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

process more easily.[6] In another study, which was carried out in our unit and involved the relatives of patients who had died in the ICU,[7] although they were very satisfied with the treatment and care received by their relative, a significant difference was noted with respect to their need for additional information and their uncertainty about the fatal outcome of the disease and whether or not they should be present during the death process. The presence of relatives during the death process appears to dispel many doubts about the treatment received and it should be a general policy with patients who are thought to be about to die; this concords with the results of previous studies, which indicate that many patients feel that having one of their loved ones present when they die would contribute to a good death.[8]

To conclude, we can confirm that the relatives of patients admitted to ICUs have a series of needs that must be addressed to avoid long-term psychological sequelae. To do this, as part of the interdisciplinary team, there should be a psychologist or psychiatric nurse who is responsible for monitoring these aspects, which, undoubtedly, go unnoticed during the highly specialized and technicalized care provided in these units.

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