Original Article

Evaluation of the FICA Tool for Spiritual Assessment

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Abstract

Context. The National Consensus Project for Quality Palliative Care includes spiritual care as one of the eight clinical practice domains. There are very few standardized spirituality history tools.

Objectives. The purpose of this pilot study was to test the feasibility for the Faith, Importance and Influence, Community, and Address (FICA) Spiritual History Tool in clinical settings. Correlates between the FICA qualitative data and quality of life (QOL) quantitative data also were examined to provide additional insight into spiritual concerns.

Methods. The framework of the FICA tool includes *Faith* or belief, *Importance* of spirituality, individual's spiritual *Community*, and interventions to *Address* spiritual needs. Patients with solid tumors were recruited from ambulatory clinics of a comprehensive cancer center. Items assessing aspects of spirituality within the Functional Assessment of Cancer Therapy QOL tools were used, and all patients were assessed using the FICA. The sample ($n = 76$) had a mean age of 57, and almost half were of diverse religions.

Results. Most patients rated faith or belief as very important in their lives (mean 8.4; 0–10 scale). FICA quantitative ratings and qualitative comments were closely correlated with items from the QOL tools assessing aspects of spirituality.

Conclusion. Findings suggest that the FICA tool is a feasible tool for clinical assessment of spirituality. Addressing spiritual needs and concerns in clinical settings is critical in enhancing QOL. Additional use and evaluation by clinicians of the FICA Spiritual Assessment Tool in usual practice settings are needed. J Pain Symptom Manage 2010;40:163–173. © *2010 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words
Spiritual care, FICA assessment tool, clinical evaluation

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Introduction

Over the past 15 years, there has been growing interest in and attention to spiritual care as a dimension of palliative care and the association of spiritual or religious beliefs and health care outcomes such as quality of life (QOL),[1] will to live,[2,3] depression,[4] and coping.[5] Implicit in the need to provide measurable patient outcomes is the need to demonstrate worth of specific services.[6–8] The National Consensus Project for Quality Palliative Care (NCP) and the National Quality Forum determined spirituality to be an essential element of care as described in Domain 5 of the NCP Guidelines: Spiritual, Existential and Religious Concerns.[9,10] Because spiritual care is important to the patient's health and a necessary domain of quality care, this aspect of care also will be essential to demonstrate efficiency and effectiveness of care. This presents a challenge to the whole ethos of spiritual care "because as spirituality becomes rationalized and reduced to make it manageable, it begins to lose the subjective and specific human experience, which makes it significant."[6]

In implementing other aspects of palliative care, there are clinical instruments for assessment of those domains, such as a social history or symptom assessments. Thus, one aspect of spiritual care often prioritized is the need for a systematic approach to spiritual history. This approach would allow the patient to share his/her spirituality or religion and would provide a means for obtaining measurable outcomes. A good spiritual history involves more than a simple list of organized religions. A spiritual history requires a broader inquiry of the patient's beliefs and values, their ability to find meaning and hope in the midst of suffering, recognition of the role of spirituality or religion in the patient's life, the importance of ritual, identification of faith traditions, and evaluation of the impact of the patient's current illness on spiritual well-being.

Patients facing a serious illness or the end of life may experience numerous spiritual concerns. Some of the most common include an inability to find meaning and purpose, hopelessness, anger at God, asking "Why?" and struggling with a will to live.[5,11–15] Palliative care clinicians need to be skilled in communication to assess, listen, and support patients and families through the process of illness, death, and bereavement. Additionally, the confidentiality implicit in the patient-provider relationship places the clinician in a privileged status, whereby the patient may feel safe in discussing spiritual issues.[16–20] Several articles have noted the ethical boundaries in discussing spiritual issues with patients, including respect, collaboration with spiritual care providers such as board-certified chaplains, and including a prohibition on proselytizing.[19,21,22]

A recent study by Phelps et al.[23] ($n = 345$) reported that most patients with advanced cancer (78.8%) relied on their religion to help them cope with their illness. A greater use of positive religious coping was associated with receiving intense life-prolonging treatment, such as mechanical ventilation or resuscitation, during the last week of life.

Past studies have shown that 41%–94% of patients and family caregivers want their clinicians to address their spiritual concerns.[24–28] In a study conducted by Ehman et al.,[29] 177 adult ambulatory patients with pulmonary disease completed an 18-item self-administered survey in which the key question asked patients to respond to the statement "If I become gravely ill, then I would like my doctor to ask whether I have spiritual or religious beliefs that would influence my medical decisions." Sixty-six percent of the participants responded that they would like their physicians to ask whether they have spiritual or religious beliefs that would influence their medical decisions if they became seriously ill.

McCord et al.[30] administered a questionnaire to 921 patients in the waiting rooms of four urban family practice residency training sites and one suburban private group practice in the Midwest. The goal was to determine when patients think it is appropriate for physicians to inquire about spiritual beliefs, reasons why they would like for this to happen, and what they want their physician to do with the information. Eighty-three percent wanted their physicians to ask about spiritual beliefs in some situations, 87% reported that the most important reason for wanting to discuss spirituality was for physician-patient understanding, 67% thought that information about

their spiritual beliefs would affect the doctor's ability to provide realistic hope, provide medical advice (66%), and change medical treatment (62%).

Balboni et al.[17] reported that 88% ($n = 230$) of advanced cancer patients considered religion to be at least somewhat important. However, almost half (47%) reported unmet spiritual needs by the religious community and 72% by the medical system. QOL was significantly associated with spiritual support from the community or medical system as was religiousness and wanting all treatment to extend life.

These studies provide examples of the paramount need for a spiritual history tool that is effective, comprehensive, and user friendly within busy clinical time constraints to facilitate health care professionals in providing care, which includes spirituality as a component of patient care.

Background of the FICA Spiritual History

An initial step in addressing spirituality in the clinical setting is to define the concept. "The absence of a clear definition of spirituality..." is a commonly repeated statement in the health care literature. There is in the literature recognition of the distinction between spirituality and religion.[21,24,31–34] A definition that is derived from a recent consensus conference is:

> Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred.[35]

A spiritual history is a set of questions designed to invite patients to share their religious or spiritual beliefs to help identify spiritual issues. It is to be patient centered and guided by the extent to which the patient chooses to disclose his/her spiritual needs. There are several tools available for taking a spiritual history, including the Systems of Belief Inventory (15R),[36] Brief Measure of Religious Coping,[37] Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being,[38,39] SPIRITual History,[40] FICA Spiritual History,[8] and HOPE.[41] Some of these instruments are intended primarily for research, whereas the others have been used primarily in the clinical setting for nonchaplain clinicians. These later clinical tools include FICA, SPIRIT, and HOPE, each of which has had minimal psychometric evaluation.

The FICA Spiritual History Tool, created by Dr. Christina Puchalski in 1996, in collaboration with three primary care physicians (Drs. Daniel Sulmasy, Joan Teno, and Dale Matthews) provides a way for the clinician to efficiently integrate the open-ended questions into a standard medical history and can be used by health care professionals (Fig. 1). The tool was developed in a consensus process, whereby the collaborators reviewed questions Dr. Puchalski used as a spiritual history in teaching medical students. They determined the key elements of what a physician or clinician would need to know about a patient's spiritual beliefs in the clinical setting. The tool has since been modified based on anecdotal feedback received from users of the tool. The FICA tool is based on four domains of spiritual assessment: the presence of ***Faith***, belief, or meaning; the ***Importance*** of spirituality on an individual's life and the influence that belief system or values has on the person's health care decision making; the individual's spiritual ***Community***; and interventions to ***Address*** spiritual needs.[8]

Methods

The aim of this descriptive pilot study was to provide preliminary clinical evaluation of the feasibility and usefulness of the FICA Spiritual Assessment Tool. The study was approved by the institutional review board of the City of Hope.

Seventy-six patients with solid tumors (breast, lung, colon, and prostate) participating in a larger National Cancer Institute-funded study (Reducing Barriers to Pain and Fatigue Management, R01-CA115323-4; B. Ferrell, principal investigator) in the medical oncology ambulatory clinics of a comprehensive cancer center were asked if they would be willing to answer questions regarding their spirituality. Their responses were written on the survey or recorded by the nurse in writing. Eligibility criteria were based on the larger study and included 1) cancer diagnosis more than one month, 2) age older than 18 years, and 3) English speaking. Patients were asked the FICA interview questions by the research

FICA Tool	
F – Faith, Belief, Meaning	**Religious/Religiosity** – Pertains to one's beliefs, behaviors, values, rules for conduct, and rituals associated with a specific religious tradition or denomination (O'Brien, 1999). **Spirituality –** Generally, an "individual's attitude and beliefs related to transcendence (God) or to the nonmaterial forces of life and of nature…the dimension of a person that is concerned with ultimate ends and values" and meaning (O'Brien, 1982, p. 88; Taylor, 2006).
• Do you consider yourself spiritual or religious?	
• Do you have spiritual beliefs that help you cope with stress?	
• What gives your life meaning?	
I – Importance and Influence	
• What importance does your faith or belief have in your life?	
• On a scale of 0 (not important) to 5 (very important), how would you rate the importance of faith/belief in your life?	
• Have your beliefs influenced you in how you handle stress?	
• What role do your beliefs play in your health care decision making?	
C – 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?	
A – Address in Care	**We have talked a lot about your spirituality and/or religious beliefs and how they may or may not be of help to you during your illness. How can your health care providers best support your spirituality?**
• How would you like your health care provider to use this information about your spirituality as they care for you?	

Fig. 1. FICA Tool.

nurse, generally in a private room in the clinic setting. Patient demographic data and items assessing aspects of QOL were derived from data collected in the parent study using the City of Hope-QOL Tool, a 45-item multidimensional tool encompassing four domains of physical, psychological, social, and spiritual well-being based on the QOL conceptual

model developed by the investigators.[42] Each of the 45 items is measured using a 10-point Likert scale. Internal consistency reliability using Cronbach's alpha is 0.77–0.89 for the four subscales and 0.93 overall. Measures of validity of the generic patient version include content validity with the Functional Assessment of Cancer Therapy instrument ($r = 0.78$) and factor analysis.

Content analysis of the FICA interview questions was used to develop relevant themes or categories to understand subject's responses to the four items of the tool including: **F**aith, **I**mportance and Influence, **C**ommunity, and **A**ddress. Using content analysis methods described by Waltz et al.,[43] data were summarized from each open-ended question, and all data were entered into preliminary tables by question. Responses were coded by the investigators. All data were reviewed independently by the three investigators, who assigned codes as key themes to the content. The investigators then jointly reviewed the data and created final summary tables, which were reviewed and discussed. Descriptive analysis of demographic data was conducted, as well as descriptive and correlational analysis of the QOL item scores and FICA.

Results

Demographic Data

Table 1 presents the demographic characteristics of the sample. Patients were predominantly female (77.6%), had a mean age of 58.7, and 50% were ethnic minorities. Most patients self-identified with a religious preference, with Catholic as most predominant. Breast cancer was the most common diagnosis.

Table 1
Patient Demographics ($n = 76$)

Variables	Frequency	Percentage
Age	Mean = 58.68 Standard deviation = 11.88 Range = 25–87	
Gender		
Female	59	77.6
Male	17	22.4
Race or ethnicity		
Caucasian	38	50.0
Hispanic or Latino	26	34.2
Mixed or Other	5	6.6
Asian	3	3.9
African American	2	2.6
Native American	2	2.6
Marital status		
Married	46	60.5
Divorced	12	15.8
Widowed	9	11.8
Never married	5	6.6
Living with partner	3	3.9
Education (highest achieved)		
College	25	32.9
High school	21	27.6
Graduate or professional	19	25
<High school	11	14.5
Religion preference		
Catholic	33	43.4
Protestant	22	28.9
None	10	13.2
Other	5	9.2
Jewish	2	2.6
Jehovah's Witness	2	2.6
Diagnosis		
Breast	33	43.4
Lung	18	23.7
Ovarian	11	14.5
Colon	10	13.2
Prostate	4	5.3

Importance of Faith or Belief From FICA

Table 2 presents the descriptive data from the single-item FICA quantitative measure. After completing the open-ended items of the FICA survey, subjects were asked "On a scale of 0 (not important) to 5 (very important), how would you rate the importance of faith/belief in your life?" These data were transposed for analysis to a 0–10 scale for comparison to the QOL items rated on a 0–10 scale.[44] The mean score was 8.4, indicating the subjects' belief that spirituality was an important aspect of their experience of illness.

Quantitative Assessments of Aspects of Spirituality

To understand the potential relationships between aspects of spirituality, correlations were computed among variables. Data for

Table 2
Single-Item Measure of the Importance of Spirituality

$n = 76$	
Mean	8.40
Median	10.00
Standard deviation	2.83

Scale: 0 = not important to 10 = very important

this analysis included the items of the Spiritual Well-Being subscale of the QOL tool (spiritual activities, change in spirituality, uncertainty, positive life change, purpose, and hopefulness) and the single items of pain, control, anxiety, depression, and isolation from the physical and psychological subscales of the QOL tool. These five variables from the other subscales were selected from the QOL tools as aspects of QOL recognized as potentially contributing to spiritual distress. Additionally, the single-item QOL rating was included. Correlations above $r = 0.30$ are included in bold in Table 3 to illustrate variables with moderate or strong correlation. The most significant information is italicized in Table 3, presenting the correlation of the FICA quantitative item with the other variables. It is interesting to note that the FICA item was moderately correlated with all items of the Spiritual subscale and the subscale total, with the exception of the uncertainty item, and the FICA item was not associated with the physical symptom items.

Qualitative Analysis of FICA

Tables 4–7 present the summary of themes from the qualitative analysis of responses to the FICA tool and representative comments from this question. Table 4 is a quantitative summary of key issues in response to the "F—Faith/Belief/Meaning" themes. The most common responses were related to appreciation of life and family followed by life activities. Other responses addressed issues such as relationship with God and many other broad aspects of spirituality.

Table 5 presents the quantitative summary of the responses to the question of "I—Importance and Influence" themes and examples of patient comments regarding the importance and influence of spirituality. Respondents expressed most often that faith or spirituality was important or very important, and that helped them cope or control their stress. Interestingly, a number of subjects stated that their faith or spirituality was a major factor in their treatment decision making.

The "C" of the FICA tool asks about patient's spiritual community. Subjects most often referred to family and friends whose general support was seen as spiritual support, or in specific examples, subjects referred to these supportive others who were praying for them or were part of a church community. Table 6 presents the quantitative summary and comments.

The final question "A" of the FICA tool asks how the patient wishes spirituality should be addressed in their care. Some subjects expressed beliefs that health care providers should focus on the "medical aspects" of care and should not focus on spiritual needs. Others did feel that attention to spiritual care was supportive, and a chaplain should be available (Table 7).

Discussion

This study was intended to advance the growing interest in spiritual care as an essential domain of palliative care. Subjects were able to complete the FICA tool and identify those aspects of their lives that provided greatest spiritual support. Patents also were able to communicate their beliefs when spiritual care needs were met and they did not need attention from professionals, which is helpful as clinical settings attempt to use resources most efficiently.

This sample was ethnically diverse, with 50% being non-Caucasian. Future studies also should seek to include more diverse religious preferences and those with no religious affiliation. From a methodological perspective, the investigators believe that having both qualitative and quantitative measures of spirituality was very beneficial and would be important in future research. The authors also recognize that further evaluation of the FICA tool should be done within the clinical practice setting by clinicians to further establish feasibility of spiritual history in practice.

Quantitative data did show that the FICA tool was able to assess several dimensions of spirituality based on correlation with the spirituality indicators in the City of Hope-QOL tool, specifically spiritual activities, change in spirituality, positive life change, purpose, and hopefulness. This latter finding is not surprising as, anecdotally, clinicians find that inquiry into spiritual beliefs of patients opens the door to conversations about many issues the patients may be experiencing such as depression or anxiety. McCord et al.[30] also found that patients felt an increased sense of trust with

Table 3
Inter-Item Correlation Matrix of Items From QOL Tool and FICA Quantitative Rating

	Religion	Activities	Change	Uncertainty	Positive	Purpose	Hopeful	Pain	QOL	Control	Anxiety	Depression	Isolation	Spiritual Subscale
Activities	**0.617**													
Change	**0.459**	**0.433**												
Uncertainty	0.173	0.104	−0.190											
Positive	**0.421**	**0.457**	**0.508**	0.114										
Purpose	**0.422**	**0.412**	**0.352**	−0.25	**0.391**									
Hopeful	0.299	**0.346**	0.225	0.186	0.268	**0.650**								
Pain	−0.173	−0.237	−0.131	−0.007	−0.188	−0.129	−0.046							
QOL	0.065	0.139	0.030	0.272	0.160	0.223	**0.321**	0.298						
Control	0.069	0.019	0.009	0.100	0.016	0.177	**0.392**	0.183	0.458					
Anxiety	0.043	0.069	0.043	**0.503**	0.013	0.043	0.115	0.186	0.249	**0.336**				
Depression	0.045	0.063	0.085	**0.465**	0.044	0.005	−2.35	0.122	0.097	**0.304**	**0.702**			
Isolation	0.230	0.169	0.074	0.145	0.078	0.012	0.136	**0.311**	**0.346**	**0.454**	**0.376**	**0.560**		
FICA quantitative	***0.535***	***0.545***	***0.405***	*0.014*	***0.306***	***0.568***	***0.369***	*0.208*	*0.115*	*0.024*	*0.063*	*0.037*	*0.066*	***0.467***

Key: actual items used
Religion = How important to you is your participation in religious activities such as praying, going to church?
Activities = How important to you are other spiritual activities such as meditation?
Change = How much has your spiritual life changed as a result of cancer diagnosis?
Uncertainty = How much uncertainty do you feel about your future?
Positive = To what extent has your illness made positive changes in your life?
Purpose = Do you sense a purpose/mission for your life or a reason for being alive?
Hopeful = How hopeful do you feel?
Pain = To what extent are general aches or pain a problem for you?
QOL = How good is your quality of life?
Control = Do you feel like you are in control of things in your life?
Anxiety = How much anxiety do you have?
Depression = How much depression do you have?
Isolation = How much isolation do you feel is caused by your illness/treatment?
FICA Quantitative = How would you rate the importance of faith/belief in your life?

Table 4
Quantitative Summary of Key Issues in Response to the "F—Faith/Belief/Meaning" Themes[a]

Faith/Belief/Meaning Themes	$n = 73$
Appreciation of life and family	47
Life activities (work sense of purpose, friends, accomplishments, self-sufficiency, and productivity)	31
Faith or hope in healing or in a higher being	18
Relationship with God or serving God	12
Appreciation for everything in life	7
Reading Bible	5
No identified faith tradition or agnostic	5
Positive state of mind	5

Examples
FICA001: Yes, I consider myself Catholic. I seek God almost every single day. I thank him for another day in life and… for opening my eyes to everything that's around me—the flowers, the trees, the beauty of things, the beauty of people. And, uh, I'm happy that I have the faith and that I have a lot of people that have been praying for me and my recovery. Oh, my family. I just love my family… I want to see my grandchildren grow up and enjoy life, you know, with my husband, get old with him.
FICA004: I guess spiritual in some way, not formally religious because I was raised Catholic but I don't practice anymore. But I did appreciate the chaplain coming to see me. There's something about that that just makes you feel—just makes you feel good, so I did appreciate that. You know, everybody says, "Our thoughts and prayers are with you." I guess I appreciate that. I have a lot of friends who are religious and say that prayer helps them and I say, "Well, I hope your prayers help me."
FICA007: Oh religious, well both. But spiritual kind of has a bad connotation, lots of people feel spiritual is a cop out… People can go to church regularly and be religious and not have a spiritual life so I would have to say both. God's in control and he is using me in some way… There have been a lot of people in our church with cancer… many of whom have died, but have been content… with their disease and situation and trusting God… the ones that have died they're like a great cloud of witnesses to me. They're my heroes… I got people in Turkana, Japan, Italy, Africa praying for me… I love the people in my church…I love being at my church… I have been blessed with a real good wife, who when she came to Christ uh just showed a difference… she wasn't pushy or anything but she was there for me.
FICA034: I consider myself a spiritual person not a religious person. We don't attend a church. But I do believe in a Higher Being and I have had to come to terms with my own mortality… as far as I feel there is a God… there's some plan to all of this and I have been given something that's difficult to get through, but I don't believe that I've been given anything more difficult than I can do… I do a lot of visualization, to maintain my level of anti-nausea… I call it "going to my zero place"…that helps my spiritual being as well.
FICA036: I am a Christian. With God nothing is impossible… He has moved mountains for me. One thing I have realized is that it's not about me. I'm here to give Him the glory. I meditate on God's word… I believe that God is God and he is in control… I stand on His words. God is the whole source of my life. I just realize I am here to love Him, to serve Him, to serve my family, to serve others. It's just a neat time.

[a]"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?"

physicians who conducted a spiritual history. It may be that having that increased sense of trust enables patients to feel more comfortable about sharing issues like depression.

The spiritual history tool FICA is also able to provide a framework for clinicians to open the door to discussion about those things that are of meaning to patients, such as family, work, and faith. It also provides information about things that are supportive to patients such as spiritual communities or spiritual sources of strength. FICA also can give information on spiritual beliefs affecting health care decision making. As seen from the data, all these factors are important in a patient's health care outcomes, including coping. This study provides a tool that can help elicit important clinical information.

Many patients surveyed in this study felt that they wanted their spirituality to be integrated in some way in the clinical plan, but many felt that these needs were met outside of the health care system. Asking about spirituality may be most important as an aspect of respectful care for people during illness, enhancing the patient and provider relationship rather than necessarily impacting the treatment plan.

Summary

This study attempted to evaluate the FICA tool, and the findings lend support to the importance of spiritual care as an aspect of quality patient care and use of the FICA tool as a valuable instrument for clinical assessment. Responses to the FICA questions reveal the depth and breadth of spirituality, and the many opportunities for addressing

Table 5
Quantitative Summary of the Responses to the Question of "I—Importance and Influence" Themes[a]

Importance and Influence Theme	n = 73
Faith is important or very important	56
Faith helps control stress	40
Prayer/faith as factor in treatment decisions	26
Faith equips in preparing/fighting/coping illness	10
Faith is not important/minimal importance	9
Faith helps make meaning	7
God is in control/does not give "more than we can handle"	5

Examples
FICA001: Without faith and belief there is nothing, so you have to have faith in God that he's going to help you through this and also help your family to cope with it. So, having faith and showing that you have faith is very important. I try not to get stressed any more, because I find that some of these things that bring stress are so tiny compared to… how life is for other people.
FICA002: Well, you know, God's in control of everything and for me to believe that he lost control when I got cancer is a pretty odd thing to think. I've come to the other side of this cancer and realized that with God even this cancer is a positive thing. Our relationship, husband and wife, is now closer. We had a good marriage. It was surrounded by our mutual belief in Christ… Stress is really just a feeling of chaos. When we're stressed it's because we don't think somebody's in control. And if you understand that God's always in control, there's no reason to be stressed out. I also believe the grace of God is enough to allow us to face anything.
FICA012: What importance does it have? I think it makes sense of your life. I do believe that things happen for a reason. I do believe that there are lessons that we're supposed to learn while we're here on this earth. I think it helps you get through situations that seem unfair.
FICA032: My faith is of foremost importance in my life. I've attended church continuously since childhood and I was a Sunday School teacher. Yes, reliance on my belief helps me to deal with stress, which is generally relieved through prayers. When making health care decisions, I offer prayers of thanksgiving and ask God to aid in my decision making.
FICA036: That is the whole substance of being… Definitely. It calms me. It assures me. It gives me light. It gives me hope. He directs my path. I would say no because I just know that… Dr. X is a gift from God. I think he anoints doctors and nurses to take care of the sick. The ultimate healer is God, but he uses his people, medicine.

[a]"What importance does your faith or belief have in your life? Have your beliefs influenced you in how you handle stress? What role do your beliefs play in your health care decision making?"

patients' search for meaning, faith, hope, and relationships at the end of life. There is a need for extensive additional research to further evaluate the FICA tool and other approaches to spiritual assessment and intervention.

Table 6
Quantitative Summary of Key Issues in Response to the "C—Community" Themes[a]

Community Key Themes	n = 73
Family/friends	49
Church	26
Prayer	8
Does not identify with a community	5

Examples
FICA002: Absolutely. My church is a spiritual community. And also there's a whole network of people on the internet. I sent out one letter and about three days later (Name of Spouse) gets a letter… unsigned and it's anonymous… Somewhere in Florida someone got that letter from somebody else and sent it to (Name of Spouse) in hopes of helping me… there's a whole internet full of people who are part of that…You've never met any of these people, but I know they're there… there's also (Name of Spouse) and then I'm part of a church staff… there is also my Bible study group.
FICA005: My church. Yes, people constantly kept in touch either through phone or cards. There are the few times I was able to get to church… and they mentioned my name under "Prayers and Concerns" when the time came in the worship service to pray for people and our prayer chains are always praying for me. My family, first and foremost, and my church family, then my friends, and I have a really close relationship with my work colleagues.
FICA034: Only amongst family and friends. Like I said, we do not go to an organized church, so talking with friends and being with family members in that respect—that's my community.
FICA035: Yes. It's a support because—it's the Catholic Church that I belong to. I'm a Eucharistic Minister, and again it's the bonding with the people there and the other ones that have gone through cancer episodes and, you know, the care is there—the hug, the handshake. My colleagues at work are like a professional sister group. I have a group that I'm with at church. I have another group that I'm involved with and that would be our junior high group when we graduated from junior high, so you know, 40 years ago; we're still in touch. And my family group is the most important.
FICA036: Yes, ma'am. Yes. I am involved in a Bible study and they pray for me. We just meet each other's prayer needs there. Oh, yes. My husband, my children, my precious grandson, my sons-in-law, my parents, sisters—oh, my. This list could go on and on. I'm very loving.

[a]"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.

Table 7
Quantitative Summary of Key Issues in Response to the "A—Address in Care" Themes[a]

Address in Care Themes	$n = 73$
Not necessary	15
Be supportive	13
Unsure	10
Should be addressed	8
Provider should do what they believe is best	7
Chaplain availability	6
Provider should not be involved	5

Examples
FICA001: Um, I'm at loss for words there. Uh, as far as faith goes? The support of the family and friends and religious beliefs that will help them pull through this… And the doctors, I mean the doctors are very important with helping the patient, you know, look at things in a positive way.
FICA010: I think it's to be more open with it. A lot of people don't like to talk about it. They think that it's a very private thing. Some people are embarrassed to bring it up like the health care provider to a patient… they don't want to bring it up because they think that they shouldn't and I think that it's important to people.
FICA011: Well I would feel that as a health care provider if someone started leaning on me from a religious point of view I would probably uh fire him or her. Spiritual guidance or whatever. Yeah well I wouldn't, I wouldn't look forward to that okay? As far as my health needs I hope to find good doctors, good health people to guide me you know. But I don't feel a need for spiritual guidance or whatever.
FICA034: In my health care? I think here at City of Hope they do, because they have the social work department. I've had long discussions with nurses. I've become friends with several of the nurses and staff here, so I think they do address that. They are willing. The attitude here is that they're willing to talk with you about more than just your physical well-being, your mental and social well-being are as important to the staff here. Over the years in the 12 years that I've been a patient, I've had many late-night discussions with nurses. If I'm fearful of this or that, they'll come in and that accessibility is always there.
FICA059: They can remind us patients to utilize and activate own support systems and spiritual practices to honor them in the hospital.

[a]"How should the health care provider address these issues in your health care?"

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