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EDITORIAL

Meeting Spiritual Needs: What Is an Oncologist to Do?

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The original report by Balboni and colleagues[1] regarding spiritual support is not a subtle message about a possible need for a few patients with cancer. It is a strong statement of a seriously unmet need in the vast majority of patients in our care. The authors found that 47% of the study patients with advanced cancer reported unmet spiritual needs by religious communities and 72% reported unmet spiritual needs by the health care system. If these figures were reported for any other dimension of patient care, cancer care settings concerned with quality would respond. How should we respond to patient needs for spiritual support?

The topic of spirituality is a reminder of another topic raised in the 1970s to 1980s in oncology, which was also a subject to be avoided—that of sexuality in cancer patients. Controversies of that era asked similar questions: do patients really care about this? Do they want us to talk about it? What if their preferences are different from my own? If I ask about it, what do I do when they voice concerns?

The authors of this research are to be commended for providing a comprehensive discussion about the implications of their findings. They conclude that physicians can participate in improved care by recognizing spiritual needs and by advocating for attention to religious and spiritual needs as a routine part of cancer care. This global recommendation is indisputable. Spiritual needs, like sexuality needs, will exist regardless of if we elect to address or ignore them.

So what is an oncologist to do? At a time of unprecedented time constraints and demands of complex patients, diminished staff resources, managed care demands, and the struggle to address even the most basic of disease and treatment concerns—where do spiritual concerns fit in?

To build on the general recommendations provided by Balboni and colleagues, I offer three specific suggestions.

MASTER THE SKILL OF A BASIC ASSESSMENT OF SPIRITUAL NEEDS

The first step toward meeting spiritual needs is assessment. Dr Christina Puchalski, founder of the George Washington University Institute for Spirituality and Health (GWISH) program, has advocated for physician education in spirituality and the first step of spiritual assessment in the form of the acronym FICA.

F – Faith, Belief, Meaning
I – Importance and Influence
C – Community
A – Address/Action in Care

The FICA tool provides a simple means of conducting a spiritual assessment. The GWISH program offers FICA pocket cards for use by physicians.[2] The FICA assessment offers oncologists a strategy and a prompt to include spiritual assessment as a component of care.

Becoming comfortable with spiritual assessment is no less challenging than becoming comfortable with assessing spirituality. But similarly, it can be guided by structured assessment and standard questions. The FICA card suggests the following:

Faith, Belief, Meaning. "Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds "no," the physician might ask, "What gives your life meaning?"

Importance and Influence. "What importance does your faith or belief have in your life? Have your beliefs influenced you in how you handle stress? Do you have specific beliefs that might influence your health care decisions?"

Community. "Are you a part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples, and mosques can serve as strong support systems for some patients.

Address/Action in Care. "How should the healthcare provider address these issues in your healthcare?" Referral to chaplains, clergy, and other spiritual care providers.

Assessment of spiritual needs, similar to other aspects of understanding the person with cancer, is not a one-time evaluation. As Balboni and her co-authors described, their study patients reported increased needs for spiritual support after diagnosis, unfortunately combined with lessened ability to participate in previous religious activities. The time of cancer recurrence or the progression of disease is a time to re-evaluate the patient's spiritual needs.

ONCOLOGIST, ASSESS THYSELF

Understanding and responding to the spiritual needs of a patient is facilitated by a spiritual self-assessment. One of the significant findings of the article by Balboni and colleagues is that religious concerns were more pronounced in patients of ethnic diversity. An important

implication here is that recognition of spiritual needs is a vital element of cultural assessment and culturally respectful care. The findings and discussion reported by these authors is framed within a Christian tradition including the "God Language" of their research instruments. Optimum spiritual assessment and care should include diverse religious beliefs and practices.

An additional important finding reported was that cancer patients who were more religious preferred care focused on extending life. This is of note at a time when the field of oncology is recognizing the importance of palliative care. Oncologists may unintentionally impose their own religious beliefs or values on patients and disregard strongly held beliefs about the sanctity of life, the belief in miracles, hope, and divine control over life and death decisions. This second recommendation of spiritual self-assessment offers us an opportunity to recognize aspects of our own spirituality that may impact our care.

BECOME AN ADVOCATE FOR CHAPLAINCY

The financial crisis impacting health care has resulted in greatly reduced budgets and elimination of programs and services. Chaplaincy is often the first service to be drastically cut or reduced to only a minor presence. It is not uncommon for one or two chaplains to serve an entire hospital with demands of patients, families, and staff addressing needs from initial diagnosis to the ritual and support required when death occurs.

Oncologists concerned with the overall quality of a cancer program can be a vital voice calling for preservation and even expansion of chaplaincy services. Chaplains can be included in interdisciplinary care conferences, advanced care planning, research and program development as well as in the design of support services for oncology staff.

Envisioning spiritual care as an essential element of cancer care is supported by several current quality initiatives. As cited by Balboni et al,[1] the National Consensus Project Guidelines for Quality Palliative Care[3] provides specific recommendations.

The first step toward advocacy is personal action. Refer to chaplaincy and serve as a model for other oncology professionals by including them in your plan of care. Balboni et al[1] reports 72% of patients with unmet spiritual needs. What percentage of patients do you and your colleagues refer to chaplaincy?

SUMMARY

Meeting the spiritual needs of patients with cancer is an overwhelming challenge. The mandate to improve spiritual care is echoed by the study findings reported in this article published in the *Journal of Clinical Oncology* that 88% of cancer patients report that this topic is at least somewhat important and frequently of extreme importance.

Oncologists play an important role in addressing spiritual and religious concerns. The recommendations in this article regarding spiritual assessment and advocacy are vital first steps.

Involvement of oncologists in spiritual assessment and advocacy for spiritual care is symbolic of a larger goal. The oncologist who dares to ask about spirituality imparts a vital message to the patient that they are being cared for by someone who has not forgotten that a broken patient remains a whole person and that healing transcends survival.

AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author indicated no potential conflicts of interest.

REFERENCES

1. Balboni TA, Vanderwerker LC, Block SD, et al: Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. J Clin Oncol 25:555-560, 2007

2. George Washington University: The George Washington Institute for Spirituality and Health. www.gwish.org

3. The National Consensus Project for Quality Palliative Care. www.nationalconsensusproject.org