This three-page article is NOT a research paper, but a commentary written by Anthony Weetman. The reason it finds a place in “Thyroid Update” is that it has been published in an international scientific Journal and deals with a fascinating and important topic.

A group of patients in the UK has just lodged a petition with a Member of Parliament and the UK General Medical Council, as ‘a formal complaint against the clinical practice of the majority of the medical profession with regard to the diagnosis and management of hypothyroidism on four counts:

1. Over-reliance on thyroid blood tests and a total lack of reliance on signs, symptoms, history of the patient and a clinical appraisal.

2. The emotional abuse and blatant disregard by the majority of practitioners and endocrinologists over the suffering experienced by untreated/incorrectly treated thyroid patients and their lack of compassion over the fate of these patients.

3. Stubbornness of general practitioners and endocrinologists to treat patients suffering from hypothyroidism with a level of medication that returns the patient to optimum health. In addition the unwillingness to prescribe alternate thyroid treatment for patients on individual grounds .... such as Armour thyroid.

4. The ongoing reluctance to encourage debate or further research on hypothyroidism.’

This has led the Member of Parliament to take the matter up with the Royal College of Physicians in London.

COMMENT
Dr Weetman discusses the background of the petition in the UK. A thyroid patient advocacy group lists on its website (www.tpa-uk.org.uk) the campaign it is mounting calling on the UK government “to raise awareness ... of the dangers of misdiagnosing an under-active thyroid”. The same website makes the startling assertion that “approximately 25% of the total population of the UK suffers from hypothyroidism and also supports the wider use of Armour thyroid extracts”.

Dr Weetman discusses the reasons why some patients are dissatisfied with and so mistrustful of standard medical advice and practice. He brings up several arguments to answer these questions. One argument is that we live in an era of post-modern medicine, implicating evidence-based medicine and scientific certainty to base our medical decisions. Another argument is the easy access to information by patients, having increased vastly due to the Internet. The point is that – by definition – anything can be found on the Internet and patients are not trained to distinguish between valid and unreliable ‘pseudo-scientific’ information. Dr Weetman argues that the majority of patients who demand thyroid hormone treatment for multiple symptoms, despite normal thyroid function tests, have functional somatoform disorders, which in the post-modern world can understandably be misdiagnosed as hypothyroidism. Another issue raised in Dr Weetman’s commentary is that of
“healthism”. Healthism is characterized by the following features: high health awareness and expectations, information seeking, self-reflection, distrust of doctors and scientists, healthy and often alternative lifestyle choices, and a tendency to explain illness in terms of folk models of invisible germ-like agents and malevolent science. The advance of healthism has its roots in postmodernism and accounts for the increasing number of bilaterally unsatisfactory consultations with patients who have an unshakeable self-diagnosis or a demand for ‘natural’ rather than ‘synthetic’ treatment. Another way of looking at this issue is to recognize the constantly increasing number of patients who often practice ‘medical shopping’, especially in the thyroid field. Dr Weetman discusses another reason for the unhappiness of some patients, arising from an innate sense of disbelief in science, heightened by the lack of consensus among endocrinologists, particularly with regard to the diagnosis of subclinical hypothyroidism and the need for treatment. Yet another debate about narrowing the serum TSH reference range (say from 0.4-4.0 to 0.4-2.5 mU/L). As with the treatment of subclinical hypothyroidism, this is a complex area, demanding a sophisticated knowledge of laboratory medicine and experience in clinical endocrinology to interpret correctly lab results and then integrate these data into an adequate assessment of thyroid function and finally translate this intellectual pattern into everyday clinical practice.

Finally, Dr Weetman asks: what can be done? The scientific debate must continue; more research is needed to answer the dark corners of our lack of knowledge; areas of scientific uncertainty must be communicated in an open manner; medical care providers should retain a sense of perspective, scepticism and humility when facing the range of educational, social, and cultural differences that can exist between doctor and patient. Communication lies at the heart of managing patients whose health problems cannot be rationally explained and the focus should be on the patient’s concern, the relief of symptoms and the avoidance of alienation. As functional somatoform disorders are dissected further by new knowledge, innovative and evidence-based ways of managing these common and troublesome disorders will undoubtedly become established. In the mean time, we must avoid endocrinological collusion as a strategy, which in turn requires the avoidance of thyroid hormone treatment in euthyroid individuals. Physicians must do what they have to so often when evidence is incomplete: use their own best judgment about the optimal management for their individual patients.

(Daniel Glinoer MD, PhD)