ISSN 2692-5877
DOI: 10.46998/IJCMCR.2025.57.001417

International Journal of
Clinical Studies & Medical Case Reports

Short Communication

A Proposed Protocol for Accepting Geriatric Patients' Proxies

Mohammed Allam*
Consultant Psychiatrist, Fellow of the Royal Australian and Newzealnd college of Psychiatrists, Australia

***Corresponding author:** Mohammed Allam, Consultant Psychiatrist, Fellow of the Royal Australian and Newzealnd college of Psychiatrists, Australia

Received: January 13, 2026 Published: February 27, 2026

Abstract

A proxy is a family member or a caregiver (a nurse or at times reliable others) who come on behalf of the patient to either get refill of medications and/or provide feedback about the patient based on which a physician can make no change in medications or make change in medications, expect feedback sooner than later to consolidate the change and might recommend further referrals and/or non-pharmacological interventions of wide verities to solve a particular problem.

So a proxy is not the easier side of the practice, on the contrary it requires phone calls to another family member or another care giver to see what is meant by what (sad could be blunt because of dementia, fearful could be hallucinating etc..) also how medications are given is a totally different story etc…. so, it is quite a process.

Doctors respond to seeing a proxy to provide help, so we do not ask proxies to come without the patient in other words we deal with the situation as it is for the sake of the patient not because we choose it.

Whose proxy to be accepted:
-Patients known to us

1. An elderly patient who cannot come due to being bed bound and cannot be brought to hospital due to practicality and difficulty of the transfer .

2. Point 1 above plus or minus point 2 which is being attached lines/tubes/cylinders/catheters/being exhausted by dialysis 3 to 4 times a day/ or needing many other face to face medical appointments which cannot be done by a proxy like lab and radiology so they need a break. So patients on oxygen when they come to the clinic they come with oxygen cylinder on the ambulance stretcher and a peeping device to alarm the nurse if oxygen is dropping, requiring certain arrangements. Those patients from the above scenarios coming face to face means to me only one thing, they are alive no other benefit from bringing such patients in the above scenarios.

Because I cannot do any assessment what so ever on him/her, because they are (asleep / already demented / will have drop oxygen if will talk) NO need for those patients to be brought to face to face for psycho-geriatrics reviews, only a short 30 seconds video in more than one occasion about a particular problem or about what the family or nursing staff want us to see or to know is enough.

By further more corroborative information gathering including how often does that happen, impact on care provision and family members, what helped in the past for this particular problem, what has changed recently in the patient environment and other questions after knowing that, I can decide what the plan is.

Bringing patients with the above scenarios results in
a. over consumptions of the acute medical service (Ambulance)
b. Delaying the Ambulance acute response time so, putting patients with possible acute coronary syndrome /strokes at eminent risk of death etc… so that those patients might die due to delayed ambulance response while our patients might be safer at home.
c. The symptoms that Psycho-geriatricians need to see might not be ready to be seen when they are at the clinic, so no point bringing the patient.
Sorry to say that, transferring some of our geriatric patients might put their life at more risk when brought unnecessarily to clinic.
d. Patient's dignity is more preserved when they are not brought on a stretcher in a waiting area, waiting t be seen.

3. Some proxies come because a patient is currently an inpatient in another health facility for a medical co-morbidity which is reasonable. So, I cannot police the proxy for that, asking why and when but I can take usual relevant medical history about

the current psychiatric problem in light of the ongoing medical comorbidity and provide the necessary advice. In many of these cases, all psychiatric medications are stopped and they need to be recommenced, or a behavioral change is causing problems etc… so, they need an advice here and now and the patient's presence is not possible.

4. Frailty and medical co morbidities which do not necessarily include being bed bound is a reasonable reason for a proxy to come.

5. Inability to come due to severe agitation as in dementia with BPSD or Psycho-geriatric patients with more than one diagnosis on AIX 1 including psychoses - or other behavioral disturbances for whatever reason so that, families are having difficulty communicating with the patient / or difficulty convincing the patient to attend the appointment. Clearly the risks of deterioration if the geriatric consultation is not done are high.

6. A family member coming to seek psychoeducation or having an urgent question about the illness or something they read about the medications, this session will be registered under the elderly patient and patient is not in attendance so it is a proxy.

7. Due to geographical reasons and family members work circumstances, the patient might not be seen for two months and feedback about medications becomes unavailable to the Psycho-geriatrician to correct what needs to be corrected so, patients and families are presenting to A/E more frequently, putting unnecessary pressure on acute medical services for matters that could have solved by a proxy coming to the clinic once or twice in 1 or 2 weeks to adjust medications tightly. This will ease everyone's life when it is very hard for the family members to come with the patient to the clinic.

In All of the above a video or more for the patient 30 seconds in length is more than enough.
Remember: I am talking about the majority, the non-commendable patients.

Who should come face to face?
Patients who will be assessed for the first time needs to be seen face to face in the clinic or home visit face to face f cannot come
Those who can depend on themselves in all of their ADL
Those who are not bed bound, not attached to tubes or lines etc….
In other words, the opposite to the above is those who can come

The argument of the KPI for our non-clinical colleagues
- If I am treating the KPI I will reduce the number of the proxy sessions asking families to go back bring the patient so, the KPI will be happy but the patient and family will be at risk
- If I am treating the patient, I will do what is right from a clinical point of view by treating the patient making the patient safer and family happier so the NEW KPI should change to safer patient care and family satisfaction

Mohammed Allam – AL Ain BSI