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The "Mad Protocol Syndrome." 5. A case of COPD overdiagnosis

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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 overdiagnosis of COPD.

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 overdiagnosis of COPD.

CLINICAL CASE: The "Mad Protocol Syndrome" applied to COPD (Overdiagnosis of COPD)

Thomas, 67 years old, former smoker (quit 15 years ago, with a moderate smoking history), moderately overweight, and with a primarily sedentary lifestyle. Retired, he spends most of his time reading or watching television. His physical activity is limited to very short walks.

The "Mad Protocol" Approach (The fatigued patient is a COPD patient)

Thomas visits his health center because he has noticed that for the past few months, he has been experiencing "shortness of breath" (dyspnea) when trying to climb the stairs in his building or when walking briskly.

The doctor, mechanically associating the symptom of "dyspnea" with the patient's history as a "former smoker," orders spirometry with a bronchodilator trial (11, 12).

The spirometry shows an FEV1/FVC ratio of 0.68 after bronchodilator use. The spirometry machine software and the doctor rigidly apply the fixed threshold of the GOLD guidelines, which dictates that any value below 0.70 is an unequivocal sign of chronic obstructive pulmonary disease (COPD). The doctor ignores the fact that the FEV1/FVC ratio naturally declines with age and that, for a 67-year-old man, this value is within the "Lower Limit of Normal." Thomas doesn't actually have COPD; he has a normal loss of lung capacity for his age, exacerbated by his excess weight and lack of physical training. Rigidly following the protocol for "symptomatic" patients, he is labelled as having COPD Group B/E and an automated treatment escalation is initiated: he is prescribed a combination of bronchodilators. As Thomas continued to report shortness of breath after a few months (because he remained overweight and physically unfit), the doctor implemented the next step in the protocol and introduced "triple therapy" in a single inhaler: a LAMA, a LABA, and a high-dose inhaled corticosteroid (e.g., fluticasone or budesonide).

Thomas used his corticosteroid inhaler daily for a year. The inhaled corticosteroid locally reduced the lung's immune defenses and altered the microbiome of his upper respiratory tract. One winter, Thomas contracted a common respiratory virus. Due to the local immunosuppression caused by the chronic and unnecessary inhaled corticosteroid, the condition did not remain a simple cold but rapidly progressed to severe bilateral lobar pneumonia.

Thomas required emergency hospitalization, high-flow oxygen therapy for two weeks, suffered tremendous muscle deterioration from prolonged bed rest, and developed a chronic fear of any physical exertion, devastating his quality of life.

DISCUSSION

This clinical case highlights a very common public health problem: how confirmation bias, coupled with the mechanical interpretation of a diagnostic test and blind adherence to treatment guidelines (such as the GOLD guidelines), can transform dyspnea due to poor physical fitness into a falsely labeled chronic respiratory disease, ultimately leading to a serious infectious complication.

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

1) Use of fixed and outdated analytical criteria: The application of the rigid FEV1/FVC < 0>

2) Severe and predictable iatrogenic effects: It is well established in the medical literature that the indiscriminate use of inhaled corticosteroids in patients who do not need them (those without a clear asthmatic component or elevated blood eosinophils) doubles the risk of developing severe pneumonia (14).

3) Conflicts of interest in guideline development: Global guidelines for the management of COPD (such as the GOLD initiative) receive substantial funding from the pharmaceutical companies that manufacture the latest generation of combination inhalers. This encourages prioritizing rapid pharmacological intensification over basic, inexpensive, and safe strategies such as pulmonary rehabilitation, weight loss, and physical exercise. The influence of pharmaceutical funding on clinical guidelines remains a subject of intense debate in respiratory medicine. Critics argue that financial ties to industry can inadvertently shape treatment priorities, while organizations like the Global Initiative for Chronic Obstructive Lung Disease (GOLD) maintain that their annual, evidence-based recommendations are shaped by multidisciplinary committees using rigorous scientific review (15, 16).

What would a Patient-Centered Intervention Plan look like?

If the medical professional had acted with a holistic, biopsychosocial, and evidence-based approach tailored to individual needs, they would have performed a contextualized spirometry assessment: They would have compared the value of 0.68 with the Límite Inferior de la Normalidad tables for his age group, ruling out COPD as the primary cause of his symptoms; and they would have addressed the true cause: They would have identified that Thomas's dyspnea was due to a sedentary lifestyle and being overweight. Instead of medication, they would have prescribed a guided progressive exercise program (walking, simple strength exercises) and a nutritional plan. Thus, the result would have been that Thomas would have significantly improved his exercise tolerance, lost weight, and kept his lungs free of corticosteroids, avoiding pneumonia that put his life at risk.

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