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The "Mad Protocol Syndrome." 11. The final synthesis. Manifesto for a Humane Medicine: Ten Commandments Against the Tyranny of Rigid 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. After 10 chapters where 10 very frequent clinical scenarios of modern medicine have been presented, showing the alarming reality of the "Mad Protocol Syndrome", below we move towards the final synthesis, presenting the principles of a medicine that protects against "Mad Protocol Syndrome."

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. After 10 chapters where 10 very frequent clinical scenarios of modern medicine have been presented, showing the alarming reality of the “Mad Protocol Syndrome”, below we move towards the final synthesis, presenting the principles of a medicine that protects against "Mad Protocol Syndrome."

The "Mad Protocol” Approach. Criteria of the "Mad Protocol":

1. Iatrogenesis: systemic, due to rigidity, generation of polypharmacy, overdiagnosis, generation of prescription cascades, drug-drug interactions, massive medicalization, and a purely biomedical perspective.

2. Controversial, ineffective, weak, changing, and biased foundations.

3. Use of fixed and obsolete analytical criteria.

4. Contradiction in recommendations between guidelines.

5. Conflicts of interest, implicit commercial interests, and industry interests, sometimes massive.

6. Lack of patient-centered care.

7. A purely biomedical perspective. Lack of a biopsychosocial perspective, biomedical perspective versus genuine well-being, pathologization of life by an extreme biomedical view

8. Lack of a community and participatory approach

9. Absence of participatory deprescribing

Studying and reflecting on these concepts is the first step toward transforming clinical practice and rescuing the humane, critical, and sensible medicine that patients so desperately need. The Quaternary Prevention approach and medical deprescribing is undoubtedly one of the most transformative and ethical fields in healthcare today.

To cure the "Mad Protocol Syndrome" that we doctors can suffer from, the following medicine is proposed:

Manifesto for Humane Medicine: Ten Principles Against the Tyranny of "Mad Protocol":

1. We Treat People, Not Numbers
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 (11-15).

2. Clinical Practice Guidelines Are a Map, Not an Order
Protocols are guidance tools, never legal or ethical mandates. The clinical judgment of the professional in the one-on-one interaction with the patient must always prevail over the computer algorithm (16).

3. The Patient Is at the Center of Decisions
Every intervention must be explained and agreed upon with the patient and their support network through shared decision-making. A protocol is invalid if it does not consider the values, priorities, and real expectations of the person receiving it (17-19).

4. First, Do No Harm (Quaternary Prevention)
The primary medical obligation when harm is suspected is to provide containment. We must actively pursue deprescribing and firmly combat therapeutic inertia, the drug cascade, and iatrogenic overtreatment (20-23).

5. Flexibility According to Age and Frailty
Rigid therapeutic goals designed for young adults are not applicable to elderly or multimorbid populations. Aging requires flexible goals that protect hemodynamics, cognitive function, and prevent falls (24, 25).

6. Biopsychosocial Approach over Biomedical Approach
Health and disease do not occur in a molecular vacuum. Social prescribing, community support, nutrition, exercise, and relational mental health should be prioritized over a purely pharmacological response (26-30).

7. Absolute Independence from Industry
Applied scientific evidence must be clean, transparent, and free from economic conflicts of interest. We reject disease thresholds dictated by clinical guideline committees funded by pharmaceutical or technology corporations (31-34).

8. Absolute Respect for the Evolution of Life
Sadness is not always depression, joint degeneration is not always a chemical emergency, and terminal physiological decline is not a call for aggressive cancer treatment. The natural course of life and grief must be respected (35-37).

9. Critical Monitoring of Evidence (Clinical Skepticism)

No clinical study or surrogate endpoint justifies the automation of medical practice. Professionals must maintain a constant critical perspective on accelerated therapeutic trends and the methodological biases of clinical trials (38, 39).

10. Time to Listen is the Best Medicine
Haste in care is the perfect breeding ground for the "Crazy Protocol Syndrome." A thorough medical history, careful physical examination, and compassionate communication save more lives and prevent more iatrogenic harm than any blind prescribing algorithm (40-43).

In short, the Manifesto for Person-Centered Medicine is a concise ten-point plan designed to protect clinical practice from the rigidity of bureaucratic dogmatism and the "Mad Protocol Syndrome." This manifesto proposes a person-centered approach to medicine, rejecting the rigidity of the "Mad Protocol" in favor of clinical judgment, patient autonomy, and quaternary prevention. It advocates for biopsychosocial care, deprescribing, and independence from the pharmaceutical industry, prioritizing listening time over automated algorithms.

References

1. Panteli D, Legido-Quigley H, Reichebner C, et al. Clinical Practice Guidelines as a quality strategy. In: Busse R, Klazinga N, Panteli D, et al., editors. Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies [Internet]. Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2019. (Health Policy Series, No. 53.) 9. https://www.ncbi.nlm.nih.gov/books/NBK549283/
2. Conroy M, Shannon W. Clinical guidelines: their implementation in general practice. Br J Gen Pract. 1995;45(396):371-5. https://pubmed.ncbi.nlm.nih.gov/7612343/
3. Lau EW, Bonnemeier H, Baldauf B. Misuse of Guidelines Could Disadvantage and Harm Patients. J Evid Based Med. 2024;17(4):705-707. https://pmc.ncbi.nlm.nih.gov/articles/PMC11684497/
4. Dörenkamp S, Mesters I, Teijink J, de Bie R. Difficulties of using single-diseased guidelines to treat patients with multiple diseases. Front Public Health. 2015;3:67. https://pmc.ncbi.nlm.nih.gov/articles/PMC4413518/
5. Rapezzi C, Lorenzini M. How far should guidelines be followed? Eur Heart J Suppl. 2020;22(Suppl L):L121-L123. https://pmc.ncbi.nlm.nih.gov/articles/PMC7673602/
6. Cramer H. Whole Health Research Thought Further: How Can We Stay Whole in a Reductionist Paradigm? J Integr Complement Med. 2024;30(12):1123-1124. https://pmc.ncbi.nlm.nih.gov/articles/PMC11659440/
7. AbdulRaheem Y. Unveiling the Significance and Challenges of Integrating Prevention Levels in Healthcare Practice. J Prim Care Community Health. 2023;14:21501319231186500.https://pmc.ncbi.nlm.nih.gov/articles/PMC10350749/
8. Wagner H. Quaternary Prevention and the Challenges to Develop a Good Practice Comment on "Quaternary Prevention, an Answer of Family Doctors to Overmedicalization". Int J Health Policy Manag. 2015;4(8):557-8. https://pmc.ncbi.nlm.nih.gov/articles/PMC4529049/
9. Furlan L, Francesco PD, Costantino G, Montano N. Choosing Wisely in clinical practice: Embracing critical thinking, striving for safer care. J Intern Med. 2022;291(4):397-407. https://pmc.ncbi.nlm.nih.gov/articles/PMC9314697/
10. Martins C, Godycki-Cwirko M, Heleno B, Brodersen J. Quaternary prevention: reviewing the concept. Eur J Gen Pract. 2018;24(1):106-111. https://pmc.ncbi.nlm.nih.gov/articles/PMC5795741/
11. Entwistle VA, Carter SM, Cribb A, McCaffery K. Supporting patient autonomy: the importance of clinician-patient relationships. J Gen Intern Med. 2010;25(7):741-5. https://pmc.ncbi.nlm.nih.gov/articles/PMC2881979/
12. Kirsh SR, Aron DC. Choosing targets for glycaemia, blood pressure and low-density lipoprotein cholesterol in elderly individuals with diabetes mellitus. Drugs Aging. 2011;28(12):945-60. https://pubmed.ncbi.nlm.nih.gov/22117094/
13. Borrell-Carrió F, Suchman AL, Epstein RM. The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. Ann Fam Med. 2004;2(6):576-82. https://pmc.ncbi.nlm.nih.gov/articles/PMC1466742/
14. Olchowska-Kotala A, Strządała A, Barański J. Patients' Values and Desire for Autonomy: An Empirical Study from Poland. J Bioeth Inq. 2023;20(3):409-419. https://pmc.ncbi.nlm.nih.gov/articles/PMC10624733/
15. Kirsh SR, Aron DC. Choosing targets for glycaemia, blood pressure and low-density lipoprotein cholesterol in elderly individuals with diabetes mellitus. Drugs Aging. 2011;28(12):945-60. https://pubmed.ncbi.nlm.nih.gov/22117094/
16. Panteli D, Legido-Quigley H, Reichebner C, et al. Clinical Practice Guidelines as a quality strategy. In: Busse R, Klazinga N, Panteli D, et al., editors. Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies [Internet]. Copenhagen (Denmark): European Observatory on Health

Systems and Policies; 2019. (Health Policy Series, No. 53.) 9. https://www.ncbi.nlm.nih.gov/books/NBK549283/
17. Costa Alcaraz AM, Almendro Padilla C. Un modelo para toma de decisiones compartida con el paciente [A model for making shared decisions with the patient]. Aten Primaria. 2009 ;41(5):285-7. https://pmc.ncbi.nlm.nih.gov/articles/PMC7021963/
18. Quevedo JA, Martin R, Lorenzo D, de Pablos A, Martínez R. ["The patient at the centre". Agreements between patients-SEMFYC associations]. Aten Primaria. 2023;55(3):102564. https://pmc.ncbi.nlm.nih.gov/articles/PMC9845792/
19. Simón-Lorda Pablo. [Patients' ability to make decisions: a task still pending]. Rev Asoc Esp Neuropsiq. 2008; 28(2): 327-350. http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S0211-57352008000200006&lng=es
20. Salahudeen MS. Deprescribing medications in older people: a narrative review. Drugs Today (Barc). 2018;54(8):489-498. https://pubmed.ncbi.nlm.nih.gov/30209443/
21. Martins C, Godycki-Cwirko M, Heleno B, Brodersen J. Quaternary prevention: an evidence-based concept aiming to protect patients from medical harm. Br J Gen Pract. 2019;69(689):614-615. https://pmc.ncbi.nlm.nih.gov/articles/PMC6867216/
22. Martins C, Godycki-Cwirko M, Heleno B, Brodersen J. Quaternary prevention: reviewing the concept. Eur J Gen Pract. 201;24(1):106-111.https://pubmed.ncbi.nlm.nih.gov/29384397/
23. Alber K, Kuehlein T, Schedlbauer A, Schaffer S. Medical overuse and quaternary prevention in primary care - A qualitative study with general practitioners. BMC Fam Pract. 2017;18(1):99. https://pubmed.ncbi.nlm.nih.gov/29216841/
24. Bolt J, Carvalho V, Lin K, Lee SJ, Inglis C. Systematic review of guideline recommendations for older and frail adults with type 2 diabetes mellitus. Age Ageing. 2024;53(11):afae259. https://pubmed.ncbi.nlm.nih.gov/39572394/
25. Kennard AL, Glasgow NJ, Rainsford SE, Talaulikar GS. Narrative Review: Clinical Implications and Assessment of Frailty in Patients With Advanced CKD. Kidney Int Rep. 2023;9(4):791-806. https://pmc.ncbi.nlm.nih.gov/articles/PMC11101734/
26. Engel G. The need for a new medical model: a challenge for biomedicine. Science. 1977; 196:129-36. http://www.drannejensen.com/PDF/publications/The%20need%20for%20a%20new%20medical%20model%20-%20A%20challenge%20for%20biomedicine.pdf
27. Engel G The clinical appplication of the biopsychosocial model. Am J Psychiatry. 1980; 137:535-44. https://www.ncbi.nlm.nih.gov/pubmed/7369396
28. Turabian JL. Biopsychosocial concept is the characteristic that distinguishes the practice of general practitioner/family doctor. J Gen Pract. 2018;6: e122. https://www.researchgate.net/publication/325149099_Biopsychosocial_Concept_is_the_Characteristic_that_Distinguishes_the_Practice_of_General_PractitionerFamily_Doctor
29. White P. Biopsychosocial medicine. An integrated approach to understanding illness. Oxford University Press, New York. 2005. https://www.amazon.es/Biopsychosocial-Medicine-integrated-approach-understanding/dp/0198530331
30. Managing chronic illness. A biopsychosocial perspectiva. Nicassio PM, Smith TW (Editors). Washington: American Psychological association; 1996. https://es.scribd.com/document/928595529/Managing-Chronic-Illness-a-Biopsychosocial-Perspective
31. Koletzko B, Cortez-Pinto H, Löhr M, van Hooft J, Rosendahl J. Medical guidelines must not be influenced by commercial interests. United European Gastroenterol J. 2023;11(6):582-583. https://pmc.ncbi.nlm.nih.gov/articles/PMC10337729/

32. Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice; Lo B, Field MJ, editors. Conflict of Interest in Medical Research, Education, and Practice. Washington (DC): National Academies Press (US); 2009. 7, Conflicts of Interest and Development of Clinical Practice Guidelines. https://www.ncbi.nlm.nih.gov/books/NBK22928/
33. Institute of Medicine (US) Committee on Standards for Developing Trustworthy Clinical Practice Guidelines; Graham R, Mancher M, Miller Wolman D, et al., editors. Clinical Practice Guidelines We Can Trust. Washington (DC): National Academies Press (US); 2011. 5, Current Best Practices and Standards for Development of Trustworthy CPGs: Part II, Traversing the Process. https://www.ncbi.nlm.nih.gov/books/NBK209540/
34. McMahon GT. Independence from industry cannot be compromised. J Eur CME. 2017;6(1):1393296. https://pmc.ncbi.nlm.nih.gov/articles/PMC5843067/
35. Ruiz-Mirazo K, Peretó J, Moreno A. Defining life or bringing biology to life. Orig Life Evol Biosph. 2010;40(2):203-13. https://pubmed.ncbi.nlm.nih.gov/20182798/
36. Veit W, Gascoigne SJL, Salguero-Gómez R. Evolution, Complexity, and Life History Theory. Biol Theory. 2025;20(3):212-221. https://pmc.ncbi.nlm.nih.gov/articles/PMC12380943/
37. Rühli F, van Schaik K, Henneberg M. Evolutionary Medicine: The Ongoing Evolution of Human Physiology and Metabolism. Physiology (Bethesda). 2016;31(6):392-397. https://pubmed.ncbi.nlm.nih.gov/27708045/
38. DiNubile MJ. Skepticism: a lost clinical art. Clin Infect Dis. 2000 Aug;31(2):513-8. https://pubmed.ncbi.nlm.nih.gov/10987714/
39. Bhatti A. Cognitive bias in clinical practice - nurturing healthy skepticism among medical students. Adv Med Educ Pract. 2018 Apr 10;9:235-237. https://pmc.ncbi.nlm.nih.gov/articles/PMC5901151/
40. Bradshaw J, Siddiqui N, Greenfield D, Sharma A. Kindness, Listening, and Connection: Patient and Clinician Key Requirements for Emotional Support in Chronic and Complex Care. J Patient Exp. 2022 ;9:23743735221092627. https://pmc.ncbi.nlm.nih.gov/articles/PMC9008851/
41. Tennant K, Long A, Toney-Butler TJ. Active Listening. [Updated 2023 Sep 13]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2026 Jan-.http://www.ncbi.nlm.nih.gov/books/NBK442015/
42. Longo DR. Listening as Work in Primary Care. Health Expect. 2007;10(1):101–2. https://pmc.ncbi.nlm.nih.gov/articles/PMC5060374/
43. Shannon MT. Please Hear What I'm Not Saying: The Art of Listening in the Clinical Encounter. Perm J. 2011;15(2):e114-7. https://pmc.ncbi.nlm.nih.gov/articles/PMC3140762/