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The "Mad Protocol Syndrome." 6. Mental Health in the Elderly Patient: The Medicalization of Human Suffering and Social Isolation

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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 Mental Health in the Elderly Patient (The medicalization of human suffering and social isolation).

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 Mental Health in the Elderly Patient (The medicalization of human suffering and social isolation).

CLINICAL CASE: The "Mad Protocol Syndrome" Applied to Mental Health in Elderly Patients (The Medicalization of Human Suffering and Social Isolation)

Margaret, 81 years old. Medical History: Controlled hypertension, mild osteoarthritis. Widowed for 6 months (her husband of 55 years passed away after a long illness). Social Situation: Her children live in another city for work. Margaret spends most of the day alone in her apartment, has stopped attending the senior citizens' club, and says that the house "is closing in on her."

The "Mad Protocol" Approach (The Automated Depression Questionnaire).

Margaret visits her health center because she has been sleeping poorly for weeks, has a decreased appetite, cries frequently, and experiences chest tightness in the afternoons. The doctor, overwhelmed by the consultation time, mechanically administers a rapid screening questionnaire (such as the Yesavage Geriatric Depression Scale or the DSM-5 criteria).

Margaret meets the criteria for "depressed mood, insomnia, loss of interest, and fatigue" for more than two weeks. The protocol dictates that she meets the criteria for "Major Depressive Disorder." Ignoring that Margaret is experiencing a legitimate grief and a profound crisis of loneliness, the doctor automatically prescribes an SSRI antidepressant: Sertraline 50 mg/day, along with a benzodiazepine for insomnia: Lormetazepam 2 mg at night.

After four weeks, Margaret returns. She is still sad (the medication cannot bring her husband back or her children back). In addition, the benzodiazepine causes morning sleepiness and confusion. The doctor, instead of discontinuing the medications, interprets the depression as "treatment-resistant." He increases the Sertraline to 100 mg and adds a low-dose neuroleptic/antipsychotic (Quetiapine 25 mg) to "boost" the effect and control the supposed agitation.

Three months after starting the psychopharmacological cascade, Margaret is no longer the same. She presents with psychomotor inhibition syndrome and drug-induced parkinsonism (tremors in her hands, rigidity, and a shuffling gait) caused by the combination of psychotropic drugs, to which her aging brain is extremely sensitive. The lormetazepam

accumulated in her body causes severe ataxia (loss of balance). One night, upon getting up to use the bathroom in a state of deep sedation, Margaret loses her balance, falls, and suffers a wrist fracture and a head injury. After being discharged from the hospital, due to the rigidity induced by the pills and the fear of falling again, Margaret becomes confined to a chair, losing all her independence. Her family, seeing her so listless and trembling, mistakenly believes she has developed "accelerated senile dementia."

DISCUSSION

Margaret's case exemplifies the development of the "Mad Protocol Syndrome" applied to mental health in elderly patients, specifically in the context of anxiety and depression. This clinical case exposes one of the most painful forms of iatrogenesis: the medicalization of human suffering and social isolation. It shows how the rigidity of diagnostic manuals and the rush to provide care transform an existential and relational process (grief and loneliness) into a supposed neurochemical illness, triggering a cascade of psychotropic drugs with devastating consequences.

In Margaret's case, the doctor suffers from the "Mad Protocol Syndrome":
1) A pathologization of life occurs (extreme biomedical view): A vital, spiritual, and social crisis (widowhood and structural isolation) was reduced to a "serotonin deficiency." Modern diagnostic manuals (such as the DSM-5) eliminated "bereavement exclusion," allowing for the diagnosis of major depression within days of a loss, which opened the door to this massive overtreatment. Eliminating the "bereavement exclusion" in the DSM-5 sparked intense, ongoing debate. The change allows clinicians to diagnose Major Depressive Disorder (MDD) shortly after a significant loss. Critics argue this medicalizes natural grief, while proponents argue it prevents life-threatening delays in treating clinical depression (11-15).

2) Iatrogenesis due to prescription cascades: "The Mad Protocol" treats the side effects of the first drug (drowsiness, dizziness) by adding a second or third drug (antipsychotics), ignoring the fact that psychotropic drugs in the elderly triple the risk of falls, fractures, delirium, and overall mortality (16-18).

3) Lack of a community and participatory approach: Official clinical guidelines dedicate little space to non-pharmacological interventions. They are heavily influenced by a biological psychiatry whose opinion leaders maintain close financial ties with the pharmaceutical industry dedicated to mental health (19-25).

What would a Patient-Centered Intervention Plan look like? (Patient and Community-Centered)

If the medical professional had applied humanistic, sensible, and evidence-based medicine: 1) They would have listened to Margaret, validating her crying and sadness as part of a normal and necessary grieving process. They would have explained that she is not ill, but rather suffering a devastating loss; 2) Instead of writing a prescription, the doctor would have issued a "social prescription." They would have coordinated with the community nurse and social worker to connect Margaret with a grief support group in her neighborhood, memory workshops, or community socialization activities to combat loneliness; 3) For insomnia, simple cognitive-behavioral therapy measures would have been prescribed, avoiding the use of addictive and dangerous benzodiazepines.

The result would have been that Margaret would have gone through her grief accompanied, made new friends in her environment, maintained her cognitive abilities and physical agility intact, avoiding the chemical cascade and the loss of her valuable independence.

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