact, Dr. Cedric Garland, one of the world’s leading researchers on breast cancer and vitamin D, fully believes – and I don’t disagree at all, I think the research is there to support – that breast cancer in particular is a vitamin D deficiency disease, as scurvy was a vitamin C deficiency disease. We don’t need to take hundreds of years to fully deal with this.

The second part of the message in a more practical way is: what matters about breast cancer and vitamin D is the serum level. The biggest message I have right now to everything we do is it’s the serum level.

I’d like to tell briefly about the study of a randomized clinical trial that was actually published in 2007. That was six years ago. Still, to me, [it’s] one of the best trials that exists about cancer and vitamin D. It was published by Joan Lappe and Robert Heaney of Creighton University. They showed with a group of post-menopausal women… They gave them all 1,100 IU of vitamin D a day, which is very small. But their serum levels were a little bit high compared to the normal today. They were 28 nanograms per milliliter. By giving them 1,100 IU a day, their serum levels got right up to be 38 nanograms per milliliter or around up to 40.

In a period of only four years, the incidence of all cancers was reduced by 77 percent. It was stunning to me when I first read it in 2007. And I thought, “Oh, my gosh, everybody’s got to get up to 40 [nanograms per milliliter].” Today in 2013, I still hear hassles about, “Oh, my gosh, 20 is enough.” It’s not enough. It’s not enough. If you can make that make a difference by going from 28 to 38, it’s time to get our level.

**DM:** And 38 [nanograms per milliliter] is probably not ideal.

**CB:** Oh, no it’s not. It’s not. I referred also to a brand-new paper that’s out by Bruce Hollis and others from the Medical University of South Carolina about prostate cancer. I think it’s time to pay attention to [inaudible 05:37], don’t you?

**DM:** Sure. Especially if you’re married to one.

**CB:** Well, yeah, that helps. I like it anyway. He just did a study, I think, where they had a group of men who already had prostate cancer, but it was very low-grade prostate cancer. They opted for the option of watchful waiting to see what happens.

For a year, these men got 4,000 international units a day, which isn’t all that much. It was safe, as it has already been demonstrated. But their serum levels started out at about – I believe it was about 37 or 38 [nanograms per milliliter]. They went up to 67 nanograms per milliliter. And again, it was safe. But they had a 55 percent reduction in the positive core biopsies that they did on these men. In other words, they got better. They got better. So, they avoided unnecessary treatment.

Back again to the serum level, that serum level is 67, close to 70 [nanograms per milliliter]. If it were up to me and I rule the world, I’d say, “Hey, everybody needs to be at least somewhere in the 50 to 70 range [from] day one.”
DM: Yeah, that seems to be the sweet spot. I’d like to comment on one of the statements you made, which seems to be quite surprising to many, including me, that vitamin D or breast cancer can be…

Well, first of all, there’s a major similarity between prostate cancer and breast cancer, which is why you brought the study in. Many experts believe that the prostate cancer in men is almost the male equivalent of breast cancer in women, because it’s the similar factors that contribute to both. When we talk about breast cancer, you can take the implications that much of it is true also for prostate cancer. But with breast cancer – because that was the statement – you had mentioned that Dr. Hollic, I believe? No, Hollis? Or Garland, Dr. Garland…

CB: Right.

DM: Had suggested that breast cancer can be viewed as a vitamin D deficiency syndrome or state. And that’s quite an amazing statement in light of the fact that we know there are many other variables that contribute to breast cancer, such as estrogen exposure (xenoestrogen), lack of sleep (which results in decreased melatonin), omega-3 fatty acids, and stress. These are all variables that will clearly increase the risks. There have been loads of studies that show that they’re connected to breast cancer.

I’m wondering – you’ve clearly looked at those – if you could sort of prioritize or give us suggestions or implication as to how important vitamin D is relative to the other known factors.

CB: It’s about a very distant level. All of those other things are important. And there’s no way that I personally or any other whatever professional would say exercise is unimportant or diet is unimportant.

DM: Sure.

CB: It has a difference. But vitamin D is critical. It truly is expected to be at the 90 percent level.

DM: So, when…

CB: [inaudible 08:56] it shouldn’t.

DM: When you say 90 percent level, did you mean your belief is that 90 percent of the cause of breast cancer is related to vitamin D deficiency?

CB: Yes.

DM: Okay. That’s a powerful…

CB: The standard [inaudible 09:10] variety of breast cancer. That does not address the inflammatory breast cancer and some of the other unique breast cancers.

DM: That’s a very profound statement. I have not encountered that before. I think one of my talents is to sort of pick out the pearls – and that’s a massive pearl.

CB: It is. Yes.

DM: So, 90 percent.
DM: It’s very powerful. Ninety percent of the most common cancer in women…

CB: Yes.

DM: Is attributed to vitamin D deficiency.

CB: That’s what he believes. I want to also add a different reference by Dr. Bruce Ames out of Berkeley, who has really spent a lifetime studying micronutrients.

DM: Is he still?

CB: I read this paper about him.

DM: Is he still alive?

CB: Yes, he is.

DM: Oh, that’s terrific. Because he’s been around for a long time.

CB: He has.

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

We met with him a couple of years ago. He actually was a classmate of my husband, Leo, at Caltech University.

DM: Oh, wow. Terrific.

CB: My husband’s still around, too.

DM: Oh, terrific!

CB: Back again to Dr. Ames, he had a statement about what causes cancer. His whole focus is on micronutrients, and the very fact that we get these diseases in later life not because some things happen in later life. But we’ve spent our whole lifetime with the major micronutrients such as calcium, magnesium, and whatever. Our major body organs like the heart, the lungs, the brain, if they need something, they go get it. And they deprive the rest of our body of these micronutrients. We really don’t grow up leading very balanced nutritive lives, so these diseases show up in later life.

What he was asked once, you know… My first knowledge of breast cancer is due to the environment. Specifically, we were talking about all the toxins in the environment. He said less than 10 percent – that’s not what it is. So, if you have a healthy body, the infrastructure with vitamin D, all of these other things take truly second place. If you don’t have enough of your vitamin D, then they [inaudible 11:34].

DM: Terrific. Well, with that profound appreciation, I think we can be really motivated and encouraged to figure out and understand how to know if, in fact, we have enough vitamin D.

CB: Yeah.
DM: Yeah. And our vitamin D levels are very similar in many ways to other known risk factors for disease in humans, which would be blood pressure and blood sugar. They’re absolutely well-established risk factors. The interesting similarity between those is that we don’t know when they’re elevated. I mean, unless they’re extremely elevated, then you might get a headache, or you can go into a hypoglycemic coma. But that’s an unusual case.

Most of the time, you can have very abnormal ranges and be absolutely oblivious to that. Yet it’s still contributing to massive diseases, very similar to low vitamin D levels.

You’ve been involved with this field for quite a bit of time now, and you’ve learned quite a bit of information. From your experience, I’m wondering if you can share your insights on the vitamin D levels and the optimum timing for testing. And you know, just that whole scenario which you’ve learned over the last few years.

CB: Okay. The first part that I would really like to address is “Why test?” Because a lot of people say, “I’ll just take some vitamin D. I don’t need a test. I don’t need to go through that process.” I want to… This one actually goes two pieces.

Number one: without testing you don’t know the effects. You just do not know the effects of a particular intake. For example, one of the big contributions Grassroots Health in its program for thousands of people – I really thank you each and every one – has already contributed is that, for example, for a group of hundreds of individuals that are taking 5,000 IU a day, right? People would take 5,000 IU a day, and they’d say, “Oh, I’ve got enough,” when as a matter of fact…

DM: In fact, they may be considered to be taking too much. There are many people who think that’s way in excess.

CB: The distribution of people, once you measure their serum levels and they’re taking all the 5,000, a lot of them literally have a serum level at 20, 30, 40, 50 up to about 110 [nanograms per milliliter]. There is no way to know. There is no way to know what the serum level is based on the intake. And that is true across every single intake range. At 10,000 IU, you still have that very, very broad distribution. Until the scientists figure out why that happens, there is no alternative to testing.

I, as a person testing, I am not going to pass up testing no matter what it may – it may matter somewhat with the cost. But honestly, no matter what it cost. Because I don’t intend to risk my life, which I think is at risk if I have a low level, for I do not know what the serum level is. Even with my testing, there is a bare minimum, to me, for people to test regularly at least once a year.

Life changes, your body changes. You might move. You might have been sick with some strange disease, take some new medicines, I don’t know. But it changes. So, you need to measure it at least every year. I would suggest every six months, but at least every year. It needs to be a part of your standard practice.

Pay attention, again, to the serum level. Do not accept; argue within the normal range. That’s not good enough. You need to be at least in that 40 to 60 [nanograms per milliliter] range, and possibly higher.
DM: Okay. Well, thank you for expanding on that. I just like to share some of my experience, too, in the last 15 years that would maybe help people better appreciate some of these. It’s that some of the variables…

Well, first of all, I believe that the best way – and I’m sure you do, too, as most experts – to increase your vitamin D levels is to do it naturally. That is the way we were designed to from our ancient ancestors, which is to expose enough skin to sunshine. So, that means getting outside, taking your shirt off or [in your] bikini, you know, going in your shorts, spending about an hour or so in midday or solar noon, which just happens to be about 12:30 if it’s not daylight saving time. If it is daylight saving time, that’s probably closer to 1:30, which is solar noon or 1:30 P.M., of course. And then you can get the UVB.

If that’s not a possibility, then you could, of course, use a safe tanning bed, which would will also provide UVB, but not as good as the sun. Then if both of those aren’t available, then of course, use the oral [supplementation].

I’m somewhat of an extreme (which is why I’m sharing this example), because I have not taken oral vitamin D for three years. And yet my typical levels – except when it’s late fall – are almost always over 50 [nanograms per milliliter] and typically over to 70 [nanograms per milliliter].

So, I couldn’t agree with you more. After reviewing this stuff for 15 years, I think that the sweet spot – and there is a sweet spot – is between 50 and 70 [nanograms per milliliter].

That’s one of the other benefits of testing. Because if you’re taking 5,000 units, and you’re at 110 [nanograms per milliliter], it is time to back off and cut down, because there are implications. Perhaps we can talk about this, too.

If you’re taking too much vitamin D, that can be a problem. Because it actually increases your requirements for other nutrients, especially fat-soluble ones like vitamin A and vitamin K2, which works synergistically with vitamin D. If those aren’t in balance, you can upset some really important metabolic pathways.

So, those are really crucial in my experience. Maybe you can comment on that, and we can go into some more aspects of testing. Because I don’t want to say too much without giving you a chance to respond.

CB: Don’t worry about that. I guess, vitamin D is turning out to be the powerhouse nutrient. We certainly don’t want to ignore all of the others. They are important. At some point, I would also like to address the issue of toxicity, though. Shall we…

DM: Sure.

CB: Discuss that for a minute?

DM: Right. Because, you know. And the reason I had mention that is that those people in your study were taking 5,000 units. Some of them were 110 [nanograms per milliliter]. One of the variables could have been they had sun exposure or other components that we don’t know of. But certainly, sun exposure is one. Significant sun exposure is great, but it’s certainly going to increase your D levels.
CB: Sure.

DM: So, why don’t we address the issue of toxicity?

CB: Toxicity or the concerns about it are the biggest bugaboo that I see at all in the whole vitamin D environment these days. I think that we need to change the word. The vitamin D toxicity is defined as being hypercalcemia or having hypercalcemia, which is too much calcium in the urine and/or the blood. This is not lethal.

One can do – and generally it’s part of an annual workup or something – where the physician will do a standard urine-calcium testing. You can detect something like that really fast. Secondly, it’s very easy to take care of just by stopping the taking of vitamin D. It’s that simple. It’s nothing, even a toxic side effect, as having breast cancer.

DM: Sure.

CB: Or having very serious illnesses such as flus and colds and even the really basic diseases. So, I think we need to stop harping about toxicity and start talking about hypercalcemia and what do you do about it. Because it can be identified very quickly and is easily taken care of. It’s the biggest bugaboo. You have all kinds of people say, “Oh, it’s toxic,” without thinking it resolves breast cancer.

DM: Sure.

[----- 20:00 -----]

CB: And also a whole bunch, a whole rep, of other diseases, which are far worse consequences.

DM: Yeah. And one of the reasons why people may get secondary hypercalcemia from too much vitamin D is that they’re taking calcium. We’re beginning to appreciate that calcium supplementation is not necessarily a good thing. In fact, most of us may get too much, especially the wrong forms of calcium.

What may be far more important is magnesium supplementation, which will counterbalance that and limit your body’s ability to do this, because they balance out really well. And actually, if you take enough high-quality magnesium – our experience suggests that magnesium threonate may be one of the best, but there are certainly others like citrate – actually that by itself will lower serum calcium levels. The combination of optimizing your D levels and making sure you have adequate magnesium would be helpful to balancing that back out.

CB: I have one more observation from my study also about the high vitamin D levels. It’s very hard to get to the toxic range with vitamin D. What happens after you get to about that 30 to 60 [nanograms per milliliter] range… As an example, if you start out at 20 nanograms per milliliter, and you take 1,000 international units a day over a period of time, your serum level might rise at about 10 nanograms per milliliter. You might get up to 30.

But if you’re already at 40 to 60 [nanograms per milliliter] – and let me put you at 60 because that’s exactly your serum level… If it’s 60 and you take 1,000 international units a day, your serum level might rise 1 or 2 nanograms per milliliter. After you get up to that sort of sweet spot
area, even taking more supplemental vitamin D doesn’t make your vitamin D just go up and up and up. It’s very hard to get in that potentially toxic range of above 200 nanograms per milliliter. It’s really hard.

DM: Okay. Now that we’ve established the importance of knowing your vitamin D level and what the optimal ranges are, let’s discuss how one can get their vitamin D level tested.

Because thankfully, when we first started bringing attention to this issue, some of the major commercial labs were doing assays that provided results that weren’t that accurate, but they have changed now. Every commercial lab that your physician would choose to order a lab test for you… Although I can’t comment on the hospital labs; they may be different. But if it’s done on a regular commercial lab, primarily LabQuest or LabCorp, you’re going to get a good result. It’s going to be solid and absolutely consistent with the levels you mentioned.

And I think we would both agree that there’s a large part of emerging physicians who recognizes and understand the right levels and are going to be able to cooperate with you. If they don’t, and you have a really good relationship with them, you can encourage and mentor them, because there’s so… I mean, there’s probably dozens of feed of published double-blind, placebo-controlled trial on this. It’s not controversial at all. We talk about a lot of controversial things, but vitamin D is clearly not one of them at this point in time.

Ideally, you’d have your physician order you a test, since it’s covered by insurance. But if those circumstances, for whatever reason, you know (and there’s lots of them), is not your circumstance, then there are some other options for you to know and understand what your vitamin D level is. Why don’t you discuss some of those options?

CB: Do I have to discuss some? Or could I really tell them what I really like to say?

DM: Oh, just tell them what you really like. Tell us what you really think.

CB: GrassrootsHealth is running a major, major, major project called D*Action, where we are providing home test kits to anybody in the world in order to be able to do a bloodspot test. It’s just a very simple little finger prick. (Actually, it hurts a little bit.) But you draw us blood on the card, you mail it to us, we’ll have our process. You’ll have an account.

At the same time, you’re providing data to support really the whole outreach program of GrassrootsHealth, which is giving the vitamin D information to everybody and substantiating what is happening.

It’s very easy. All you have to do is log on to GrassrootsHealth.net and register. You do have to fill out a questionnaire. Also, Dr. Mercola’s group is now providing these kits as well from his site.

DM: That’s terrific. These test kits, I think we do offer them on our site. They’re available. That is an easy resource for you. Of course, this test kit is not covered by insurance. I don’t think [it is]. Ideally, you get it from your primary care physician or whichever physician you’re seeing. And if you have insurance, that should be covered, because it’s a well-recognized test.
But interestingly, this test is sent by mail, I believe. So, it’s really easy. It could go all over the world. And there’s no problem with storage. The sample doesn’t deteriorate with time. That’s great. It doesn’t have to be frozen or refrigerated.

And it does support your research. [It’s] not only finding out good information about vitamin D, but also educating the individuals.

So, let’s discuss some of the research you’ve done, because I think your involved with a five-year breast cancer project.

**CB:** That’s right.

**DM:** I’m wondering if you could describe that in more detail and what were the results you’ve seen so far.

**CB:** Sure. The Breast Cancer Prevention Project was established just two years ago. We don’t have really definitive results, again because it’s a very… It takes lots of people to shift things. But regardless, our objective is to demonstrate that the women could choose to participate and get their serum levels to a minimum of 40 [nanograms per milliliter] or within that 40 to 60 range for sure, so that this group of people will have a lower incidence of breast cancer that those in the general population. Even after two years, the trend is in the right direction. But we don’t have enough data to firmly say anything. But that’s one thing.

The other thing that is of great interest is we are truly the only [inaudible 26:26] in the world of such large numbers of people above 40 nanograms per milliliter. So, we can also see that it doesn’t matter if you get up to 50. It doesn’t matter that you get to 60. It doesn’t matter that you get to 70.

One of the things that we’ve already seen was the disease requirement or the anti-disease (how do we rephrase that), really do vary by disease. We already knew, for example that rickets, once you get to about 20 nanograms per milliliter, getting higher doesn’t help rickets any more. With gum health, you need to be about 30[nanograms per milliliter], farther or higher than that really doesn’t help gum health any more.

I’ve already told you that getting to a minimum of 40 nanograms per milliliter helps with cancer. Thirty is not good enough. So, that’s one of the areas that we intend to explore. Certainly, with breast cancer in this project that we’re doing is what difference does it make when you’re over 40, 50, 60, 70, to 80 [nanograms per milliliter], because we have people with many different ranges.

**DM:** Yeah, that’s a very good point. Because many people may not fully appreciate that science progresses very slowly.

**CB:** Correct.

**DM:** And researchers are very cautious. Many of the studies that have been published or are actually currently in process are not using the goal of a higher reference range that you alluded to earlier as being ideal, which we both agree. Probably many of the experts that you associate with
are somewhere between 50 and 70 nanograms [per milliliter]. The research is really, most of the vast majority, far lower levels.

If someone is convinced of this research like we are and they find out that they really do want, they’re motivated to get their levels to that window of 50 to 70 [nanograms per milliliter], and they do this test. They have the test from whatever source, and they find out they’re at 20 or 30, what recommendations can you provide individuals to implement? I mean, what’s your strategy to increase that and the testing frequencies? Because you’ve done a lot of work in this area.

**CB:** In order to guide people a little bit when they get their serum level measurement back – you know, if they find out, what do they do? – we actually give them the benefits of the research that they and others have participated in. We’ve developed a very handy little chart that says, for example, based on our research, if you’re at about 20 nanograms per milliliter and you want to be at 40, the dosage for average within our [inaudible 28:59] is about 4,000 IU a day. It’s all over the map.

Again, that takes into account what I mentioned earlier, which is the higher you are, the less you get from increasing your dosage. It takes that into account. And we’d recommend a higher dosage. But it’s a good starting point.

But then the next step that’s really critical is to test again. Because back again to that big distribution that we have on every intake level, you don’t know what this is going to do for you until you try it for at least three months and then test again.

So, with a person just starting in the cycle of testing their vitamin D, they need to test first to get a baseline. Where am I starting? They need to try some dosages, something for a period of time for, at least three months. But six months is fine. Test again and see how that level worked for you. And then try to adjust. Do whatever you need to do, and then test again.

Add a minimum. People need to kind of do that cycle of three. And then if everything is fine, they can stick to annual testing if they wish. Or if they’re in our project, every six months.

**DM:** Now, one of the insights that we obtained from you in our previous interview is that the average dose required to achieve this sweet spot window of 50 to 70 [nanograms per milliliter] was 8,000 units. With that piece of information, I’ve been recommending that people start at 8,000.

But you think that it’s better to tear the level like you suggested 4,000 [units] and then test? Or could they just safely start at 8,000 (since that’s the last one), and then test again, of course? Because you have to retest. I mean, you just can’t test initially. That’s great. But it’s a two-faced process at a minimum. Ideally, [you should test] every six months to a year after that.

**CB:** Right. I think it’s how you want to ask the question and answer the question. If you take doing what I was just suggesting with kind of like tearing that approach; if you took about 4,000 [units] from 20 [nanograms per milliliter] to whatever, you would end up being average. The
8,000 that I mentioned to you earlier (actually that number is even a little bit higher), would get everybody above 40, right?

If you want to go for the gold, that’s still a very safe thing. Even according to our very conservative Institute of Medicine, they have said and published that 10,000 IU is considered to be of zero adverse effect level. So, good results.

**DM:** Or NO-AL, I think it’s called. It’s a common term used in research (N-O-A-L). So, maybe you can enlighten us, from your current appreciation of the mechanism of action, on how vitamin D works. I mean, why does it provide this massive protection against cancer, which seems to be one of its primary benefits? Obviously, it has hundreds of other benefits. One of the other primary ones, of course, is reducing the risk of the other major disease that affects most Americans, which is heart disease.

But let’s focus on cancer. How does it work? Or what is its mechanism of action in cancer or any other disease that you care to comment on, at least from the current understanding?

**CB:** I’d like to talk specifically about breast cancer – that’s the one that I know the most about. One of the really obvious things is that vitamin D levels or having an adequate vitamin D approach is set to performing apoptosis. In other words, killing the cells because they’re bad cells.

But back again to breast cancer and how does it work, Dr. Garland has put together an absolutely beautiful example that he calls DINOMIT Method, where the way vitamin D works in almost all breast cancers is epithelial cell kills cancers. Epithelial cells are held together in the body by a substance called E-cadherin. You can think of it as kind of a glue-like or just a structure, a very simple cell structure.

E-cadherin is made up predominantly of calcium and vitamin D. It’s what it’s made up of. If you don’t have enough vitamin D, that structure that holds the cells together comes apart. And then the cells go out and act like what Dr. Garland calls as “[inaudible 33:45] cells” They do what cells ought to do when they’re out on their own in an evolutionary stage. They multiply. They grow. And then ultimately, they break through the cell walls, and then they become metastatic and cause cancer.

This also makes sense with how cancer can be stopped even though it’s already started. You have to regrow these E-cadherins, so that it’s proper again, so it holds all these new cells in their proper place. The body then is strong enough in many cases to take care of the [inaudible 34:23] cells that have gotten out there. Because it’s not dealing with gazillions of them; it’s just dealing with the leftovers. That’s the DINOMIT theory of Dr. Garland, which makes lots of sense, and that’s very well substantiated by the biological researchers.

**DM:** Oh, terrific.

**CB:** We would have… Part of what we’re doing is a webinar series. Every week now, there’ll be topics on various aspects of vitamin D. Dr. Jo Ellen Welsh will be presenting (she’s a biological cancer-vitamin D researcher) a webinar. I believe it’s on April 2nd on our site. That would be interesting for other people to look at, I think.
DM: Yeah. Most people listening to this will not hear this before that time. But is there an archive of these webinars?

CB: Absolutely. There is an archive.

DM: Is there a charge for viewing those?

CB: I’m sorry?

DM: Is there a charge for viewing those?

CB: None.

CB: Okay. If you’re interested in this, it seems like a really great resource to expand your information on, because you connect with some of the leading experts in the world on this. So, they go to GrassrootsHealth.org.

CB: GrassrootsHealth.net.

DM: Oh, GrassrootsHealth.net, I’m sorry. Sorry about that.

CB: It’s okay.

DM: Then they’d go to… Where do they find these archives?

CB: Videos.

DM: Videos.

CB: GrassrootsHealth.net, Videos. They’re all there. Most of them [are there] already.

DM: It’s a menu link at the top of the site?

CB: Yes.

DM: Okay, perfect. All right. Now you’re also involved with your organization with a few other things or projects. Protect Our Children Now, I believe, is one of them. I’m wondering if you could expand on that and explain to our viewers what that is all about.

CB: I’d be absolutely delighted. We moved around for quite some time to find out where we could make, from a public health standpoint, of [inaudible 36:10], because we’ve raised funding in enormous amounts of time and energy. And as I [inaudible 36:15], “We’re going to go faster.”

It became clear that if you look around, where would you find a group of people who truly care in a very positive way? They’re not necessarily preventing disease. We picked pregnant women. They care about their health. They care about the infant that they’re bringing into the world. Those, I think, are highly motivated people to start with. That’s good.

Number two: there was a randomized trial by Carol Wagner and again Bruce Hollis from the Medical University of South Carolina, where they gave 4,000 international units of vitamin D each and every day to a group of pregnant women, and had absolutely phenomenal results with
lowering many common risks of pregnancy. But probably extremely, significantly lowering by almost 50 percent the preterm births.

That got their attention and so was our attention. That’s like, “Okay, how do we put this into a project to make for a healthier world?” Because if we can address it there, you got it through life.

The other part of that project that is extremely significant is that it’s intended to be a community project. Where can we find communities of all kinds of race? Basically, here in San Diego, here in X, Y, Z community. It could also be a community of Mercola listeners with tens of thousands. Because number one, it’s certainly statistically significant. It will show a difference.

But we really want to do with this community grouping is to have this community or each and every community. And I say march on city hall. It’s time to provide the incentive to our public health officials to take action. It’s only going to be done, in my mind, through a coordinated community-type effort, where if it’s done, say, in San Diego, we will have enough women right here in San Diego to literally show up at government meetings of public health to demand action for everybody in their community.

I certainly would like to expand that to major groups like yours, which say, you know, “We may not physically be able to do something.” But you can make a big enough noise that things will happen, because you’ve pulled the people together. That’s our latest and greatest; it’s called Protect Our Children Now.

**DM:** How does one become involved in this project?

**CB:** We will launch it formally toward the end of April. It will be very easy. The pregnant women will be doing three different vitamin D tests. It has a slightly different structure from our ongoing one. The infant will as well. We already have the information about that on our website under our Protect Our Children Now Project link.

**DM:** Okay. Good.

**CB:** You can find out about it there.

**DM:** Are there any public health agencies cooperating with this or participating?

**CB:** Joe, I wish there were. I wish there were.

**DM:** Of course not. No, we have…

**CB:** We have been suddenly sponged by a number of…. So, I truly am believing in trusting in the general public to make this happen.

**DM:** Terrific. So, I’m wondering if you could provide some concluding comments and summarize what you’ve said. You’ve shared a lot of good information. And then give some specific details on how people might, you know, [learn] a little bit more about the test, if people want to utilize that as a resource to help achieve some of the benefits we’ve discussed.
CB: Thank you. Number one message that I hope I could make is it’s the serum level, it’s the serum level, it’s the serum level, it’s the serum level; it’s not how much you’re taking. It’s not even how long you’re spending outside; it’s the serum level.

Associated with that is the fact that you don’t know what it is until you test it. And that it’s absolutely critical based on what has been proven through randomized trials about many diseases that the serum level has to get up to at least 40 [nanograms per milliliter] and ideally higher than that to prevent a whole host of diseases. So, please do it.

DM: Okay.

CB: The testing part is very simple through Grassroots Health. Certainly, you can, if you’re covered by insurance, by all means take advantage of that. But make sure that you pay attention to what the serum level is, not just you’re okay [level].

DM: Okay.

CB: Secondly, we would encourage anyone who can to participate in the Grassroots Health D* Action Study, where you can get a home test kit for your use and enroll in our major project.

DM: Sure. Just one minor point of clarification is that we’re kind of assuming everyone knows, but vitamin D tests we’re talking about is 25-hydroxy-D, not the more comprehensive one, 1,25-dihydroxy. It’s the standard test. It’s pretty widely known at this point. There’s not a lot of confusion, but I just want to make sure that people understood that.

CB: Thank you.

DM: This test is available on our site and our stores. If it’s convenient, we’ll probably put a link to it on this video.

I think that’s it. I really want to thank you for all you’ve done and will continue to do to inspire and educate so many people about the importance of this really crucial nutrient that really truly isn’t a vitamin; it’s really more of a hormone, but has such profound implications for our health. You can get a good argument that it’s hard to know too much about this important nutrient. So, thank you so much for helping us understand more.

CB: Thank you so much.

[END]