



Henry A. Nasrallah, MD  
Editor-in-Chief

**There is no such thing as an average patient and an average treatment—every patient is unique**

## Treat the patient, not the disease

### Practicing psychiatry in the era of guidelines, protocols, and algorithms

**Personalized care is at the heart of good medical care. It is an indispensable ingredient for optimal clinical outcomes because each patient is unique, as an individual and as a patient, and requires customized treatment.**

If 10 patients with depression walk into a psychiatrist's office on any given day, each will be different and should be treated accordingly. Their symptoms may be similar thematically but they differ widely in presentation and content. Their medical and psychiatric histories and social, educational, religious, ethnic, socioeconomic, and attitudinal diversity can be stunning in complexity and disparity. Just as patients' symptoms can be similar yet different, so can their response to a specific antidepressant or psychotherapy. Their clinical and functional outcomes will vary widely in degree and valence. Every psychiatrist expects (and enjoys) the richness of patient backgrounds and manages each individually.

Given these individual differences among our psychiatric patients, why are practitioners being barraged by various entities to abandon the traditional medical approach to their patients? Why is there a push to transform personalized clinical care to an assembly-line system, where patients are defined by their disease and are managed like "human widgets" as though they can be "processed" in an identical, protocolized, mechanical manner? This is completely antithetical to the magnificent personal approach inherent in the classic and highly effective doctor-patient relationship.

There is nothing wrong with treating patients based on up-to-date practice guidelines and evidence-based principles of clinical effectiveness. The issue is whether clinical decisions should be made by the physician, one patient at a time, rather than imposing the dreaded "cookie-cutter" approach of protocols or algorithms on a population of patients whose only commonality is a DSM-IV-TR diagnosis. The not-so-hidden agenda of the business-oriented managed care systems is to lower costs, not to provide

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the best personalized medical care. Who came up with the absurd notion that there is such a thing as “an average patient” who would respond to a prepackaged, economically efficient “average treatment”? That is a serious disservice to the spectrum of patients suffering from psychiatric illnesses and an insult to skilled, compassionate psychiatrists who can provide customized care to each patient.

It is certainly paradoxical that at a time when personalized medicine is advocated as “best practice” in medical care, managed care health systems are propagating and implementing a contrarian movement of homogenizing treatment into rigid protocols with a preset, algorithmic approach. These competing messages create a confusing state of cognitive dissonance, especially for trainees, as to how clinicians should deliver medical care for their patients.

It is well known that a large proportion of psychiatric disorders (>80%) have no evidence-based, FDA-approved treatments, and no practice guidelines, protocols, or standards of care.<sup>1</sup> This is where psychiatrists have to use more art than science—including the necessary, but often maligned, off-label treatments—to help reduce their patients’ suffering. In these situations, the physician-patient relationship simply cannot be superseded by any prepackaged protocol, and physicians should decide what is best for their patient.

So let physicians unite behind what makes medicine such a noble profession: combining the best available scientific knowledge with experience and well-honed clinical judgment to deliver customized care, one patient at a time. We must treat our patients exactly as we want to be treated when we inevitably suffer from an illness.



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