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# The "Mad Protocol Syndrome." 8. A Case of Dyspepsia: Omeprazole per protocol

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## Abstract

The "Mad Protocol Syndrome" is a condition in physicians who rigidly or normatively apply clinical guidelines or protocols. This syndrome, understudied but widespread, is seriously dangerous because it generates iatrogenic effects, promotes polypharmacy and drug interactions, is frequently based on controversial, unsound, and rapidly changing foundations due to the rapid emergence of new studies, fails to consider patient-centered care, is not developed collaboratively by medical specialties and patients, is often influenced by powerful interest groups (such as the relationship of almost all panelists on clinical guideline development committees with the pharmaceutical industry), always maintains an exclusively biomedical perspective ignoring broader biopsychosocial viewpoints, and because there are hundreds or thousands (or perhaps millions?) of clinical guidelines that contradict each other in their recommendations. The patient is a biographical, social, and spiritual reality, never an isolated analytical value. No laboratory target (HbA1c, LDL, or blood pressure) justifies destroying a human being's autonomy, lucidity, or daily well-being. "The Mad Protocol Syndrome" ultimately represents the dehumanization of medicine through bureaucracy. To break this absurd cycle of over-prescription and alienation, 21st-century medicine doesn't need to generate more guidelines from distant experts, but rather urgently reclaim the sovereignty of clinical judgment, safe deprescribing tools, and critical methodological approaches that return control to the primary care physician and dignity to the patient. Studying and reflecting on these concepts is the first step toward transforming clinical practice and rescuing the humane, critical, and sensitive medicine that patients so desperately need. Here is an example of clinical guidelines and protocols for Dyspepsia: The endless cascade of gastric protectors (Omeprazole per protocol).

**Keywords:** Guidelines; Methodology; Applicability, Evidence-based medicine; Patient-centered; Personalized medicine, General practice

## Introduction

Clinical practice guidelines provide evidence-based recommendations to optimize patient care, while protocols dictate rigid, step-by-step procedures. In general medicine, these tools are designed to reduce practice variation and translate complex scientific research into actionable, patient-specific encounters (1, 2). However, clinical guidelines face significant systemic challenges. Key problems include a one-size-fits-all approach that fails to account for

individual variations, a lack of universal applicability, and potential conflicts of interest. Misuse of guidelines can sometimes lead to suboptimal care (3-5).

The concept we describe as the “Mad Protocol Syndrome” perfectly defines the phenomenon of the tyranny of clinical guidelines or normative biomedical reductionism.

This refers to the growing concern that modern medicine focuses too rigidly on treating isolated biological pathways and rigid, one-size-fits-all algorithms. This severely limits personalized care and ignores the complex, multifaceted realities of human illness (6).

In the scientific and critical medical literature, promoted by movements such as Choosing Wisely, evidence-based medicine without conflicts of interest, and quaternary prevention (7-10), there are blatant examples of guidelines that exhibit these characteristics: medicalization of risk factors, rigid objectives that induce massive polypharmacy in patients with multiple pathologies, a high rate of panelists with conflicts of interest with the pharmaceutical industry, and a complete disconnection from the biopsychosocial model. Below is an example of clinical guidelines and protocols for Dyspepsia: The endless cascade of gastric protectors (Omeprazole per protocol).

## CLINICAL CASE: The "Mad Protocol Syndrome" applied to Dyspepsia: The endless cascade of gastric protectors (Omeprazole per protocol)

Loretta, 45 years old, lawyer. No significant medical history. Married, no children.

### The "Mad Protocol" Approach (Omeprazole per protocol)

She presents with heartburn and indigestion for the past month, coinciding with a period of high workload and a divorce. The doctor applies the standard "uninvestigated dyspepsia" protocol: prescribing Omeprazole 20 mg/day for 4 weeks. At the follow-up appointment, Loretta reports continued occasional discomfort. Following the established procedure, the doctor automatically records the prescription indefinitely in the computer as "gastroprotection." Five years later, Loretta is still taking Omeprazole daily. Blood tests reveal anemia due to vitamin B12 malabsorption, and a bone density scan reveals premature osteopenia due to calcium malabsorption caused by chronic gastric acid suppression. When she tries to stop taking the pill, she suffers such a severe rebound effect of heartburn that she is forced to resume taking it, trapped by the medication.

## DISCUSSION

In Loretta's case, the doctor suffers from the "Mad Protocol Syndrome":

1) The systematic initiation of Proton Pump Inhibitors (PPIs) such as Omeprazole for any symptom of upper gastric discomfort, heartburn, or reflux, prolonging their use indefinitely under the automated protocol label of "chronic gastroprotection."

Although considered harmless drugs, the rigid and chronic use of Omeprazole alters gastric pH. This causes malabsorption of vital nutrients (Vitamin B12, iron, magnesium, and calcium), which in turn causes anemia and osteoporosis. Furthermore, it drastically increases the risk of serious infections such as pneumonia and Clostridioides difficile colitis (11). These side effects stem directly from the physiological changes caused by long-term acid suppression (12). Stomach acid is required to cleave B12 from dietary proteins. Elevated gastric pH hinders this process,

leading to a deficiency that can cause neuropathy or anemia (13, 14). Optimal absorption of minerals (Iron, Calcium, Magnesium) requires an acidic environment to enhance solubility. Chronic PPI use lowers the solubility and absorption rates of iron, calcium, and magnesium (15, 16).

Chronic PPI use increased Infection Risks. Immune Barriers: Gastric acid is a primary immune defense mechanism that kills swallowed bacteria before they reach the rest of the gastrointestinal tract and lungs (17-19). Raising the stomach pH allows pathogens to survive and thrive (C. difficile & Pneumonia). The altered pH may also encourage harmful changes to the overall gut microbiome profile (20-22).

2) Lack of patient-centered care: The protocol masks the true biopsychosocial problem of dyspepsia. Stomach discomfort is frequently linked to work stress, anxiety, poor eating habits due to lack of time, or family problems. Giving a pill ignores the need to address lifestyle. The true psychosocial problem in functional dyspepsia lies in the brain-gut axis. Studies indicate that the condition is often driven by somatization and stress intolerance rather than anatomical issues. Dysregulation between the brain and digestive tract alters pain perception and gut motility, heightening physical symptoms during stress (23). Furthermore, high rates of anxiety, depression, and neuroticism are frequently observed in patients (24), and a high tendency to experience and communicate psychological distress as physical bodily symptoms that is a major factor driving symptom severity (25). Research emphasizes that a biopsychosocial model—rather than treating the stomach in isolation—is critical for diagnosis and management (23).

3) Lack of participatory deprescribing: Clinical guidelines fail to provide clear guidelines for withdrawing the medication. When patients attempt to stop abruptly on their own, they experience a severe "rebound effect" of heartburn (rebound gastric hyperacidity). The physician interprets this as the patient "still being ill" and perpetuates the prescription indefinitely.

## What would a Patient-Centered Intervention Plan look like?

The doctor identifies the biopsychosocial component: Loretta's dyspepsia is closely linked to stress and the speed at which she eats due to her job. Omeprazole is prescribed only "as needed" (for 2 or 3 days if the symptom is very acute) rather than continuously. Nutritional education is provided (eating slowly, avoiding heavy dinners), and stress management techniques are recommended. From the outset, the treatment is planned with an end date. As a result, Loretta modifies her habits, manages her anxiety, her digestion improves, and her B12 levels and bone density remain completely healthy and free of chronic medication.

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