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The "Mad Protocol Syndrome." 2. A Case of High Blood Pressure: "Perfect Blood Pressure"

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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 Arterial Hypertension in the frail elderly patient ("perfect blood pressure").

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 Arterial Hypertension in the frail elderly patient ("perfect blood pressure").

CLINICAL CASE: The "Mad Protocol Syndrome" applied to Arterial Hypertension in the frail elderly patient (The Myth of 120 mmHg; The "perfect blood pressure").

Corinne, 82 years old. Medical history: Long-standing hypertension, severe knee osteoarthritis, and mild cognitive impairment. Social situation: Independent for basic activities, but uses a cane to walk due to balance problems.

The "Mad Protocol" Approach (The Myth of 120 mmHg)

Corinne comes for her annual check-up. Her blood pressure reading is 145/82 mmHg.

Her doctor, strictly applying clinical guidelines that recommend intensive and universal systolic blood pressure (SBP) targets of <130>

Three weeks after starting triple therapy, Corinne experienced severe episodes of orthostatic hypotension. One morning, upon getting out of bed quickly to go to the bathroom, she suffered cerebral hypoperfusion (transient ischemia due to lack of blood flow), became dizzy, and experienced syncope with a head injury and loss of consciousness. In addition, the diuretic causes her severe hyponatremia (low blood sodium), which drastically worsens her mild cognitive impairment, plunging her into a state of confusion and disorientation that her family mistakes for advanced dementia.

DISCUSSION

Corinne's case exemplifies the "Mad Protocol Syndrome" applied to hypertension in frail elderly patients. This clinical case exposes the paradigm of "perfect blood pressure" driven by rigid and aggressive guidelines (derived from maximalist interpretations of trials such as the SPRINT study and others) (12-14).

In Corinne's case, the doctor suffers from the "Mad Protocol Syndrome." The clinical practice guidelines of the American College of Cardiology (ACC) and the American Heart Association (AHA) modified the formal definition of hypertension, lowering the diagnostic threshold from 140/90 mmHg to 130/80 mmHg. This change implies massive medicalization and iatrogenesis: Overnight, millions of healthy people were considered ill (Stage 1 hypertensive). In rigid clinical practice, this triggered the automatic prescription of double or triple antihypertensive therapies. In elderly patients, this leads to orthostatic hypotension, falls, hip fractures, and acute kidney injury. Furthermore, there is a complete contradiction between guidelines: This guideline directly contradicted the criteria of the American College of Physicians and the American Academy of Family Physicians (15, 16), which advocated much less aggressive targets (≤ 140/90 mmHg) based on the fact that iatrogenic harm outweighed the benefits in the general low-risk population (15, 16).

Moreover, the "Mad Protocol Syndrome" lacks a biopsychosocial perspective: The protocol pushes the physician toward purely pharmacological treatment of the blood pressure reading (a biomedical perspective), ignoring the influence of stress, socioeconomic factors, or non-drug lifestyle interventions. Ultimately, these "Crazy Protocols" create iatrogenic harm through rigidity: The protocol ignores the fact that the blood vessels of an 82-year-old are rigid. They need slightly higher systolic filling pressures (140–150 mmHg) to ensure that blood reaches the brain with sufficient force upon standing. These guidelines have controversial and biased foundations: Restrictive guidelines were based on studies like SPRINT (2015), where blood pressure was measured automatically and without medical personnel present (artificially lowering readings by about 10–15

mmHg compared to real-world practice). Simply transferring this number to routine clinical practice is a serious methodological error. Furthermore, they pit the biomedical perspective against actual well-being: the physician prioritized achieving an "ideal number" on the blood pressure monitor at the expense of the patient's hemodynamic stability, mental clarity, and physical safety.

What would a Patient-Centered Intervention Plan look like?

The Alternative Approach is Patient-Centered. If the doctor had applied evidence-based medicine in a real and contextualized manner, they would have set a flexible target: For an 82-year-old patient with balance problems, a target SBP between 140 and 150 mmHg is perfectly acceptable and safe. They would have avoided polypharmacy: Enalapril would have been continued as monotherapy. Blood pressure measurements would have been prioritized both while sitting and standing (actively looking for orthostatic hypotension) before making any changes. The result would have been that Corinne would have maintained her blood pressure at 142/80 mmHg, preserving her cerebral perfusion, her gait stability, and her functional independence.

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