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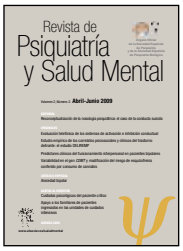

LETTERS TO THE EDITOR

Psychological care of critically ill patients

Cuidados psicológicos del paciente crítico

To the Editor:

In the holistic care of the critical patient physical or organic problems have to be addressed, but other problems, which may go unnoticed, such as the patient's psychological, spiritual or social needs, must not be neglected either. These other aspects of critical patient care are no less important, given that they may even influence the prognosis for the critical patient admitted to an intensive care unit (ICU).

Critical disease and the use of a large amount of technology will be associated with a series of psychological and emotional problems derived from the patient's admission, as well as sleep disturbances, which will have consequences, not only during admission, but even in the long term.

The large number of technical devices which may be used for a patient in an ICU creates substantial barriers, which impede physical contact between the patient and hospital personnel and the patient's relatives.[1] This may mean that the work that personnel do is more technical than should be the case in their profession, which comprises five aspects[2]: moral commitment to care provision; awareness of the vital significance that the process of falling ill has for the individual; taking into account the biological, psychological, emotional and spiritual aspects of the patient during the application of each care task; applying techniques and protocols from a logical and reflexive standpoint and, finally, an awareness that there is an interpersonal interaction and that care is not just the application of a procedure.

In the critical patient, both as a result of the disease itself and of the use of treatments, a series of psychological changes and, therefore, behavioural changes may be produced, which the professional must recognize and evaluate appropriately, exercising special care in the unnecessary use of sedatives to treat this problem; in this way the patient's suffering will be reduced and his morbi-mortality will improve.[3,4] Thus, we need to bear in mind that delirium, especially in elderly individuals admitted to the ICU, is very common, so that neurological disorders on waking, which will often be accompanied by delirious ideas, whether real or imaginary, will not be lacking.

We can provide a series of tips for avoiding, as far as possible, these psychological changes, for example enabling the patient to find his bearings in time and space, telling him repeatedly where he is, why he is there and who he is, placing a clock or calendar where he can see them, talking to him calmly and in a soothing tone, touching him gently so that he realizes that we are there. When we are with a patient who is having hallucinations we should not deny their existence or discuss them, and neither should we leave the patient's side. It would also be advisable to limit unnecessary alarms and to avoid conversations at the patient's bedside or in his room, as, even though we are not speaking about him, the patient may think we are and feel disconcerted. If hospital policy permits it, it is advisable to be flexible with respect to visiting hours. Placing familiar objects where the patient can see them may also help them to find their bearings. Finally, we must attempt to make the patient feel as comfortable as possible and minimize any painful stimuli.

In relation to sleep disturbances suffered by the patient admitted to the ICU, we ought to mention that sleep is affected not only as a result of the disease itself, but also because of the psychological stress the patient is undergoing and the effect of certain medications so we need to know these effects and alleviate them in so far as this is possible.[5] We know that sleep is an active and complex process, which is divided into REM phases, characterized by rapid eye movement, and NREM phases, which lack rapid eye movement. Research indicates that deep sleep and dreaming during REM sleep are essential to mental stability. A lack of knowledge of these phases of sleep means that evaluations or interventions that can alter the patient's ability to sleep may be performed.[6] Although the importance of the interruption of sleep in the critical patient has not been properly studied, we do know the effects of sepsis and widely used medications on sleep, the relationship between sleep and sedation and, finally, the physical and psychological consequences which its deprivation produces.[7]

Similarly, protocols for the daily interruption of sedation in critical patients which do not appear to produce adverse psychological effects have been developed and, moreover, they seem to reduce the incidence of post-traumatic stress.[8]

Our conclusions are, firstly, that we must not lose sight of the fact that ICU personnel, who handle a great deal of technology, must not neglect the care tasks which are intrinsic to their profession. They need to constantly remember that the recovery of the critical patient is not only physical but also psychological and that both aspects will have an equal influence on prognosis. We need to take

into account sleep requirements as part of the overall care of the critical patient and monitor the medications used to induce sleep on an individual basis, as well as all those medications which might affect it. Nursing care could be scheduled to ensure that periods of sleep are not interrupted: minimizing noise, reducing lighting during periods of sleep and ensuring tranquillity and support.

It is important for there to be a person in the multidisciplinary team which is looking after the critical patient who is in charge of addressing these non-physical aspects, which will undoubtedly result in earlier recovery of the patient in an intensive care unit. We propose the implementation of joint intensive and psychiatric care protocols when the critical patient presents problems involving behavioural changes and the vision of the psychiatrist or psychiatric nurse would be of unquestionable help. Furthermore, the incidence of post-traumatic stress in patients who have been kept in the ICU after they have been discharged to the ward should be monitored.

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Support for the relatives of patients admitted to intensive care units

Apoyo a los familiares de pacientes ingresados en las unidades de cuidados intensivos

To the Editor:

For any family having a family member in an intensive care unit (ICU) causes tremendous emotional pressure and it is the obligation of medical personnel to try to resolve their queries and help them prepare to cope with this stressful situation.

It is the relatives who implicitly take on board the medical facts and it is their responsibility to make decisions about the treatments that patients will receive. In a study we conducted,[1] our attention was drawn to the different attitudes of the people who were interviewed, depending on their marital status, it being the case that single patients demanded more participation in the decision-making process. This could correspond to an attitude in married patients which made them more inclined to delegate decisions to their partner or family than single patients, who are possibly more used to living independent lives and have fewer family ties.

Clearly the role that the family may have in decision-making is important to the patient,[2] and, this in addition to the actual crisis situation itself, which their relative's admittance to the ICU has precipitated, means that over two thirds of relatives of ICU patients experience symptoms of anxiety and depression,[3] which can affect their participation in the decisions which are taken at the end of the patient's life.

There should be training programmes for doctors and nurses to help them evaluate the relatives of ICU patients, assessing aspects such as attitudes, awareness, satisfaction, values, symptoms of stress, anxiety and depression, financial situation and social support.[4] Undoubtedly, this would help to achieve more effective communication, which could make being in the unit less stressful, leading to an improvement in relatives' psychological and mental well-being and ensuring that the experience leaves as few sequelae as possible.

The information offered to these relatives is extremely important and, although the majority are satisfied with the information they receive, as we demonstrated in another study conducted in this unit, we should make an effort to improve certain aspects: concerning ourselves a little more with the feelings of relatives and also explaining the technical equipment which is used for the patient in a simple way.[5]

Furthermore, it is very important to explain to the relatives of patients who are dying what is happening to them, why and how they will die, the palliative care applied to relieve their symptoms and how the family can accompany the patient during these last moments; all this will ensure that relatives understand and accept the