(LAmin 27 dB and LAmax 85.4 dB) – Fig. 1A. The 24-hour recording (from 9 am to 9 am of the next day) found a Leq 60.6 dB (LA min 27.2 dB and LAmax 102.0 dB) – Fig. 1B. Ethics approval was not required for this study, since no personal information was collected.

The recording of 24-hour noise shows a substantial reduction from daytime to nighttime noise; however, this also highlights that there is substantial daytime noise in the ward, which is potentially uncomfortable and inadequate to an elderly patient with acute medical illness. As for daytime noise, the World Health Organization recommends that the LAeq level should not exceed 35 dB in most rooms in which patients are being treated.

Although these results are exploratory and preliminary, they do suggest that daytime and nighttime noise and its consequences in patient health should be further studied, and awareness should be raised to this potential problem.

We consider that educational sessions could reduce daytime and nighttime noise and improve sleep quality among hospitalized patients. Therefore, we intend to evaluate the effectiveness of a protocol for non-pharmacological treatment of insomnia, which includes nighttime noise reduction.

The present project expects to have immediate effects in terms of improving health care provided to hospitalized patients, mostly elderly, where the improvement in sleep quality has multiple benefits. This could be the first step of a larger project focused on an 'elder-friendly hospital', where it is essential to raise awareness to this and other geriatric problems among healthcare professionals.

AUTHORS CONTRIBUTION

MA: Draft of the paper.

CT, JFS, NG, TF: Critical review and approval of the final version of the paper.

PROTECTION OF HUMANS AND ANIMALS

The authors declare that the procedures were followed according to the regulations established by the Clinical Research and Ethics Committee and to the Helsinki Declaration of the World Medical Association updated in 2013.

DATA CONFIDENTIALITY

The authors declare having followed the protocols in use at their working center regarding patients' data publication.

COMPETING INTERESTS

The authors have declared that no competing interests exist.

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Stigma among Physicians Towards Patients with Mental Health Disorders

Estigma em Relação aos Doentes Mentais pelos Médicos

Keywords: Attitude of Health Personnel; Mental Disorders; Physicians; Social Stigma
Palavras-chave: Atitude do Pessoal de Saúde; Estigma Social; Médicos; Saúde Mental

Dear Editor,

Recently, an interesting study regarding stigma towards mental health in medical students[1] raised an important question that should be the subject of extended discussion within the medical community – Psychiatric stigma in healthcare providers and, particularly, medical professionals. A study led by the Canadian Psychiatric Association showed that 79% of medical providers reported a first-hand experience of discrimination against psychiatric patients and 53% reported that they observed other medical collegues discriminating these patients.[2] These numbers demonstrate the magnitude of this problem. Stigmatization, defined as a "process wherein a condition or an aspect of a person is linked to some pervasive dimension of the target person´s identity" or "a mark of disgrace or discredit that sets a person aside from other"[3] leads to prejudice and discrimination and inevitable negative attitudes or behaviors towards mental health patients. These negative tendencies worsen

their global prognosis.

Although stigma towards mental health is a common problem across society, it should not be seen as a minor issue or even be tolerated as far as healthcare professionals are concerned because it increases barriers to accessing care and recovery, leads to delays in help-seeking, unsatisfactory therapeutic relationships, treatment abandonment and decreases the quality of mental and physical care of these patients.[2] Moreover, stigmatization within the medical profession may affect not only patients but also colleagues who have some mental disorder which ends up undermining the work environment and productivity,[2] and, ultimately, affects patient care.

Previous literature addressing mental health stigma in medical students has shown disparities regarding the effect of Psychiatric education in stigma, either reducing[4] or increasing it.[5] However, medical training could be an important opportunity to put in place specific interventions to reduce stigma in those who will have such direct contact with people suffering from mental disorders or experiencing vulnerable periods of their lives. Other strategies have also been suggested as being effective in reducing stigma such as teaching skills to deal with psychiatric patients, listening to testimonies of patients and their healthcare experiences, specific interventions to address unconscious biases and false beliefs, or by reinforcing how all healthcare providers may contribute to recovery from a mental disorder.[2]

More studies are needed to allow us to draw a clear picture concerning the dimension of this problem. However, evidence points to an imperative need of implementing specific strategies to reduce stigma in healthcare settings.

AUTHORS CONTRIBUTION

FN: Conception, design and first draft of the manuscript.
DTC: Critical review of the manuscript.

COMPETING INTERESTS

The authors declare no competing interests.

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Gestão de um Banco de Sangue Português Durante a Pandemia COVID-19

Management of a Portuguese Blood Bank During the COVID-19 Pandemic

Palavras-chave: Bancos de Sangue; COVID-19; Dadores de Sangue; Portugal; Transfusão de Sangue
Keywords: Blood Banks; Blood Donors; Blood Transfusion; COVID-19; Portugal

Caro Editor,

A pandemia de COVID-19 colocou desafios na gestão das reservas nos bancos de sangue a nível global.[1] Em Portugal, o maior banco de sangue hospitalar português, o Banco de Sangue São João (BSSJ),[2] sofreu, em março de 2020, uma redução em 30% do número total de dádivas, provocando um risco iminente de escassez de componentes sanguíneos.

Perante esta redução abrupta de dádivas, foi colocado em marcha um plano de contingência, que incluiu medidas como o apelo à dádiva através das plataformas digitais; o estímulo para o trabalho em equipa; o reforço do contacto com os médicos responsáveis pelos pedidos transfusionais e o incentivo à utilização de medidas incluídas no *Patient Blood Management* (PBM - conjunto de intervenções médicas e cirúrgicas com o objetivo de conservar e otimizar o próprio sangue dos doentes, corrigindo os principais fatores causais para a utilização de transfusão). A gestão dos componentes plaquetários, mais perecíveis, constituiu um enorme desafio em termos de autossuficiência do BSSJ. Assim, reforçou-se o contacto com os dadores de plaquetas, que receberam um telefonema do BSSJ na semana anterior à dádiva agendada, em que eram esclarecidos eventuais receios relacionados com a deslocação ao hospital. Esta medida permitiu um aumento de 16,8% do número de dádivas de plaquetas por aférese em 2020, contrariamente ao número de dádivas de sangue total, que sofreu uma redução de 10,3%. Na Tabela 1, encontram-se descritas todas as medidas implementadas pelo BSSJ no período pandémico, em consonância com a evidência relativa à importância da utilização de equipamento de proteção individual[3] e ao risco de transmissão do vírus SARS-CoV-2 por transfusão.[4]

Apesar da diminuição de dádivas, as necessidades