PUBLIC PETITIONS COMMITTEE, PETITION NO. PE01463 Oct. 18, 2013
Scottish Parliament, Edinburgh, Scotland

Dear Women and Men of the Scottish Parliament,

There was little fruitful communication in the committee meeting of Oct. 1. The petitioners are not physicians and cannot present the medical evidence and arguments to support their claims. The underlying problem is that many women suffer from fatigue, muscle/joint aches, headaches, depression, anxiety, menstrual disorders, insomnia and other problems for which conventional medicine offers only labels and drugs. The petitioners represent an increasing number of patients who reject this facile and ineffective pharmaceutical practice. They assert that the causes of their problems are discoverable and correctable, and include hormone or nutrient deficiencies. I and a steadily increasing number of doctors agree with them. By using more sensitive clinical and laboratory methods than conventional endocrinologists, we are finding that the vast majority of these patients do indeed have undiagnosed or undertreated thyroid, cortisol, sex hormone, Vitamin D and iron deficiencies. We are able to help these patients by diagnosing and treating all their deficiencies. See my prior submission and my website for details.

Endocrinologists do care about their patients and do want to provide the best care; but they are locked into a set of false assumptions. Decades ago they abandoned clinical medicine for a laboratory reference-range scheme, misusing the very broad “normal” ranges as definitive guides to diagnosis and treatment. The ranges are not made for this purpose; they include almost everyone—95% of “apparently healthy” adults, not screened for signs or symptoms. Far more than 2.5% of such a group has some degree of hormone deficiency. Thus endocrinologists are incapable of diagnosing most hormone deficiencies, and when they do diagnose their treatment consists only of “normalizing” the level. They thus have no experience at all with actually trying to help patients by optimizing their hormone levels and effects. They are even trained to disregard the patient’s signs and symptoms if test results are “normal”. This approach is particularly damaging when it comes to the two most powerful hormones in the body, cortisol and thyroid. Women are more likely to be deficient in these hormones than men. In hypothyroidism, endocrinologists rely on an indirect, fallible test—thyroid stimulating hormone (TSH). They can only diagnose primary hypothyroidism (high TSH) and the most severe cases of central hypothyroidism. Drs. Toft and Williams claim that patients with primary hypothyroidism are well-treated by “normalizing” their TSH with levothyroxine therapy. The majority of scientific studies indicate otherwise and I routinely find that they remain clinically hypothyroid, sometimes severely so, and improve remarkably on T4-T3 combination therapy titrated to the best clinical response, not the TSH test. Endocrinologists believe that their TSH-based thyroidology works because they refuse to look for or acknowledge persisting signs and symptoms of hypothyroidism. They instead give the patient other diagnoses: aging, lack of exercise, overweight, bad habits, stress, depression, chronic fatigue, fibromyalgia, mitochondrial disease, etc. Dr. Toft admits that he put too much faith in the TSH in the past; other doctors will continue treat the TSH level, not the patient, until they are taught how to practice clinical thyroidology.

As it is, patients have no one to appeal to but the state. I have submitted a treatise on hypothyroidism to a peer-reviewed medical journal; I will provide copies to the endocrinologists present at the hearing if requested. I am preparing another treatise on cortisol deficiency. I repeat my prior recommendations, in short:

1. Ask the General Medical Council and endocrine associations to review their reference-range-based guidelines.
2. Ask for the meaningful reporting of endocrine test results with adjudicated diagnostic and treatment ranges.
3. Remove regulatory barriers to the practice of clinical endocrinology; remove the fear of prosecution.
4. Preserve patients’ endocrine freedom—to seek and obtain effective endocrine diagnosis and treatment.
5. Provide accurate hormone prescribing information to physicians and patients. Hormones are not drugs.
6. Assure the availability of human-bioidentical hormone products to physicians and patients.
7. Isolate the practice of endocrinology from the pharmaceutical industry—zero tolerance for conflicts of interest.
8. Prohibit pharmaceutical direct-to-consumer advertising which strengthens the pharmaceutical paradigm.

Henry Lindner, MD
Falls, Pennsylvania, USA www.hormonerestoration.com